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CASTE, UNEQUAL STATUS, AND DISCRIMINATORY ACCESS TO HEALTH SERVICES IN INDIA

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Health Disparity and Health Equity in India: Understanding the Difference and the Pathways Towards Policy

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Health is essential in all spheres of everyday life. It is crucial for well-being, longevity, and for availing economic and social opportunity. Therefore, resources and services needed to be healthy to go beyond medical care. Living and working conditions which promote health assume greater importance as they have the potential to reduce the need for medical care (Daniels, 1981; Daniels et al., 1999). Therefore, the discourse on health needs to begin from the socioecological framework and move towards the biomedical through the biopsychosocial. The health promoting elements require to be distributed according to need, rather than treated as commodities which can be accessed based on one's economic propensity. Evidences are aplenty that health status is contingent to health promoting environment, and imbalances in this environment are likely to produce disparities, inequities and inequalities in health.

Disparities, Inequities and Inequalities in Health

It is necessary to understand that health disparity is embedded in health differences linked with economic, social, and environmental disadvantages. As evident from the *Healthy People* (2020), 'Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.'

In this definition, economic disadvantage refers to inability to purchase goods and services, due to low income. Social disadvantage includes economic disadvantage, one's position in social hierarchy based on economic resources, ethnicity, caste, religion, gender, sexual orientation, and disability. These characteristics often determine the behaviour of others towards the 'self' and the group to which 'self' may

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belong. The environmental disadvantage refers to a poor neighbourhood with social disadvantages.

Therefore, achieving health equity is possible only when social determinants of health address poverty (Marmot, Friel, Bell, Houweling, Taylor, & Commission on Social Determinants of Health, 2008; Williams, & Mohammed, 2009; Adler, & Stewart, 2010; Braveman, & Gruskin, 2003); discrimination (Williams, & Mohammed, 2013; Braveman, Egerter, & Williams, 2011), and work environment (Burgard & Lin, 2013; Pickett, & Wilkinson, 2015) in which people are born and continue to live. Poverty and discrimination accentuate vulnerabilities, including powerlessness (Wallerstein, 1992), lack of access to resources, services, and opportunities—all of which are crucial for good health. Achieving health equity requires eradicating barriers and improving access to the resources known to affect health. These resources primarily include work opportunities (Burgard & Lin, 2013), education (Cutler, & Lleras-Muney, 2006; Egerter, Braveman, Sadegh-Nobari, Grossman-Kahn., & Dekker, 2011); housing (Banerji et al., 2018; Gordon-Larsen, Nelson, Page, & Popkin, 2006); and healthcare services and health-promoting environment (Gordon-Larsen, Nelson, Page, & Popkin, 2006), particularly for those who lack access to resources and have poor health (Daniels, Kennedy, & Kawachi, 2000; Marmot, 2015). Health and well-being can be impacted positively for everyone, but should be prioritised for the excluded or marginalized groups (Rawls, 1971; Pickett, & Wilkinson, 2015). Thus, poverty and discrimination emerge as core causes of health inequity.

Health equity and health equality—both engage with improving outcomes and increasing access to services, especially for underserved populations and marginalized groups. 'Health equality' means giving the same opportunities, care, and services to all. For instance, a medical professional may offer the same service, or provide the same information to all, without taking cognisance of any plausible risk. The likely assumption is that everyone has been treated equally and therefore, they are not biased. Health equality, therefore, focuses on treating everyone the same and ensuring equal access to healthcare. Health equity, however, aims to end, or at least minimise institutional and discriminatory barriers that create inequality. The factors within the healthcare system (racism, casteism and sexism); as well as factors outside the healthcare system (poverty and unequal distribution of resources and opportunities) come under the fold of health equity. It is based on the principles of fundamental justice with a goal to ensure equal access to quality healthcare and good health. It emphasises on distributive justice requiring more support and resources to the underserved, excluded and the marginalised populations.

This issue of the journal has engaged with such realms of health. The essays assorted for this issue have addressed the question of health inequality and health equity; and in doing so, the endeavour has been to understand health differences and health disparity.

The essay on 'Public Policy, Social Identity, and Delivery of Healthcare Services in India' authored by G. C. Pal, engages with community and the delivery of services through the intersections between the public policy processes, dynamics of social

identity of care service providers and users, and the consequent access to healthcare. Pal, in doing so, highlights that the delivery of healthcare services is *fraught with social injustice*. The dominant socio-cultural norms around social identity supersede the intent of the healthcare centres and the providers to address the health needs of all. This essay brings together the superimposition of inequality and inequity in understanding delivery of care. From the perspective of the providers, health equality has been addressed as they impart care and other related service to all without any difference. However, the differential access to resources due the social identity makes it imperative to ensure that the healthcare providers recognise the impact of social determinants of health and strategize for addressing them as important. A doctor, for instance, has to acknowledge that some people may have limited access to healthy food. Therefore, they would be required to plan the ways to overcome this deficit and minimise the risks for health. Thus, health equity approach takes into account differences in socio-cultural characteristics, access to resources, and economic status (Daniels, 1981; Daniels, Kennedy, Kawachi, 1999; Braveman, Gottlieb, 2014; Dwivedi, 2017).

Structural Hierarchies and Health

Navin Narayan's essay raises some moot questions of structural hierarchies and juxtaposes them on the notion of health justice—drawing from equity framework. In most countries including India, as the author argues, the justice system functions in favour of the *wealthy and powerful* while the underprivileged remain devoid of justice given the context of health equality. He traces the connect between social stratification moorings and access to healthcare and corroborates that in an unequal society, the underprivileged remain entrenched in deprivation and marginalisation (Dias & Welch, 2011) which affects their health (Braveman, 2006; 2010;) all the more when the health professionals adhere to the principles of equality rather than equity (Whitehead, Dahlgren, 2006). Thus, social inequality affects everyday life in which health is intrinsically intertwined. The author argues that in a society dedicated to the ideal of equality, evidence of equality remains non-existent, sporadic at best. He draws an engaging parallel with the science of immunology to explain this persistent inequality. The *culturing* technique from immunology has been used by the privileged Indian society for *culturing casteism* through the *Sociology of Sufferer—or the healthcare seeker—and Sociology of Supremacy'*—of the healthcare profession and professionals. The author highlights that casteism is cultured in both these spheres; and uses empirical evidence to establish the dominance of privileged groups in nurturing casteism in health. It is illustrated that the privileged groups occupy best of professional as well as care seeking realms by virtue of their privilege.

Some essays in this special issue of the journal focus on specific population groups to reflect on their health through realms of inequality, disparity and equity. The essays reflect on 'health disparity' which needs to be seen as different from 'health difference'. While the empirical evidence suggests that different groups have different

health outcomes, yet health disparity is not the same as health difference. While difference is reflected through biological markers, health disparities are due to social values which lead to differences that are unjust and preventable.

The essay on Hadis by K. M. Ziyauddin traces the historical disadvantages which have perpetuated health inequalities and hampered the processes of minimising disparities in health. The author traces the historical journey of the Hadis in asserting themselves and opting out of their conventional cleaning occupations in search of alternatives. He also highlights their contribution in building urban spaces. Their engagement in sanitation work keeps the urban environment clean, while they experience health hazards of varying degrees. Health disparities, are socially influenced, and cause different but preventable outcomes across different social groups—as is evident in the case of Hadis. Very little has been studied about this community—certainly not from the perspective of health. The author adds a new dimension to the existing discourse by engaging with the question of right to city for these crusaders of cleanliness. Through the empirical evidences, the author exemplifies their exclusion from the city—which they sanitise at the cost of their own health—to the margins, both metaphorically and physically.

The Pandemic

In a just society, everyone has to have a fair chance to be healthy, since health is integral to well-being—physical, economic and social. Health differences can be understood by the following example. Uterine cancer affects women aged 50 years and above. Those less than 50 years are less likely to be affected. Therefore age is the factor causing illness differential. However, if women with certain socio-economic characteristics (such as low income and low social rank) are affected more than the others, then it is health disparity. This is a difference that is unjust and preventable. Disparities are socially influenced and cause different but preventable outcomes among groups. In some cases, health equality can overcome disparities, especially when the disparities are due to unequal treatment. The studies on COVID-19 address this aspect. The state was providing safeguards to everyone 'equally' without any distinction. But this equality could overcome disparity in certain situations. Differentially endowed care facilities and ill-prepared care providers were restrictively addressing the needs of the underprivileged as compared to the privileged population—both socially and economically. By and large, 'equal treatment' accentuated the pandemic. Care provisioning for the privileged groups is likely to have minimised the disparity among them, but not across the social groups—broadly the privileged (or advantaged) and the underprivileged (disadvantaged).

The essay on media coverage of COVID-19 and portrayal of the marginalised population by Achla P Tandon raises questions on the role of media in inducing prejudice, stigmatising and inflating social inequality. The media's portrayal of 'infectors' with specific labels, based on religion (Muslims), region (North-East India), and work (biomedical waste/sanitation/ cremation related) aggravated the

already existing prejudices. It affected the already vulnerable health of all; but more of the disadvantage groups. Media reporting was selective. COVID-19 induced health inequality was reported as disparity, when the need was of health equity in order to address the differential needs of the people, infected as well as affected by COVID-19. The author highlights that the crowdsourced data and the online platforms reflected on the multiple vulnerabilities of those who were stranded in the camps consequent of the lockdown. It is noteworthy that the larger share of these people were from socially and economically marginalised groups. The unprecedented health emergency required to be dealt with caution while reporting the situation, or the safety protocol or the perils of those in need of healthcare. Mainstream media was minimal in reporting on the marginalised population in the camps and as they travelled to their place of origin amidst the lockdown. Much of the information on such groups was made available by the non-government/community-based organisations. Taking this issue of marginalised population and COVID-19 forward, the essay by Dilip Diwakar G. et al. focusses on the migrant workers, more than 90 per cent of whom are from underprivileged populations synonymous with the administrative categories of Scheduled Castes, Scheduled Tribes and the Other Backward Classes. To understand about their health and livelihood issues during COVID-19, the authors have tracked the rural-ward distress migration of the informal sector migrant workers in Kerala. Engaging with health equality notion, the authors use the state mechanism to address COVID-19 in general and its impact on the Dalits (Scheduled Castes) migrant workers in particular. Using the mixed method approach, the authors examine the lives, livelihoods, and healthcare utilisation by the migrant workers; and lived experience of interstate Dalit migrant workers who have adopted Kerala as their workplace. While the quantitative analysis of empirical evidence suggests that health disparities not only existed, but were accentuated by COVID-19, the narratives drawn from the field for qualitative analysis reiterate the higher vulnerabilities among the Dalit migrant workers.

Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. Medical education is often an issue relegated to the background by academics in the area of health as well as education. Khalid Khan draws from his training in economics to confront some stark markers of differentials leading to inequality. He explores access of the students belonging to diverse background, to medical education in India. Using secondary data and robust statistical techniques, he highlights that the social inequalities precede social injustices and thus affect access to a career in medicine which is linked to the caste/ethnicity and religious identities. The author focuses on the differential access to medical education which is aggravated for the students from the underprivileged background. The high cost of medical education in itself becomes a negative factor in creating enabling environment for the underprivileged. The probability of attending medical courses is relatively lower for Scheduled Castes, Scheduled Tribes and the Muslims than the

Hindus High Caste as has been illustrated by the author as supported by data. The essay captures social inequalities and disparities to comment on the access to medical education in the light of it high cost.

Allopathic Supremacy in Medical Hierarchy

The discourse on health inequality or disparity usually engages with the healthcare system predominated by the allopathic supremacy. Despite the rich legacy of alternative systems and local healing traditions, the advent of allopathic medicine systematically eroded the existing systems. Supported by the market, largely pharmaceuticals, the local systems embedded in AYUSH and local healing were relegated to secondary positions. The process also affected the care providers, many of whom, such as bone setters and traditional birth attendants, for instance, have a specific social identity (Acharya, 2022). They mostly hail from scheduled communities—both caste and tribe. Aptly titled *'Addressing Hegemony within the System of Medicine for an Inclusive and Sustainable Health System: The Case of Traditional Medicine in India',* the essay authored by Nemthianngai Guite, showcases the dominance and interplay of the power relations and social structural inequalities. She illustrates that power relations and social structural inequalities are crucial to encourage and perpetuate medical hegemony. The author's commentary on codification of and regulations for traditional medicine systems, raises some pertinent question on inequalities in health—of yet another kind—in professionalization, commoditization and in access to intellectual property rights. The initial superiority attributed to the allopathic medicine is due to the 'supremacy of the 'developed' West as compared to the 'developing' and colonised oriental countries including India'. However, at present the transition is largely due to differential access to medical education (see Khalid Khan's article); and medicine systems for care-seeking as well as care-provisioning. The author argues for the due recognition to the practitioners of traditional medicine systems; and preservation and protection of their knowledge for inclusive, equitable and sustainable health system.

Caste Identity-induced Inequality

Similar to COVID-19 specific studies, Raushan et al. examine caste identity-induced inequality in child health outcomes such as mortality, malnutrition and anaemia. Using the NFHS data of two decades, the authors examine the association of socioeconomic factors with child health outcomes through Disparity Ratio (DR) and Concentration Index (CI). The association of socioeconomic factors was also tested using logit regression. It was found that the marginalised groups were more likely to have poor health outcomes as compared to the other. This essay becomes relevant in the context of the public policies. Health equality ensures for all the same opportunity to access healthcare, while health equity prioritizes justice. The authors draw a connect between the two by emphasising on the need for transition from *same opportunity to all*, to prioritising access to the most needy, thereby moving towards health equity. For the public policy process, the authors allude to an intersection between *equality-based*

approach, whereby everyone would get the same healthcare funding and services; and an *equity-based approach*, where by access to care services would depend on the care seekers' needs. For example, all the *Hadis* engaged in the cleaning occupations (see Ziyauddin's essay), would have the option to have a regular medical check for their infections, etc., and fitness test to carry out the work. This essay establishes the persisting disparity and inequality in child health and nutrition with high burden among the underprivileged populations of the Scheduled Castes and the Scheduled Tribes despite the affirmative action induced progress in emancipating some such groups.

Public Spending on Health: We Need to Invest More

The policy environment for health in India inevitably crosses paths with health investment. Given the low share of public spending on health, despite increase post COVID, we still remain one of the countries with lowest public health spending: 1.0 per cent of the GDP. Even countries like Bhutan (2.5 per cent), Sri Lanka (1.6 per cent) and Nepal (1.1 per cent) with lower national income, spend more on their people's health. Notably, India's per capita public expenditure on health increased from ₹ 621 in 2009–10 to ₹ 1,112 (around $16 at current exchange rate) in 2015–16. However, it is still nominal, compared with other countries. Switzerland spends $6,944 on health per capita, the United States spends $4,802 and UK $3,500. The Union Budget 2021–22 proposed to increase healthcare spending to 2.2 trillion Indian rupees ($30.2 billion). The need to enhance public health spending to at least 5 per cent of the GDP has been proposed for a very long time. The pandemic affected all sectors, but the already weak health sector was worst hit. The government increased the expenditure on public healthcare in 2021–22 by 73 per cent from 2020–21 to ₹ 4.72 lakh crore (Economic Survey, 2022). According to the National Health Accounts estimates for 2014–15 (MoHFW, 2016), the Government Health Expenditure (GHE) per person per year is only ₹ 1,108, or about ₹ 3 per day. In contrast, the Out-of-Pocket Expenditure (OPE) of ₹ 2,394, accounts for 63 per cent of the total health expenditure. The WHO's health financing profile for 2017 shows 67.78 per cent of total expenditure on health in India was paid out of pocket, while the world average is just 18.2 per cent. It is noteworthy that if such is the scenario for all, then given the marginalisation and exclusion of the underprivileged population, GHE of ₹ 3 per day is likely to further reduce for the underprivileged groups.

Indrani Gupta's essay titled 'Health investments to reduce health inequities in India: do we need more evidence?' co-authored with Avantika Ranjan, illustrates this. Authors categorically states that inequalities in health outcomes and treatment-seeking behaviour contribute the most to multi-dimensional poverty. High out-of-pocket spending continues to be a critical for India's health sector, as, they reiterate, the negative impact of continued low of public investment on health. They illustrates with the COVID pandemic reflecting on the inept preparedness of the country to address the health needs due to the pandemic. The authors have unequivocally advocated for *a resilient health sector* which can be put in place by improving the infrastructure,

recruiting personnel, and enhancing supplies and training. While this essay does not deal with social identity-induced inequalities, the authors rest their argument on regional and economic disparities leading towards inequalities in health. They also relate these persistent inequalities with the COVID situation. Drawing from the evidence that most poor are among the underprivileged groups—largely the SCs and the STs, their observations on multidimensional poverty and its linkage with health outcomes mark the accentuated vulnerabilities of the underprivileged groups.

Taking this forward is the essay on the hierarchy in the health workforce in the public and private sectors authored by Rama V. Baru and Seemi Zafar. This essay adds to the idea of enculturing casteism in health (see Navin Narayan in this issue). Intersecting religion, class, caste and gender, the authors reiterate that the health workforce is hierarchical in structure (skill and capacity); and social composition. This essay highlights that most of the studies on the health workforce have focused on the public sector, although the private sector in health has a significant share of the total health workforce. Baru and Zafar hinge on the existing literature and relevant data—drawn from primary and secondary sources, to inform that there is *under-representation of minorities and women as owners of private health services*. The authors also highlight the gender bias in the health workforce whereby the middle and lower rung positions are occupied by women and men located at the lower end of the caste-class hierarchy. In contrast, those at the higher end of the social rank are also located at the higher work hierarchies. Drawing from the statistics on composition of occupational groups, the authors reiterate that there is domination of Hindus, followed by Muslims and other minorities respectively as 'Physicians and surgeons'. As 'Nursing and Other Technicians' too, proportion of Muslims was lower than other minorities. The authors observe that the representation of Christians in the healthcare workforce reduced with increase in participation by Hindu and Muslims women. Corroborating the earlier work (Baru, 2005; Iyer et al., 2005) they reiterate that these nurses were mostly from the underprivileged groups and their remuneration was very low. The *untrained workers like dais (traditional birth attendants) were predominantly from the* Scheduled Castes; and about two-thirds of the Auxiliary Nurse Midwives (ANMs), were upper and middle class Hindus, while only one-fifth were from underprivileged communities (SCs and STs); and a negligible share was from the Muslims and Christians. This essay establishes the connect between social inequalities and access to resources needed to become care providers, thereby also reflecting on social disparities which perpetuate the inequalities in access to medical (and para medical) education (see Khalid Khan in this issue). Access to medical education is determined by disparities which are socially influenced, very often, unjust and therefore preventable. Better socio-economic propensities, act as enablers for access. Among those who can access, some reach higher positions in their work hierarchies while the others have to settle for lower positions in their work hierarchies. Thus, given the differential access to resources consequent of marginalisation, the outcomes are different. However, these differentials which act are the barriers in access, are preventable through affirmative action policy. However, it is noteworthy that while state's motive of affirmative action as defined,

is to bring about parity between historically deprived and the advantaged population groups, the social reality induce prejudices and biases which inevitably demand more competence from the deprived to be able to prove themselves equal to the privileged.

Sub-group Disparities

The differences in access to health resources are analysed to understand disparities among Dalit sub-castes in the essay authored by Kanhaiya Kumar. The author examines the disparities in socio-economic status of various sub-castes within Scheduled Castes, drawing from a study located in a selected district of Uttar Pradesh, the state with largest population in India. Using mixed method approach, perceptions about health, illness and disease have been studied to provide the context of the prevalence of morbidity across subcastes among SCs. The concentration curves based on the primary data and quantitiative methods, reflect on the disparities in out-of pocket expenditure, possession of landholding and income among the sub-castes within the SCs (or Dalits). The author corroborates that like major social groups (SCs, STs, OBCs) and Others) have differences and disparities, there are differences in access to health resources among various sub-caste of Dalits (SCs) too. Using the empirical evidences, the author establishes that these disparities are a function of an intersection between social identity, socio-economic status and geographic location of healthcare services. Therefore, it is imperative to understand and identify the differences and distinguish them from disparities within sub-castes. This will enable one to overcome the gap between their health needs and accessibility to healthcare services; and also build a transition from health equality to health equity. For instance, the most marginalised sub-caste is likely to be worst affected by a given illness condition as compared to the least marginalised sub-caste. When adjusted for social, economic, infrastructural and environmental differences, such as access to quality care, distance and availability of the health providers, there is no significant difference in morbidity conditions between the most and the least marginalised sub-caste. This suggests that preventable issues account for the higher morbidity among the most marginalised sub-caste group, rather than any pre determined differences. These issues include access to quality care, the type of care a person receives, and social inequality that undermines health (Daniels et al., 1999; Deshpande, 2000, Goli et al., 2013; George, 2015).

Health Disparities, Equality and Equity: Why We Need to Know the Difference

Health disparities and health equity are interlaced. Health equity connotes social justice in health. In other words, no one is prevented from availing the opportunity to be healthy, because of belonging to a historically disadvantaged group(s). Health disparities enable measuring progress toward achieving health equity. Low health disparities reflect on greater health equity. This can be achieved by selectively improving the health of those who are economically and socially disadvantaged, not by providing equal access to all; or by impairing the health of the privileged or advantaged groups (Keleher, & Murphy, 2004; Whitehead, Dahlgren, 2006).

Health inequality and disparity are known to be discriminatory. It is difficult to identify and prove intentions and actions as discriminatory. The often extended reason is that medical practitioners are wedded to the Hippocratic oath and hence have very little scope for discrimination. But as humans, located in the hierarchical social structure, greater harm to health may be done as a result of unintentionally discriminatory processes and structures (Williams, Mohammed, 2009; Borooah, 2010). Considering that the discrimination no longer exists, processes and structures which persist as the socially sanctioned prejudices and biases —religious and ethnic segregation, caste based exclusion, call for enforcement of affirmative action for ensuring access to health resources—ranging from medical educational and training and care. Even when the conscious intent to discriminate is often not recognised and passed as unintentional, such intent perpetuates economic and social disadvantages and influences health consequences across generations and population groups.

The essays in this issue of the journal may not have addressed the human rights issue as central to health, but all are knitted through the understanding and addressing of the links between health equality and equity; difference and disparity. The authors converge in thinking about the transition from equality to equity; and distinguishing between health difference and disparity; and alluding to the need to work toward minimising the disparities in the process of enhancing health equity. The human rights principles of non-discrimination and equality are inevitable in addressing health disparities. These principles are based on equal rights (to health) for all. The State is obligated to promote health through public policies and affirmative action embedded therein. The State is also required to prescribe policies that are prejudiced and discriminatory against particular social groups. Therefore, predominance of health literature from equality perspective needs to be understood from disparity and equity lens.

In addition to the articles based on the theme of this special issue, two more articles feature in the forum section. In his article, Chief Justice, High Court of Orissa S. Muralidhar has touched on the theme of access to justice and legal representation of the marginalised communities in the Indian justice system. He has not only highlighted the challenges faced by the marginalised communities, but has also tried to make comprehensive suggestions towards institutional reforms in the justice system. The article by C. Jerome Samraj discusses the manifestations of academic untouchability and exclusionary practices in admissions in higher education institutions. The essay attempts to understand the nature of the practice of untouchability in higher educational institutions in India and the politics behind the method of implementing reservations in admissions in higher education institutions.

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Being Insider-Outsider: Public Policy, Social Identity, and Delivery of Healthcare Services in India

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Abstract

The pivotal role of community level workers in the delivery of public services is well-recognized. But, they often fail to provide equal opportunities to all 'eligible' beneficiaries to utilize a variety of public services. Although several predisposing household factors are held responsible for inequalities in access to the public services, in recent times, one factor that has been recognised as critical to such unequal access is the 'exclusionary nature of social relations' based on social identity embedded in the social life of village community. It is also argued that certain sections of the population are deprived of equal access to public services due to their social identity, which is different from service providers. However, the question remains–whether it is the social identity of users or providers of public services that is critical to unequal access to various services? What will be the extent of utilization of public services when the social identity of both users and providers of the services remain same? Do the social dynamics of the community life play any role in the delivery of public services? This essay addresses these questions in the context of delivery of integrated nutrition and healthcare services at the community level under the largest national flagship scheme of Integrated Child Development Services (ICDS). Drawing evidence from a larger sample survey of over 4000 household beneficiaries and 200 service providers, the essay sheds light on how the delivery of healthcare services is fraught with social injustice due to dominant socio-cultural norms around social identity despite the values of healthcare centres to cater to the health needs of all sections of society.

Keywords

Public policy, social identity, village community, delivery of healthcare services

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Introduction

Public policy prescribes specific norms and guidelines for the delivery of public services in order to fulfill a set of objectives. Functionaries in public institutions are expected to deliver public services in a specific manner, and address the needs of all sections of society. While majority of public institutions function within larger social contexts, there are institutions which operate within local social structures. Given that dominant socio-cultural norms, beliefs and practices at a societal level often become salient to influence the thoughts and behaviours of individuals (Hogg, 2015), this may have implications for the service providers working in close association with the community in particular.

The health sector of India has witnessed significant improvement in public health infrastructure in the forms of availability of public health centres and sub-centres, and community health centres. However, inequities in access to healthcare services continue to persist. Despite the expansion of public sector healthcare facilities, socio-economically disadvantaged groups continue to derive lower benefits from various health services. Macro level data based on national level survey validates inter-group inequalities in various health outcomes (IIPS, 2017). It is often argued that this has much more to do with poor living conditions and lack of access to healthcare facilities (UNICEF, 2013). They are mainly affected due to inequities in the availability, utilization and affordability of health services (Baru et al., 2010).

In recognition of the concern of persistence of group inequalities in access to nutrition and healthcare facilities, while the National Health Policy (NHP) -2017 has a specific focus on most socio-economically vulnerable groups (NHFW, 2017), the National Nutrition Strategy (NNS) prioritizes interventions to address nutrition and healthcare needs of various target groups (MWCD, 2017). Evidently, public policy initiatives on nutrition and health include a 'multi-sectoral strategy' to strengthen the delivery of the integrated nutrition and health services. In this regard, the role of the national flagship scheme of Integrated Child Development Services (ICDS) is assumed most significant. Given that basic health care services are largely provided at public health centres and community health centres with the aim of reaching out to all sections of people, lower access of marginalised communities to healthcare facilities raises questions not only on the functioning of the service delivery system but also the health delivery behaviours of service providers.

In the context of village community, one factor that has been recognised as critical to the inequality in access to various public resources and services is the phenomenon of 'exclusionary nature of social relations' based on social identity of people. A body of literature around the social identity framework (Tajfel, 1982) establishes that in a stratified society, various social identities not only govern the intergroup social relations but also shape the behaviours of individuals towards each other primarily based on social categorization into 'in-group' and 'out-group' (Tajfel and Turner, 1986). Socio-psychologically, the need to maintain a distinct identity through downward comparison (Wills, 1981) serves as a psychological function for the differential behaviours towards each other (Hogg, 2015).

In the Indian context, caste has been a prominent social identity category and caste-based discrimination is one of the most complex human rights issues. In line with the social identity framework, the hierarchical structure associated with caste and identification of members with their caste group remains salient to influence individual behaviours significantly. The quest for necessitating caste identity frequently urges individuals to indulge in reproducing the discriminatory rules of the caste system (Jaspal, 2011) and this effects the structure of opportunities (Hoff and Pandey, 2006). The significant role of caste identity in accessing public resources and services, particularly in rural areas has been documented extensively. But, this is largely seen from the perspectives of high and low caste groups in general, with scant and limited focus on the social identity of the service providers in the delivery of public services.

In the healthcare system at the community level, the public functionaries like the Auxiliary Nurse-Midwife (ANM) and Anganwadi Workers (AWW) form the major proportion of health workers cadre. Although, an ANM provides health services to women and children in public health sub-centres, she also plays a key role in providing healthcare at the community centres like AWC along with AWW as per the healthcare needs of the community. While ANM provides specific services to women and children, the AWW plays an important role in health services like weight monitoring, visiting pregnant women to understand healthcare needs, providing supplementary nutrition, visiting newborn children, referring for health services, and educating adolescent girls about healthcare. These workers, irrespective of their caste identities, are expected to deliver healthcare services in compliance with service delivery norms. However, in the delivery of all nutrition and health services under ICDS at a community level, the AWW plays a vital role in close association with target groups. Their performance determines the extent of utilization of these services. The question that this essay explores is: Are there any variations in the access to specific healthcare services across caste groups in villages with low caste and high caste AWW?

Following the universalization of ICDS in 2005, there has been an expansion of the nutritional and health intervention nets. A network of community-based centres, popularly known as Anganwadi Centres (AWC) remains the focal points for delivery of integrated nutrition and health services. Although, the operational aspects of AWC have been examined over the years, the equity and inclusion aspects in relation to delivery of various nutritional and health services remain a major concern (Borooah, 2012; Gill, 2012; NAC, 2011; Pal, 2016). Several studies clearly indicate not only poor health status of people from socially-marginalised groups but also lower access to healthcare facilities (Acharya, 2013; Acharya and Pal, 2017; Bansod, Salve and Jungari, 2022; Baraik and Kulkarni, 2014; Baru et al., 2010; Borooah, 2010, 2018; George, 2016a, 2018; James, 2016; Nayar, 2007; Raushan and Mamgain, 2021; Shah et al., 2006). Studies also indicate discriminatory practices in delivery of health services based on social identity (Acharya, 2010, 2013; George, 2018; Thapa et al., 2021).

However, there are studies which indicate unequal access to nutritional and health services delivered under the ICDS (Borooah, 2012; MWCD, 1015; Maity, 2016; Mittal and Meenakshi, 2015; Sinha, 2006; Swain and Kumaran, 2012); besides

discriminatory and exclusionary practices against certain sections of people based on their group identities (Diwakar, 2014; Mamgain and Diwakar, 2012; Mander and Kumaran; 2006; Pal, 2016, 2021). Avoidance of home visits by the community level service providers based on social identities of healthcare seekers is a common practice of exclusion and discrimination (Acharya, 2010, 2013; Pal, 2016; Shah et al., 2006). During delivery of various health services at institutional and household levels, while a few typical discriminatory behaviours of service providers are explicit, many occur in subtle manner.

The linkages between social identity and healthcare thus assume significance when we look at the group inequality in health status, deprivation of health facilities by certain groups, and evidence of exclusionary practices during delivery of health services, and consequently unequal access to health services. Despite considerable research on inequities in healthcare, a significant knowledge gap exists with regard to the nature of exclusion and discrimination faced by different marginalised groups in accessing nutrition and health services at a community level. The effect of the social identity of the service providers on delivering nutrition and health services under the ICDS remains a neglected issue. For example, the evidence on various forms of discriminatory practices or behaviours against low caste beneficiaries as a rule is linked to the social identity of the high caste service providers and community members. One of the most dominant views is that the high caste identity of the service providers and their unfair treatment against low caste people has implications for their unequal access to nutritional and healthcare services. But the question that arises is: In villages where the service provider is from a lower caste, will it affect the utilization of healthcare services and health-seeking behaviors of low and high caste groups differentially?

In recent times, few studies draw attention towards the social identity of healthcare providers in the context of denial of access to health services. George (2016b) while looking into inclusion in healthcare delivery system using macro level data concludes that denial of access to health services for marginalized groups occurs due to lack of accessibility to health services and the practice of discrimination by various healthcare personnel at public health centres like, doctors, nurses, assistants, ANM, etc. However, the argument is made based on macro level data on the social profile of healthcare personnel at public health centres which may not adequately reflect actual discriminatory behaviors. At the interpersonal level, the personnel like doctors and nurses might not have awareness of social identity of care seekers in many cases, to manifest any unfair or exclusionary behaviours. In another study, Verma and Acharya (2017) examine discrimination in the context of the caste identity of the ANM as health service providers from public health centres. It focuses on the experiences and perceptions of beneficiaries in relation to the social identity of the service providers and vice versa. The study indicates how the caste of health service providers and seekers shape their perceptions towards each other, leading to limited social interaction between them and inequity in healthcare services. However, these observations are based on a relatively small sample and case study approach. Further, the study has

a specific focus on service providers like ANM who visit villages intermittently and households rarely, and health seekers use to have limited interaction with ANM for specific health services delivered mostly at care centres (AWC) or in a location away from a low caste locality.

This essay draws attention towards some research questions in the context of delivery of and access to healthcare services under the ICDS at the community level. These include: How do the social identities of the 'targeted' beneficiaries and service providers under ICDS matter in access to healthcare services? Do low and high caste households have equal access to healthcare services provided through community-based centres like AWC? Are there any differences in access to healthcare services in the villages with low and high caste AWW? What challenges do the low caste AWW face in delivery of healthcare services in mixed-caste villages? Thus, special attention is given on the utilization of various healthcare services delivered by the service providers with different social identities, and understanding the challenges that low caste service providers face in delivering services to diverse social groups. An attempt is also made to understand institutional and household determinants of utilization of healthcare services, and psychosocial implications of differential access to healthcare services, and unfair behaviours of service providers. The essay, thus takes a holistic approach to understanding the complex linkages between the caste identity of care seekers and service providers, and access to healthcare services at a community level given dominant social-cultural norms based on social identities of people.

Methods and Data Base

This essay is primarily based on community level data collected during 2012–13 through a large sample survey of over 4000 households and 200 service providers (AWW) at AWC spread across nearly 200 villages in three states. A multi-stage sampling method was used to select mixed caste villages whereas purposive sampling was used to select sample households across social groups as beneficiaries of healthcare services under ICDS. Household data was primarily collected from women because of their overall knowledge about how they utilize services and a limited data from small children of households. Further, the service providers under ICDS interact largely with women and children while delivering various healthcare and nutritional services. Data was collected using a household schedule designed specifically for the study purpose. The household data were supplemented by over 200 focus group discussions (FGDs) with women from different social groups.

Service providers' data primarily included experiences and perspectives of AWW in relation to delivery of various services across social groups and challenges that they face during service delivery at a community level. Data was collected using an institution interview schedule to document facilities and functional aspects of AWC and details about experiences of main functionary (AWW). Besides, institutional data included observations of normal functioning of AWC. Thus, data sets included issues

on the delivery and utilization of various healthcare services, besides other information about household beneficiaries. The analyses based on both quantitative and qualitative data have been structured around the specific research questions, mentioned earlier.

Key Findings

The findings discussed in the following sections are related to access to healthcare services across social groups at a community level under the ICDS scheme, experiences and perspectives of beneficiaries of healthcare services, access to healthcare services in the villages with low caste and high caste AWW and challenges that the service providers face during delivery of healthcare services, household and institutional determinants of healthcare services, and psycho-social implications of unequal access to health services.

Differential Access to Healthcare Services

This section addresses the question: What are the intergroup differentials in the access to healthcare services provided by AWC at the community level? The differentials examined across social groups (low and high caste) in access to different health services by target groups include children between ages 0–6 years, pregnant women and lactating mothers and adolescent girls. As per the ICDS norms, most health services are to be delivered at household levels. For this, visits of AWW to households/hamlets of different social groups remains critical. Results indicate that the frequency of visits of AWW to households vary across groups with a higher number of AWW visits to high caste households. The differentials in home visits would have bearings on access to specific health services. The results however show that low caste households have relatively higher utilization of overall health services as compared with high caste households. (see Table 1)

With the exception of home visits by the service provider within one week of the birth of a child and growth monitoring of children between 0–3 years of age, low caste households show higher utilization of a majority of services for different target groups. The difference between percentage share of low caste and high caste beneficiaries was found the highest for services like supplementary food during a prior pregnancy (10 per cent), followed by weighing and monitoring the growth of children between 3–6 years (9 per cent), immunization of children between 3–6 years (8.2 per cent), and Janani Suraksha Yojna (JSY) entitlements (5.8 per cent). It was lowest for the service of immunization of children 0–3 years and health-related counseling for women. As per the norms, during pregnancy, women are entitled to supplementary nutrition for six months. Although the percentage share of women receiving supplementary nutrition in the form of 'take home rations' during pregnancy is conspicuously higher for low caste women (58 per cent) compared with high caste women (48 per cent), a majority of women beneficiaries (86 per cent) receive it for up to two months. However, a higher percentage of high caste women receive it beyond two months or for a higher number of days. For example, while about 13 per cent low caste women receive supplementary nutrition beyond 2 months, the figure for high caste women is about 19 per cent.

Results show that a relatively higher percentage of children between 0–3 years from low caste (80 per cent) are beneficiaries of at least one health service than high caste children (75 per cent). However, it varies for different services like care after birth, immunization, Vitamin A supplements, health check-ups and weight monitoring. While the percentage of children between 0–3 years who are beneficiaries of growth monitoring and immunization does not show group difference, a higher percentage of high caste households are beneficiaries of home visits by AWW within one week of childbirth, and a higher percentage of low caste households are beneficiaries of Vitamin A supplementation. Among the healthcare services, the percentage of beneficiaries was considerably higher for immunization and growth monitoring for both age groups of children between 0–3 years and 0–6 years. The fact is that immunization is a programme activity for children and growth monitoring is one of the regular activities. In contrast to no group difference for children between 0–3 years in access to immunization and growth monitoring, a considerably higher percentage of low caste children between 3–6 years have access to these services. The latter may be due to a higher percentage of registered low caste children in AWC, opening better opportunities for access to these services at an institutional level. Notably, adolescent girls have the worst access to nutrition and health-related services. Only about 6–9 per cent adolescent girls utilized services like nutrition and health education/counseling and IFA supplementation. The percentage of adolescent girl beneficiaries is found relatively higher among low castes.

Table 1: Percentage of households across social groups which receive health and nutrition-related services for women, children and adolescent girls

Category	Specific Services	Low Caste (in percentage)	High Caste (in percentage)
Pregnant Women and Lactating Mothers	TT injections and health check-ups	35.6	32.5
	Iron and Folic Acid supplementation	33.0	30.1
	Supplementary food during a prior pregnancy	58.2	48.3
	Monitoring of weight	31.4	28.8
	Health-related counseling	48.9	48.2
	Janani Suraksha Yojna (JSY) entitlements	29.6	23.8
	Counseling on feeding behaviours	20.7	24.6
0-3 Year Children	Home visits within one week of birth	30.5	34.2
	Weighing and growth monitoring	57.1	58.6
	Immunization	62.4	62.3
	Vitamin A supplementation	49.2	45.9
3-6 Year Children	Weighing and growth monitoring	70.8	61.9
	Immunization	68.1	59.9
Adolescent Girls	Nutrition and health education/ counseling	9.4	6.0
	IFA supplementation	9.7	7.7

Source: Field Survey

Contrary to studies showing a lower access of socially excluded groups to various public services, the low caste households have a higher utilization of nutrition and healthcare services provided through ICDS at the community level. However, the question remains as to whether the group differences indicating better access to many health services among low caste households, is 'supply-driven' or 'demand-driven'. When many of these services are highly required by low caste households and with lack of better alternatives, they might have higher demand and reach out for various services when compared with high caste households. This may be investigated in future research by looking at the processes of accessing various services. To some extent, this can be understood later from the analysis of differences in service delivery at two delivery points: institutional and household.

Another critical issue is that although low caste households have higher utilisation of various health and nutrition services, are there identity-based exclusionary bias and discriminatory behaviors during delivery of services? In view of the limited scope of this essay for a detailed study of this aspect, some cases in point are discussed in the following section. Results based on FGDs indicate different forms of discriminations experienced by low caste beneficiaries in access to health services. According to household data, 62 per cent low caste households report that high caste AWW do not come inside/enter their houses. As shared by low caste women in some villages:

> 'High caste AWW rarely visits houses of low caste to extend assistance to pregnant and lactating mothers. In this village, a three-month pregnant low caste woman even did not get TT injection.'

> 'High caste AWW does not come to our hamlet rather distributes supplementary nutrition from her house.'

> 'Till today no member from our hamlet has seen AWW. There is [a] reason for not coming here. She is [the] daughter-in-law of [a] high caste who does not like to come to our house.'

When responding to the question of whether the AWW touch children and women while providing health services like weighing and providing polio drop?, nearly half of the low caste households report in negative terms. This is also substantiated by statements made by low caste women during FGDs, as below:

> We do not like to visit ANM due to preferential treatments to high caste women. ANM does not visit low caste colonies but visits high caste colonies regularly whenever she comes to [the] village. While she provides health services to high caste households in their colonies, [she] asks AWW to call low caste women to high caste localities for health services.

> Although ANM visits village just once every month, she normally performs her duty sitting at AWC. Both ANM and AWW sit at AWC only. Low caste women have to walk to AWC to visit them and get their health check-up even

> during the pregnancy, and also have to bring their small children for health services. Both ANM and AWW practice untouchability when they deliver health services like weight monitoring and body check-up.
>
> Low caste women do not want to come to ANM, as they do not receive proper timely information, besides discrimination that they face in the form of preferential treatment. Despite the fact that we reach the AWC first, we are asked to sit or stand outside AWC for long whereas high caste women occupy space inside AWC. We remain vulnerable to aggressive gestures, abusive words and other caste-related derogatory remarks.
>
> During the last stage of pregnancy and the first few weeks of delivery, women normally do not want to go to AWC for a check-up because of the risk of moving out and waiting for long periods for immunization. As ANM does not visit low caste localities and many women do not come to AWC meeting, many pregnant women and lactating mothers are deprived of timely immunization and other health-related services. Yet, ANM will sometimes visit the high caste localities for health check-ups due to pressure from a few high caste persons.

Low caste women also report similar experiences of discrimination when they go to the AWC to receive supplementary nutrition. Given the focus of the essay on health services, their experiential accounts in this regard are not discussed.

Social Identity, Service Providers and Utilisation of Healthcare Services

The Anganwadi Centres (AWC), one of the last rungs of the government system, is largely located within community. A majority of AWC functionaries belong to the village community and serve as community workers. They play key roles in providing healthcare and nutrition services nearer to home although many health services under the ICDS are delivered in coordination with other health workers from the formal primary health care system. But, unlike other health functionaries, AWW as a public community worker in the care centre (AWC), remains connected with each household in the community on a regular basis, and facilitates linking households to many health facilities. Although public health facilities have increased over the years, still people mainly from socio-economically marginalised groups in villages find it difficult to have easy access to these facilities. The AWW, as a local resident worker, facilitates the processes for better utilisation of health services. Within the public policy framework, when there is always a need to ensure accountability with the community, the role of AWW remains crucial given the delivery of several integrated public services under ICDS for different 'target' groups, including strengthening and facilitating access to healthcare services and also offering referral health services.

The critical question that has been a major focus of this essay is: Does the caste of the AWW, the main service provider in the community care centre (AWC), matter in access to and utilisation of health-related services? In specific terms: Are there differences in the utilisation of health services by the eligible household beneficiaries across social groups in the villages with low caste AWW (LC-AWW) and high caste AWW (HC-AWW)? This section presents some findings based on household data on utilization of health services in relation to the caste of the AWW in villages. As a practice, AWW play a role in providing health services in collaboration with ANM from the nearest health centre. But in case of certain health services, the AWW plays a significant role. The results reveal that the access to nutritional and health services by the households varies by the social identity of the AWW.

The data indicates a perceptible difference in the home visits of low and high caste AWW to households of different social groups to provide various services including health services. While 62 per cent households in villages with LC-AWW report frequent visits of AWW, 51 per cent households in villages with HC-AWW respond the same. The disaggregated data by the caste of households indicates that a higher percentage of high caste households (62 per cent) report the visits of LC-AWW compared with 52 per cent reporting visits of HC-AWW.

This is further corroborated by visits of AWW for specific services, for example, visiting the newborn child at home. While 42 per cent households in villages with LC-AWW report AWW visits for this purpose, only 25 per cent households in villages with HC-AWW report the same. Both low and high caste households had similar responses on the visits of LC-AWW and HC-AWW for newborn child. The factor of 'avoidance of home visits' is found to be important behind the dislike towards the AWC. In villages with LC-AWW, only 7 per cent households attribute the non-visit of AWW as the cause of disliking the AWC, whereas 15 per cent households in villages with HC-AWW have similar responses. Further, a higher percentage of households (41 per cent) report visits of HC-AWW to similar caste and well-off households compared with LC-AWW (26 per cent). Thus, findings suggest that LC-AWW make more home visits to both low and high caste households than the HC-AWW. The views of the household respondents on AWW home visits to an extent corroborated with AWW self-reporting. A considerably higher percentage of LC-AWW (77 per cent) than HC-AWW (64 per cent) report their visits to individual households.

Thus, it is evident that more visits are made to high caste households by both high and low caste AWW either due to preference or pressure. HC-AWW frequently avoid visiting low caste households due to caste bias. The differences in the visits of LC-AWW and HC-AWW are however not found consistent with access to certain health services. For example, growth monitoring of children between the ages of 0–3 years and 3–6 years is found to be better in villages with HC-AWW. A higher percentage of low and high caste households receive growth monitoring for children between 0–3 years in villages with HC-AWW (61 per cent and 56 per cent, respectively) compared with LC-AWW (54 per cent and 49 per cent, respectively). The corresponding figures

for children 3–6 years are 34 per cent and 37 per cent respectively in villages with HC-AWW, and 27 per cent and 22 per cent respectively for villages with LC-AWW.

In contrast, a higher percentage of households (31 per cent) in villages with LC-AWW report immunization of children of 0–6 years than villages with HC-AWW (24 per cent). A higher percentage of both low and high caste children are being immunized in villages with LC-AWW. While responding to whether the AWW examines persons by touching them while providing services like vaccination and weight monitoring, about 55 per cent households in villages with LC-AWW gave a positive response while 45 per cent households in villages with HC-AWW had a similar response. As reported, in many cases HC-AWW manage to provide these services with the help of other community members.

With the higher home visits by LC-AWW, a higher percentage of households across social groups show satisfaction with the behaviour of the LC-AWW (45 per cent) compared with HC-AWW (36 per cent). This is true for both low and high caste households. A higher percentage of low and high caste households (47 per cent and 44 per cent respectively) show satisfaction with the behaviour of LC-AWW compared with HC-AWW (35 per cent and 37 per cent respectively). Although the main reason for dissatisfaction is 'non-performance of duty' by AWW, a higher percentage of households (16 per cent) attributed 'unfair/dishonest practices' as reasons for dissatisfaction with HC-AWW compared with LC-AWW (7 per cent).

The equity and inclusion aspects of the public services to a great extent are determined by the performance of service providers. This however needs to be understood from the constraints and challenges that the service providers face in the delivery of public services because of their group identities. Understanding the challenges of public community workers like AWW in delivery of interlinked health and nutrition services, would have implications for delivery of public services at a community level. The data revealed that a considerably higher percentage of LC-AWW (56 per cent) than HC-AWW (37 per cent) feel the pressure to provide services to high caste households on priority basis. Similarly, another one-third of LC-AWW and 17 per cent of HC-AWW report pressure to provide services at the homes of high caste groups.

Overall, half of the AWW report facing some kind of problems during home visit. The reported problems are related to 'not seeking advice on immunization and family planning' (26 per cent), 'non-availability of many low caste parents during home visits due to working outside home' (20 per cent), and 'demanding for work which are not part of AWW duties' (16 per cent). About half of the AWW report that all parents did not show interest in sending their children to the AWC. Of these, a majority of AWW (57 per cent) report that children belonging to general caste and OBC (those are economically well-off) do not send their children to AWC. Out of these AWW, 48 per cent cite reasons such as 'feeling bad' due to the 'presence of other poor and low caste children', 'do not want to make their children sit with low caste children with dirtiness [*sic*] as a matter of social position and self-respect.' Further, the presence of LC-AWW in AWC also deters many high caste parents from sending their children. Consistently,

a higher percentage of LC-AWW (76 per cent) reports it to be a problem compared with HC-AWW (49 per cent).

There are evidences to show that LC-AWW often have to work within social constraints because of the identity-based discriminatory practices in community life. However, only eleven per cent of LC-AWW report experiencing discrimination while providing certain services, may be due to fear of reporting such a sensitive issue. Some common forms of discrimination reported include: not being allowed to enter a high caste house to provide health services, maintaining physical distance, and refusing to accept services from them. As a few LC-AWW are of the view: 'In villages, discrimination based on caste is a common practice, if we go to a high caste home they never allow us to go inside.'

Although the AWC remains a focal point of delivery of ICDS services, the AWW have to coordinate with other health functionaries like ANM, ASHA, nurse and doctor in providing health services like immunization, vaccination and polio drops. The responses of household respondents and AWW indicate that the visits of health officials have not been regular. The doctors' services at a community level are mostly confined to referral services. Their visits to villages have been non-existent. Thus, there has been a weak link between beneficiaries and high level health service providers. However, while a majority AWW report a good relationship with other health workers like ANM and ASHA, only 12 per cent report difficulties in coordinating with these health workers allegedly due to their non-cooperation.

At the community level, a village *pradhan* (head of village) as part of local self-government remains the focal point of contact between officials under the local governance system and people of the village community. He/she plays an important role in many decision-making processes so far as the delivery of public services is concerned. It is assumed that low caste village heads may have some influence on service delivery for low caste people.

An analysis of household responses in 75 mixed–caste villages with information about the social identity of the *pradhans* working since last one year reveals that in 16 villages with low caste *pradhans,* the level of awareness about health services and home visits by AWW is found higher than in villages with high caste *pradhans.* For example, 60 per cent of low caste households in villages with low caste *pradhans* report AWW home visits compared to 54 per cent household in villages with high caste *pradhans.* However, the presence of low caste *pradhans* does not guarantee better access to several health services by low caste households.

The actual benefits of health services in the villages with low and high caste *pradhans* provides mixed results. While villages with a high caste *pradhan* have better access to services like weight monitoring of children, and health counseling and supplementary nutrition for adolescent girls, in villages with a low caste *pradhan,* households have better access to the services like health counseling for women and follow-up visits for newborn children.

Factors Affecting Utilisation of Healthcare Services

The World Health Organization proclaims that health cannot be achieved by medical care alone, social factors are equally important (WHO, 2010). Although it puts down two broad categories of social determinants: structural conditions and health system, several factors operate around them at multiple levels. Importantly, while highlighting priority areas that need public policy attention, it draws attention towards the limited access to healthcare among certain sections of people due to exclusion (Acharya and Pal, 2018). In India, various health programmes, mainly system-driven, have not helped all communities equally, thus resulting in the health disparities between different sections of the population defined in terms of social identities such as caste, ethnicity, class, region, etc. The high level expert group instituted by the former Planning Commission of India recognised that it would be difficult to attain and sustain universal health care without action on the wider social determinants of health (Planning Commission of India, 2011). The National Health Policy (NHP, 2017) clearly recognises the role of social and environmental determinants in the context of promoting health. Thus, the complex interplay of social and health system related factors in health outcomes, always asks for understanding major challenges in achieving equity in healthcare. Based on a meta-analysis, Thapa et al. (2021) establishes a wide range of factors that limit access to health services among socio-economically marginalized groups. While the previous sections provide an overview of the inequities in utilization of health services by different target groups, and healthcare behaviours of the service providers in relation to their social identity, this section examines the role of some household-related factors (e.g. caste, education of head of family, and membership of members in committees) and institution-related factors (i.e. distance between households and AWC, caste of service providers, and frequency of home visits) in the utilisation of health services by different target groups. The results based on logistic regression analyses are briefly discussed in the following sections.

Results (Table 2) show that the caste of the household does not play a significant role in the access to healthcare services by pregnant women and lactating mothers although high caste women have better access to health counseling. While low caste women demand for many health services as a better option for them, high caste women receive them as per their requirement and as reported by AWW earlier mostly due to preferential treatment. However, families with the membership of a member in any committees increase the chances of access to health counseling ($\beta = 1.00$), health check-ups ($\beta = .90$), and weight monitoring ($\beta = .83$) by pregnant women and lactating mothers. For those families with a lower level of education of the head, there is more likely utilisation of services like health counseling ($\beta = -.76$) and weight monitoring ($\beta = -.42$) by the women.

Table 2: Determinants of utilisation of healthcare services by pregnant women and lactating mothers

Independent Variables		Dependent Variables					
		Health Counseling		Health Check-ups		Weight Monitoring	
Reference Category	Other Category	β	SE	β	SE	B	SE
Low Caste Household	High Caste Household	.17	.11	-.04	.10	-.04	.10
Non-literate	Primary and above	-.76*	.11	-.14	.10	-.42*	.10
No Membership	Membership	1.00*	.13	.90*	.18	.83*	.13
Within 0.5 km	About 1 km and above	-1.29*	.39	-.73*	.24	-.41	.25
< 5 Hours of AWC Functioning	> 5 Hours of AWC Functioning	.79*	.10	.05	.09	.59*	.09
Less Home Visit	More Home Visits	1.73*	.13	1.03*	.09	1.19*	.09
Low Caste Service Providers	High Caste Service Providers	-.52*	.10	-.20**	.09	-.26*	.09

Source: Field Survey; SE= Standard Error; * p > .01; ** p > .05

Alongside, among institutional factors, the lesser the distance between household and AWC (care centre), more likely is the utilization of all three healthcare services. Understandably, higher the home visits of the service provider (AWW), higher the likelihood of utilization of all healthcare services. Similarly, higher is the hour of functioning of AWC, there is more likely utilization of services of health counseling (β = .79) and weight monitoring β = .59). In AWC with high caste AWW, there is a higher likelihood of health counseling by women (β = -.52), possibly due to the factor of social acceptance by women from both caste groups.

From the results, it appears that institution-related factors to a greater extent determine the utilization of healthcare services by the target women compared with household factors. It also suggests that the supply side factors are important in the utilization of health care services by pregnant women and lactating mothers.

The results also indicate that factors like membership of family member, education level of head of family, distance of AWC, and caste of AWW play a significant role in utilization of health counseling by adolescent girls. These factors also significantly influence the utilisation of IFA supplementation. The likelihood of utilisation of health counseling and IFA supplementation by high caste adolescent girls increases with high caste service providers.

Table 3 shows factors that determine the utilisation of healthcare services by children from both the 0–3 and 4–6 years age group. Caste plays an important role in growth monitoring of children between 0–3 years, indicating higher growth

monitoring by high caste households (β = .30). The group-specific service like follow-up visits for children between 0–3 years is determined by the education of the head (β = -.55), membership (β = .53), distance of AWC from households (β = -1.64), caste of AWW (β = -.65), home visits of AWW (β = 1.74), and hours of functioning of AWC (β = .60). Factors which determine the utilisation of healthcare services, mainly growth monitoring of children in both 0–3 and 4–6 years are: membership of family member, caste of service providers, home visits of service provider and hours of functioning of AWC. The higher the education level of the head of the household, the less likely of growth monitoring of children between 4–6 years ((β = -.39), but the education does not play a significant role in growth monitoring of children between 0–3 years. It may be due to the fact that often, parents irrespective of their education, do not like to go for growth monitoring of small children due to certain beliefs associated with it. As evident from AWW responses, they sometimes face difficulty in providing services like weighing children and counseling to women on health-related issues due to social taboos. In many villages, high caste parents do not send their children to AWC when the AWW are from low caste. This is reinforced by the findings that greater the distance between household and care centre, the lesser likelihood of growth monitoring for children 0–3 years (β = .56). Further, higher the home visit of AWW, it is more likely that children will have access to various health services including weight monitoring. But, the notable aspect is that with the exception of the distance factor and home visits, no other factor plays a significant role in the immunization of children between 0–3 years, but almost all household and institutional factors determine access to immunization for 4-6 years. The difference may be attributed to the nature of health services like immunization being a programmatic service of the state for specific age groups.

Table 3: Determinants of utilisation of healthcare services by children, 0–3 and 4–6 years

Independent Variables		0–3 Years Children						4–6 Years Children			
		Follow-up Visits		Growth Monitoring		Immuni-zation		Growth Monitoring		Immuni-zation	
Reference Category	Other Category	β	SE	β	SE	β	SE	β	SE	β	SE
Low Caste Household	High Caste Household	.10	.10	.30*	.10	.16	.11	.11	.10	-.05	.09
Non-literate	Primary & Above	-.55*	.10	-.18	.10	-.17	.10	-.39*	.10	-.30*	.09
No Membership	Membership	.53*	.12	.56*	.13	.25	.14	.97*	.13	.78*	.13
Within 0.5 km	About 1 km and above	-1.64*	.40	-.54**	.25	-.55**	.24	-.43	.26	-1.02*	.27
< 5 Working Hours of AWC	>5 Working Hours of AWC	.60*	.10	1.12*	.09	-.16	.10	1.09*	.09	.33*	.09
No/Very Less Home Visits	More Home Visits	1.74*	.12	1.23*	.09	.66*	.95	1.26*	.10	1.00*	.09
Low Caste Providers	High Caste Providers	-.65*	.10	-.31*	.09	-.10	.10	-.21**	.09	-.29*	.09

Source: Field Survey; SE= Standard Error; * p > .01; ** p > .05

The results thus point to many factors— locational, operational and behavioral— that determine the utilization of health services by different target groups. Among household- related factors, membership and education level largely influence the utilisation of services. The caste identity of service providers plays an important role in the utilization of some health services by women and children. Contrary to beliefs that many clinical issues affect low caste, a variety of social determinates play a vital role in unequal access to healthcare services.

Inequity in Healthcare: Psychosocial Implications

When we talk of caste, inequity and discrimination in healthcare system, it brings the debate of how the dominant cultural practices of discrimination that creates psychosocial conditions effect one's mental and social well-being. Caste-based inequity impacts an individual's opportunity to have access to basic public resources and services, and in turn, upon their physical and psychological health. The basic premise is that inequality in utilization of any public services like health, damages the quality of social relations, one of the most important ways that inequality affects the quality of life (Wilkinson, 2005). The extents to which people are involved in local community life also confirm the socially corrosive effects of inequality (Wilkinson and Pickett, 2007). The inequality is sometimes linked with psychosocial health (Chandra, 2009). Despite public policy and institutional guidelines and principles in delivery of public services, the persistence of caste-based inequity creates dejected and deserted situations for low caste groups—both as consumers and providers of health services.

Some disadvantages witnessed in public service delivery are common to all social groups, mainly due to failure on the supply side or gaps in the operational aspects. However, many disadvantages are a function of discriminations in delivery of services. One of the most perceptible evidence of discrimination is found in fewer AWW visits to low caste households either voluntarily or under pressure from others. This limits not only access to healthcare but also knowledge about health problems and information about possible cures. There are evidences of specific discrimination against low caste at the time of service delivery, for which the service providers are held responsible as they are expected to work as per professional ethics rather than community norms. These would not only effect the utilisation of services but also other psychological aspects in terms of loss of faith in institutional norms and health-seeking behaviours. Attention is drawn to the consequences of discriminatory practices to shed light as to how some of the disadvantages due to unequal access to health services besides behavioural manifestations of service providers are intensified for low caste.

The data confirms that most service infrastructures are located in places closer to high caste habitations. It creates not only physical distance between service delivery points and low caste households but also social distance between social groups within the community. With the distanced service delivery points (AWC), the physical distance becomes even wider by the occasional visits of service provider. Thus, the distance factor limits the move of both beneficiaries and providers. This isolates

low caste groups physically and socially, and affects access to health services. The locational disadvantage coupled with other challenges due to fewer visits of service providers accentuates the problems of pregnant women and lactating mothers from low caste, forcing them travelling to AWC for essential services. As many do not have other provision of healthcare except AWC, they live with this reality, which deviates from the norms of public service delivery.

Very often, AWW instead of visiting the low caste households to pass information, prefer to call a meeting in a place outside their hamlet. For example, monthly health camps/programmes are held either at AWC or community places located in high caste localities. As a practice, AWW in collaboration with ANM provides health services at AWC or in a 'liking place' at a high caste locality. It is expected that the pregnant women and lactating mothers travel to these places to receive health services. This puts low caste women at additional disadvantages.

As evident from FGDs with low caste women, they sometimes avoid such meetings at high caste localities because of past experiences of exclusionary bias such as sitting away from women of high caste, waiting for longer, being subject to 'casteist remarks' and rude behaviour of service providers, exposing them to humiliating situations. These service delivery points become deterrents for low caste women, leading to lower access to vital information about health-related issues. Verma and Acharya (2017) find exclusionary practices have negative implications for the health-seeking behaviours of the low caste groups. However, the service delivery mechanism sometimes makes low caste women helpless as they cannot dare to complain against it, and even if they do, it may not help them much. As low caste women in a few FGDs express:

> 'We do not complain because we know, no action will be taken, rather she (AWW) will scold us.'
>
> 'To whom should we complain? No one listens. If AWW knows, she will fight.'
>
> 'AWW says that nothing will happen complaining against me. In turn, you will suffer. The supplementary nutrition material will stop.'
>
> 'People from our community do not complain, because we are poor. Rich people will start pressurizing. No one listens to poor.'

The results also suggest that low caste households have relatively higher access to the institutional 'in-house services' (i.e. services provided in AWC) whereas high caste households to the 'out-house services'. The findings also indicate that the awareness level of low caste women about various aspects of health services under ICDS is lesser than high caste women. This 'awareness gap' is wider between social groups particularly on issues related to frequency of weighing children and referral services. It is clear that the social identity of service providers matters in the utilization of health services by different social groups. As observed, there is a lot of hesitation among high caste parents to send their children to the AWC where AWW are from lower castes

(Mander and Kumaran, 2006; Pal, 2016). This type of exclusionary bias frequently eases the process of exclusion of low caste and creates social conditions that intensify 'feelings of inferiority' among low caste beneficiaries and threaten their dignity. When we talk about such humiliating behaviours, the role of service providers remains critical. But, sometimes this is reinforced by the indifferent behaviour of service providers themselves. Given that caste norms at a community level very often dominate the process of service delivery, this results in not only unequal access to healthcare services or limited access to certain services under discriminatory conditions, but also brings several adverse consequences that intensify social disadvantages.

Discussion and Conclusions

In recent times, inequalities in health status and access to healthcare services across socio-religious groups have been widely documented. While macro level official data points to the poor outcomes on several health indicators among the socio-economically marginalised sections of society, empirical evidences indicate their differential access to health services. In light of the persistence of group inequity in access to interrelated nutrition and health services in India, this essay looks into factors that affect utilization of healthcare services with a special focus on the social identity of users and providers of the healthcare services. Based on the experiential accounts of a large sample survey of household beneficiaries and providers of healthcare services, the essay identifies a few areas of concern that need special attention.

The essay reaffirms that the social identity of caste marginalizes low caste people in a multifarious manner in their access to healthcare services. Despite specific norms and guidelines for the implementation of various healthcare programmes, the dominant caste norms at a community level interfere with the delivery of healthcare services. It is not only the low caste identity of users of services but also of service providers that matters in differential utilization of healthcare services. The delivery services are largely influenced by the local social environment in which they live and work as public service providers. The service providers from low caste group even fail to do justice for low caste people under social compulsions. The service providers across caste groups remain indifferent to the day-to-day concerns of low caste beneficiaries, in turn bringing multifaceted challenges for them.

The public policy focuses on universal access to healthcare services. Still, health-related programmes have a specific social orientation in the delivery of healthcare services wherein marginalised groups always remain a priority in delivery of services. The unequal access to such services across social groups raises concerns over the supply side deficiencies, particularly the accountability and behavior of service providers. The major public policy concern remains on how to address the effects of the social identity of providers of health services at a community level in ensuring equality in utilization of the services when the local social structure is entrenched in a hierarchical system.

While high caste service providers in a pursuit of maintaining high caste identity and autonomy, tend to show differential behaviours towards low caste users of health services, low caste service providers, on the other hand, under the influence of dominant social norms, face conflict in course of providing health services to different social groups. This minority face many challenges including the experience of differential treatment while delivering health services to different social groups. Being in a weak 'social position', they have to comply with dominant social norms in the course of delivery of health services under compulsions.

Low caste service providers are 'avoided' or 'neglected' by the high caste people during delivery of services while high caste providers themselves avoid visiting low caste households for service delivery. Given that high caste people can have access to alternative health services without taking any kind of help from low caste service providers, hence, this may not have much implication for them. However, for the low caste people, fewer visits/interactions of high caste service providers to low caste people matter. With the caste- based social order at a village level, sometimes both low caste service providers and beneficiaries are forced to accept the way high caste people or service providers accept it. Thus, the low caste service providers sometimes have to deliver health services under certain compulsions whereas high caste providers work with much liberty. It is interesting to note that when the low caste AWW faces difficulties in providing health services during her visits to high caste households because of her caste identity, the high caste AWW makes fewer visits to low caste households. They can refuse to visit low caste households as it may be accepted by the social norm. Thus, in mixed-caste villages, the healthcare behaviours of service providers with different social identities may not always be intended behaviours, but takes place due to the interplay of social identity and local social norms.

As a matter of fact, health policy framework and community level health system in India have not been well-found to address exclusionary practices based on social identity, affecting delivery of and access to healthcare services. Given that public health services are the only options for marginalized groups including low caste groups, when low caste service providers cannot ensure health services within their own community due to dominance of other socio-cultural norms, this is a challenge for achieving inclusion in the health services. Since, caste-based exclusions are entrenched in many mixed caste villages, social inclusion in delivery of healthcare services needs special policy attention. Given that providing health security to all has been a national priority, a special focus on health equity through community level services remains a critical area of public health policy interventions.

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Enculturalising Casteism in Health Care in India

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Abstract

Immunology depends on culturing technique, practice, and procedure. Society depends on culture. The change in the enculturing technique has always got promoted and accepted, while a change in Indian society is discouraged and not accepted despite claims of change happening. The 'Society of India' heavily depends on casteism and ensures all mechanisms for keeping it functional without change. By accepting culturing techniques from immunology, privileged Indian society developed a new technique with the old ethos that may be called 'culturing casteism'. It has a deep presence in both spheres of health: 'Sociology of Sufferer', namely, the healthcare seeker and 'Sociology of Supremacy', namely, the healthcare profession and professional. This essay explores the way casteism is cultured in both spheres. The essay's main aim is to understand and define the existence of casteism in health. The data establishes that the domination of privileged castes exists and is nurturing casteism in health. Privileged castes have captured the whole (health) sector while the dispossessed and deprived have been trying hard to 'catch' the care.

Keywords

Caste, dalit, casteism, health, health profession and social justice, doctor and patient, India

Introduction

The problem of poverty and disease unabatedly haunts the developing countries. Despite faring better than many developing countries on several counts, India has been plagued by diseases of different kinds, where millions go with scant or without medical care. It is worthwhile to study the sick component of Indian society systematically, and the social aspects are much more relevant to the system's normal functioning.

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Therefore, a sociological analysis of 'patients' (or care seekers) and the medical profession in the Indian context assume great significance.

Social stratification in India is a prominent symptom of illnesses of all kinds, both social and physical. Hence it is imperative to understand social stratification. In a most general sense, it is a sociological concept that refers to the fact that both individuals and groups of individuals are conceived of as constituting higher and lower differentiated strata or classes. In the terms, it has some specific or generalized characteristics or set of characteristics. In the caste stratification systems, individuals are permanently assigned a social position purely because of caste. However, the Indian government has made caste barriers illegal. Yet, India is the most famous example of a caste system. Indian society is broadly divided on the Varna Ashram model, and it is also considers caste in practice and function. However, prominent features of caste hierarchy exist on occupational superiority, which can be tagged as decision-makers in the system. Brahmans were priests and holders of opportunity of religious knowledge—now education holders, Kshatriya were rulers and warriors, Vaishya were traders and merchandizers, and the rest were Shudra who were assigned the duty to work for the above three varna. Untouchables are out of the Varna system based on their occupation primarily, skinning, sweeping, and other occupations that as a result of which they are not directly in touch with persons of any varna—that is why they are known as Untouchable. Untouchables are historically considered so inferior that they were forbidden to mingle with upper varna groups on the streets. In India, Untouchables continue to face 'exile' within systems.

The phrases 'sociology of sufferer' and 'sociology of supremacy' shall be used for subjective purposes in this essay. Those at the margins of access to healthcare facility, utilization, and primary facility for 'good' health will be considered under 'sociology of sufferer'. The phrase 'Sociology of Supremacy' will be used for both, individuals and institutions of care provisioning. Healthcare providers are those trained and educated by an institution and/or certified to provide the service with professional ethics to their 'clients' (care seekers), and the institutions/hospitals/chain of hospitals are the facilities providing services to sick.

Theorizing Caste and Explaining Casteism: Past is Present

This understanding provides the backdrop to explore the construction of casteism as a social, economic, and political category, given the historical background of Indian society. Also, its effect on Dalits due to discrimination, exploitation, and atrocities continues because of traditional subordination, thus affecting their position in Indian society today.

The origin of caste and untouchability lies deep in India's ancient past. The evidence of those origins provided by the archaeological and literary sources is, at best, circumstantial. We now have not hard and clear facts but various competing theories that have proved challenging to substantiate convincingly (Webster, 2007). There are three schools of thought in the origin of untouchability. They are racial

and /or conquerors vis-a-vis native, religious, and economic (Shah G., 2002, p. 11). None of these explanations about the origin of untouchability is a conclusively proved fact. Infact, casteism has been cleverly introduced by the privileged in all human institutions. Therefore, no single cause can explain untouchability. It is deeply rooted in Indian history and the agrarian social order that dominated the Indian economy through the British period and remains the most significant economic sector even now. Although the relation of India's rural untouchables to this social order has shifted in subtle ways in the past two centuries, there remain pervasive continuities, especially in meaning and cultural construction with this deeply rooted past (Michael, 2007, p. 20).

Hence the most apparent feature of Hindu society[1] is its division into caste. Perhaps the untouchables earlier and the most straightforward Western image is embodied in the term 'outcaste'. In this view, being untouchable is beyond the reach of Hindu culture and society and almost cultureless (Michael, 2007, p. 14). This phenomenon had been studied by missionaries, colonial administrators-turned-historian and ethnographers like Abbe Dubois and his contemporary Dr Frances Buchanan—from 1792 to 1823 and 1799, respectively—and later by Nesfield (1855), Risley (1908), Senart (1930) and Bougle (1971). As articulated by Dubois, the earlier outcaste image implies a significant disjunction between the higher caste Hindu and lower caste untouchable or outcaste. The term 'outcaste' expresses the distinction (Michael, 2007, p. 18). The 'occupational factor' comes first in Senart's understanding of the origin of caste. Celestine Bougle, an early theoretician of the Indian caste system, came up with more concrete characteristics and fundamental principles of caste. He defines caste as: heredity, hierarchy and repletion or isolation of the group from another, and found all three principles interrelated, which form a unique institution called 'caste'. He further pointed out that the caste hierarchy was determined less by an occupations' usefulness or complex nature than by their relative purity and impurity. Hutton (1963), the last administrator scholar to review the existing theories of caste, remarked that although most of these theories had contributed to the subject, they generally emphasized the phenomena 'rather than the causes of caste system'. His theory finds criticism for ignoring the fact that 'caste is primarily a system of interreacted groups' in which differences in the distribution of economic and political power are expressed through a cultural language such as restrictions on commensality and matrimonial (Jaiswal, 1998, p. 34). Despite receiving heavy criticism, Hutton's theory shows that caste is not a sudden artificial creation but an organism that evolved gradually through a multiplicity of factors. Even though Hutton regards the caste system as a composite unit of many cells, each functioning independently and, as such, unduly minimizes the importance of those socio-economic and cultural bonds which sustain the system, making it an organic whole. His study remains a classic investigation into the origin, nature, and function of caste.

Later, sociologists shifted the focus to a search into origins, which they regarded as 'speculative to synchronic' studies of caste based on fieldwork. Two authors,

[1]Hindu society implies a system exists in Indian society because the majority of the population, around 81 per cent are the followers of this religion.

particularly, F.G. Bailey and Louise Dumont, on this subject and other social anthropologists have aligned themselves with one theory (Dumont, 1957, 1960, 1966, 1970).

Two prominent Dalit thinkers during British India engaged with untouchables and their situation through two different theories. Jyotirao Phule (b. 1827–1890) propagated the 'invader theory' as a prominent reason for the low status of untouchable and untouchability. Jyotirao Phule, now popularly known as Mahatma Phule, portrayed Aryans[2] as 'Invaders' and lower caste people as 'original inhabitants' of India and described Arya culture along with the caste system (Phule, 1991) as alien to these original people whom he termed Bahujan Samaj.[3] On the other hand, Ambedkar rejects the 'race theory' and propagates the 'religious theory' of untouchability. He argued, "there is no evidence in the Vedas of any invasion of India by the Aryan race, and it is having conquered the *Dasyus and Dasas*[3] who were supposed to be natives of India" (Ambedkar Caste Origin) (Ambedkar, 1946, pp. 57–82, quoted Shah, 2002, p. 22). According to him, there was no racial distinction between the Aryans and the Dasas.[4] As far as physical characteristics were concerned, there was hardly any difference, he argued, between the Brahmin and untouchables belonging to the same region.

Untouchable, Scheduled Caste and Dalits

These three words seem to have different meanings and differentiation, but they are synonymous in connotation and used for those at the margins. Specific terms come into existence at different time points and evolve over a period, changing from a different time. They were called 'untouchable' during the ancient/historical past, 'Scheduled Caste' during the British and 'Dalit' in the present discourse. The word 'Untouchable' was used in communication in the Vedic times by society. The 'Scheduled Caste' came into existence during the British Period for administration and identification based on deprivation, and the term 'Dalit' came into use correctly and effectively in India after Independence. They are used by the liberal thinkers and the untouchables/schedule castes as an assertive term, portraying the struggle to resent discrimination and fight for their rights simultaneously. Now all three words are interchangeably used in any discourse on caste in Indian society. The term 'Dalit' has been embraced in academia and media within the country and aboard alike. Despite the interchangeability, there is a need to explain the origin of these words as follows.

In practice, there has been a tendency since the Vedic times to emphasize birth as a criterion for membership of Varna, viz., Brahmin, Kshatriya, Vaishya, and Shudra. The idea of Varna has initially been based on race, culture, character, and profession. It takes account mainly of man's moral and intellectual worth and is a system of classes that appears neutral (Kane, 1941, p. 1). The birth-based criteria for allocation of Varna gained supremacy over others in subsequent scripts of the Smritis, Purana

[2]Has also been claimed by Brahmin.

[3]Majority community, except for Brahmin, Kshatriya, and Vaisya.

[4]Hindi meaning of an enslaved person.

and Upanishad. These were the written codes of conduct projected as the norms for all. The privileged groups promoted the idea as evident historically, which continues the process of strengthening it such that it has metamorphosed in the kind of 'acceptance' that birth-based allocation to Varna/Jati even in present times.

Finally, this birth-based idea is mainly accepted by the residents of this country as the sole criteria of status until death (Ibid., p. 2).

The very contradictory concept popularly used in Indian society and academics is that "Varna is the origin of caste". Previously, the essay used the term "Savarna" as a club of four varnas: Brahmin, Kshatriya, Vaisya, and Shudra. The Brahmin Varna does not have any other caste, similar to Kshatriya and Vaisya. Is Shudra having any caste in Varna? The answer will be "yes". That is why there are so many castes within Shudra Varna. It means Varna is not the origin of caste. Hence practically, caste is the origin of 'occupation'; hence all the different occupations emerged from Shudra varna and were assimilated as 'servant of all three Varna' and compelled to do duty to serve them without any rights, as created by God.

Almost all the Shudra communities and occupation names are similar to Nai,[5] Badhai,[6] Gadria, etc.[7] Caste is the prime decider of occupation and positions. There are some occupations (on the pretext of using the word duty) that can occur without touching, like cleaning/collecting human excreta or carrying a dead animal. Almost all untouchables do sweeping, skinning-related work that can happen without human touching and in isolation. Untouchables live on the outskirts of their village and near ponds, and always in the southern part of villages. The wind direction in the Indian climatic conditions is from east/west to south. Therefore, the wind should first touch the 'Savarnas' and then reach the 'Avarna', the 'untouchables', to avoid 'pollution'.

Dalit[8] is a Marathi word meaning ground, broken, or extracted to pieces. It gained a new cultural context when two movements in Maharashtra—the state Ambedkar lived and worked—in early 1870 used this word to define the agony of a social group constituted of untouchables to assert their rights as human beings. One was known as Dalit Panther, and another was Dalit literature.

Dalit Panther supported consciousness and uprising on the social-cultural front while Dalit literature did so through writings. Eleanor Zelliot (1992), in her book *From Untouchable to Dalit,* writes about this transition "by substituting the word Black for Dalit. The reader can immediately understand that a phenomenon comparable to the American Black Panthers and Black literature has surfaced among the lower castes in social and literary affairs in western India. Like the American movements, the Dalit Panther and Dalit school of literature represent a new level of pride, militancy, and

[5]Barber to cut hair, body massage and other work regularly during marriages, funerals. Even the womenfolk of the community are assigned the duty to serve women of the three other Varnas even during delivery and rituals. Duty is compelled based on compulsion and not on choice.

[6]Badhai is a carpenter who does wooden work, making even beds/cots.

[7]Gadaria is shepherd who rears sheep. 'Gadar' is the Hindi word for sheep.

[8]Marathi is a dialect spoken in the state of Maharashtra and written in Hindi script.

sophisticated creativity. The Marathi word Dalit like the English word Black was chosen by the group itself and used proudly. Even in the English press, the unfamiliar Marathi word must be used". She further writes, "None of the normal words—untouchable, Schedule caste, Depressed Caste, Gandhi's euphemism, Harijan—had the same connotation". Dalit implies those who have been broken, ground down by those above them deliberately and actively. There is in the word itself an inherent denial of pollution, Karma, and justified caste hierarch (Zelliot, 1992).

Now, in India, those castes under a legally recognizable identity as the protected group are called Schedule Caste (SC), Schedule Tribe (ST) and Other Backwards Caste (OBC). All these historically dispossessed communities comprise the demographic majority of India, around 104 crore (1040 million) out of 130 (1030 million) crores as per government data. Sixteen per cent are SC, and 8 per cent are ST; government highlights no official percentage of OBC, but in jobs, 27 per cent representation (called reservation) for 50 per cent of the population of OBC. Hence the total population of OBC would be around 54 per cent. By adding the population of all the dispossessed community: SC (16.2 per cent), ST (8.2 per cent),[9] OBC (54 per cent) around 80 per cent population of India as per Census of 2011. There are many other religious communities other than Hindu, such as Parsi, Christian, Sikh, Buddhist, Muslim, and Jain. Schedule Caste status is given to those from Hindu or Sikh and Buddhist religion (only an untouchable can convert to this). Even Dalits who converted to Christianity are not given the legal identity of Schedule Caste, while their social status remains the same. Schedule Tribe is from any religion. The numerically highest minority is Muslim, in which 90 per cent are covered into OBC - also called Pasmanda[10] within the Muslim religion. There are many invisible communities known as a de-notified community (Felony or Civilization; Ambedkar) in India—ancestors of Roma and Sinti of Europe and the USA—also out of the census because of 'invisibility'. The legal status of castes (SC, ST, OBC and none) is a principal matter of state, not the union, so that the same caste may have a different legal identity in different states. However, the social status will be the same in line with discrimination, exclusion, and atrocities.

Class-Caste in India: Analogue or Alien

The relationship between the ideas of caste and class has been a matter of controversial discourse. Some say that caste is analogous to class and that there is no difference between the two. Others hold that the idea of castes is fundamentally opposed to that of class. It is necessary to emphasize one feature of the caste system that has not been referred to before. Although caste is different from and opposed to the notion of class, the caste system—as distinguished from caste—recognizes a class system which is somewhat different from the graded status referred to above. One does understand how the Hindus were graded and divided into so many castes. Further, castes get divided into different classes or castes. The Hindu is caste conscious, and he is also

[9]Office of the Registrar General & Census Commissioner & Ministry of Home Affairs, 2021.
[10]Synonyms of classification of Ajlaf and Arjal together in Muslim religion except for Ashraf.

class conscious. Whether one is caste conscious or class conscious depends on the caste; one comes in conflict with one's own identity. If the caste with which he comes in conflict is a caste within the class to which he belongs, he is caste conscious. If the caste is outside the class to which he belongs, he is class conscious. Anyone seeking necessary evidence on this point may study the Non-Brahman Movement in the Madras and Bombay Presidency. Such a study will undoubtedly indicate that "to a Hindu caste periphery is as accurate as class periphery, and caste consciousness is as absolute as class consciousness" (Ambedkar, 2017, p. 152).

In general, a caste-based society and economy are in which property rights, as well as occupations, are heredity, compulsory and endogenous. The organisational scheme of the caste system is based on the division of people into social groups (or caste) in which the civil, cultural, religious, and economic rights of each caste are predetermined or ascribed by birth and made hereditary. Moreover, endogamy remains the central feature of the caste system. However, the assignment of civil, cultural, and economic rights is unequal and hierarchical. The system also provides a regulatory mechanism to enforce the social and economic organisation through the instruments of social ostracism (or a system of social and economic penalties) and reinforces it further with justifications from the philosophical elements in the Hindu religion (Thorat, 2004). This feature of caste makes society's institution rigid, stubborn and change-resistant. These features imply that the Hindu social order is based on three interrelated principles. These predetermine social, religious, and economic rights among the caste and provide intense social, religious, and economic ostracism supported by social and religious ideology to maintain the Hindu social order.

In Ambedkar's view, the doctrine of inequality is the core, the heart, of the Hindu social order. What is essential is that the philosophical elements of Hinduism also directly or indirectly support this system. He also observed isolation and exclusion (social and physical) of untouchables as a unique feature of the Hindu social order. The principle of rank and gradation governs the caste system as the rights increase in ascending order from the untouchable to the Brahmin. It is a hierarchical interlinked system. Graded inequality based on birth exists and is nurtured too—no rights, only duty and punishments given to untouchable or Dalit. The rights increase as the varna hierarchy is ascends towards the Brahmins, who have all the rights and no punishment. Ambedkar recognised caste as a system of social and economic governance. The organisation of production and distribution is essential based on specific customary rules and norms, which are unique and distinct.

Within this framework, castes are artfully interlinked in a manner such that the rights and privileges of the higher castes become the disability of the lower caste, particularly the untouchables. In this sense, in Ambedkar's view, caste can exist only in plural numbers, and there cannot be such a thing as caste as a singular phenomenon. Castes need to be conceived as a 'system' of societal governance interlinked in unequal measures of societal, cultural, religious, and economic relations with each other (Beteille, 2011).

Profession in Class Structure

The close association between caste and occupation in the traditional social system of India is widely known. Against this background, it is instructive to know the caste background of those who take to modern occupations for which none of the castes had any legitimate claims.

The most significant change in the occupational structure, mostly in advanced industrialist societies during this century, is the growth of white-collar jobs such as clerical, technical, scientific, administrative, managerial, and professional occupations. In recent years, the professions have been the fastest growing sections of the occupational structure and increased the complexities of trade and commerce, giving rapid growth to professions. Trade and commerce are occupations of Vaisyas in Indian society. Indian industrialists are from these segments, and these professions are in the clutch of these sections (Damodaran, 2018).

It is pertinent to recall that the old system of Chaturvarna made a distinction between the first three Varnas, the Brahmans, Kshatriyas, Vaishyas and the fourth Varna, namely the Shudra; the first three 'classes' are the regenerated classes. The Shudra is the unregenerate class. The first of the Varnas were entitled to wear the sacred thread and study the Vedas. Vaisya was/ is for business and trade. The Shudra was entitled to neither, so they were regarded as the unregenerate class.

In a society where education is a private service and to be purchased by the consumer based on the strength of the family's economic resources, entry into those professions, which require significant investments of time and funds, invariably remain restricted to the rich. Inequality in education and class/caste are significant because they are the basis for social distinctions. Sociologists agree that the nature of the society largely determines whether some people are more affluent or more powerful than others (Coser et al., 1983, p. 158).

Even when steps are initiated through appropriate social policies to facilitate the entry of deprived sections onto these occupations, given the persistence of traditional disabilities, the erstwhile deprived categories will, in all probability, not be equipped to avail of these opportunities. This gap between the provision of opportunities and utilization of opportunities (Bondre, 2013) is vast and can be narrowed only by taking drastic measures favouring the deprived.

Health for Justice and Justice for Health: Equality without Equity

In most counties, the justice system serves the wealthy and powerful quite well, so also in India. Similarly, justice for the health of the wealthy and, worse, deprived living in an unequal society (Dias & Welch, 2011). Thus, it is all about social inequality. Why does it exist, and how does it affect everyday life? Why is it tolerated in a society dedicated to the ideal of equality? Inequalities of wealth and power underline many of the world's problems.

In Indian society, Brahmanism is a way of theory, discipline, or conceptualization to understand the social function or sociology of Indian society. Similarly, Marxism is to understand the function of the political economy of Western society. Marxism is silent on sociology; without sociology, political economy cannot be understood adequately in Indian society. A different 'ism' is required to understand Indian society practically, which is Amdekarism.

Ambedkar confronted the Western authors against their racial notions of caste. Ambedkar said that Western writers opted for race roots of the origin of caste because they impregnated themselves with colour prejudice. He blamed other Western authors—Emile Senart to HH Risley, including JC Nesfield and Denzil Ibbetson, for defining 'caste' as a unit by itself and not as one within a system of castes (Kumar, 2014).

Ambedkar as a thinker studied Indian society in addition to the Western with its peculiar way of functioning based on the core system that is different from Western society called the "caste system". This system continues to be the driving force in Indian society even today, discussed in detail initially in the conceptualization. Here the focus is to understand Ambedkar's views on Indian society and consider them as an approach called "Ambedkarism" to study Indian society. Ambedkar defines the nature of Indian society as structurally rigid, with unequal power relations and exclusion based on birth. Birth is the decisive point in Indian society. In his book *Annihilation of Caste* (2013), Ambedkar writes in the preface that: "I shall be satisfied if I make the Hindus realize that they are sick men of India and that their sickness is causing danger to the health and happiness of others".

Health and Illness: Contradictory Correlation

Health is dependent upon economics. And one's economic situation is based on social and psychological mindsets. Both are interdependent, but psycho-social is hidden, and its visibility is based on economics. Social identity is the foundation stone of economics, and economics is the foundation stone of health. Health interlinked with one's living condition. That is why one's health condition can be considered as a 'creator' of symptoms of illness. Health is the deciding factor in illness. Illness refers to the absence of ill health, and vice versa; health is the absence of illness. The perception of 'illnesses and 'health' is governed by the economic propensity to access care (Gwatkin, 2000). The 'Action taken' stage, which is assumed to follow the recognition of the 'symptoms' of illness (or health) in the health culture model, is largely determined by economically driven access. It, therefore, means 'wealth is health' and not 'health is wealth'.

The concepts of health and illness are neither clear-cut nor objectively factual. They are but subjective experiences which are historically and culturally bound and therefore need to be understood in a context (Thorat, 2009). Many approaches concerning the social dimension of health, illness, and medicine have been developed in the past years. The sociological approach is very illuminating and helps us understand

the relations between health, illness, medicine, and society. Similarly, the theories and concepts developed around health-illness and medicine in time are affiliated with social, financial, and cultural conditions. They interact dynamically due to various social, financial, political, cultural, environmental, and other factors that affect health and illness. The systemization of medical knowledge in a society is also related to social relationships, standards, institutions, social structure, and the organization of social life (Kadda, 2010). Several sociological perspectives such as Parsonian or functionalism, the Marxist perspective of political economy, social constructionism, feminism and medicalization, biomedical approaches and holistic approach have also been employed over the years to understand health and illness as social phenomena. These approaches are helpful to understanding the societal aspect of health-as-wellness and illness-as dysfunction by putting them together at intersections with the issues of gender, class, knowledge, and power.

'Sociology of Supremacy[11]' and Sociology of Sufferer'[12]: Fact and Figure

There are two dimensions in this section which capture the holistic picture of healthcare in India. The first section examines the supremacy in healthcare businesses, the second explores the ambit of healthcare professionals, and the third construes Dalit people's lives based on field data.

Sociology of Privatization of Healthcare in India: Examining Supremacy

Sociology is the systematic study of human society. Does it provide evidence and explanations of *'how society works'?* Sociology can be considered as the actions of individuals and groups, patterns of similarities and differences between people within a single society and between societies of the distribution of social resources, and economic and political power. Sociology is concerned with studying individuals—social actors and agents operating in the social world and trying to understand how the social world works—by investing in how social structures and relationships develop, persist and change.

Social and cultural factors play a critical role in the dynamics of economic and political systems. The Hindu social order is universally recognized as a uniquely Indian approach to philosophical and worldly affairs, and its complexity has inflexibilities which cause backwardness, rigidity, and unchanging stereotypes. Considerations of caste community and clan relationship persist at all levels and in all spheres of activity, whether industry, bureaucracy, or politics (Veit, 1976).

[11]Supremacy is a symptom of the Brahman Tantra (system) based on birth and diluting/not furnishing democracy with the support of religion by hook or by crook and still holding onto all the spheres—business, trade, professionalism, academics, even the mechanism of a democratic system such as politics and bureaucracy.

[12]Based on occupations mainly related to skinning, sweeping, weaving, and washing, 1231 castes are in the schedule.

'The colonial period and pro-independence struggle substantially altered Indian conception of 'how society should be organized'. The Congress Party, later recognized as the party of independence, began its life in 1885 as an organisation of upper class, urban India, who sought greater privileges from the British within the then existing order of colonial rule. It owed its strength to the combinations of mass support in rural India, its intellectual elites' political and organizing role, and the financial contributions of nationalist-inclined industrialists' wealthy landowners. Thus, when the Congress became India's ruling power, its choice of economic policies was affected by commitments to various factions of the party and a strong desire not to alienate any of its supporters (Veit, 1976, p. 25). The aspirations of mass supporters and elites, industrialists and landowners, were undisputedly opposite. Nonetheless, almost all the diverse interests within the Congress had (and still have) symbolic representation. Generally, the real power has been kept in the hands of the politically active urban petty traditionalist and the newly emergent rural upper-middle class.

The 'Bombay Plan' or the 'Tata-Birla Plan' in 1944 was the first collective effort made by the bourgeoisie giant businesses to outline the path of advancement for independent India. They wanted a national government to exist at the centre, which would have complete freedom in economic matters. The 'People's Plan' proposed that the land and underground riches (mineral resources) would be the collective property of the nation, and heavy industries and banks would be subject to state control. Small agricultural producers were to be free from all other taxation, except local rates, large-scale cooperative agriculture, minimum wages, etc. A third plan known as the 'Gandhian Plan' was different from both these plans and the general stand taken by the National Planning Committee. Author of the Gandhian Plan, Shriman Narayan Agrawal, said, "I feel that these plans have not considered the special cultural and sociological foundations on which our economic planning in India must be based; merely copying western plans, whether the capitalist or socialist type, will not do; we must evolve an indigenous plan with its roots firmly in the Indian soil" (Namboodiripad, 1974, p. 32).

The decade before the attainment of Indian independence, was one of intense discussion on the necessity, possibilities, and general direction of planning the post-independence economic setup that the country went through. These discussions led to the emergence of three distinct groups of thinkers on the question of planning: the left radical, the frankly capitalist and the Gandhian. The conflict of trends represented by these three groups has left a clear imprint on post-independence planning *(*Ibid.).

This discussion concludes that except for democracy, which modern India has never challenged as an objective, India has had so many ideological differences to prevent anyone's approach from becoming dominant. In practice, for each policy objective—democracy, egalitarianism, nationalism, and centralism—there are several counter objectives. These include: authoritarianism, elitism, internationalism, and decentralism. In 1948, India announced its first industrial policy resolution, regarded as a retreat from socialism. Nehru defended it because the economy was weak and that the achievement of India's economic development required the full participation of the private sector (Pavlov, 1975, p. 90).

Health problems and health practices are community-specific and deeply embedded within ecological, social, economic, and political systems. These profoundly influence the size, extent, and nature of community health problems. While the public health system evolved on the Health and Development Committee (or Joseph Bhore Committee) in 1946, the private sector is not new to the Indian health service system. It was a predominant mode of service for the well off. Bhore Committee (1946), Mudaliyar Committee (1962), Junglewala Committee (1967), Kartar Singh Committee (1973), Srivastava Committee (1975), and Bajaj Committee (1986) mainly brought effective healthcare and shaped the path of the healthcare system in India. In addition, the Chopra Committee (1948), Mehta Committee (1957), Renuka Roy Committee (1960), Jain Committee (1966), Krishna Committee (1982) and Mehta Committee (1983) were constituted for different tasks and objectives. Different committees, constituted over a while, show that the 'idea of health', which was articulated by Sir Joseph through the committee's recommendations, was being defeated gradually by the government. Over the period, 'health', perceived holistically, has been reduced into health services via family planning to healthcare services. Later, the idea of *'health for all through* the international agenda based on the Alma Ata Declaration-health for all by 2000 *AD*' was implemented. The goal remained unattained by many countries, including India, and the 'deadline' was pushed to 2010. It was seemingly subsumed by the MDGs and SGDs subsequently. Examining and investigating the much-talked international agenda for achieving health and wellbeing is pertinent in today's context to know whether it is serving the purpose of 'health'.

Sociology of Doctors: Indian Scenario

Healthcare professionals are a significant entity in the sphere of health. A doctor is the leading actor in the therapeutic process of healthcare delivery and is solely responsible for people's health. These men and women are trained as professionals by medical institutions to take care of the sick and cure illness. In short, social, economic, and political opportunism affects careers.

All the more, when the social system of India is a hierarchical ranking system often represented as a 'ladder' in which there are differences in access to social resources, individuals at the top ranks have more access. At the same time, those at the bottom lack social resources also called structured inequality (International Encyclopaedia of Sociology, 1972). The social background of doctors becomes an essential indicator in two ways. The first strong indicator is the social mobility among scheduled caste communities in the profession and their acceptance as doctors and entrepreneurs. Second, who are these doctors; what are their caste, tribes, religious affiliations, etc. By analysing this, we can understand the social fabrics, opportunities, and chances of becoming doctors.

Scarce studies on the basic scenario of a doctor's profession—not on the sociology of doctors—were undertaken by medical sociologists till the 1980s. Few systemic studies of medical professionals, in general, have been done, but not of the persons 'who are in the profession' or 'persons studying the discipline

of medicine'. Professional issues have been studied, but issues of the profession have remained neglected when it is much needed to understand the very diversity which exists in India.

Some sociological studies have also been conducted on doctors in the making, that is, on medical students, their background characteristics, professional socialisation, work value and professional aspirations by Rao (1966). In 1972, Madan (1972) examined both aspects—health professionals and organisational aspects of health professionals in Ghaziabad city of Uttar Pradesh. Another study by Madan (1980) does provide important work on 'doctors and society'. Similarly, the occupational roles and structures of doctors and nurses were studied by Oomen (1978). In 1979, Venkata Ratnam located his study in the southern part of India—Tamil Nādu—on medical services and the social background of doctors and nurses in hospitals. The study conducted by Ramalingaswami (1980) stands out in that it examined the social background of medical students and estimated the cost of medical education. This study contributed to understanding the aspirational resources and barriers to actualising aspirations. Chandani (1985) worked on a sociological exploration of the medical profession to examine the social background of doctors, while Nagla (1988) dealt with the socio-cultural background of doctors, their attitudes towards their profession and measures of satisfaction.

Most of these studies are focused on medical sociology by a sociologist. They were/are entirely silent or ignored to study, understand, and discover the causes of non-participation/almost nil participation of the Dalit section in the profession. Investigating social identity and its influence on the medical profession leaves much to be explored.

Despite the policy of protective discrimination pursued by the government of India, the scheduled caste, scheduled tribe and other backward communities are not represented in prestigious professions such as medicine, as studies show (Narayan, 2017). The primary condition for entry into medicine as a profession calls for substantial economic investment. It is the economic resource base of one's family and an appropriate cultural base and social capital for the aspiring individuals, which determines the aspiration and entry into the profession. A minimum level of socio-economic development is a prerequisite for even utilising the unique benefits extended to underdeveloped social categories. On the one hand, they do not seem to have attained the basic minimum level of socio-economic development, which is a prerequisite to entering the profession. The spread of education is minimal among scheduled caste and scheduled tribes compared with its spread among the total population. On the other hand, it seems clear that in a hierarchically organised society, unless specific policies are consciously evolved and vigorously implemented to protect the interest of the underdeveloped social categories, they are not likely to be represented in prestigious professions. Group-specific policies are becoming more relevant and propose better outcomes.

For example, data on the same aspect gathered for the doctoral research[13] has exemplified some of the observations made in the preceding paragraphs. The field data suggested that there were twenty-two health service providers, including Jarrah[14] and quacks. Half of the doctors did not have any professional degree. Most of them had worked as 'assistants in trained doctors' clinics and had opened their own 'clinic'. Nearly 83 per cent of doctors were from twice-born[15] communities, the club of Brahmin, Kshatriya and Bania, two out of twenty-two doctors were women. The majority of doctors were the followers of Hindu religion. Sixty per cent were native dwellers of this block[16] which comprised the study site. There were only eleven as far as degree holder doctors were concerned. All were from twice-born castes. Among them, two had MBBS degrees, three had MBBS and other medical degrees, and six had BAMS/BHMS degrees-Bachelor of Ayurvedic and Medicine Science (BAMS) and Bachelor of Homeopathic and Medicine science degree—both acquired after studying at university-recognized colleges for three years.

Hence, the fact is that despite reservations in medical education, not even a single trained doctor or even quack has a clinic in the vicinity of the Schedule Caste localities. Education is still a matter of a family's social and economic capacity. In the area, schedule caste is so poor that becoming a doctor is a distant dream to many parents and having a successful clinic in the area is also one of the dreams.

Sociology of Sufferer

The sufferer is a noun and synonym for the victim, casualty, subject, target, martyr, object, patient, and case. Though a 'disease victim' might be anyone, but the 'sufferer' would be unable to access health services, opportunities of access and utilisation and equality in the domain. After all sociology of economics will play a decisive role. In this parlance, the objective of this section is to analyse 'who becomes and remains the sufferer.'

As mentioned earlier, the meaning of sociology of sufferers expands its wings on all synonyms in field data collected for the PhD.[17] This section's qualitative and quantitative data are collected from four villages in Agra district of Uttar Pradesh,

[13]Collected for PhD thesis submitted to CSMCH, JNU in 2017.

[14]Urdu word for quacks, basically a traditional healer.

[15]Twice-born is the English meaning of the Sanskrit word "Dwij". Dwijcan only is a male member—not woman—of the first three varnas in Brahminical Hindu Society: Brahmin, Kshatriya, and Vaisya. The first birth is from the mother's womb, and the second is spiritual after 'Upanayan Sankskar'. First birth, meaning born from the mother's womb, is impure till Upanayan Sansakar. The purity is considered after Upnayan Sanskar. That is why the word Dwij came into existence.

[16]Shamashabad is the block's name located in Agra district of the state of Uttar Pradesh. It is India's highest populated state, bigger than Pakistan, and very politically active on Dalit issues, where a Dalit woman has became Chief Minister of the state three times. It has a significant number of Dalits. Agra is famous for the Taj Mahal and manufacturing shoes and leather items in India and abroad.

[17]Collected for PhD thesis submitted to CSMCH JNU in 2017.

India. Identification of villages has been done based on differentiation in all four villages, such as different percentages of Dalit, different powerful community that dominates and mixed population in the percentage of socially dominants, Shudra, and Dalit. The percentage of Dalits in all four villages is different. The identity of the dominant caste and classification of health centres can be as two sub-centres, and the rest two are non-sub centres. Two hundred respondents were studied in this research. Half of the respondents were from Scheduled castes, the rest were from OBC, and the others were from the historically privileged castes. An alarming situation emerged based on the details provided by them. The endeavour has been to understand and define the existing situation to establish the 'sociology of sufferers' and use the data of narratives.

A set of indicators was included in the respondents' schedule to understand access and utilisation of healthcare services as 'sufferers' from Schedule Castes. Health perception and the components of health and illness as health as *'illness'* were explored. Hindu religion is prominent in the villages. More than half (60 per cent) have studied up to class five. Education is still a matter of the privileged caste and has a robust correlation between caste and poverty. Availability and access to basic facilities are essential prerequisites of good health. Access to water facility, electricity, toilet and availability of rooms, kitchen, bathrooms, personal transport facility and even the type of PDS—Public Distribution System (subsidised food grain, monthly)—card are significant parameters that directly correlate with good health.

Seventy-two per cent have a separate water source and are not allowed to fetch water from others even in an emergency. Only nine per cent of SC houses have toilets in their home. Landlessness among schedule caste communities is very high, and families are heavily dependent on subsidised food grain (only 17 per cent have subsidised food grain card). Irregularity in the opening of PDS shops makes the situation worse. PDS shops are allotted or run by a local politician or family or relatives. Scheduled caste communities live in unhygienic conditions at the corner of the village without any basic facilities, insufficient water availability, food availability and consumption, and in overall poverty compared to other social groups.

The overall health conditions of the people of India are not satisfactory, and this implies that those from scheduled castes sections of the population would be miserable (Shah & et al., 2006). The causes for discrimination are many and exist in healthcare access, and non-Dalits are governed by age-old beliefs and stereotypes to continue practising discrimination (Acharya, 2010). The SC and ST in India have faced historical and continuing forms of discrimination and deprivation, and this is obliviously reflected in the incidence of poor health conditions among them relative to the others (Deshpande, 2000; Borooah, Diwakar, et al., 2014; Dwivedi, 2017).

The socially weaker sections have higher mortality rates and poor nutritional conditions. The women and children who form the marginalised sections receive less health care than their 'others' counterparts. The data indicated that the conditions are worse for SC than the others, and therefore, the scheduled sections of the population are miserable.

Some questions have been used to know about the number of rooms, availability of kitchen or separate kitchen space and bathrooms as an indicator for primary facility required for human existence. It has also been used as an indicator of their economic situation. Only 4 per cent of Dalits have kitchen space, while 21 per cent of the privileged community has the same, and 89 per cent have pucca (made of bricks) rooms. A considerable difference in the availability of primary facilities in their house reflects a life full of stress and a poor economic and living environment.

Theoretically, being poor and excluded, schedule caste communities are more prone to seasonal disease and chronic illness than other social groups. Data reveals the well-established fact of poverty and illness around the health status of Dalits in India (Ramaiah, 2015). Narratives from the field of Dalit respondents have also been penned down on aspects of availing government health facilities equally, including personnel behaviour. People are afraid to complain about the staff member of insufficient time being given, because of the fear of mistreatment by personnel against whom the complaint has been made or his supporters. "*Doctor does not listen. They do not pay attention to any complaint,*" was the observational 'complaint' shared by one respondent. They also said, "*Jaan Phahchan ho to kaam hota hai anyatha Nahin*. (If you know any staff member, you are likely to get some attention; otherwise, no attention is given to patients)." Also, one statement by a respondent reflected that they felt comfortable consulting the doctor(s) from their community. However, the doctor(s) from other communities often make them feel 'different' and therefore are 'scared' to talk to them. "*Mariz ka apni samaj ke doctor se baat karte huye himmat badata hai*. (Patients get confidence when talking with doctors and staff from their community.)" They feel that casteism is a potent symbol of social capital, which strongly supports their community and suppresses others.

Conclusion: Reclaim the Rights

The exclusion, discrimination, and 'suffocation' aspects of being born as a Dalit in Indian society completely missed out on the ambit of public health researchers and policymakers. Even government studies or data gathering exercises report disparity among social groups but do not consider them 'causes of caste'. As a result, caste appears and gets reported as a mere social factor such as age, sex, literacy, occupation, etc., but one is unable to extract its effect. It is a policy blunder that considers the caste but not its effect. Until last year, India has had four rounds of NFHS reports (National Family Health Survey) (the fifth was released in 2020) that boldly reflect disparity among different social groups. However, the policymakers still refrain from accepting and addressing them as policy matters. It should address both preventive and promotive levels. The disparity in health service outcomes among different social groups should be considered a result of discrimination which has a legal bearing. Therefore, the responsible person should be held accountable. Social diversity should be respected in spirit and encouraged at all levels of the system by providing significant space for people from diverse backgrounds. Orientation of health personnel

on the caste question should be part of their study and training, and sensitivity should be enforced and ensured in the curriculum. The NFHS and other micro-level data are solid evidence that discrimination exists, but nothing has been put in a system to weed out discrimination. Hence, a policy intervention is immediately required.

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Situating Hadis' Occupation and Caste: Exclusionary Journey from Manual Workers to Sanitation Workers in India

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Abstract

This essay is an outcome of a long ethnographic account of an occupational group that remains low-paid, polluting in nature, and historically considered menial. In India, various names are used to refer to the people, but they are called Hadi/Hari caste in Bokaro, Jharkhand state. The essay examines the exclusionary process deeply rooted due to the occupational association with sanitation, cleaning of toilets, and all work that is not carried out by other castes and communities. The oral histories of the Hadi community brought in by intensive fieldwork demonstrate how occupational association brings a different level of social status by changing the workplace. In the last two hundred years (somewhat after 1802 A.D.), this community has not found the fruit of change that many other deprived groups could receive in reality; instead, they live in a dilemma to be urban but consistently remain at the margin. Further, there has not been a single study locating Hadis as one of the most marginalized and discriminated caste groups and they are never addressed in the policy framework except a few[1] on the same caste groups of Chas town[2] in Jharkhand. The services of Hadis played a pivotal role in the life of the new township in the sixties. Nevertheless, where and how they survived over a few decades is examined in India this research. Sociologically, communities and occupational groups like Hadis find an apt example of discrimination and exclusion even in twenty-first century India.

Keywords

Dalits, manual scavengers, exclusion, Jharkhand, ethnography, Hadi caste, sanitation worker, safai karamchari

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[1]Ziyauddin, K. M. 2016. Occupation and Dignity of Unseen Population: Yes they are manual Scavengers, *Journal of Exclusion Studies.* 6 (2): 125-140.

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Introduction

India is multi-cultural, diverse in works and occupation, historically complex, and a socially stratified society. Some writings manifest and ignite feelings of celebration to the spirit of historical multiculturalism and the vividness of diversity that stands true. The scientific journey of researchers studying people and their occupations could involve:

- Discrimination
- Deep-rooted unequal social structure
- An unglorified caste-based occupational association to the people's lives.

A few communities and castes did not even find correct mentions in the census of India documents, historical textbooks and social scientists' writings. Hadi caste families felt neglected—when individuals carrying out documentation exercises miswrite their names or caste names while doing survey or official work. One of them is the Hadi caste, a sub-caste of Mehtar, referred to as manual scavengers at the pan India level. They go by more than a dozen distinct titles, yet they all refer to the same thing: a standard and single occupation; in other words, one occupation with a wide range of names (Ziyauddin, 2017; Ziyauddin, 2021). The Hadi caste is one of the lowest ranking castes groups among twenty-two SCs listed for the Jharkhand State (District Handbook Bokaro, 2011) and settled in Bokaro, Dhanbad (Jharkhand) and Purulia (West Bengal), comprising around 500 households (Ziyauddin, 2016).

Historically, Hadis are engaged in menial occupations, including serving the royal families in the region. By serving for more than one generation, their job remained less respectful until they helped royal families and were not seen as unclean as it is now. In 2011, the Census of India mentioned three castes (Hadi, Mehtar and Bhangi) in one category of occupation of manual scavenging and sweeping. The Census of India's subsequent reports reveals officials' and census enumerators' apathy and ignorance in conducting census enumeration on Hadis. Hadi's caste is referred to as Hair in census documents with Mehtar and Bhangi (Indian Census, 2001); afterwards, like Hari, Hadis are referred to as Hair (Census of India, 2011). Another type of exclusion is imagining their caste names having been misspelled and incorrectly mentioned.

Hadis, angered by the way their names were spelt and reported said, "Why can't you find mistakes in the names of any other castes except my people" Santu Hadi emphasized. Though they are misspelt in census reports, Hadis assert themselves as Hadi caste and not as Hari. Volume IV, compiled by Russel and Lal states, "The Bengal name Hari is supposed to come from Haddi in Bengal which is supposed to derive from 'Haddi' a bone' and is the bone gatherer and was [to] familiar early settlers of Calcutta" (1916, pp.216–217).

In volume IV and volume I (1916, p. 367), Russel and Lal described "Hadis as the sweepers" and a bone gatherer synonym of Mehtar, the sub-caste of Mehtar in Bengal.

Castes' names and titles have changed in the past, even in his study in Mysore; M. N. Srinivas (1942) found caste names changed in census records. It is thus not surprising that Hadis are spelt as Hair or Hari in different census records. Altogether, the three mentioned castes in the state stand out as 58,242 (Census of India, 2011). In urban Jharkhand, 36,044 and 22,198 were rural figures of the total population. Historically, the demand for both urban households' toilets and public toilets compared to rural areas in the state has been higher than in rural due to significant chunks of the population being urban.

The population of Hadis, Mehtar, and Bhangis (formerly manual scavengers) in the studied district (Bokaro) are 10,581 out of 58,242 persons in the state. They comprise 5,286 rural and 5,295 urban at the district level. Almost an equal number of people reside in rural and urban areas at the district level. It is crucial to consider that Chas is the most populated town in the Bokaro district. Further, Chas town employs many sweepers (manual scavengers) who are Hadi.

Unlike studies (like Shyamlal in Rajasthan and Pathak in Bihar) that show sanitation workers are more urban than rural, Hadis' bring interesting dissimilarities in various ways. The population appears almost equal between urban (5,286) and rural (5,295) in this research field. The scattered population of Hadis tells another fact that the region of Dhanbad, Bokaro, Purulia, etc., has had a more prominent presence of sanitation workers (erstwhile manual scavenger workers) in the last few centuries. Second, Muslim rulers brought the toilet system into West Bengal province that ruled for long. The arrival of the British Empire, initially the East India Company into trade and commerce that gradually converted as an established empire, also influenced local royals and kings in most of their lifestyles and standard of living. Dhanbad became the first area to get underground mining by the British administration, and it is still referred to as the coal capital of India. The coal mining also brought new sub-urban settlements and regions in large numbers across Jharkhand (earlier Chota Nagpur division of Bihar), creating demand for toilets.

It is essential to consider that coal and other mining industries existed in the Bokaro (a part of district Dhanbad before 1991) region even during British rule. Each mining site also had residential settlements for the workers employed in the mines. Hadis are engaged in cleaning jobs in the residential colonies of mine employees and live nearby. Thus they are dispersed in Bokaro and Dhanbad.

Out of 35 wards of Chas town, five wards were added after the Chas Municipality was converted into Chas Municipal Corporation on 9 February 2015 (Census of India, 2011; Chas Municipal Corporation, 2015). The field site of this study, Hadi Cooli, falls under ward 11. This ward has a population of 3,632 and has 646 households referred to as sweepers, but local folks call them Hadis, a synonym for sweepers.

I have tried to describe and analyze the various living aspects of Hadi's settlement, the people themselves, household census, amenities, schools, the problems, work and everyday life, and related aspects of health and illness.

Population and Linguistic Speaking Diversity of Hadis

The linguistic population of Hadis at all India level, largest clusters of them are associated with Bengali-speaking families (5,81,000 Bengali speakers), followed by Oriya 21,200; Hindi 1,26,000; Rangpuri 44,000; Bhojpuri 38,000; Maithili 4,600; Santali 4,400; Kui 2,400; Kharia 1,700; Kurux/Kurukh 1,500 and Magahi 1,400 (Jhosua Project, 2014). Similar to Hadis, Bhangis are also widely populated, as Shyamlal (1981) writes. Interestingly Hadi castes are kept in different constitutional categories in different states, unlike Bhangis and Mehtars. Himachal Pradesh categorizes the Hadi caste under the Other Backward Classes (OBCs) category. Though, they are put in the SCs category in all other states of India.

Majority of Hadis' population resides in 10 states of India. In descending order, it would be: West Bengal (5,89,000); Orissa/Odisha (2,24,000); Bihar (1,06,000); Jharkhand (84,000); Uttar Pradesh (8,300); Himachal Pradesh (2,100); Andaman and Nicobar Islands (1,600); Chattisgarh (1,500); Tripura (1,000) and Meghalaya (1,000) and in small numbers both across and outside India.

India's neighbouring country, Bangladesh, has a population of 59,000 Hadis who speak Rangpuri as their primary language. They follow the religious rituals and faith of Hindus (Joshua Project World, 2014).

In general, the details of Hadi's population are limited and not representative due to the lack of a countrywide survey and differences in the mention of castes by state. Further, there is a lack of an extensive sociological study on the Hadi caste compared to other social groups. For instance, research on the Bhangi of Rajasthan studied by Shyamlal (1992), Sachchidananda (2001), and Pathak (1991) wrote extensively based on their fieldwork studies in Bihar. Whereas the writings of Srivastava (1997) on Bhangi/ Mehtar in the book '*Manual Scavenging in India: A Disgrace to the Country'* are some significant reflections that pose questions why manual scavenging remained as a practice even in twenty-first century India. Geeta Ramaswamy (2005), on the manual scavenging castes in Andhra Pradesh, elaborated on the plight of manual scavengers in her book '*India Stinking*'. However, Hadis as a caste group did not find the attention of any researcher. One does not get a proper reference about the Hadis even in the edited volume of the People of India[3] series for Bihar that includes Jharkhand in part I and part II. Scanty references that Hadis existed and have been engaged in menial occupations of manual scavenging are found in the Census of India documents, 1991, 2001 and 2011. A survey by the Committee on 'Improvement of Living and Working Condition of Sweepers and Scavengers' headed by IPD Salpa on the sweeper Pourakarmiks in Karnataka working in various municipalities in the state shows that

[3]Kumar Suresh Singh. 2008. People of India series for Bihar that includes Jharkhand in part I and part II. Anthropological Survey of India.

besides the Scheduled Castes, there are Muslims, Christians, Lingayats, Kurubas, and Mudaliars engaged in this profession. It proves that members of different castes and communities have also taken up this vocation mainly due to economic compulsions. However, debates on how various occupations based on birth and caste are a reality in non-Hindu communities demand further research. Hence, this paper is limited to low-caste Hindus' caste and occupational history. Another report in *Frontline* shows the existence and continuity of such practice in many states (Venkatesan, 2005).

There is also a mention in this chapter about the entry of tribal youth as a sweeper in Chas town, mainly employed in private hospitals. My research is one such initial intensive and qualitative study on Hadis in India, elaborating and examining the community's life extensively and how they suffer exclusionary practices in multiple ways.

Hadi Cooli as a Site of Discrimination

Bokaro town is classified as Class I, Chas as Class II, and Bokaro Steel City are classified as an Urban Agglomeration in 2011 All India Town Directory of Census Enumerations. Chas is governed by the Nagar Parishad (Municipal Corporation). After the state government passed the Jharkhand Municipal (Nagar Palika) Act, 2011, the term 'Nagar Parishad' became popular (Jharkhand Municipal Act, 2011). The Chas Municipality was created on January 21, 1977. According to the 2011 Census report, Chas town has 35 wards with 141,640 people, with 74,727 men and 66,913 women. The town's population density is 338 people per square kilometre, up 23.19 per cent from 1991 to 2001 and it grew at 6913 in the year 2011.

Hadis Working Population by Sex

Females outnumber males 167 to 139 in a Hadi Cooli population of 306 people. The sex ratio in Chas (Nagar Parishad) is 895, lower than the state average of 948. Though in Hadi Cooli, several factors have contributed to the improved status of female sex proposition. The number of females in the 0–9 year age group is 43, compared to 37 males. Between the ages of 50 and 59, the proportion of females and males changes, with eight females and five males.

Further, in the 60 years and above age group, there are six males and twelve females. The underlying fact in this data is an unequal number of males and females. Still, these observations of the lesser numbers of males in the older age groups reflect a different aspect of Hadi's life. The shorter longevity of males is also attributed to their occupation and heavy addiction to liquor. It is reported that Hadi men died earlier than women due to their higher liquor habits. The health status degrades due to the continued consumption of low quality locally made liquor. Hence, the sex ratio of Hadis may be better not due to Hadis' preference for girl children but due to the high incidence of male mortality in the old age groups as well.

Tracing History and Lineage of Hadis in Chas Region

The Maharaja of Kashipur, Maharaja Bhuvaneswari Prasad Singh Deo, in the Purulia district, governed the territory until 1947 and opposed British rule to establish an independent state. Hadis first settled in the Kashipur area of Purulia district, a nearby district of Bokaro with a long history of cooperation, and then dispersed throughout the region. In Bokaro and Chas town, a few senior-most Hadi caste people maintain that the area's Raja imported their forefathers from other states to labour in their houses and forts.

This claim is supported by land records that reveal Hadi settlements in the Chas region dating back nearly 200 years. Hadis in Hadi Cooli have a long history dating back to the Maharaja of Kashipur, who granted them state favour and enabled them to reside in the beautiful region of Chas, now Hadi Cooli. The land was given to them by the Zamindar of the Chas region. This information is supported by land records, which reveal that the local king allocated some land to the first inhabitants in 1802 (Map 2.2).

Hadis themselves reported that most of them worked for the ruling families until the end of the kingship of the Maharaja of Kashipur. Later there was a change in the geographical and territorial entity of Manbhum[4] to Dhanbad, which affected Hadis' life. Due to historical facts and being a joint ruler in the past, Hadis in Bokaro district had common bonds with the families of their caste in Purulia district, West Bengal. Hadis of Chas identify themselves as Maghaya Hadi, different from Hadis living in Purulia, Bengali Hadi.

The history of settlement helps to understand how Hadis continued doing traditional occupation and examine their occupational conditions. Ramesh Hadi (69) and Somesh (62) narrated that the local kings were Brahmins (or Brahmans) and were paid high respect due to the patronage given to Hadis. Both of them said,

"*hamni ke Budha Purna ke raja zameen dalae halau aur vehe zameenva par hamnee baes galiye. baaede mein konhon soche na partil ke hamni kae zameen kamae aur aadmi logan boaidh jitae. Ab kahan jeebin, badi samasya hau. Chas mein konhon zameen nae hau ke hamni liye paarbin. Joria thheen kutchau nae bachal hau*." "It is literally said that Raja gave some land to our ancestors who first settled in Chas, and we all continued living on the same piece of land. No one thought that in years to come, our family would expand and that very land would be a problem to us. There is no land in Chas which we can buy. Even land near Joria (an earlier natural stream turned into the drain) is sold, and houses have come up." The settlement of Hadi

[4]In 1833, district Manbhum was made a separate district out of the Jungle Mahals district and the headquarters at Manbazar. Just five years later, headquarters was transferred to Purulia in 1838, which is closely located to Chas at fifty kilometers. In Independent India, Manbhum district was again partitioned between Bihar and West Bengal under the States Reorganization Act and the Bihar and West Bengal (Transfer of Territories) Act 1956 in 1956 AD (Purulia District Profile, 2014). In the same year, Dhanbad was given a separate status of a district that included present-day Chas town.

Cooli can be read and seen in the following Map 1.1.[5] It also provides sociological insights as to how habitations in India have been patterned by social distancing and occupational purity and pollution.

Map 1.1: Hadi Cooli

The families find it challenging to understand the de-sanskritization in their community life over the last few decades. The patronage of Raja provided some social respect to Hadis. Hadis differentiated themselves and claimed higher social ranking as they worked for Raja's families, similar to Bhangis in western Rajasthan who claimed higher social ranking who worked in upper castes families than those who worked for Dhobi castes (Shyamlal, 1981).

[5]The map was prepared after the fieldwork and Dr. Navin Narayan finalized it.

Khortha is one of the recognized languages in the state of Jharkhand. Perhaps for this reason, except for one Hadi household in Purulia, who later settled after getting a job, all kinship ties are traced within the neighbouring districts of Bokaro in Jharkhand state but not in Purulia; however, it is not far away in terms of considerable distance.

It is also vital that there are no government lands in the vicinity of Hadi Cooli where they could settle down temporarily, as discussed with Hadis. Generally, some land is found that is neither owned by individuals nor by the government, known as "*Gair Majurwa Zameen*" (Lahiri-Dutt, Krishnan, and Ahmed, 2012). The government can use such lands for community purposes, and at times people also use them until the government takes over. The absence of *Gair Majurwa Zameen* near Hadi Cooli also minimized their residential expansion. They got confined in the same land, which was enough when the first settlers constructed their houses and settled down in the present Hadi Cooli.

People narrated that except Hadis, most people had some land, and they used to pay taxes to the ruler at the time. The Misree (Brahmins were referred to as Misree earlier, and the colloquial term for the ruler in the past was Misree (Mishra) would send his revenue staff to collect taxes from each house as per the landholdings and available assets of the agriculturalist or farmers in Chas. The team in charge would also use a drum to inform the households about his visit to the localities. The revenue collectors gave Hadis an exemption in the regular tax collected from all the families. This fact denotes that this area was under the Raja of Kashipur, and he promoted local Zamindars to run the administration and collect revenue (Purulia District Profile, 2014).

Hadi's oral narration of their past is a testimony to the fact that they lived and worked in the estate of the local king, Maharaj of Kashipur. It is also reported that a few Hadis worked in the houses of landlords and zamindar in the Chas region. Such stories are transferred from one generation to the next. Although most elders, including Ramesh Hadi, the oldest and most vocal man, pointed out that Hadis had better social status in his time than the later period and years after the decline of Maharaja's rule. The stigma associated with Hadis took rigorous forms, and they became the most discriminated caste among all the lower castes. The old generation provided several narratives of being humiliated and discriminated against as children born into Hadi families. The identity of a child was also associated with the work performed by their parents. Ramesh says, "I was not allowed to have a cup of tea in the tea stall at Chas bus stand. If at all I insisted, tea would be poured in an earthen cup (kulhad). After putting the tea in an earthen cup, a hotel helper would be asked to keep the cup down on the floor, and I would then pick it up to sip it. I felt degraded and would mostly avoid going to the tea stall."

There are a few commonalities from the past to the present in a Hadis' life. Senior elders reported that the nature of work has relatively changed in the last generation. Shailender Hadi said, "We used to live filthy life at an early age due to dirty work and had less number of dresses. We were also less in number than the available workers. Now our children and new generation live a decent and good life. They can use washed clothes; eat better food than us; what else you can see as a good chance than this."

The work and occupation have not entirely changed, but the stigma and discrimination have significantly reduced. A noticeable change took place like work. Twenty years ago, houses in Chas had a large number of dry latrines and Sandas[6] that needed regular cleaning. An informal understanding existed between the households and Hadis. Five rupees were paid to clean the lavatory and the connected drain or outflow pipes for each house. Such an arrangement would give Hadis everyday earnings to take home. The change in latrine system, dry to flush based, has changed the mindset of the households. It is noticed that now people do not hire Hadis for everyday cleaning until there is a blockage and major cleanings are required. Families are doing the cleaning jobs themselves. A large proportion (40 persons) of the total (75 male) Hadi men workers have got employment in Chas Nagarpalika (municipality) as sweepers.

The land records available with Ramesh Hadi show the lineage of Hadi families having been settled at Hadi Cooli of Chas town since 1802. Ramesh's sister Dhulia Devi, a widow, lives in Hadi Cooli. Dhulia lives with her younger son, Jhomda Hadi. The other two sons, Somda and Komda, reside separately with their respective wives and children in Hadi Cooli.

The diagram (Chart 1.2) prepared with the help of land records available with Ramesh Hadi in the form of Khatiyaan[7] shows that it was 1802 AD that the first person (Narayan Hadi) of Hadi lineage settled in Chas. Khatiyaan paragraph refers to the original land records kept with the owners, which shows the family history of Hadi caste in Chas. As per the same land records at the disposal of Ramesh Hadi, out of the nine members shown in the lineage, only three continued to live in Bokaro district in Hadi Cooli. The ancestors settled at Chas are Gadaghar Hadi (also known as Manu Hadi), Manik Hadi (also known as Makun Hadi) and Ganesh Hadi. The other seven members migrated to other localities and regions within the state (as told by Ramesh Hadi). There are 36 of the 51 households who belong to the above mentioned three persons, and the remaining households are either of those who came from other localities and settled at Hadi Cooli or grooms who moved in uxorilocally after marrying a woman who is a daughter in Hadi Cooli in Chas and settled there.

[6]Sandas word rooted in Sanskrit origin and the term is used for toilet.

[7]Khatiyan is called Land records.

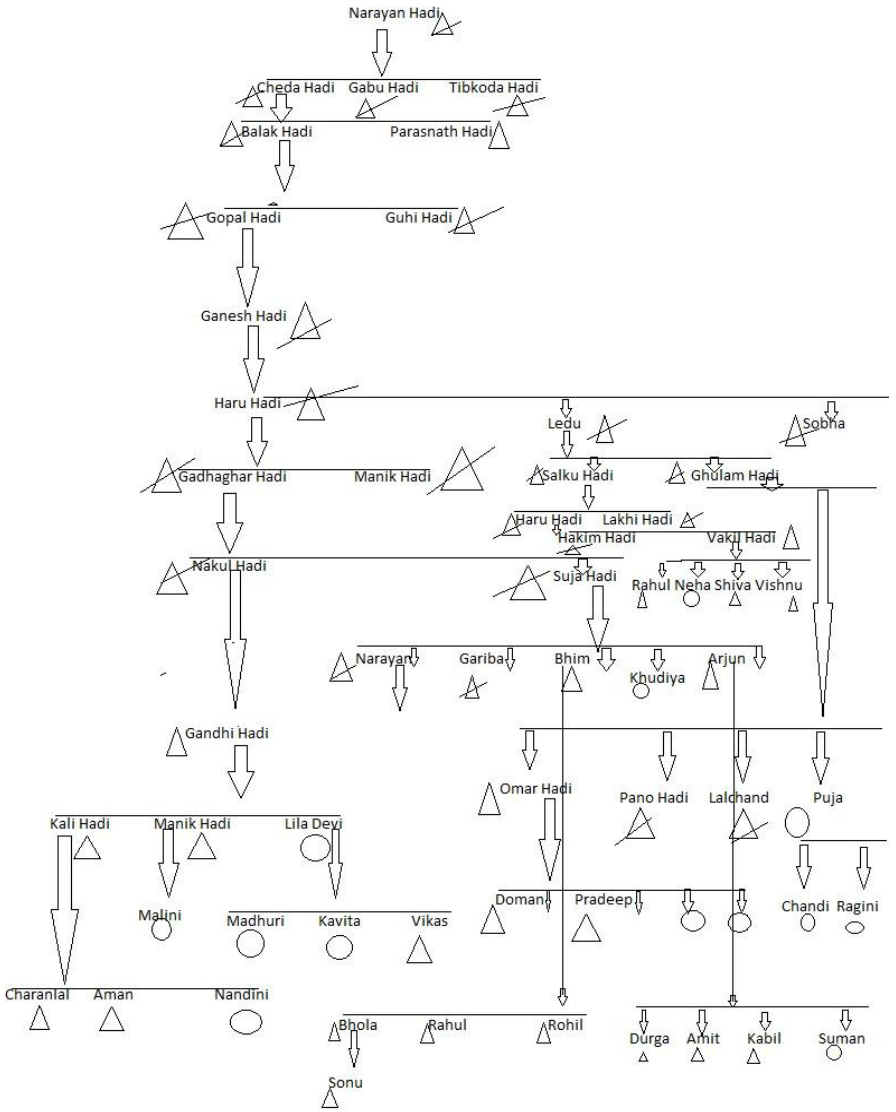

Chart 1.2: Lineage of Hadi Cooli

Hadi Sub-Castes

Hadis can be further divided into four sub-castes. One of the four sub-castes, Maghaya Hadi, is settled in Hadi Cooliin Chas. The three sub-castes, who have not been studied are: Sahir Hadi, Digar Hadi and Bengali Hadi. The other sub-castes have settled in different districts of Jharkhand and neighboring states like West Bengal. The data on three sub-castes are not collected and analyzed, demanding further research be conducted. As Maghaya Hadis have associated with the kings in the past, they assert themselves as higher in social status than the other three Hadi sub-castes.

It is believed that only families belonging to Maghaya Hadi are found in Dhanbad, Hazaribagh, Ranchi, Purulia, Giridih and Ramgarh districts in the state. Ramesh Hadi finds it challenging to provide community details to give the date and year-wise information. The data of elder Hadis have been most relevant to bring out the social history of Hadis in the Chas area. I was informed that the four sub-castes are found among Hadis, but the younger generation is unaware. A few Hadis were observed sitting and learning about their history, but mostly they were not interested. The newer generations are not able to connect with the account of Hadis. The last older generations may take away all the social history with them if they don't share it with the present age. Only a few elders in Hadi Cooli discussed Maghaya Hadis during a couple of meetings, and a group discussion clarified the facts and understanding related to sub-groups. A few interviews were also held with the Hadi elder women and men residing in another village, Mahar Basti.

The elder Hadis, who pondered over and illustrated the occupation and work of Hadis in the past, found that Hadis was left with fewer choices after Raja's rule was taken over by the British. In several interviews with mostly senior members, namely Ramesh, Somesh, Pintu, Goli, Haribabu, Jagdish Hadi, Shailender Hadi, and Panbabu Hadi who supported the data, they said, "Our elder had less choice after the rule of Raja was taken over. Gradually the relatives of Raja left Kashipur. Hadis adopted doing other menial jobs, mainly removing excreta and cleaning jobs. The existence of MADA (Mines Area Development Authority) in Dhanbad provided opportunities to Hadis in Chas. The cleaning job in government offices continued to remove dead animals and carcasses as there was no Chamar caste in Chas urban area." As Goli said, "Except for us, most castes had agricultural lands. In this condition, our job continued in menial and polluted works and transferred from one to another generation traditionally." In response to the researcher's question, "Why did you take up manual scavenging as your occupation?" Pintu responded and said, "*Hamni ke itihaas ke jaen ke kee karbeen hao. Ab hamar baap-dada yehe karo halae are hamro ekre main laga dal hathin. Ye batvaa hamni kee jaanbeen puchae ke konhon reeti naae hau. bus kartae jau yehe hau hamni ke budhha-purna ke niyam*." "What would you know about our history? My father and grandfather were doing this occupation, and they also put me into the same. We never thought of reasons. There is no way of questioning why we chose and practiced manual scavenging. Just keep doing our job is what we have learned from our elder community members."

Gradually, Hadis found themselves getting engaged and occupied with scavenging jobs and the social status of Hadis reduced as polluted caste groups. Still, this data is only reported by senior members, as mentioned previously. The younger generations believe that it is their traditional occupation inherited from their parents. Now the assertion to report the social history of Hadis are recorded in the data that there is the degradation of Hadis' work status from Ghoda Sahej to Manual Scavenging.

Maghaya means a sub-caste to Bhumihars in this region, as claimed by Ramesh Hadi. Hadis in Hadi Cooli belongs to Ghoda Gotra. As per the memory of the 69-year-old Ramesh Hadi, initially, it was only three households that settled in Hadi Cooli,

Chas and the available lands where they settled belonged to three paternal brothers. However, a significant social fact emerges that there is a gradual and subtle change in using the caste surnames as Hari. A few use Hari, while a large number continue to use Hadi. The Census of India has misspelled their original caste surname 'Hadi' and has mentioned Hadis as 'Hair' in the census report 2001—a term that is unrecognized by Hadis in written or other references.

Occupational Structure

The research focuses upon manual scavengers who are engaged in a certain manual occupation as their traditional jobs. Sachchidananda (2001) rightly observes that manual scavenging has received proper attention, neither about its inception nor its existence, desirability, or epistemology. In the volume prepared by Vasant Moon in 'Writings and Speeches of Bhim Rao Ambedkar' published in 1989, Ambedkar writes once an untouchable always he remains an untouchable, similarly, Hadis have remained sweepers once born as sweeper. This expresses the existing concerns and reality of Dalits and this context still finds relevance in the data on Hadi Cooli. The above illustration of Ambedkar meant that a sweeper remains a sweeper throughout the life due to his ascribed status and birth in caste that does not change once born in a particular caste family.

Most Hadis assert that in the last three centuries, their socio-economic situations have worsened. They live in a prejudiced world and are surrounded by caste-based social interactions. Rajen Harshe (2013) reviewed the forms of prejudice mentioned by Gyanendra Pandey (2013) as more or less 'universal' and refers to 'natural'.

As Hadis too shows certain changes in their occupation, in the past, several castes have attempted to change their castes from one to another. M.N. Srinivas in his published paper on 'An obituary to caste system' illustrates other changes as brought about by technological changes and how those products are transforming the lives of villagers who are governed by caste and traditional occupation. He illustrated the changes brought by new technologies in occupation like barber, shifting into market and cash-based work, washerman opening laundry. However, a few castes could not adopt new technological changes due to certain limitations. For instance, Hadis have not been able to transform their work because sweeping jobs are to be done at the work-place like, office, house and similar with jobs removing garbage from streets and roads. The change can be brought gradually in the nature of work, to use gloves; tools etc. to clean the garbage and drains etc. Sweeper could never follow the better way of some castes. The nature of work of Hadis requires them to visit workplaces unlike a barber and washerman. He describes how those products are transforming the lives of villagers who are governed by caste and traditional life occupations. A few examples are, "Edible oil is now produced in factories and they have rendered the oil presser and his bullock drawn wooden press….the barber and the washerman, two essential castes, have had to change their working styles" (Srinivas, 2003, p. 457). This change is taking place in those castes's for whom occupational technology is finding

technological way out but a lesser quantum of change is noticed in the work of manual scavengers (mentioned earlier), Hadis' sweeping job. The continuation of sweeping occupation has perpetuated discrimination but the forms of such discrimination have started changing. People still call Hadis as Hadis (when they want to call a Mehtar) but not by names; it reflects a kind of prejudice against one occupational caste like Hadi.

The ethnographic data provides the continuation of unequal treatment meted out to Hadis but the forms and crudity has changed over the period of the last one generation. There is quite a visible change as mentioned earlier by Somesh and Ramesh that the tea stall was also place of discrimination and prejudice against Hadis. Such forms of discrimination show a gradual change in the market place and also while visiting temples. Hadis are now allowed to pray. The attempt to change their surnames is not very visible although the names of some children have kumar and hari but not Hadi as their surname. This needs further study to illustrate whether it is a deliberate attempt or a normal act. Unlike the study of Tulsi Patel's paper, 'Stigma Goes Backstage: Reservation in Jobs and Education', which shows that there is a conscious attempt by the first generation parents who worked as sweepers (safaiwala) in offices to hide their caste identity and had gone through humiliations. Tulsi Patel writes,

> "It is not surprising that people from the SC category react in ways to avoid their traditional caste or surnames and use the relatively caste neutral surnames, such as Kumar, Pal, Ram, Lai, Chand and Nath. They also prefer to use surnames used by higher castes to hide their caste identity and the anticipated ensuing humiliation in life. Some of these surnames are Singh, Vyas, Guru and Charan. Parents, especially fathers who have been in jobs through the reserved quota have given their first names as surnames to their children to conceal their quota category identity, such as Kapoor, Chand and Swaroop" (Patel, 2008, p. 104).

One does not find deep data on Hadis' attempt to change their surnames. The existence of Hadis as their surnames identifies their occupational category in the eyes of others. The level and forms of unpleasant experiences at the workplace vary from one person to another. The field data makes it true to quote that an 'untouchable' caste would remain lowest in the caste rankings, would remain excluded and this system of stratification functions systematically (Michael, 2007).

Hadis have not been able to benefit from the several welfare schemes perhaps due to their hesitation in approaching the concerned offices. There is also a mindset inherently found among Hadis that they are lower among all the other castes. It is for these reasons as well that, in general, have been called by various names in the past, such as 'untouchables', 'Harijans' (a glorified term, coined by Narsimha Mehta later adopted and popularized by Mahatma), 'Exterior Caste' (a term used by J.H. Hutton), 'Depressed Classes' (a term used by British officials).

Nayak (1995) in his paper writes that a Brahmin would not do any other job like a cobbler or scavenging. Similarly an untouchable would not recite the Vedas. This reality connects to all those occupational groups including Hadis in Chas who

would not perform prayers in temples. He further describes the caste and the practice of inequality in different forms. As regards the notion of pollution we may look at an interesting account given by Aiyappan in his study on the Nayadis in 1937 (see Srinivas, 1952), Caste members of Nayar stay at a distance of 7 feet when a Nambudri Brahmin is present. Iravan people must stay at a distance of 32 feet; a Cheruman caste should stay at 64 feet and a Nayadi between 74 to 124 feet like the other castes (Nayak, 1995). This account would merely be humorous if it were not the case that some of the above-mentioned notions are still prevalent, even though in a diluted form in certain quarters of India.

Such strict social distance is diluted at a minimal level and this crude form does not reflect in Hadi Cooli. The respondents in the field also narrated the practice of discrimination in the past that was visible. Goli Hadi, 52-years-old, works as a sweeper, narrated, "During my childhood, in all eating joints (Dhabas), I was not given space inside the hotel. Tea was not served directly by hand of the worker at the stall either. Most tea stalls keep kulhad (earthen cups). Tea was served in the same cup to everyone but our cup would be kept at some point and I would pick [it] up. Now my son does not believe me when I tell him about my childhood stories."

The household census data shows there are 113 Hadis in the age group 0–14 years. This figure includes both boys and girls, and they are a working population in Hadi Cooli. However, out of 61 Hadi youth in the age group of 15–24 years, 18 males and 10 females are working. Out of 53 Hadis in the age group 25–34 years, 21 are working men and nine are working women. The number of working women decreases in the age group of 35–44 years as there are only three women in comparison to 23 men out of a total of 34 Hadis. Table 2.1 provides the distribution of workers in the age group of 15 years and above among the Hadis. No one under the age of 14 years is reported to be working.

The Hadis are found engaged in their caste occupation which continues even today. Only one person among the 105 Hadi workers is found to be doing non-caste work. Jhomda Hadi, 33 became the only exception in the entire Hadi Cooli, working in a private firm, Tata Indicom, as an office clerk. He spends the entire day in an office unlike his friends who go back home in the afternoon. But he finds comfort due to the nature of his work. It is an office equipped with an air conditioner. During an interview he questions, "Why does the birth in a certain family and caste restrict us from the freedom of choice in all aspects of life and work?" Most are overly dependent on available jobs and consequently spiraled in their traditional occupation. Although it gives both a sense of security and over-dependency, the result is rarely helpful in bringing a change in their life. Jhomda asserts, "I am the only Hadi who has completed graduation (B.A.) and I am not doing my caste based occupation unlike my friends and peers in Hadi Cooli."

This is true of caste based communities that are still found to be engaged in the same or similar occupation for generations and this fact is much more prevalent among the low castes in the region including Hadis. The Hadis are not exploring other avenues of jobs and other jobs as such, rather they find it easier to take up sweeping

jobs. It is the sector where there is little chance of competition from other castes than Hadis themselves. It is in this milieu that Hadis have retained their traditional occupation and have been unable to find a way for social mobility. His life in Hadi Cooli is completely different than at his workplace.

The existence of Hadis reflects the reality and continuity of manual scavenging in different names (sweeper) of my study's caste in the state of Jharkhand. The onus does not lie on the state machinery due to the fact that Hadis are now called sweepers therefore they do not fall into the group of people doing scavenging. But the works of Hadis are similar. There is a possibility of a drastic reduction in the number of scavengers as most who got employed in government and state offices were named as Sweepers or Safai Karamcharis. Hadi castes were already into scavenging occupation but mostly employed in the municipality way back from 1977 onwards and continued to do work in the sanitation department of the Municipal Corporation. The nomenclature changed but the work of Hadis continued to remain the same.

Households Living in/at Margin

As per the household composition census data collected, there were 51 households in Hadi Cooli. The total population of 51 Hadi households is 306, of them 139 are male, and 167 are female. It is important to note that in such a small population there are 19 widows and one divorced woman. One widow, Dhulia, 65-years, lives with her son and daughter-in-law in Hadi Cooli. She is the younger sister of Ramesh Hadi. Another woman, Bijla Devi, a divorcee, lives with her two unmarried daughters. Her husband, Kamal, is married to a woman in Ranchi and settled in his father-in-laws' house. No widower was found at the time of data collection.

Among the six surviving old age males, four worked at Bokaro Steel Plant and other two were in private jobs. Lakhicharan worked in ICICI Bank and Haribabu at a private office. The better working conditions at the offices of Bokaro Steel Plant (BSL), like Bokaro General Hospital (BGH), Administrative Block (ADM) building, etc., kept them a little away from hazardous working conditions and less liquor consumption too. This difference between steel plant employees and others was found during interviews. Steel plant employees reported having the best health care services at BGH that could help to diagnose disease or illnesses. Somesh and Ramesh are examples who benefited from BGH health facilities. Having heart surgery for Ramesh Hadi has been only possible due to the facility of BGH for the staff. The manual workers in Steel Plant offices and Municipal Corporation live at the two extremes of margins due to their varied income category and status associated with the work.

Marriage Practices

The average number of persons per household in Hadi Cooli is six. The walls of a few houses are common to each other. Krishna Hadi and Binod Hadi are brothers and their houses are in one homestead but it has two different households settled there.

Similarly, Ramesh Hadi and his sons live in one building whereas his married daughter Lila Devi and son-in-law Ganesh live on the other side of Hadi Cooli. They were given a small house after their marriage by Ramesh Hadi (Lila's father) and were helped to settle down in Hadi Cooli. There is a very close familial interaction between them. Ramesh's sister, Dhuria Devi is also settled in Hadi Cooli. She lives with her younger son Jhomda Hadi. The other two sons, Komda and Somda, also reside in their separate household with their respective wives and children on the same compound. Pintu and Goli's houses are next to each other and have a common wall between their houses.

The number of married persons is 160 including 19 widows and one divorced woman. There are 9 men and 57 women who were married in the age group of 10–17 years while 48 men and 23 women were married in the age group between 18–24 years. Only three men were married late, i.e. in the age group of 25–31. But none of the women fall in this category. Marriage happens early among Hadis. However, the average age at marriage is increasing from 15 to 20. Pintu was married when he was 12 years of age and his wife was younger than him. His father liked the bride when he saw and met her at one of the weddings. Despite his repeated request to delay, he was told that her burden is not an issue, "Once you start earning things will be alright." But his elder son married at the age of 24 years and other children are still unmarried. One son, Vishnu is 19-years-old and the daughter is 18 years. But he has not made up his mind to marry them off quickly. He opines that 20 years is a normal age when a girl should be married and a boy can marry even later than 20 years. Even boys do not wish to get engaged and settle down early. It increases the burden on their shoulders and in this way their youth is numbered.

A large number of women married before attaining 18 years of age and a few men as well. Fifty-seven women married between 10 and 17 years. This is quite high in a total of 80 married women in contrast to nine men in the age group of 10–17 years.

The household composition of Hadis shows that they have both simple and complex households. Of the 51 households, 23 are complex and 28 simple households. Jhomda, his wife and a child live with his mother and two of his brothers reside separately with their respective wives and children. Jhomda said, "I wanted to live with my mother whereas my elders did not prefer that. They wanted to live separately so that their households get a better life, good food and daily complaints are minimal."However, it has been found that lower castes prefer to live in simple households once they get married (Shah, 1996). Married sons moving to live in a separate household is common. The number of simple and joint households is almost equal. The younger generations want to live in a separate household as each one of them earn and contribute to the household. It is also true that lower castes preferring to move into a separate household after they get married is a common practice. A.M. Shah writes that, "The emphasis on joint household was greater among higher castes and classes, who formed a small section of the society, than among lower castes and classes, who constituted the vast majority of the population" (Shah, 1983, p. 3). This becomes the obvious fact that Hadis' preference to a simple household is not uncommon but similar to many other lower castes in the background literature of A.M. Shah. Individual earning, the choice

to spend on their wives and children, preference of food, and type of recipe becomes important to Hadis to an extent that makes them shift in a simple household after marriage. However, very limited land in Hadi Cooli and lack of saving or money in hand restricts them to move immediately into a newer house. A few of them got support from their in-laws' families to construct a new house after marriage. At times parents and other relatives also helped.

Kinship network is typically based on blood ties, marriage or adoption. Marriages are arranged with matches outside Hadi Cooli following marriage within the Ghoda Gotra. This practice is contrary to gotra exogamy, i.e. not to marry within the same gotra. The avoidance rule of marriage is limited to the paternal lineage. They avoid marrying a person with whom there is a known lineage association. In other words, a Ghoda Gotra groom does not marry a woman from Ghoda Gotra if she is known to be an offspring of a man related to the male line within a traceable depth of Ghoda Gotra. Otherwise, marriage can take place as told by Ramesh Hadi. But all of them do not belong to the same gotra in the surrounding region of Chas. They do not marry the children of their father's siblings. This practice is seen until traceable generations in the male line. However, marriage alliance is arranged within Maghaya Hadi, one of the four sub-castes of Hadis mentioned earlier in this chapter. The localities of married women in Hadi Cooli are scattered at different places in the above-mentioned districts.

Sanitation and Sewage Conditions

Besides economic distress, there is a lot of struggle for basic amenities such as water and sanitation. The area surrounding Hadi Cooli has three ponds that dry up during peak summer. Due to the absence of public or private wells, deep bore, etc., the Hadis are mostly dependent upon these ponds, as ponds cater to the needs of bathing and washing for the Hadi and other castes. The open ponds do attract stray animals, drains of neighboring houses adding to the filth and dirt into it. Except for one hand pump installed by Municipal Corporation and another one at Bauri Cooli, there is no other source of drinking water.

The condition of the sewage system in the town is very poor. It is essentially a public health concern for all but Hadis have the worst situation in their Cooli. Ramesh Hadi said, "How can there be such an insensitive government although the head of the state is represented by a native tribal, Shibu Soren, then Chief Minister of the State, one of the most neglected social groups of Indian society?" *Times of India* in its Ranchi edition on May 23, 2011, reported that Jharkhand perhaps is the only state in India that does not have even a sewage treatment plant at a time when the world is moving ahead with a mission of total sanitation and a hygienic environment under Millennium Development Goals (MDGs) across the globe. The important towns like Ranchi, Bokaro, and Dhanbad having more than two million people, exist without this facility.

Further, the increasing contamination of groundwater is affecting the drinking water through wells, hand pumps, and tube wells that are the main source of water

for the poor population including Hadis. The state stands at the bottom of the list in the implementation of the total sanitation scheme against the national average of 63 percent as only 41 percent of households in Jharkhand have toilets in the state. The absence of sanitation and toilets adversely affects everyone in general but women in particular. One of the documents of the World Health Organization (WHO, 2008: cited from Rebecca, 2008, p. 172) points out that "Sanitation is a cornerstone of public health." The lack of toilets not only challenges the dignity of Hadi women but also exposes them to bacterial infections. Females and males still practice open defecation. There is no data to discuss the increasing problem in Open Defecation due to crowding as Open Defecation Free (ODF) is not a problem.

Source: Fieldwork, 2012

Photograph 1: Krishna Hari's Two Private Flush Toilet at Hadi Cooli, Chas

Photograph 1 shows the two flush toilets that remain mostly unused in Krishna Hari's house. His house is better constructed but the rooms are very small and congested. However, there is one corner in the courtyard allocated for prayers. There are a large number of households that have some familial association with first settlers. In an interview in the field, the Deputy Commissioner (DC) of Bokaro especially reiterated that Bokaro stands out for its greenery in the entire state but the adjoining town of Chas is a contrast to it. Bokaro has been one of the well-planned and developed towns much before its separation from Bihar. But the development is purely confined to the industrial civic areas of the steel plant and Chas is left out.

Men and women have to fetch water from a distance. They find it difficult to walk long distances and one does not know exactly where water would be available.

As a few men use cycles to go farther. In the afternoon most Hadi men get free from work; hence they find it easy to do this job. However, a constant effort and appeal are addressed to the Municipal Corporator to provide a deep borewell in the Hadi Cooli locality. They say it is under consideration.

Apathy in Schooling and Educational Interest

A primary school is located at the outskirts of Hadi Cooli, closer to Bauri Cooli and Muslim Mohalla. The school has children from all three localities Hadi, Bauri and Muslim. There are five teachers in the school. It is a small building of four rooms and one large veranda. In front of the school, a deep well was sunk as a source of water for the school. This well was used to fetch drinking water by the Muslim Mohalla and Bauri Cooli. But it has now dried up and is filled with garbage. The school has no source of water these days.

A number of children are enrolled but they barely attend classes. During the mid-day meal, the children return to school and enjoy the food. Teachers find it difficult tomanage the regularity of attendance. As a teacher stated, "It is very difficult to teach children from lower castes. Their parents do not bother about the progress of their children. Most parents from Hadi Cooli do not visit school and even when their children do not turn up to the school even for a month sometimes. ``The educational level of Hadis is quite low as shown in Table 2.5. A larger number of them are illiterate among both male and female. Not a single woman is found who reached class 11, except for Jhomda Hadi who completed graduation.

The lapses in regular schooling are another serious problem in Hadi upliftment. After primary schooling, only a few enroll in the high school located at a distance of three kilometers east of Hadi Cooli. But they hardly attend school. The apathy towards education is dominant in the minds of Hadis, including the youth. Youth are aware of the son of a tea stall, who studied in a common school, Ram Rudra High School, and he qualified for an officer's job (Probationary Officer) in the State Bank of India. In an interaction with young children, they had less interest in talking about education.

Conclusion

Exclusion is a perceived and lived reality to the Hadi community and as a polluting caste group. Educational backwardness is rampant among the Hadis. Almost every day a discussion on educational backwardness took place in the field while I was there. The socio-economic condition does not allow them to spend on their children's education. Schooling is free for all SC children in government schools. Uniforms are given. Though several children got uniforms and books, they are still not made available to every Hadi student.

Neighboring localities resided by the Bauri caste show that they have started sending their children to school as they are aware of the jobs in the government sector

through reservation. But Hadis are found to be unsure about such avenues outside their traditional jobs.

A strong perception among Hadis exists that degrees will neither bring prosperity nor feed them. They have to work daily without failing to earn a minimum amount. Food and clothing are essential items in the life of every Hadis. In the whole of Hadi Cooli only one, Jhomda Hadi is a graduate but he is unsuccessful in people's perception. He tried his best to find a good job but a simple graduation degree did not help him. He was not ready to revert back to the same sweeping and scavenging job. It was very difficult for Jhomda to survive in such an environment where education does not have significance in earning for everyday living. There is one Bangla (Bengali) medium middle school located near Joria and it gives an edge to Bauri Cooli due to its location.

There are no success stories in the lives of the Hadi community. Most parents do not aspire to encourage and educate their children as it is believed that after spending years of time and money on education there are still no job opportunities. Their only hope is for the children if they overcome the deprivation and attain higher education. Life in Hadi Cooli is relatively different in several aspects. Hadis have to follow their work that demands different working hours than most other jobs. Community solidarity is observed and the same can be noticed when the elders pass any information to anyone. Any new visitor will be asked and enquired upon his / her purpose to visit Hadi Cooli. The young children primarily spend time among themselves except school-going students who have friends outside the Hadi Cooli.

The lives of Hadis have been changing but there is less social mobility. Bhangis in Rajasthan started following customs and traditions of upper castes and have shown the process of Sanskritization as Shyamlal (1984) writes. There is diversity in the occupation of Bhangis in Rajasthan but Hadis do not show many variations, except two households doing other jobs; one person has a grocery shop in a portion of his own house, and other works as an office staff at Tata Indicom Retail shops in the private sector. In 'The Bhangis', Shyamlal (1984) found they were engaged in nine other occupations. The study is 30-years-old when private-sector employment had lesser avenues in a town like Jodhpur. But the growing industrial and urban sector would have increased the opportunity for Bhangis as it has also helped Hadis in Chas. But Hadis in Chas has retained their own occupation of sweeping than diversifying into other jobs. Thereby nomenclature changed, spatial expansion of the town changed, demographic and population size has increased but what has not changed is the same occupation carried for generations. Traditional occupations of sweeping, cleaning drains and toilets is the main work that the Hadi community does even today that keep the discrimination and multiple forms of exclusion as an essential part of their socio-cultural life even today.

The social history, occupational background and spatial location multiply their agony and pain to live in poverty and on the margins. Present generations have no idea of their lineage that may die or fade away by the time elders pass away. In the eyes of the administration and state, Hadis are occupational caste groups that do find work

in sanitation and cleaning jobs of the municipal corporation. Hadis also cater to the sanitation job in the private sector on a casual payment basis keeping them on their toes every day. It would be interesting to observe in future, if other caste members and a few tribal youth start joining into sanitation and menial jobs on the formal set-up like hospitals and nursing homes. A negligible number is found in the field data. Will the arrival of a new workforce reduce the discrimination meted out and social distance kept with Hadis sustain for longer time in future? New research in the future would have to take this aspect into consideration while studying Hadis as an occupational caste group to understand new phenomena.

Though their exclusionary journey from Workers to Sanitation Workers continues even today despite various efforts and policy initiatives, they are still manual scavengers by occupation, and sweepers/sanitation workers by name.

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Media Coverage and Corona Induced Health Emergency: Understanding Prejudice, Stigma, and Social Inequalities in India

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Abstract

This essay traces the impact of the Corona pandemic during 2020–21 and issues related to stigma, prejudices, marginalization as well as virulent forms of social inequality that arose thereafter. Social distancing fortified boundary maintenance on social, economic and even ethnic lines. The role of media during the spread of the Corona pandemic left a lot to be desired, especially in the portrayal of the marginalised groups. Had it acted responsibly, not only would the world have been able to grasp the do's and don'ts pertaining to precautions with due diligence, the world would have been more harmonious and many fatalities could perhaps have been avoided.

Keywords

Stigma, bias, role of media, interaction, inequality, appearance, reportage, attribution, marginalisation

Introduction

The impact of Corona pandemic and issues related to stigma, prejudices, marginalization, and the virulent forms of socially unequal situations that arose as a consequence of the virus and its global spread is a matter of immediate concern. The entire world was caught unaware with the fatal blow of a pandemic which continues to rage even at the time of writing. Not only have governments been caught unprepared, many people have been unable to completely grasp the horrific nature of this virus, resurfacing in its myriad variants, till over two years after its origin. This has included scientists, paramedics as well as policymakers and those who work on the

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ground, law enforcers like policemen, security personnel as well as media persons and teachers. The following discussion focuses on the role of media in reporting about the pandemic. This essay attempts to trace social stigma as a result of the global pandemic, accentuating the trend for binarizing along ethnic as well as economic parameters. It did not even spare the most sanitised, health conscious as well as economically sound nations. Employment and business opportunities did the vanishing act, people had to head back to their homelands, mostly in regions which were far from their places of work, with no idea of what the future held. Schools and colleges were shut and so were conferences, weddings and gatherings called off, every time the virus reappeared, in its new avatar. In this backdrop the essay attempts to reflect on the marginalised groups (like DNTs, NE Indians, Muslims and Dalits), and their media representation which aggravated their vulnerabilities.

Interactions: Paradigm Shift

An unprecedented paradigm shift in interactions has taken over now. In (hopefully) post COVID times it is considered socially acceptable, in fact recommended, to maintain social and physical distance, a social sign identified with classist and sometimes majoritarian high handedness in pre-Covid times. So, what would have been considered outright offensive and questionable has become the socially, medically mandatory requirement for sheer survival. This social distancing, in true sense physical distancing, has unfortunately taken the shape of fortifying boundary maintenance on social, economic and even ethnic lines. The latter have been justified through the circuitous route of claimed and actual necessity for maintaining physical distance due to medical or health reasons, as well as preconceived notions about different categories of communities, based on religion, class and ethnic background. It is this latter rationale which is a cause for concern. The media did not help much in this regard. I shall take that up in detail too.

Coronavirus belongs to a large family of viruses, out of which only seven of its members can infect humans. Four of these types cause minor illnesses like the common cold, whereas the other coronaviruses have had more horrific impacts such as SARS, MERS, and now COVID-19, in its subsequent variants. It is mainly a respiratory disease that starts in the lungs, leading to pneumonia-like symptoms, but affects the entire body. More often than not it spreads through small saliva or mucus droplets that an infected person expels when coughing, sneezing, or talking. These droplets can travel three to six feet and remain infectious for anywhere between four hours to two days, depending on the surface. In late December 2019, reports emerged of a coronavirus outbreak linked to pneumonia cases at a wildlife-food market in Wuhan, China. Covid-19 spread across that nation within weeks—and then spread like wildfire across the globe. The virus was believed to have spread from person to person though it originated from animals and spread to humans. By March 2020, the World Health Organization had announced Covid-19 as a pandemic. The fact that it was initially denied by the most powerful nation's leader, is another socio-political

discourse and narrative altogether. Much is to be learnt about the coronavirus that has changed lives across the spectrum, but this experience of dealing with disease, death as well as being in denial mode has also taught many lessons to all across the globe.

With more than nine million infections, India was at the top rung of worst affected countries, along with United States as 2020 ended. There were visible and traumatising cracks in the economy, polity as well as educational institutions. Never before, had so much havoc been wreaked by the spread of a disease. As is obvious, this disease is more than a health and science story only. Its impact has been seen in spheres like education, corporate world, tourism and travel, stock market and even numerous people losing their jobs because of them coming from most affected countries or regions. Major sporting events, including the Tokyo Olympics 2020 had to be cancelled. Offices, schools and colleges have undergone a paradigm shift in their logistics of conducting meetings and interactions. Some of that may become permanent propositions. In fact, most of 2020 and 2021 has had an unprecedented shift in the interactional aspects of social and professional life itself. Just as general public as well as professionals were unprepared, so was the media unable to deal with the changed scenario. At the micro interactional level too, people have had to take some very tough decisions about staying home or not being able to host even close relatives or friends, and, having to do away with outside help for household tasks, unless they had the luxury of permanent live-in staff, a proposition that few would have had. Even an ordinary visit to the grocery store or market became a moment of stress with extreme measures of sanitation and distance being maintained. Online marketing became a household term for many in India and elsewhere.

Stigma: Surreal Reality

What is most striking is that 2020 brought about an unprecedented and surreal reality into play, across the globe. What could have been an ironing away of inequalities has ironically highlighted the same too. Boundary maintenance became unabashedly stereotypical and extremely discriminatory. Social stigma in the context of health is the negative connotation associated between a person or a community of people who share certain characteristics and a specific disease. Those being affected feel marginalised by those who label them as dangerous ‘spreaders’ of that disease. In an outbreak, this could result in people being labelled, stereotyped, discriminated against, treated separately, and/or experiencing loss of status because of a perceived link with a disease. Such treatment can negatively affect those with the disease, and even their caregivers as well as people they are in close contact with. As speculation soared with regard to the origin of the disease, migrants and refugees were branded as being the main culprits of being super spreaders and some were even denied access to medical treatment. The UN Secretary General, Guterres (2020, 2021) also noted that migrants still face stigmatization, xenophobia, inequalities, and racism. According to him, migrant women, especially young girls faced heightened risks and vulnerabilities of gender-based violence.

Even those who may be sharing some outward appearance-related characteristics with them could face ostracism and marginalisation. There were cases of health workers, including doctors being denied entry into their residential societies as people feared that they would be spreading the disease. The 'virus of hate', as UN has referred to it, seems to have taken as much of a virulent form as the actual virus in 2020. "We must act now to strengthen the immunity of our societies against the virus of hate," United Nations Secretary-General António Guterres said while appealing for an all-out effort to end hate speech globally (Ibid.). Helen Davidson (2020) says that according to the World Health Organization (WHO), stigma may even drive people to be secretive or diffident about their illness to avoid discrimination and even prevent them from seeking immediate health care.

Physical Appearance

Unfortunately, in March 2020, there was a case reported of a student being spat on in University of Delhi because her appearance was seen as being like the inhabitants of the neighbouring country which was globally labelled as the cause for Corona. The motorbike-borne riders, while speeding away after spitting on her had shouted, "Oye Corona!" in a frequently used street near the University campus. People hailing from the North East in India are frequently at the receiving end of several discriminatory barbs with regard to what they wear, eat as well as their appearance. Despite governmental measures to curb ethnocentric behaviour, there have been numerous cases of students and migrants from North East being targeted as foreigners or being generally marginalised, discriminated against or at the receiving end of ethnic slurs in their neighbourhoods or campus spaces. Unfortunately for them, Corona virus made them the easiest and soft targets due to their appearance being perceived as closest to the most suspected villainised nation globally (and India's neighbour) of 2020. Several other similar incidents surfaced across the globe where people were identified with the disease merely because they happened to look similar to the suspect region, even if it meant the entire Asian one.

Crises like disease outbreaks lead to creation of fear psychosis, in turn leading to victimisation and alienation of certain groups. These groups may be of a particular ethnicity or religion and could be directly or indirectly affected by such an outbreak. Discriminatory behaviour and prejudicial perceptions have taken an upswing across the globe ever since the spread of the virus. The U.S President referring to it as the 'Chinese Virus' in the beginning of 2020, is indicative of the supremacist attitude pertaining to the cause of the disease (Watts & Howard**,** CNN, 2020 March 18). He continued to use the term, despite being advised against it (Mangan, 2020).

What merits attention is also that 2020 brought about dual and almost conflicting processes of social stratification. To some extent, it was an unprecedented equaliser of a situation, where rich and poor nations, across the globe, were attacked with the same stroke of probability of fatality or vulnerability. As the pandemic continued to spread, it was making clear that people around the world are also surprisingly alike. No matter what

divides us, gratitude for healthcare personnel for their titanic work is one aspect that seems to have united the world. In their name, authorities around the globe have asked people to follow the recommendations, to ignore false information and to protect them from discrimination. However, as discussed above, a parallel process of conflict, including suspicion and hatred has emerged, where the spread of the disease has resulted in stigma and accentuated inequalities too.

The year 2020 and the spread of what could have been seen just as a virus, has brought into the limelight hidden prejudices against a community and even a country, where everything associated with them in terms of food, appearance or their cultural practices was attacked or came under harsh criticism. They have had to face countless accusations of being agents of spreading Corona, despite many others having been lax on treating the spread of the virus as a serious problem, despite being given the information about Corona well in time. This denial mode led to these otherwise very powerful and affluent nations going through a lot of stress, besides grappling with horrific statistics of fatalities.

The phenomena of an invisible virus making visible hidden inequalities makes us aware of the raw underbelly of seemingly harmonious settings within democracies. Due to policy initiatives, for curbing the pandemic in India, by default, inequalities became the order of the day. The very proposition as well as practice of 'lockdown' or even 'physical distancing', better to be referred to as social distancing, was something that many in India could ill afford. It was something that people who lived in clustered neighbourhoods could hardly implement. Plus, street vendors as well as many from the unorganised sector were left totally stranded, once the announcement was made in India about the lockdown. Inequalities became evident even in terms of gender equations at home as well as work. While many household-helps were able to retain their jobs, men who lost their jobs resented having to be at home. Domestic violence took an upswing and women had to manage home as well as work outside the house. An attention-seeking leader of the world's purported strongest country added to global disaster mismanagement, in the initial few weeks, when he refused to acknowledge the existence of the pandemic. Misinformation and denial mode fed into speculative reportage. What needs to be reiterated however is that as what Mike Ryan says, "Viruses know no borders and they don't care about your ethnicity, the colour of your skin or how much money you have in the bank" (Nehginpao, 2020).

Role of Media

The focus on the role of media in such an unprecedented crisis is inevitable, rather most pertinent for exploration. News in general, including printed articles as well as electronic media information channels, impart to occurrences their public character which would mean that our understanding of the pandemic was fed and even reinforced by what the media conveyed to us. In many ways, news can be understood as a social institution. The manner in which it is conveyed, the focus given to some aspects, the near obliteration of significant aspects can have a deleterious effect on perception about

not only a pandemic but can add to the air of speculation that such crisis situations beget. Especially in urban areas, news pervades daily interactions and even decisions, especially if they are about care and caution to be exercised as a consequence of spread of a disease. Dickinson (2013) opines that: "The internet and the world wide web have had an extraordinary impact on the political economy of the global news industry. This impact has been felt in the gathering, processing and dissemination of news." What is also discussed are events related to the carrying forward of a disease. As Osterholm says, "Assume this virus is everywhere. This is a global influenza pandemic caused by a coronavirus" (Bergen, 2020). Is there a possibility that what was conveyed in the beginning about a country being the cause of a disease could have been conveyed with some caution as well as factual information? Is it possible that China made a huger error of judgement, or some scientists may have had some devious intent, but not the entire governmental machinery? Is it possible that even that was not the case that any scientists had biological warfare as their intended project, but it was just an experiment gone wrong where the virus escaped and was not traceable till it became too late? Isn't it possible that biological warfare may sometimes be used as a rationale for enhancing one's own budgetary expenditure on defence-related equipment and research? Our information channels, from print as well as electronic media did not give much coverage to the disruption of ecological niches that the animal world deserves, the way we would like to be assured of the same.

The reverse process of invasion that struck us, had to happen, some day. If we have taken animal habitats and environment for granted, whether for our commensal /social or research purposes, so much that we think nothing of deforestation, rampant urbanisation and whatever else goes on in the name of development, including research, is it any wonder that the universe had to showcase its own karmic, perhaps calculated move of striking from the very world we thought we had been able to rein in? The fact that Wuhan and its animal market was the propellent may be a mere incidental factor, even though it was the most highlighted one. It could have been any other animal market where the usual sanitation and health parameters could have been compromised. But it being China, may have been about jumping at the opportunity of vilifying a fast, and somewhat unpopular, global market player. Undoubtedly, many sanitation and security standards were compromised there but the initial weeks' frenzy and communication channels were more about it being a China virus rather than the roadmap ahead to curb the same. Had the latter been the priority we might have been able to get a timely grip of the world's worst entrapment which left no scope for comprehending its gravity, till massive damage had been done to lives, jobs and interactions. Even if China was the culprit, the world's leaders needed to reach out to them for information rather than have a pigeon- sighting- cat approach, which many nations did initially or latch on to only on-the-spot or symptomatic solutions, instead of having a comprehensive, holistic template of disaster management.

Most of the world's medical community was also caught unaware. Quite naturally there were varied approaches to deal with the disease. To label a disease on the basis of which place or which community, or country started it all, could be unfair, illogical

as well as very damaging to our logical comprehension and dealing of the disease. Having access to technology did not necessarily help. What sapped videos and other modes of media, including print and electronic, continued villainising a nation which was in reality the first victim, indicating the stereotyping on the basis of Western perceptions about disease and health in other than Western parts of the world. Olshaker & Osterholm (2017) while emphasizing on the accurate dissemination of information express that: "In any pandemic, effective leadership is critical, and the first responsibility of the president or the head of any nation is to offer accurate and up-to-date information, provided by public health experts, not agenda-oriented political operatives."

Reportage: Pandemic Voyeurism

This also brings us to the discourse around reportage of disease and its spread. Does reportage of disease and ensuing displacements, physically, occupationally and socially, inform in a manner that it makes people who are readers or consumers aware of the agony of those who were marginalised or stigmatised? Or does reportage take the form of disaster voyeurism where pictures highlighting death and starvation are used to garner greater viewership or readership? In India, visuals and write ups about social gatherings of a particular sect in a minority religion, became the touchpoint for an entire nation going into a frenzy about wilful attempts to spread the virus by members of that minority group. Hateful memes and WhatsApp video clips added fire to undercurrents of pre-existent and deep-seated feelings of suspicion and doubt. The fact that other religious as well as political gatherings were held around the same time, did not attract the attention of the suspecting-their-intention kinds. Why were different rules of perception applied for different communities when the actions committed by all were of casual behaviour towards precautions, across the board?

In this scenario, printed as well as viral images of fruit and vegetable vendors selling their wares without adequate precautions added to anxieties. This anxiety quickly transformed to anger when there were images, including clips of the vendors spitting on the fruits, for instance. In such images and clips, a headgear like the skull cap instantly gained symbolic significance enough to add fury to the fire. This was not only irresponsible social media gymnastics, but no effort to verify validity or reliability of time period, source as well as region, in presentation of purported facts. However, in August 2020, the order of the High Court chastised the police for "non-application of mind" and brought some closure to the 'sustained vilification of the largest Muslim organisation' in India. According to Salam (2020) the order clearly stated that: "A political government tries to find a scapegoat when there is a pandemic or calamity, and the circumstances show there is a probability that these foreigners were chosen to make them scapegoats."

The impact on people who had migrated to big cities for work and were suddenly left jobless and had to head home have been chronicled in many accounts. The voyeurism in presenting death and distress overshadowed the real issues pertaining

to respective state governments as well as bureaucratic failure to gauge the extent of problem as well as intensity of demographic exodus from the industrial cities back to rural settings. It is generally believed that those who write history belong to the society that they write about. Journalists who may not necessarily belong to the governing or what is known as the ruling /decision-making class, do happen to knowingly or unknowingly reflect an upper- or middle-class perspective in their writings. Robert Merton's paradigm for sociology of knowledge is of relevance here. It provides us with a tool for investigating relationships between the socio-cultural environment and mental productions. Merton's work can be seen as an attempt to demonstrate the many ways in which facets of social existence influence mental productions through their relationship to the existential bases. Even according to Mattlert (1981), mass media plays a very significant role in reinforcing a pre-existing class structure and journalistic by-words are used as means of suppressing dissent.

Corona pandemic for all media persons was a major crisis situation. A crisis is signified in the manner in which people, including media persons treat communities, religious, national or ethic. Latching on to convoluted ideas about any group or country can just add to a situation that the spread of corona set off. Today's competitive world of reporting, in electronic as well as print media world has entailed a one-upmanship of the kinds that is unprecedented. Social media channels also throw reliability and validity to the winds, in favour of 'breaking news' so to say. The issue of objectivity becomes a bone of contention in such cases. Hamilton & Krimsky (1996) showing the importance of attribution state that: "To establish they are not first making up information, reporters find authorities or written reports and documents to which they can attribute facts. Attribution, as it is called, is the reporters' security blanket. The beauty of attribution is that it allows the reporter to introduce opinions into a story without losing the appearance of neutrality." This attribution of statements to doctors, other medical personnel, community service workers, practitioners claiming to have other than allopathic solutions, became quite a practice by media persons, during the pandemic which even resulted in some loose, highly questionable statements about causes, consequences as well as precautions. It even helped in the marketing of some indigenous products as if they were foolproof methods of controlling Corona.

There is a school of thought which believes that to be a good reporter one must be biased in favour of truth and biased in favour of life. One must be biased in favour of the future of the young and biased in favour of peace and order. This has been expressed in relation to drug- related crime but basically it is an attempt to encourage reporters to have the courage of reporting the truth rather than clamour for glory through voyeuristic reportage of disaster and disease.

Mental Health Impact

Even mental health is something which seems to have gained more attention ever since the onset as well as continuance of the pandemic-induced lockdown, world over and especially in India. In itself, this did have a positive contribution to people being

informed about some issues which were generally ignored or not considered worthy of mention, leave aside analysis. However, the deep-seated taboo as well as stereotypes related to discussing mental health did not help matters. This is to do with the stigma attached to mental health being seen as a peripheral, almost frivolous rather than a significant aspect of human health and sense of well-being. So, most of the reportage, during the pandemic, was to do with episodic detailing of people's lifestyles as well as speculative causes of the extreme step rather than discussing the larger macro system of highly stressful and meritocratic, including cutthroat competitive -comparisons-fixated lives. Sensationalism overshadowed sound analytical reportage. As a result, most of the mental health issues that were reported were to do with extreme cases of suicides committed by celebrities, known public figures or those who were from middle /upper class background plus those associated with well-known institutions. Whenever reported, it was unable to grasp the broader spectrum of how mental health issues are not just about those who lost their well-paid jobs, could not meet friends, family or go out to their school college campuses. It had to cover the inter-sectionalised aspects of individualism in urban spaces, consumer culture, conditional friendships and fragile familial bonds along with failed governmental initiatives to foresee and implement sensitised policies.

What was hardly reported was sheer fragile psyches and unpreparedness of individuals having to be suddenly holed up in their homes. Plus, the media did not bother to highlight mental health consequences as well as attempts to take lives by those who found themselves on the roads of India, for weeks, not just days, in order to grasp their sense of dignity, sanity as well as a sufficient proportion of food. Those who must have collapsed on the way, back to their villages were left untouched by most of Indian media, till foreign media captured those footages. To add to the ignominy of hungry and exhausted travellers, televised and photo-friendly attempts to distribute food did not go down well with those who had not only lost their means of earning, but were made to wait for hours in quest for an insufficient amount of food doled out in the various places that such initiatives were undertaken by NGOs as well as different state governments. Several thousand preferred to walk back home than face the humiliation of an inept bureaucracy or government machinery caught unawares by the extent of the problem caused by a seemingly straight cut, well-intended governmental measure like 'lockdown'.

In fact, more of the foreign media captured images of the migrant disaster that followed the health-related and medical one. Are we equipped to understand the nuances or empathise with what all is entailed in mental health challenges? The policies and actions initiated during the pandemic do not seem to have been suitably prepared or fitted in for the scale of suicidal as well as general mental health traumas, during that period. How the media reported these was more about sensationalising than analysing. Statistics of suicides took precedence over qualitative understanding of linkages between disease, trauma and governance. Reportage of celebrity suicides overshadowed the reality of many others who would have taken their own lives or were under extreme stress due to financial, social or emotional or sheer physical reasons.

And what about those who were caught unawares with the logistics of lockdown? What about those who had no place to call home? Or those who were in small dwellings with overpopulated spaces wherein heading out for work may have been the only escape to their sense of respectable existence as well as sanity? Even gendered aspects of inequality surfaced across the globe, in terms of how women domestic workers who had to stay at home had to bear the double brunt of domestic labour for stay-at-home families, state of pennilessness as well as domestic violence and aggression offset by the men's own frustrations of being jobless or without much opportunity of being able to head out. All this was hardly taken up in a concerted way by the media. Ironically, what we did get were a surfeit of options to cook different varieties of food, through various social media platforms, which merely added to the expectations from women. The few times men and boys would try out something it would always be highlighted and shared as an achievement par excellence through social media.

Prejudice and People

Although the concerns over the coronavirus are understandable, the stereotypes and exclusion are not. Instead of excluding an entire race, we should try to support them as a form of solidarity. It is imperative to see us in all our diversity and challenge the existing stereotypes.

According to Anand Chandrasekar (27 April 2020, CNBC TV18), "Even as the world grapples with the Covid-19 pandemic, numerous instances of anti-Asian sentiments are being reported. Hysteria, anxiety, confusion and a largely unchecked flow of fake news laced with conspiracy theories have only fuelled the prejudice against Asians, who of course, are no strangers to the phenomenon." This can be explained by the dangerous social media "infodemic" fuelled by false information.

In the case of the coronavirus, social media has not only propagated doubtful rumours on the emergence of the virus, but also has brought forth absurd methods for prevention. It must be noted that it is not as if infectious diseases like Corona are linked to discrimination and prejudice. This syndrome of stereotyping and preconceived notions determining how we deal with each other have existed for diseases like TB, HIV/AIDS too. This discrimination, abuse and denial of facilities or opportunities operates at the level of jobs, education, medical support as well as even access to basic needs. Fear and xenophobia can not only add to the feeling of being labelled but even force people to hide their disease. Media has to play a very responsible role in this aspect where the misinformation and voyeurism is the last thing that should be their focus. They should in fact make all out efforts to curb misinformation in times of crises. Use of appropriate language and carefully explained terminology along with publication of myth busters from credible bodies like WHO as well as medicos from ICMR helped to quite an extent. Reporting has to be more about the precautions to be taken in the eventuality of anyone having infected others, than giving details about the identity of the person. Much as politicisation of events and happenings may be part of journalistic practices, it has to be given a back seat at the time of reporting a major crisis like Corona pandemic. What needs to be given precedence is the outbreak of a

disease and not jump at the opportunity to politically vitiate global as well as national atmospheres by using scapegoats for the pandemic.

COVID, Media and the Marginalized

As nations have dealt with COVID, and media has reflected on the efforts put by states and non-state institutions towards addressing the pandemic, little has been recorded about how the marginalized groups have been affected (Deshpande, 2021) and what has been the media coverage of their situation. Data paucity has been one very important aspect for this near absence of coverage. Some of the most marginalised communities of the country—the de-notified tribes (DNTs), the Adivasis, Dalits and Muslims have borne the brunt of the 'stay home' policy in the severest form. These communities have suffered on most social indicators historically, and due to a mix of poor logistics superimposed by prejudice and ostracization. While there is no disaggregated data available from government sources, data collected by a group of civil society organisations[1] has showed that during the countrywide lockdown, these marginalised communities were the worst sufferers. They were unable to avail the food from the government distribution centres because they were located at unyielding distances from their settlements. Muslims suffered from the additional realm of Islamophobia, as did the Dalits and DNTs the prejudices. Data collected indicates that the households in 30 per cent of the locations remained without any food supply. This has been attributed to the poor public infrastructure like absence of fair price shops under the Public Distribution System (PDS) in the Dalit settlements. They often do not have access to information regarding the schemes and the benefits. Most of them could not benefit from the cash transfer under the Jan Dhan Yojana because their accounts were 'dormant'. They were neither aware of the requirement of an active account, nor had any information on how to revive their accounts from dormancy (Samajik Seva Sadan, 2021; Praxis, 2020 http://www.covid19voices.wordpress.com/). The Muslims had restricted access to the block office. Consequently, many households did not have necessary documents in order to access the supplies provided through various schemes (Pragati Madhyam Samiti, Uttar Pradesh). The households from nomadic and denotified tribes do not have ration cards because of which households in 73 per cent locations, could not receive food and women and children did not get supplementary nutrition. Due to the perceived criminalisation and stigma associated with the community, their families lived away from the Anganwadi centres and hence were rendered devoid of the supplies. Two-thirds of migrant workers did not have access to government ration (DTE, 2020).

These findings are based on the data[2] which covers about 475 locations from the states of Bihar (69), Chhattisgarh (24), Gujarat (70), Jharkhand (20), Madhya Pradesh (61), Delhi (8), Odisha (80), Rajasthan (10), Tamil Nadu (75), Uttar Pradesh (50) and West Bengal (9). Besides the Right to Food, the data also looked at what support hamlets

[1]Partners in Change; Praxis Institute for Participatory Practices; National Alliance Group of De-notified and Nomadic Tribes; and Gethu Group Workers' Think Tank.

[2]www.communitycollect.info

received through other schemes earmarked for COVID relief. This included additional ration as part of the Pradhan Mantri Garib Kalyan Yojana, the Ujjwala scheme, the Kisan Samman Yojana and the Jan Dhan Yojana.

It was observed that across the schemes, proximity to service providers and/or their acquaintances often determined the access to entitlements. Since these communities are already marginalised, they become invisible to the system. Most services were located in neighbourhoods of the dominant groups where the marginalised have no or at the most restricted access. In a health emergency such as this, these inequities have led to gross violation of human rights. Such inequity induced inability to access entitlements need to be recognised in the larger societal context. The data suggests that 74 per cent locations mentioned an increase in indebtedness, reflecting on social inequities. It is noteworthy that 88 per cent of Dalit-dominated hamlets reported an increase in loan-taking.

As regards online classes, children were able to access online education in only one per cent of the locations; and in 69 per cent locations no child was able to attend classes. As a consequence, nutritional supplements were also missed.

"Due to the announcement of sudden lockdown, children were not able to access nutritious meals even once in a day. It was accessible for households living near the distribution centre." (Blasius Tigga, secretary of Gyan Sagar, Chhattisgarh cited in DTE, 2020)

Muslims experienced prejudice and ostracization. Media portrayal of the Tablighi Jamaat led to a systematic resentment against the Muslim community. Boards were put up restricting the entry of Muslim hawkers in some areas. Those who are self-employed (carpentry, welding, tailoring and embroidery work) were badly affected by the lockdown (Sahyog, Gujarat). The high courts of Bombay, Madras and Karnataka termed the media coverage of the Tablighi Jamaat event in Delhi as 'unjust and unfair' (Chandrasekar, Anand, 2020).

Therefore, the role of media during the spread of Corona-19 left a lot to be desired. Had it acted responsibly, not only would the world have been able to grasp the do's and don'ts pertaining to precautions with due diligence, the world would have been more harmonious, and many fatalities could perhaps also have been avoided. Coronavirus does not justify any kind of discrimination or xenophobia. Asian countries are still nursing the stigma due to the "Asian Flu" caused by the H2N2 virus (1957-58), the "Hong Kong Flu" caused by the H3N2 virus (1968), SARS caused by a coronavirus known as SARS-CoV (2003) and now Covid-19 which initially started getting identified as the Chinese virus. When HIV/AIDS had spread across the globe, the tendency was to present its origin and cause with reference to the African continent plus homosexuals. Misinformation around HIV/AIDS had not only given impetus to homophobia but even encouraged anti-African sentiments. Stigmatisation also takes a toll on those who are actually affected by the disease. It is natural for people to be scared when they show a few symptoms of a disease during a pandemic. Panic and fear created by outbreaks can expedite the spread of a disease. It is anxiety that stops one from seeking healthcare thereby undermining the public health response. Studies have

shown that depression rates soar during epidemics and pandemics. Corona 2020 was a year of shocks and imbalances, a lot of disruptiveness and to a large extent a paradigm shift as far as everydayness was concerned. However, the equaliser effect of how it impacted all nations, all classes, regions as well as ethnic communities as well as the positive role played by medical, para medical and other essential services staff across the world should have made us that much more of humanistic individuals rather than xenophobic and ethnocentric ones.

Conclusion

To think that the world's greatest democracies, India and America have experienced increased instances of stigma and discrimination of either religion, race or ethnicity is quite an indication of how inhuman values and practices may thrive despite the setbacks that viruses may give to humanity. The role of media was far from a responsible one in a scenario which was in need of empathy and concern. Reportage during a crises should not feed into panic and fear. It needs to be like a guardian of those who are marginalised and stigmatised. Loss of livelihood has remained a major concern—a topic where the media has been completely silent. It may be an opportune time for the media to reflect on the short-term and long-term measures which will address these issues. As regards the short-term measures, it may take upon itself to highlight the potential of the state to offer cash transfer for a fixed duration as a rehabilitation strategy, putting a subsidy holiday for the rich and the affluent corporate sector and revisiting some opulent projects of the infrastructural kinds may help in taking care of the cost thus incurred.

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Impact of Covid-19 on Livelihood and Health Experiences of Migrant Labourers in Kerala, India

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Abstract

Covid-19 is the most consequential crisis in our memory and has affected everyone irrespective of class, caste, gender and ethnicity. The pandemic also exacerbated pre-existing inequalities, and those who were marginalised took the brunt of the unprecedented crisis. Inter-State Migrant Workers was one such community who were at the intersections of marginalisation. Mostly they belong to economically poor Scheduled Caste/Tribe and Backward Communities. Most of them are agriculture labour, and often due to poor rains and unemployment they migrate to other states for better employment and wage. This essay explores the confluence of elements that helped Kerala to manage the Covid-19 pandemic during the first wave, March to May 2020. The study adopted mixed method, about 132 migrant workers were interviewed using a structured schedule and 10 case studies were collected. The study finds that a majority, 92 per cent are SC/ST/OBC, education level less than high school and economically very poor. The study examined the measures taken by the government to address the crisis and how it helped to address the need and concerns of the migrant workers. It also captured the life, livelihood, healthcare utilisation and overall experience of interstate Dalit migrant workers who reside in Kerala.

Keywords

COVID-19 pandemic, migrant workers, healthcare, livelihood, housing

I. Introduction

Some of the disturbing images of India's lockdown came from the exodus of interstate migrant workers, leaving cities and towns and returning to their home states. With

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bags perched on their heads, children in their arms, and swollen feet, they walked back to their native states as the lockdown paralysed their employment and livelihood. The Supreme Court of India took 'suo motu' cognisance of their plight and ordered the state and central governments to take action to address the needs of the stranded workers (Bandhua Mukti Morcha Vs Union of India, 2020). However, at the same time, a small state in India, Kerala, stood up, took timely interventions, and efficiently handled the crisis.

At that time, Kerala won international praise for the way it handled the pandemic (Viswambaran & Diwakar, 2020). Kerala's ability to diagnose and track viruses and other infections was praised by multiple global media such as the *BBC*, *The Guardian*, and *Washington Post*, among others (Masih, 2020; Biswas, 2020; Kurian, 2020; Faleiro, 2020). The Indian Council for Medical Research (ICMR) has lauded the containment strategy and Kerala's robust public healthcare system and said it refers to the Kerala model for testing and containment strategies (PTI, 2020).

Though the pandemic affected everyone, some took the brunt of the unprecedented crisis. The pandemic exacerbated pre-existing inequalities as those who were marginalised on the basis of different identity markers had to deal with the worst (Diwakar & Viswambaran, 2022). Inter-State Migrant Workers was one such community who were at intersections of marginalisation. Most of them are agriculture labours, who migrate to other states for better employment and wage. In most cases they belong to Scheduled Caste/Tribe and Other Backward Communities. This essay explores the confluence of elements that helped Kerala manage the reverse migration crisis and examines the experience of interstate migrant workers who reside in Kerala. Even though there are many factors that have contributed to this success, however, i) a robust healthcare system, ii) swift governmental response and, iii) community participation are the three pillars that allowed Kerala to manage the first wave of the pandemic (WHO, 2020). Despite Kerala having several constraints such as low per capita income, dependence on foreign remittance, and low agricultural output, the state displayed tremendous achievement rates in health outcomes. This is generally attributed to intersectoral factors such as the emancipatory social movements, the spread of education, political awareness of the people, and investment in healthcare infrastructure. It has been claimed that all sections of people in Kerala have benefitted from these progressive and timely policy initiatives (Isaac et al., 2020; Sadanandan, 2020).

A state's efficiency and its effectiveness can be better judged by how it treats the most vulnerable sections. Interstate migrant workers are a significantly vulnerable population of a state, because they don't have any social support mechanism other than the state administration. Migration is a phenomenon that primarily happens due to inter-regional and intra-regional disparities at the macro level and due to the lack of employment opportunities and resulting low standard of living at the micro-level (Pandey & Mishra, 2011). Several factors like language barriers, cultural bias and low education levels put inter-state migrant workers at a disadvantage. Studies exploring the living conditions of the interstate migrant workers show that they often have to

live in shanty houses and have limited access to sanitation facilities and safe water. (Surabhi et al., 2007).

While looking at the health access and utilisation of migrant workers, factors like lack of awareness about the provision of health facilities, lack of confidence in accessing the health services due to apprehensions about approaching the healthcare system, language barriers, cultural bias and patriarchal dominance affects the inter-state migrant workers from accessing healthcare services (Babar, 2011; John et al., 2020). On top of these factors, in India, the laws relevant to the social security of inter-state migrant workers were not effectively and appropriately implemented. Covid-19 lockdown has further exacerbated the vulnerabilities of migrant workers (John et al., 2020). Immediate concerns faced by migrant workers during the first phase of Covid included matters related to joblessness and loss of livelihood, food security, paying rent for house, healthcare expenditure, anxieties about family's safety and apprehensions about the future (MoFHW, 2020; Singh, 2021).

II. Factors Contributing to Better Public Health Care System in Kerala

The region, which later became the modern state entity known as Kerala, had a comparatively better health infrastructure than other parts of India. A historical analysis of social development in Kerala is required to understand the reasons for this advantage. We need to take a brief detour from the health aspects and focus on the history of the Malayali (native speakers of the Malayalam language) people and their shared sub-nationalistic "*pride*", which is important to understand how Kerala had the foundations enabled to counter the first wave of Covid-19 crisis in an efficient manner.

Kerala had a concept of organised healthcare for centuries. Families of practitioners of indigenous systems like Ayurveda handed their traditions from generation to generation. People were used to approaching caregivers when they were sick rather than turning to self-treatment (Kutty, 2000). But this tradition cannot be seen as public health as it was not accessible to all people because of the fragmented nature of Kerala society. Kerala society was highly fragmented on the lines of caste, class and ethnicity, which prevented the concept of public healthcare from materialising. Till the end of the eighteenth century, social development in Kerala remained latent. This latency was caused by the caste system in Kerala, which was perhaps the most brutal and most oppressive of any other state in India (Desai, 2005). There were strictly enforced injunctions on the use of public facilities, such as roads, wells, temples by lower castes, and elaborate specifications of the physical distance allowed between each caste (Franke & Chasin, 1992). This practice of alienation ensured that there was no common identity. The lack of common identification meant that there was little support for collective welfare and virtually no demands for the provision of social services (Singh, 2010). However, this changed after the arrival of Christian missionaries. The developments in the eighteenth century caused by a domino effect of their arrival constitute an important turning point in Kerala history (Washbrook,

1994). Missionaries used the promise of access to education and healthcare to further their proselytising efforts. Protestant missionaries who arrived in the early nineteenth century considered education to be a necessary prerequisite for their religious work (Tharakan, 1984). By the middle of the nineteenth century, missionary societies also opened the first Allopathic dispensaries and provided instruction in hygiene and public health (Ramachandran, 1998). This missionary work was an attack on the foundations of the caste system and paved the way for the questioning of this religiously-sanctioned hierarchy that facilitated caste. As a result of lower castes getting access to education and health facilities, people from lower castes started to convert to Christianity. This, along with British-initiated advancements such as granting proprietary rights to land tenants, and opening wastelands for cultivation, created a new class consisting of middle-level agrarian workers, artisans and traders. These strata were primarily from Syrian Christians and the Ezhava caste (Isaac & Tharakan, 1995). The creation of a newly-empowered section led to an asymmetrical condition, i.e. the new section was economically improved but still socially discriminated. The economic advancements of these previously 'avarna' (outside the varna system) castes caused them to unite and revolt against the unjust social practices that they were subjected to. This resulted in several socio-religious movements that were formed with the intention of fighting against upper caste dominion. Narayana *Guru* who urged the followers to strengthen through organisation and liberate through education and Ayyankali who called out the oppressed sections to promulgate an indefinite boycott of agricultural operations till the right of education was accessible to them were all products of this movement (Tharakan, 1998).

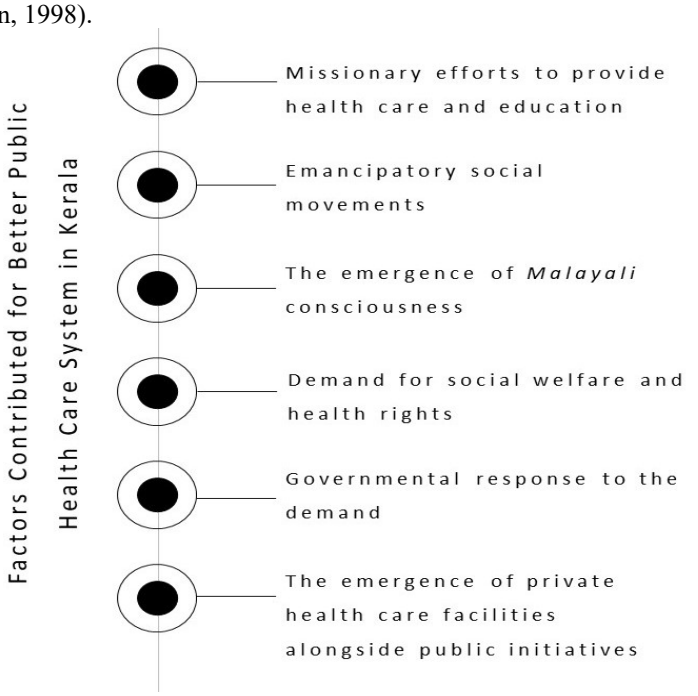

Figure 1: Factors Contributing to Better Public Healthcare System in Kerala

Due to the power of these social movements and out of the fear of large-scale conversions, and also seeing that the reform movements were garnering power, other monarchies of present-day Kerala, Travancore and Cochin monarchies, were forced to initiate reforms that abolished caste restrictions which fostered unprecedented economic mobility across caste lines which in turn got reflected in the general public's access to health and education (Singh, 2010). The expenditure on public health by the Travancore kingdom saw a six-fold increase during the period between 1900 to 1945. In the 1941–42 period, 25 per cent of total expenditure on the medical department was allocated toward measures designed to stem the outbreak of diseases such as cholera and smallpox, which had been a causative factor of high mortality, particularly among the vulnerable factions (Singh, 1944). The renewed focus on social policies was bolstered by reform movements that ensured equal distribution and access to public goods. As a result, mortality rates started declining steadily in the 1920s, and by 1940 Kerala had the lowest death rate among the major states in India (Thresia, 2014). Another important development that needs to be noted is the Aikya Kerala movement, a campaign that aimed to consolidate all Malayalam-speaking regions and create a united Malayali homeland. This began around the 1920s and led to the emergence of a "Kerala-wide consciousness of shared community" (Chiriyankandath, 1993, p. 650).

Due to a combination of all these historical factors, Kerala state was already at an advantage at the time of its formation in 1956. One indicator of the government's commitment to health services provision is the proportion of government expenditure set apart for health, and in this aspect, the state's budget allocation for health was considerable (Kutty, 2000). The historical factors mentioned above resulted in creating a democratic environment in the state where two major political parties, Communists and the Congress party, had to engage in tightly contested electoral races. These tight electoral races and alternation of administrative power heightened government responsiveness to popular pressures.

Social welfare emerged as a key area of competition between political parties in Kerala as each government attempted to outdo the other in the extension of the social security net (Venugopal, 2006). As a result, investment in education and healthcare remained a consistent policy of all elected governments in Kerala, irrespective of their political leaning. This tradition of government support for health development has been a catalyst for the advancement of healthcare in the state (Kutty, 2000).

The thrust in public funding in public health took a hit during the period between the mid-1970s to the early 1990s due to the fiscal crisis that the state faced (George, 1999). At the same time, reports on the private medical institutions in Kerala by the government show that the state saw a marked increase in the number of private hospitals. More significantly, private hospitals have outpaced government facilities in the provision of hi-tech methods of diagnosis and therapy (Kutty, 2000). It is safe to say that, at present, Kerala has a healthy division of labour between the public and private sectors. Along with these factors, having proper sanitation, drinking water facilities, clean air, and nutritious food have contributed to an overall healthy environment. The rich history and characteristic features of its population have made several scholars note that public health in Kerala stood a cut above the rest of India.

III. Kerala Government Initiatives for Inter-State Migrant Workers

Kerala, since its formation in 1956, has had inter-state migrant workers. In the beginning, it was from the neighbouring states of Tamil Nadu and Karnataka. Labour migration beyond south India began with the arrival of inter-state migrant workers from Odisha (Peter et al., 2017). Perumbavoor in Ernakulam district and Kallayi in Kozhikode were flourishing timber industry hubs during that time and were home to several migrant workers. Later in the 1990s, Kanjikode in Palakkad emerged as a hub of the iron and steel industry which heavily relied on the labour force from Bihar. In 1996, after a supreme court ban on forest-based plywood industries in Assam, those who lost their job due to the ban, migrated to Perumbavoor, which became a new hub of plywood industries. The profile of the inter-state migrant workers varies as per the native place of the worker, sector of engagement and location of job opportunity (Peter, 2020).

Various organisations such as the Centre for Development Studies (CDS), Centre for Migration and Inclusive Development (CMID) and Department of Labour and Skills (DOLS) have always been at the forefront of collecting data and providing insights to the government. The Kerala Migration Survey in 1998 by CDS was the first large-scale household survey that exclusively focused on the issue of migration in India. These insights were used to create meaningful policy initiatives to address the vulnerabilities of the migrant worker population and improve their living standards. Kerala is the first Indian state to enact a social security scheme for migrant workers (Srivastava, 2020). As part of the 13th five-year plan, Kerala constituted a Working Group on Labour Migration that looked into the concerns of the migrant population and recommended several legislative and psychosocial welfare initiatives to better their working and living conditions.

Several welfare initiatives such as ISMWWS (Interstate Migrant Workers Welfare Scheme, 2010), Aawaz Insurance Scheme (2017), and Apna Ghar Housing Scheme (2019) were taken up by the state government. However, these initiatives were not always outright successful. ISMWWS went defunct after gaining momentum; Aawaz Insurance Scheme overlapped with ISMWWS and is criticised for being a cover for law enforcement agencies to collect their biometric data (Sreekumar, 2019; Peter et al., 2020). The only housing facility functioning in the Apna Ghar programme in the entire state offers a total of only 620 beds and is created to meet the requirements of single male migrants (Desai, 2019).

IV. Kerala Government Responses to Covid-19 Pandemic

The grassroots level organisations—Kerala's robust panchayat raj system—mobilised support for contact tracing and supported the quarantined and disease-affected families. They were also responsible for running community kitchens which were responsible for feeding people who were unable to do so due to the India-wide

lockdown (Viswambaran & Diwakar, 2020). The government was also the first state in India to announce an economic package worth ₹ 20,000 crore as a relief to the state affected by Covid-19 on 19 March 2020 (DHS, 2020).

While the lockdown in India was characterised by apathy towards the migrant workers, Kerala set an example in handling the issues. Community kitchens were equipped across the state, and helpline numbers and tele-counselling facilities were arranged by the state labour Commissionerate (HRLN, 2020). However, on 29 March, an incident took place that was considered to be a blot on the Kerala's Covid-19 response. A gathering of inter-state migrant labourers flooded the streets of Kottayam with the demand that they need to be sent back to their homes. The protest caught the state administration off guard, but the situation was efficiently defused within hours (*The New Indian Express*, 2020). An inquiry into the reasons for the protests showed that one of the major causes of discontent among the inter-state migrant labourers was over the Kerala style food that was provided for them by the community kitchens. This issue was immediately solved by taking steps to ensure that they had a diet that was preferable for their taste buds. But it wasn't adopted as a consistent policy. The government also took care of their other needs, such as places to recharge mobile phones and arranging provisions for recreational activities and games such as chess and carroms (HRLN, 2020). Another major transformation that happened is how the state replaced the terminology used to classify them. Earlier, government records used the term "migrant workers", but they have been classified under the term "guest workers" ever since the crisis. Even while migrant protests sprung up in other parts of the country, Kerala hasn't seen any such protest since the first one (Arnimesh, 2020).

V. Methodology

The aim of the study is to examine Kerala's response to the Covid-19 pandemic and how it has affected the inter-state migrant workers. The study adopts an exploratory research design, as there are not many studies which have examined this particular phenomenon. The study used a mixed method, both quantitative and qualitative data was collected to understand the phenomenon. The study was conducted in Ernakulam District, quantitative data was collected from 132 migrant workers from 5 different locations using a structured interview schedule. As the study focussed on the concerns of the Dalit migrant workers, case study method was used to understand their specific concerns. Purposive sampling method was used to select the respondent for the study. A systematic review of literature on history of public healthcare system in Kerala, government initiatives for migrant workers and response to Covid-19 pandemic was done to understand the issue and the research gaps. The qualitative data focussed on the life experiences of the migrant workers in Kerala. Their livelihood, employment, access to healthcare facilities, housing and social security of the migrant workers during Covid-19 pandemic.

VI. Analysis and Key Findings

This study has two parts, the first part is the analysis of the quantitative data and the second part is the analysis of qualitative data. The quantitative analysis covers the socio-demographic profile of the respondents, crisis faced by migrant workers during Covid-19, services received during the first phase of lockdown, issues of housing & paying rent and access to healthcare facilities.

i) Socio-demographic Profile of the Respondents

Socio-demographic analysis of the migrant workers was done to understand their caste, native place, age, educational status, occupation, type of migration and for how many years were the migrant workers employed in Kerala (Table 1). Understanding socio-demographic details is very important to locate the study and to understand the findings in a comprehensive manner. Altogether about 132 respondents were interviewed from the study area of which 34.8 per cent (46) of the participants belonged to the SC/ ST workers, about 56. 8 per cent (75) are backward class and only 8.3 per cent (11) are from general community. It is clear that 92 per cent are from socially backward community belonging from SC/ST and backward class. A majority of these migrant workers have come from West Bengal (38.6 per cent), followed by Assam (28.8 per cent), Bihar (15.2 per cent), Odisha (14.4 per cent) and Tamil Nadu (3 per cent). An analysis of the age-wise distribution has shown that a majority, 55.3 per cent are in the age group 26–35 years, 24.2 per cent between 16–25 years, 13.6 per cent between 36–45 years and 6.8 per cent between 46–55 years.

Table 1: Socio-demographic profile of the respondent

Socio-demographic Characteristics	Frequency	Percentage
Caste Category		
SC/ST	46	34.8
OBC	75	56.8
General	11	8.3
Native place of participant		
Assam	38	28.8
Bihar	20	15.2
Odisha	19	14.4
Tamil Nadu	4	3
West Bengal	51	38.6
Age		
16-25	32	24.2
26-35	73	55.3
36-45	18	13.6
46-55	9	6.8
Education Level		
Illiterate	19	14.4
Primary	29	22.0

Socio-demographic Characteristics	Frequency	Percentage
Middle	31	23.5
High School and above	53	40.2
Occupation		
Construction Site	45	34.1
Factory/Industry	51	38.6
Daily Labour	33	25.0
Other Job	3	2.3
Type of Migration		
Temporary	122	92.4
Seasonal	10	7.6
Years spent in Kerala		
6 month – 2 years	22	16.7
3 years – 9 years	66	50.0
10 years – 12 years	22	16.7
13 years and more	22	16.7

Source: Based on the field data collected for this study during 2022

The data analysis has found that 40.2 per cent of the migrant workers had education of high school and above, followed by 23.5 per cent with middle level education, 22 per cent had primary education and 14.4 per cent were found illiterate. About 38.6 per cent of the migrant workers were employed in factory/industry, 34.1 per cent worked in construction field, 25 per cent of the migrant laborers were daily laborers and a small section of workers were engaged in working in other jobs.

While analysing the nature of migration it was noted that majority (92.4 per cent) of the migrant workers were temporarily settled in Kerala and they visit their hometown during festivals, functions and other emergencies. The remaining 7.6 per cent of workers were seasonal migrants.

Majority 83.3 per cent of the respondents have been working and residing in Kerala for more than 3 years. Of these, about 33 per cent have been working in Kerala for more than 10 years. Only 16.7 per cent of the respondents have reported they are working in Kerala for 6 months – 2 years. From this it is clear that a majority of the respondents have spent sufficient time in Kerala to have an opinion on any specific aspect.

ii) Crisis faced by Migrant Workers During Covid-19

The analysis of the data shows that 91 per cent of migrant workers have lost their job during the first lockdown period (March to May 2020). Because of the loss of their jobs, those migrant workers had to face a huge financial crisis.

Table 2: Crisis faced during lockdown 1 (March to May 2020)

Covid Lockdown 1 (March to June 2020)	SC/ST/DN			Others[1]			Total		Over all Total
	Yes	No	Total	Yes	No	Total	Yes	No	
Lost job	40 (87.0)	6 (13.0)	46	80 (93.0)	6 (7.0)	86	120 (90.9)	12 (9.1)	132
Financial Crisis	40 (87.0)	6 (13.0)	46	80 (93.0)	6 (7.0)	86	120 (90.9)	12 (9.1)	132
Not had 3 meals in a day	7 (15.2)	39 (84.8)	46	13 (15.1)	73 (84.9)	86	20 (15.1)	112 (84.9)	132
Not had Nutritious Food	5 (10.9)	41 (89.1)	46	12 (14.0)	74 (86.0)	86	17 (12.9)	115 (87.1)	132

Source: Based on the field data collected for this study during 2022

Even though there was a huge financial crisis, about 85 per cent of the migrant workers' food security was ensured and they managed to have 3 meals a day. Moreover, when explored further on the quality of food, about 87 per cent of the respondents have reported that they had nutritious food during lockdown period (Table 2). Though, there were a few concerns raised by the migrants on the food provided by the panchayat through community kitchens, however it met the nutrition requirements of the respondents.

Table 3: Services received during the first phase of lockdown (March to May 2020)

Services received during lockdown 1 (March to May 2020)	SC/ST/DN			Others			Total		Over all Total
	Yes	No	Total	Yes	No	Total	Yes	No	
Free Food Ration by State Authorities	10 (21.7)	36 (78.3)	46	13 (15.1)	73 (84.9)	86	23 (17.4)	109 (82.6)	132
Grocery kit from Panchayat or State	23 (50.0)	23 (50.0)	46	36 (41.9)	50 (58.1)	86	59 (44.7)	73 (55.3)	132
Employer provided food grains and vegetable kit	12 (26.1)	34 (73.9)	46	39 (45.3)	47 (54.7)	86	51 (38.6)	81 (61.4)	132
Food from community kitchen	4 (8.7)	42 (91.3)	46	8 (9.3)	78 (90.7)	86	12 (9.1)	120 (90.9)	132
NGO or philanthropist provided food kits	1 (2.2)	45 (97.8)	46	4 (4.7)	82 (95.3)	86	5 (3.8)	127 (96.2)	132
Free food ration under Pradhan Mantri Garib Kalyan Yojana	1 (2.2)	45 (97.8)	46	3 (3.5)	83 (96.5)	86	4 (3.0)	128 (97.0)	132

Source: Based on the field data collected for this study during 2022

[1]Others includes both backward class and general

Even during such a huge financial crisis, this was achieved only because 74 per cent of the migrant worker's received free food grains from various government and other agencies. Table 3 data revealed a majority 45 per cent of respondents have received grocery kits from the panchayat and about 39 per cent respondents received food grains from their employer. Moreover, about 17 per cent of migrant workers have received free food grains from ration shops and 9 per cent have received food from the community kitchen. Nearly 7 per cent of respondents have received food grains from philanthropists, NGOs, and other sources. Some of the respondents have received food grain from multiple sources. However, there is another concern that 15 per cent of the migrant workers could not get 3 meals in a day during lockdown and 12 per cent said the food was not nutritious. The data has been further disaggregated by caste category as there was no significant variation across the group in receiving food grains it was not considered for further examination.

iii) Housing and Accommodation

Table 4: Issues of housing and paying rent

Services received Lockdown I (March to May 2020)	SC/ST/DN			Others			Total		Over all Total
	Yes	No	Total	Yes	No	Total	Yes	No	
House rent was waived off by the owner	21 (45.7)	25 (54.3)	46	35 (40.7)	51 (59.3)	86	56 (42.4)	76 (57.6)	132
Free food and accommodation	16 (34.8)	30 (65.2)	46	28 (32.6)	58 (67.4)	86	44 (33.3)	88 (66.6)	132
Unable to pay rent	5 (10.9)	41 (89.1)	46	7 (8.1)	79 (91.3)	86	12 (9.1)	120 (90.9)	132
Unable to meet basic needs (electricity bills, mobile recharges, etc.)	3 (6.5)	43 (93.5)	46	9 (10.5)	77 (89.5)	86	12 (9.1)	120 (90.9)	132

Source: Based on the field data collected for this study during 2022

Concerning the financial crisis and jobless situation of the migrant population, house owners understood the difficulties of migrant workers to pay house rent. Table 4 shows that about 42.4 per cent of house owners were waived off their house rent during the first lockdown (March to May 2020). Moreover, it was also found that 33 per cent of migrant workers have received free food and accommodation from their employers. However, 9 per cent of the migrant worker's house rent was neither waived off nor taken care of by the employer. So, they faced difficulty in paying the house rent. Nearly 9 per cent of workers also expressed that they had difficulties in meeting their basic needs like paying electricity bills, mobile recharge, etc.

iv) Access to Healthcare Facilities

Access to healthcare institutions and utilisation of health services is a concern for migrant workers. As they work in unorganised sector they are vulnerable to many health hazards, however, they were not covered under any social security schemes. During the time of any health emergencies when they have to visit a hospital for treatment they have to skip a day of work without payment, and this puts them at peril. While Covid-19 affected everyone irrespective of their socio-economic condition, the poor and marginalised suffered significantly.

Table 5: Access to healthcare

Covid Lockdown I (March to June 2020)	SC/ST/DN			Others			Total		Over all Total
	Yes	No	Total	Yes	No	Total	Yes	No	
Unable to purchase required medicines	3 (6.5)	43 (93.5)	46	0 (0)	86 (100.0	86	3 (2.3)	129 (97.7)	132
Difficulty in consulting doctor for common illness	3 (6.5)	43 (93.5)	46	1 (1.2)	85 (98.8)	86	4 (3.0)	128 (97.0)	132

Source: Based on the field data collected for this study during 2022

However, the analysis of access to the healthcare institutions and purchasing medicines during the lockdown period shows a positive sign in Kerala. Table 5 shows that only about 2.3 per cent were unable to purchase medicines and 3 per cent had difficulty in consulting doctors for common illness. Otherwise, the remaining 97 per cent of respondents did not face any problem in access to and utilizing health facilities.

v) Qualitative Analysis

To substantiate the quantitative data and to know the plight of the Dalit migrant workers, a case study was collected from 10 migrant workers. This qualitative analysis gave a deeper insight on the i) access to food and accommodation, ii) provision of healthcare and, iii) financial security of the migrant workers. The case study was conducted only with the male workers, that was a limitation of this analysis.

However, the information collected was enriching and gave a comprehensive picture on the above-mentioned aspects.

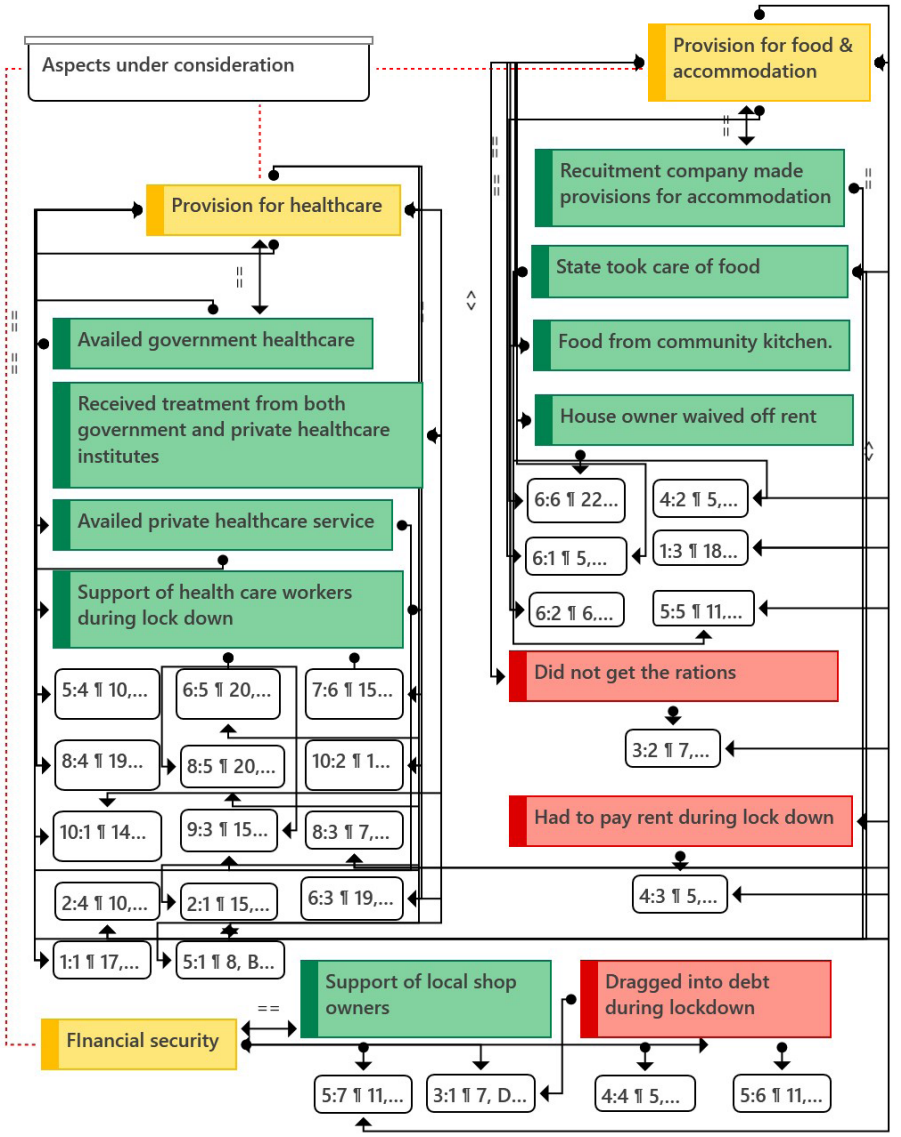

Figure 2: Thematic analysis of life of migrant workers in Kerala

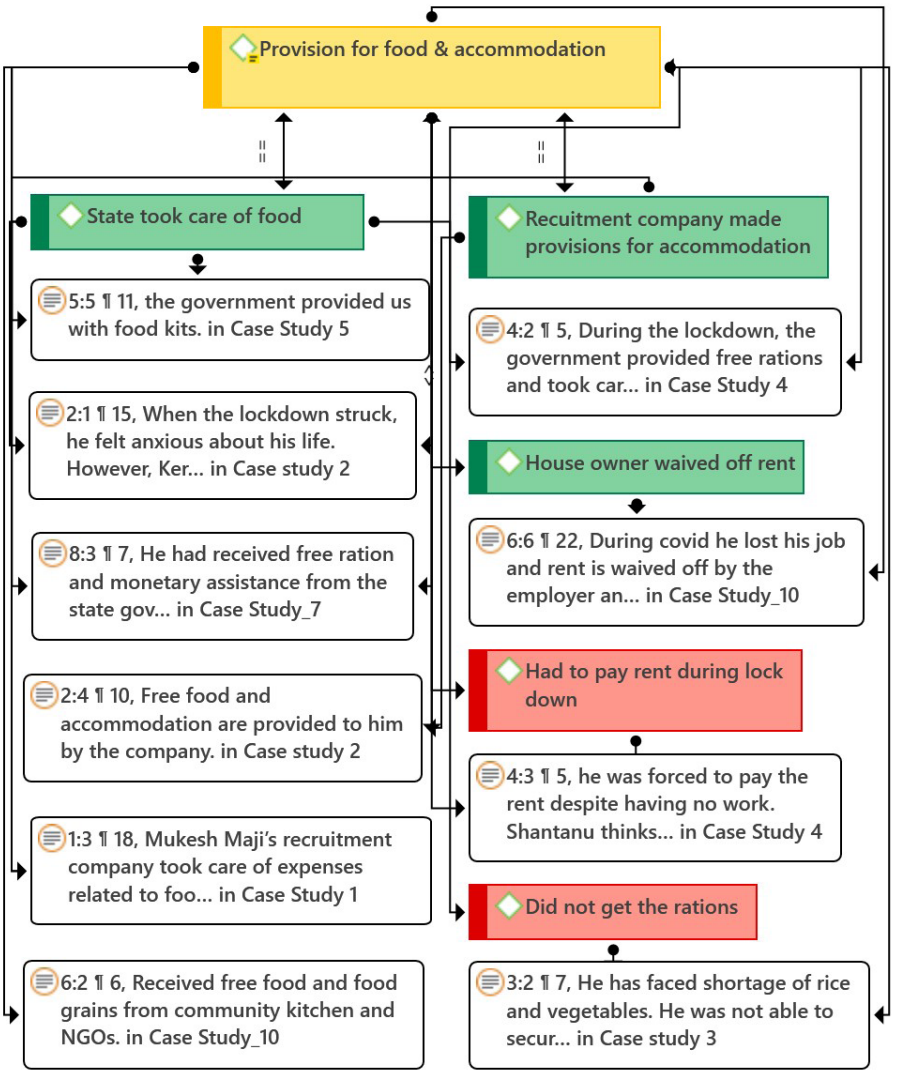

Figure 3: Provisions for food and accommodation

The responses of the participants corelated with the quantitative data, that their needs for provisions for food and accommodation were taken care of by the appropriate government initiatives. Almost all the participants have expressed that they were very anxious and worried when the central government has announced a sudden lockdown, they were apprehensive about how to meet the food requirement for them and their family.

'When the lockdown struck, I felt very anxious about the life and how I am going to meet the basic requirements such as food and accommodation.' (Case 2)

The respondents said that the state machinery took appropriate measures to address the food security concerns by providing free grocery kits, free food rations,

food through community kitchen and financial assistance (case 1, 5, 7 and 10). Apart from the government, the employer, recruitment companies and the contractors were very considerate and took care of the employees. NGOs also played a vital role in addressing their food concerns (case 1, 2 and 10). However, case 3 reported difficulties in receiving food kits from a ration shop.

The cases 1, 2, 6, 8 and 9 reported that the recruitment company took care of their accommodation. Case 10 reported that the house owner waived off his rent for two months. Case 4 did not got any waive-off, he was forced to pay the rent, however he got an extension of time to pay his rent and he "did pay it off later".

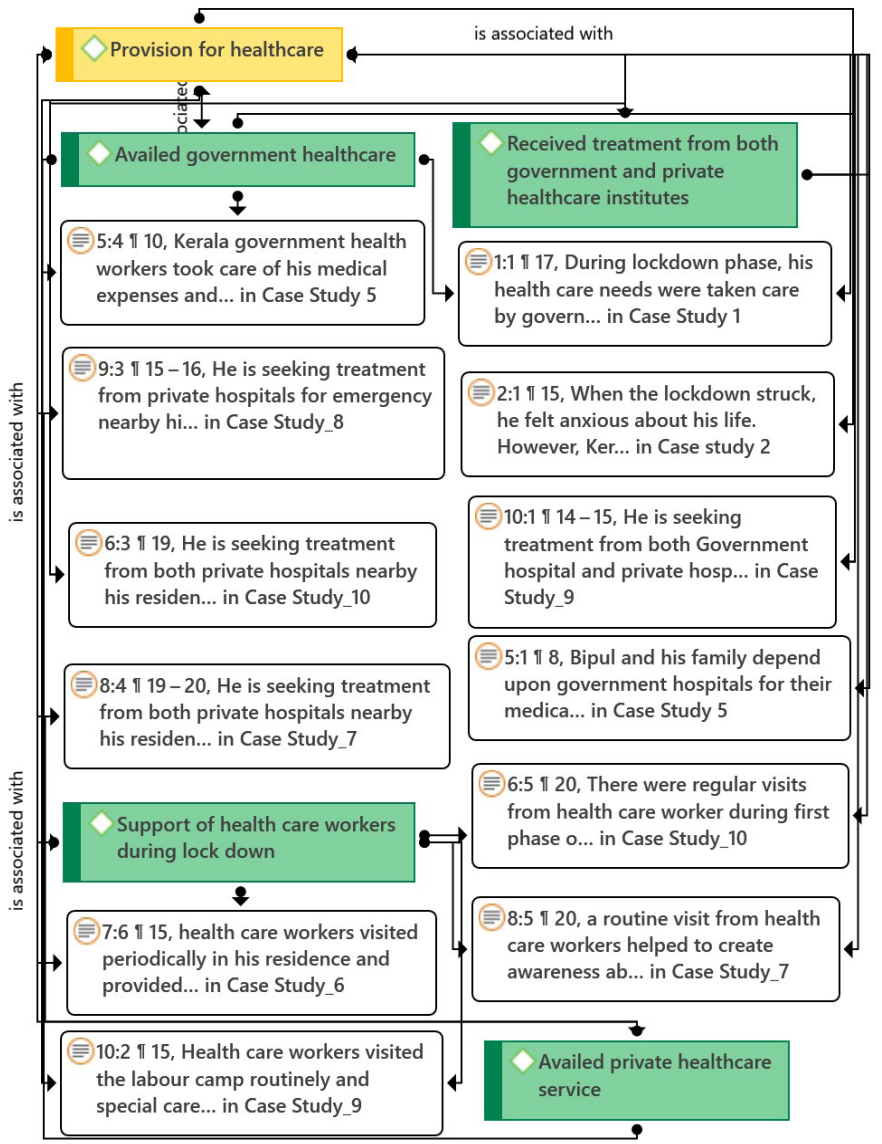

Figure 4: Provision for healthcare

All the respondents of the study reported that they have availed healthcare services. Cases 1, 2, 5, 6, 7, 8, 9 and 10 received healthcare from healthcare workers of state public health institutions. Some (cases 7 & 8) also reported of taking medical treatment from private hospitals. Under normal circumstances, if they want to avail any treatment for minor illness during weekdays, they visit private hospitals in the evening, otherwise if they have to go to a government hospital, they have to lose a day's work. During the weekend and for major illness they prefer the government health facility. Cases 6, 7, 8 and 10 reported that regular visits and support from public healthcare workers were much appreciated.

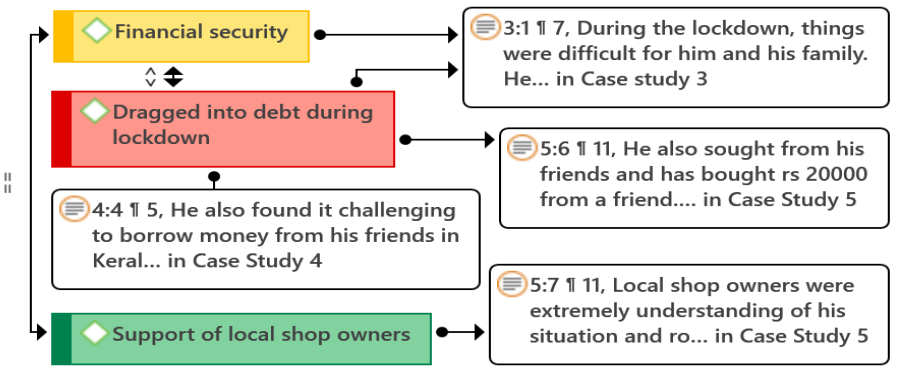

Figure 5: Financial security

Case 3, 4 and 5 reported that they were dragged into debt during the lockdown. It was a very challenging time for the migrant workers during the first phase of lockdown, even though food and accommodation had been taken care of by the government and the employer to certain extent. However, to meet other expenditures they had to borrow money. Usually in Kerala no one would give them a loan, so they borrow money from fellow migrant workers or from their friends and relatives from their hometown. During the lockdown even fellow migrant workers did not have a job, so they borrowed money from their hometown to meet expenses. "Case 5 reported that he was not having money but the local shop keeper was extremely understanding and helped him out", otherwise he would have faced more difficulties to meet everyday needs.

VII. Conclusion

It is clear from this essay that successful tackling of Covid-19 pandemic or any other emergency situation cannot be done by a single entity like an individual, NGO, PRI, government, employer. etc. Usually, it is achieved only by working together, with direction from the government and with the active support of the PRI, NGOs, citizens and other stakeholders. Even within the government, convergence of various departments is required to achieve success.

In Kerala's fight against Covid, while the government heralded the effort, this fight was well appreciated and collectively backed by people and other stakeholders. This is characterised by several factors, namely, an efficient public health infrastructure with dedicated medical professionals & health activists, an efficient bureaucracy that works together with the government with a sense of direction and a civil society that willingly cooperates at times of crisis.

Another interesting aspect which needs appreciation is that in general during a crisis, the state government struggles to meet the concerns of their state people, and so they would be least concerned about migrants. However, in the case of Kerala, they have addressed the concerns of their people and alongside took care of the needs of migrants. In the case of Kerala, the study finds a majority, 92 per cent of migrant workers belonged to SC/ST/OBC. Their education level is low, economically they are extremely poor, and they have faced marginalisation on the basis of their caste identity in their hometown. All these factors pushed them out of their state, and they have migrated to Kerala in search of better employment and wage.

However, the migrants residing in Kerala have reported that they have better living conditions and were happy in Kerala as compared to their home state. Their livelihood, income, healthcare provisioning, food and accommodation has been well taken care of in Kerala. Migrant workers all over India suffered during the pandemic, however with the foresighted vision of the Kerala government and the efficient PRI, NGOs and other stakeholders the situation was handled effectively. The quantitative and the qualitative data shows the life of migrant workers both pre-Covid and during the Covid period was satisfactory. A state with a progressive policy, effective administrator, vibrant civil society and NGOs can handle any emergency far better and can even address the concerns of the marginalised section, including migrant workers.

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Inequality in Access to Medical Education in India: Implications for the Availability of Health Professionals

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Abstract

This study examines the access of students from diverse backgrounds to medical education in India. It shows how inequalities existing in society may entail significant social injustices with regard to access to a career in medicine. The study is based on data from secondary sources. The major part of the analysis is from the Periodic Labour Force Survey, 2019–20; All India Survey on Higher Education, 2019–20; and National Sample Survey data on Social Consumption, Education 2017–18. It is observed that the availability of health professionals is very low overall but it is even lower among underprivileged groups. There are indications of a better share of salaried health professionals among underprivileged caste/ethnic groups probably due to the presence of affirmative action but inequality prevails in self-employment and high quality occupations, thus reflecting the inequality prevalent in society. However, the pattern among Muslims is different from the caste/ethnic groups as the share of regular salaried workers is lower and self-employed is higher among Muslims. The study shows that access to medical courses is linked to family background depicted by caste/ethnicity and religious identities. The availability of medical education in general is very low. The situation is further aggravated for students from underprivileged backgrounds. The high cost of medical courses combined with the dominance of self-financed courses and private unaided institutions may make it inaccessible to students from weaker sections of society. In fact, the probability of attending a medical course is relatively lower for Scheduled Castes/Scheduled Tribes (SCs/STs) and Muslims than Hindu High Castes (HHCs). The low average expenditure of medical courses confirms the low quality of education accessed by the student from underprivileged backgrounds at every level. It is important to note that education of the head of the family emerges as the most important predictor for access to medicine education. Similarly low household size also improves the probability of attendance. It is thus important to improve the access to medical

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education through establishing new educational institutions with affordable costs. The challenge is to ensure equal access for students from underprivileged groups so that the existing inequality in the availability of health professionals may be addressed. For this, affirmative action for the students from poor families and first generation learners may be worthwhile to address the problem of inequality of access to medical education. Such policies would also improve the availability of health professionals from the underprivileged socio-religious background which in turn would play an instrumental role in ensuring better access to healthcare services for patients from underprivileged communities.

Keywords

Higher education, choice, employment, inequality

Introduction

The years of school are considered as one of the most important factors that lead to improved labour market outcomes (Card, 1999). However, this approach does not take the quality of education into consideration. With improving access to education to a large section of society, the years of education can't determine the labour market outcomes effectively, rather specialisation becomes an important factor (Altonji, 2015). Studies indicate that the earning gap across colleges major is notably high (Altonji et al., 2012) and increasing (Altonji et al., 2014; Gemici & Wiswall, 2014) over time.

Despite continued expansion of higher education, the equity in access to higher education is still a major concern; it becomes highly exclusive when access to professional courses is examined (Khan, 2022). Much research focuses on overall access to higher education, while comparatively lesser research focuses on courses. The focus on medical education is completely absent so far higher education in India is concerned. The study on medical education is scant despite the fact that the availability of trained medical practitioners is significantly low and numerous students migrate outside to get a medical degree in the wake of low number of seats and high fees. The existing literature suggests a severe shortage of healthcare workers in India (Kasthuri, 2018). India is categorised among the most severe crisis-facing countries in terms of human resources in health (Karan et al., 2019). The situation is more worrisome as observed by the representation of underprivileged groups in such prestigious courses. This study investigates the broad inequities in the availability of health professionals and access to medical education recognizing that the underrepresentation of underprivileged groups is not random but systematically connects to their group identity. This study fills the gap in literature in the wake of the paucity of research focused on the postsecondary major choice. The study attempts to capture the influence of students' background, parental influences and occupational background of the family as a proxy for students' social and cultural capital, which are linked in part to their major choices in higher education (Astin, 1993; Carrico & Matusovich, 2016; Simpson, 2001).

Data and Methodology

This analysis covers three important aspects of medical education. First, it examines the labour market outcomes in relation to the medical education at aggregate level and across different groups. Second, it examines the status of medical education in India and the status of different social and religious groups. And third, the study analyses the attendance in medical education and factors affecting it.

The analysis is based on the data from three prominent datasets. The analysis of labour market outcomes examines the estimated number of workers and their distribution by gender, social and religious groups using periodic labour force survey data, 2019-20 (PLFS). The number of workers engaged in health-related industrial activities is considered as a proxy for the measure of the number of health professionals. The group of industries comprises three types of workers in health-related activities. First type (Type 1) covers workers engaged in activities of general and specialized hospitals, sanatoria, asylums, rehabilitation centres, dental centres and other health institutions that have accommodation facilities, including military bases and prison hospitals. The second type (Type 2) of workers covers those activities that can be carried out in private practice, group practices and in hospital outpatient clinics, and in clinics such as those attached to firms, schools, homes for the aged, labour organizations and fraternal organizations, as well as in patients' homes, medical practice activities and dental practice activities. The third type (Type 3) includes activities related to nurses, masseures, physiotherapists or other para-medical practitioners, activities of independent diagnostic/pathological laboratories, activities of independent blood banks and other human health activities not elsewhere classified (including independent ambulance activities). This is to note that Type 1 activities are highly specialised in nature and are linked to institutional activities, Type 2 is largely privately operated activities while the Type 3 covers activities that assist health services. The three types of industrial groups are analysed by gender, social and religious groups and across rural and urban areas.

Another way of estimating the number of health professionals is based on the occupational status of the workers. The occupational classification of workers provides information about the health professionals engaged as physicians and surgeons in Allopathic, Ayurvedic, Homeopathic, Unani system; dental specialists; veterinarians and health professionals not elsewhere classified except nursing. This group of occupation largely covers doctors and hence may be treated as a high quality occupation.

The analysis based on the All India Survey on Higher Education (AISHE, 2019–20) examines course enrolment related to medical sciences covering all types, though paramedical sciences is excluded from the analysis.

The analysis of attendance in medical courses is based on the 75 th round national sample survey data on household social consumption: Education, 2017-18 (NSS). The variation in access to medical education by social and economic background is explored in the analysis. The course covers attendance of all types, viz., certificate, diploma, graduate, postgraduate and higher. We explore the access to medical education as a function of gender, race/ethnicity, and economically disadvantaged status. The

social and religious groups are combined to identify socio-religious groups, namely, schedule tribe (STs), schedule castes (SCs), Hindu other backward castes (HOBCs), Hindu Higher Castes (HHCs) and Muslims. Additionally, the access to private unaided institution for medical courses is also investigated. This shows inequality in access to medical courses by gender, race, and socioeconomic status (and the intersections among those demographics). The econometric analysis is based on NSS data. The analysis is confined to the age group 18–35 years. The first model analyses the access to medical education for the population in the age group 18–35 years. The second model examines the access to medical education with regard to other types of higher education, while the third model analyses the access to medical education against the access to other courses at graduate and above levels.

Health Professionals in India

The PLFS, 2019–20 data shows that there are nearly 4.8 million health workers in India. The figure is higher for male than female, 2.5 million and 2.3 million, respectively. The corresponding figure is 0.36 million among tribals, 1.1 million among SCs, 1.64 million among OBCs and 1.7 million among forward castes (HHCs). The figure widely varies across religious groups also. There are 0.30 million health care workers among Muslims, while this figure is 0.28 million for Christians, 0.12 million among Sikhs and 0.10 million among Buddhists. The health workers comprise 0.47 per cent of the total population aged 15 years & above with share being relatively higher for male than female, 0.49 per cent and 0.45 per cent, respectively. This figure is highest among HHCs at 0.59 per cent followed by 0.54 per cent among SCs, 0.38 per cent among OBCs and 0.41 per cent among tribals respectively. The figure is relatively lower among Muslims across religious groups whose 0.27 per cent population under consideration are engaged as health workers. This is relatively higher among other religious minorities (Table 1).

Table 1: Availability of health workers, 2019–20

	Number	Percentage Pop.
M	2.49	0.49
F	2.26	0.45
ST	0.36	0.41
SC	1.09	0.54
OBC	1.64	0.38
HC	1.67	0.59
Muslims	0.30	0.27
Christians	0.28	1.20
Sikhs	0.12	0.71
Buddhists	0.10	1.31
Rural	1.75	0.26
Urban	3.00	0.94
Total	4.75	0.47

Source: Periodic Labour Force Survey, 2019–20

There is very high disparity in availability of health workers between rural and urban areas. There are 1.8 million health workers in rural areas while the figure is nearly 3 million in urban areas. This is a concern as nearly 68 per cent of the population resides in rural areas while the urban areas comprise 32 per cent of the total population. This is evident from the remarkably high rural-urban disparity in terms of workers population ratio. Nearly 0.26 per cent of the 15 years & above population is engaged as health workers whereas this figure is close to four times in urban areas, 0.96 per cent (Table 1).

The majority of the health workers are engaged as regular/salaried (RS) worker, though it widely varies across different groups. Nearly 84 per cent of the total health workers are engaged as RS workers. This figure is relatively higher for female than male which is indicative of gender-based norms as women are allowed to work in secured high paying jobs. The share of Self Employed (SE) workers is almost four times higher among male than female. A similar pattern is observed among SCs/STs wherein more than 90 per cent workers are engaged as RS workers, though figures are 83.9 per cent and 78.2 per cent for OBCs and Others respectively. This probably may be due to the inclusive role of government sector as affirmative actions are available for SCs/STs in employment. However, their presence among SE workers is far lower than OBCs/HHCs reflecting the impact of identity-based patterns that are highly prevalent in the social sphere in India. Only 7 per cent and 9 per cent of STs and SCs workers are engaged as SE workers while the figures are 16 per cent and 21 per cent for OBCs and HHCs respectively. The figure for Muslims is lower in RS jobs than Hindus and other religious minorities, 76.6 per cent among Muslims as against 85 per cent among Hindus and 83.7 per cent among other religious minorities. However, the share of SE is far higher among Muslims which implies that Muslims end up mostly as self-employed health workers instead of RS works. The share of RS by types is roughly similar in rural and urban areas. The share of casual workers is negligibly low at aggregate levels and among the different groups as well. This is indicative of high quality employment in terms of job contracts and social security benefits prevalent in medical profession (Table 2).

Table 2: Health workers by type of works, 2019–20

	SE	RS	CL	Total
Male	23.7	75.9	0.41	100
Female	6.1	93.3	0.53	100
ST	6.8	93.2	0	100
SC	8.5	91.4	0.2	100
OBC	15.6	83.9	0.48	100
Others	21.1	78.2	0.73	100
Hindu	14.5	85.0	0.52	100
Muslims	22.8	76.6	0.59	100
ORM	16.3	83.7	0	100
Rural	14.9	84.7	0.39	100
Urban	15.4	84.1	0.52	100
Total	15.2	84.3	0.47	100

Source: Periodic Labour Force Survey, 2019-20

Nearly 62.1 per cent of the workers are engaged in health-related activities while 14.1 per cent are engaged in medical and dental practice and 23.8 per cent are engaged in other human health related activities. Consistent with the share of RS workers, a relatively higher share of workers among female than male and SCs/STs than OBCs/HHCs are engaged in hospital related activities. However, this is not the case for religious groups as a relatively lower percentage of Muslims than Hindus and other religious minorities are engaged in hospital activities. The other human health activities which are of relatively lower preference than hospital related activities comprises 27.3 per cent of workers among female and 20.7 per cent of workers among male. This activity comprises 26.3 per cent workers among STs and 21.6 per cent among OBCs and 27.7 per cent among HHCs. The figure is 31.6 per cent among Muslims while it is 21 per cent among Hindus and 21.6 per cent of the workers among other religious minorities. The share is roughly similar in rural and urban areas (Table 3).

Table 3: Health workers by industrial categories

	Hospital Activities	Medical & Dental Practice	Other Human Health
Male	59.7	19.6	20.7
Female	64.5	8.2	27.3
ST	62.2	11.5	26.3
SC	68.8	9.6	21.6
OBC	58.0	14.3	27.7
Others	61.6	17.4	21.0
Hindu	62.4	14.1	23.6
Muslims	52.7	15.7	31.6
ORM	65.3	13.2	21.6
Rural	60.9	15.0	24.1
Urban	62.7	13.6	23.7
Total	62.1	14.1	23.8

Source: Periodic Labour Force Survey, 2019–20

The number of health workers according to the occupational classification which shows high quality occupation is 0.848 million at all India level. The figure is higher among higher caste followed by OBCs, SCs and STs respectively according to the social groups. There are only 0.046 million health professionals as per the occupational classification among Muslims. The figure is similar for other religious minorities also. The rural-urban disaggregation shows 0.214 million and 0.634 million health professionals in these areas, respectively. The number is far higher among male than female, 0.684 million and 0.164 million, respectively. The percentage distribution also reveals that SCs/STs, OBCs and Muslims are underrepresented in terms of share. Muslims are the least represented group followed by STs and SCs respectively. Nearly, 81 per cent are male while only 19 per cent are female indicating that female are

seriously underrepresented in this occupational category. Similarly, three-fourth of health professionals are confined to urban areas while the share is 25 per cent in rural areas (Table 4).

Table 4: Health workers by occupational categories

	Total (Million)	Share (%)
Male	0.684	80.7
Female	0.164	19.3
ST	0.057	6.7
SC	0.117	13.8
OBC	0.246	29.0
Others	0.428	50.4
Muslims	0.046	5.4
ORM	0.045	5.3
Rural	0.214	25.2
Urban	0.634	74.8
Total	0.848	100

Source: Periodic Labour Force Survey, 2019–20

Access to Medical Courses

So far the access to medical courses is concerned, the enrolment is close to 19.8 lakh in medical sciences and 28,400 in paramedical courses. In terms of gender wise composition, female constitutes 61 per cent of the total enrolment in medical sciences while the corresponding figure for male is 39 per cent. This shows that medical sciences is highly female-oriented. However, the female-centric enrolment is confined significantly to the lower level of education in medical sciences (Fig 1).

Table 5 shows the share of medical courses in total attendance/enrolment in higher education at aggregate level 2.5 per cent of the total attendance takes place in medical courses. The figure is lower for SCs/STs but it is slightly higher than the overall average for Muslims. This course comprises nearly 2 per cent of the total attendance among SCs/STs while this figure is 3 per cent among Muslims. The AISHE data shows a higher share of medicine in total enrolment. It comprises nearly 6 per cent of the total enrolment while the corresponding share is 5 per cent among SCs/STs and 5.6 per cent among Muslims.

Table 5: Share of medicine in total attendance/enrolment

	ST	SC	Muslim	Total
NSS, 2017–18	1.6	2.2	3.1	2.5
AISHE, 2019–20	5.0	5.0	5.6	5.5

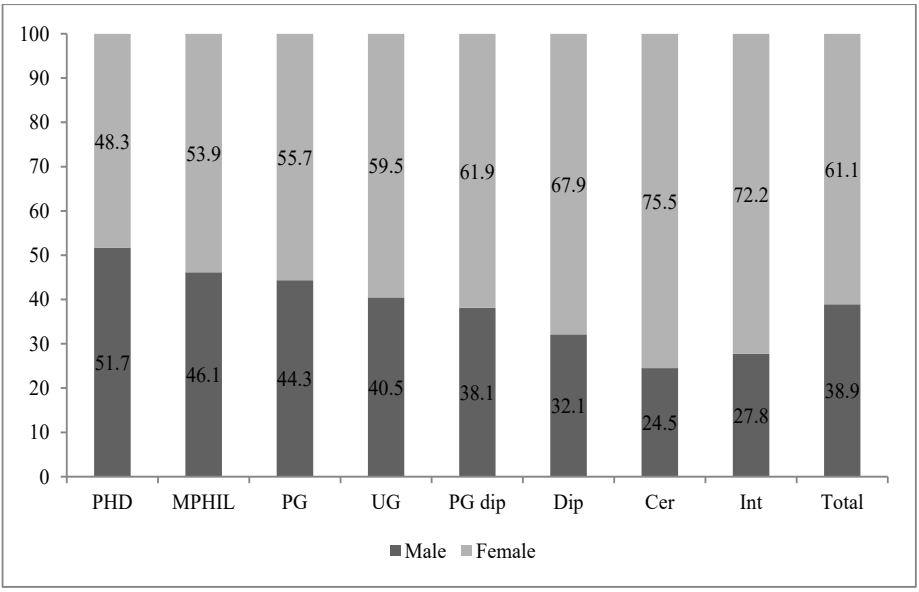

Fig 1. Gender-wise share in enrolment in medical science by level of education

The share of females in enrolment at a certificate level is nearly 76 per cent but it continues to reduce as one moves up to higher levels of education and reduces to 48 per cent at Ph.D. levels. The high share of enrolment of women at lower levels of education indicates that a large number of women join the medical sciences to earn a livelihood which is consistent with the social norm imposed upon them.

The majority of students are enrolled at undergraduate level. The figure is relatively lower among SCs and STs while it is higher among Muslims. At aggregate levels, nearly 66 per cent of students study at undergraduate levels. This share is 72 per cent among Muslims, 57 per cent among SCs and 54 per cent among STs. The share of diploma is higher among STs and SCs than the aggregate level. It is relatively lower among Muslims. The share of PG is also relatively lower among SCs/STs though it is higher among Muslims. The share is lower than aggregate level among Muslims also. Similarly the share of PHD is lower than aggregate level among all the three underrepresented minorities but it is relatively higher among Muslims followed by SC and ST respectively.

In order to compare the performance of different groups enrolment per thousand population in 18 to 23 years population is used as an indicator. The enrolment in medical sciences is only 13.0 per thousand of the total population in the age group 18–23 years. This share is 10.3 for male and 18.0 for female. The figure is lower among STs and SCs at 7.5 and 7.9 respectively while it is lowest at 5.5 for Muslims. The gap vis-à-vis aggregate levels is high for undergraduate courses wherein only 4 per thousand students are enrolled in medical courses for underprivileged groups while the corresponding figure is 8.5 at aggregate level. Thus, the representation of underprivileged groups is very low in medical courses (Fig. 2).

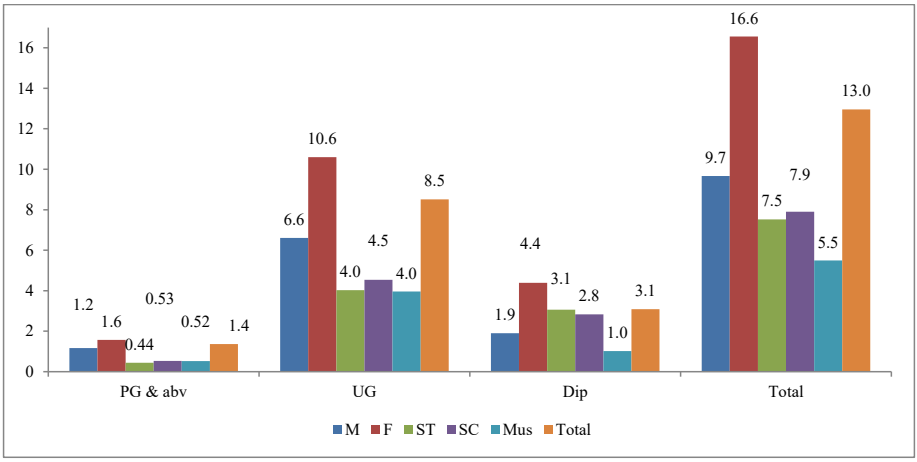

Fig 2. Share of enrolment per thousand population (18–23 years) by level of education

The distribution of enrolment by level of education reveals that while a relatively higher number of SCs/STs students are enrolled at diploma levels, their share at graduate and higher levels is low. However, the share of undergraduate level for Muslims is higher than overall average. Notably, the share is higher for SCs/STs in diploma courses than Muslims which leads to high gap at aggregate level. The low access to medical courses is a common problem for all the underprivileged groups. However, the low representation at higher level is specific to SCs/STs only (Table 6). The pattern among the three underprivileged groups shows that medical education for Muslims probably confines to their economically well-off section while weaker sections among SCs/STs join short-duration medical courses to earn livelihood. Consequently, the share of higher level of education is relatively better among Muslims than SCs/STs despite lower number of enrolment per thousand 18-23 aged population among them.

Table 6: Access to medical courses by level of education, 2017–18

	ST	SC	MUS	TOT
PH.D	0.08	0.16	0.26	0.46
M.PHIL	0.01	0.00	0.02	0.04
PG	5.8	6.6	9.1	10.0
UG	53.5	57.4	72.1	65.7
PGD	0.26	0.21	0.23	0.31
DIP	39.5	35.0	17.9	23.1
CERT	0.86	0.65	0.17	0.39
INT	0.00	0.01	0.17	0.03
Total	100	100	100	100

Source: All India Survey of Higher Education, 2019–20

Privatization and Household Expenditure on Medical Education

As per the AISHE, 2019–20 data, more than half of the total enrolment in medicine takes place in self-financed courses. It comprises nearly 55 per cent of the total

enrolment in medicine. The share is slightly lower among SCs and STs whose 52 per cent and 48 per cent of the total enrolment respectively takes place in self-financed courses. A relatively higher share of Muslim students are enrolled in self-financed courses, 59 per cent.

Table 7: Share of self-financed courses in total enrolment in medicine

	Self-Financed	Share in Total Enrolment in Medicine (%)
ST	49275	48.0
SC	135038	51.5
Muslims	65267	58.8
Total	1097468	55.4

Source: All India Survey of Higher Education, 2019–20

The share of unaided institutions is higher at lower levels of education, i.e. the private sector is highly concentrated in short term courses. As one moves upward in terms of level of education, the share of unaided institutions continues to reduce. Nearly 75 per cent of the total attendance at higher secondary levels takes place in private unaided institutions. For diplomas, this figure is 18 per cent at secondary level and 48 per cent at HS level and 35 per cent at graduate & above levels. However, unaided institutions comprise 44 per cent of the total attendance at graduate level. The corresponding figure is nearly 29 per cent at Post Graduate & higher levels.

Table 8: Attendance in medicine course by type of institution & level of education

Level	Gov.	Aided	Unaided	NK	Total
Secondary	98.3	1.7	0	0	100
HS	22.5	2.7	74.8	0	100
Diploma secondary	71.6	10.7	17.7	0	100
Diploma HS	27.0	22.7	47.9	2.34	100
Diploma grad & above	43.7	20.7	35.1	0.46	100
Graduate	35.5	21.0	43.5	0	100
PG & above	44.9	26.3	28.5	0.35	100
Total	38.0	20.6	40.9	0.57	100

Source: 75th Round National Sample Survey, 2017–18

The share of attendance by types of institutions also indicates higher dependence of underprivileged groups on unaided institutions. The private unaided institutions constitute nearly 41 per cent of the total attendance at aggregate level. However, this share is only 28 per cent among HHCs. The corresponding shares are 62 per cent and 52 per cent among STs and SCs respectively. The high share of private unaided institutions among SCs/STs might be possible due to a high share of diploma courses among them. The share is 44.5 per cent among HOBCs and 37 per cent among Muslims. This is to note that the higher share of SCs/STs in unaided institutions coexisting

with a lower share in self-financing courses might reflect their lower representation in self-financed courses in government and aided institutions. The management-wise distribution of enrolment misses out on the self-financed courses in government and aided institutions where it is highly likely that students from privileged backgrounds might be concentrated. The high share of unaided institutions among Muslims again confirms the hypothesis of medical education being confined to a minuscule economically well-off section among them. The minority institutions might also be playing an instrumental role in the provision of medical education to a small section of the community. However, the community as a whole is lagging in terms overall access to medical education behind all the other social and religious groups.

Table 9: Attendance in medicine course by type of institution

	ST	SC	HOBC	HHC	Muslim	Rest	Total
Government	19.5	21.3	35.3	47.7	53.1	12.9	38.0
Aided	18.0	26.5	20.2	22.3	10.2	25.8	20.6
Unaided	62.3	52.0	44.5	28.4	36.7	61.1	40.9
NK	0.19	0.27	0	1.56	0.1	0.26	0.57
Total	100	100	100	100	100	100	100

Source: 75th Round National Sample Survey, 2017–18

The expenditure incurred on medical courses in an academic year is shown by types of institutions and socio-religious groups (Table 10). Nearly ₹ 57,000 is spent by a household in an academic year. The expenditure incurred by the underprivileged groups is lower than those belonging to the well-off groups. The figure is highest for HHCs followed by HOBCs, Muslims, SCs and STs respectively.

The average expenditure by type of institutions reveals a huge difference between government and private institutions. Interestingly, the expenditure is highest in private aided institutions followed by unaided and government institutions. The expenditure is nearly ₹ 20,000 in government institutions while it is ₹ 83,900 in private aided institutions and ₹ 78,300 in private unaided institutions. This is to note that higher average expenditure in aided institutions than unaided institutions is attributed to the higher average expenditure among the underprivileged groups, namely, SCs/STs/HOBCs. The average expenditure in private unaided institutions is ₹ 1.14 lakh for HHCs which is highest among every socio-religious group. This figure is ₹ 77.8 thousand for HOBCs while it is ₹ 37.4 thousand for STs and ₹ 41.8 thousand for SCs. The average expenditure among Muslims is also relatively higher than the other underprivileged groups but lower than HHCs. It is ₹ 79.9 thousand among Muslims. A similar pattern is observed in private aided and government institutions wherein the average expenditure is higher for HHCs/HOBCs than STs/SCs. The expenditure is lowest for government institutions. In government institutions, the figure is lower for Muslims than HOBCs/HHCs. It is a matter of further inquiry whether low expenditure

of Muslims is attributed to their participation in low cost short duration courses or in government supported courses in minority institutions.

Table 11 shows the expenditure by level of education. The average expenditure is higher at higher levels of education among every group. This is to note that the average expenditure is higher for HHCs/HOBCs at every level except PG & higher level wherein Muslims have the highest expenditure. The expenditure at PG & higher level is highest among Muslims followed by SCs, HOBCs, HHCs and STs respectively. This pattern changes at the graduate level. The figure is highest for HHCs followed by HOBCs, Muslims, SCs and STs at graduate levels respectively. The fact that the average expenditure is lower for the underprivileged group for a particular level of education reflects low quality of medical education among them. The relatively higher expenditure among Muslims and SCs at PG & higher level demands further inquiry.

Table 10: Expenditure in medicine course by type of institution (In academic year)

Groups	Government	Aided	Unaided	NK	Total
ST	16967	39811	37398	42663	33864
SC	13077	53698	41830	24999	38804
HOBC	24276	84165	77776	-	60174
HHC	20946	112672	114058	34521	68085
Muslim	9768	62411	79900	25039	40846
Rest	53913	54607	93541	73164	78339
Total	19699	83900	78290	34596	56936

Source: 75th Round National Sample Survey, 2017–18

Table 11: Expenditure on medicine course by level of education (In academic year)

Level	ST	SC	HOBC	HHC	Muslim	Rest	Total
Diploma secondary	13459	14563	5878	20119	6626	61495	8837
Diploma HS	21265	25079	34137	37142	15195	35647	28519
Diploma grad & above	43589	26523	42769	33508	23532	53498	34604
Graduate	46968	57955	82288	85827	74801	111947	80813
PG & above	17642	125255	91569	79456	147742	61271	94610
Total	33864	38804	60174	68085	40846	78339	56936

Source: 75th Round National Sample Survey, 2017–18

Econometric Exercise

The econometric analysis is based on the three models as shown in Table 12. The table shows the odd ratio for the three models.

Model 1: Attending courses related to medicine vs. not attending. This model is used for examining the factor affecting access to medical education in the age group between 18 and 35 years.

Model 2: Attending courses related to medicine vs. other course in higher education. This model is used for those attending higher education in the age group between 18 and 35 years.

Model 3: Attending Post Graduate & high level in course related to medicine vs. lower level of medical courses. This model is used for those having graduate and above level in the age group between 18 and 35 years.

The independent variables used are socio-religious groups, gender, education of the head of the households and size of the household. For social groups, STs, SCs, HOBCs, HHCs, Muslims and rest are considered. The education of the head is a binary variable comprising those having level of education upto primary/middle against higher level of education. Gender is a binary variable comprising male and female. Size of the households is a continuous variable.

Table 12: Result of the logistic model

	Access	**Choice**	**Level**
ST	0.384	0.554	0.497
SC	0.644	0.780	0.787
HOBC	0.627	0.790	0.903
Muslim	0.963	1.061	0.865
Rest	1.363	0.806	0.897
Head's education	4.575	2.277	2.827
Female	1.687	2.385	2.528
Household size	0.659	0.680	0.570
_cons	0.007	0.047	0.051
Observation	1,36,372	23,237	19,252
Pseudo R2	0.1022	0.0984	0.1577

Source: Based on 75th round National Sample Survey data, 2017–18

Note: All coefficients are statistically significant

In model 1, the odds for attending medical courses is 62 per cent lower among STs than HHCs while this gap is 36 per cent for SCs and 37 per cent for HOBCs. The odds for Muslims is 4 per cent higher than HHCs. The education of the head of the family significantly improves the probability of access to medical courses. Similarly, the odds for attending medical courses is higher among female than male. The higher the size of the household the lower are the chances of attending medical courses which is understandable as larger households may have lower capacity to finance expensive medical courses than smaller households.

Model 2 also shows the similar result with a few differences. The odds for attending medical course is lower by 45 per cent among STs, 21 per cent lower for SCs, 10 per cent lower among HOBCs than HHCs. The odds is 13 per cent higher for Muslims than HHCs. The odds for attending higher education is higher for female

than male in this model also. The education of the head of the household continues to affect the attendance in medical courses positively. However, the higher household size reduces the chance of joining medical courses.

Model 3 shows that the odds for attending higher education is lower by 50 per cent for STs, 21 per cent for SCs, 10 per cent for HOBCs and 13 per cent for Muslims than HHC. The odds for female continues to be higher than male. The role of household size and head's education also remains the same.

Thus, the education of the head of the household remains the most prominent factor affecting access to medical education in all three models. The lower household size also improves the access to this course. The probability of attendance for female remains consistently higher than male in all the three models. The access of underprivileged caste and religious groups is lower than HHCs in all the models. However, the probability of attendance of medical courses vis-à-vis other courses in higher education for Muslims is higher than HHCs.

Conclusion

This study examines the access of students from diverse background to medical education in India. It shows that inequalities existing in society may entail significant social injustices with regard to the access to a career in medicine.

It is observed that the availability of health professionals is very low overall but is even lower among underprivileged groups. If one considers the share of high quality occupation by different groups, the inequality becomes stark and remarkably high. There are indications of relatively better concentration of regular jobs among health professionals belonging to the underprivileged social groups probably due to the presence of affirmative action. However, the concentration of self-employed health professionals is relatively higher among Muslims. This pattern reflects the impact of caste/ethnicity-based prejudice in the social sphere leading to the lower concentration of caste/ethnic groups in self-employment on the one hand and high concentration of self-employment among Muslims due to seggregation and the absence of affirmative action in employment for Muslim minorities on the other hand.

One may note that the inequality is high in access to medical education which also indicates that the prevailing inequality among health professionals is linked to the existing inequality in higher education. The analysis further shows that the access to medical education is linked to the family background as depicted by caste and religious backgrounds. The access of underprivileged caste/ethnic groups, namely, SCs/STs is lower than HHCs. Similarly, the access of Muslims is lower than the HHCs. Apart from identity, the existing inequality is related to economic background as well. The household size and education of the head of the family is used as a proxy to capture the impact of family background on access to medicine courses.

The share of unaided institutions and self-finance courses is notably high in medical education. More than half of the total enrolment in medicine takes place in self-financed courses, while 41 per cent of the total enrolment in medicine takes place in private unaided institutions. The concentration of unaided institutions is higher at lower levels of education. The concentration of unaided institution is high among SCs/STs also probably due to the high share of short-term courses among them. This is also evident from the low expenditure on medical courses among SCs/STs in every type of institution. The high share of unaided institutions among Muslims again confirms the hypothesis of medical education being confined to a minuscule economically well-off section among them. The minority institutions might also be playing an instrumental role in the provision of medical education to a small section of the community. However, the community as a whole is lagging in terms overall access to medical education behind all the other social and religious groups.

The average expenditure among the underprivileged groups is also lower than HHCs. The average expenditure is higher at higher levels of education among every group. The fact that the average expenditure is lower for the underprivileged group for a particular level of education reflects low quality of medical education among them.

The econometric analysis shows that head's education remains the most prominent factor affecting access to medicine courses in all three models. A lower household size also improves access to this course. The access of females remains consistently higher than males in all the three models which might be due to gender-based norms in higher education as medicine is considered a suitable profession for women. The access of underprivileged caste and religious group is lower than HHC in all the models. However, the probability of attendance of medicine courses vis-à-vis other courses in higher education for Muslims is higher than HHC.

Thus, the challenge is ensuring equal access for students from underprivileged groups so that the existing inequality in the availability of health professionals may be addressed. For this, affirmative action for students from poor families and first generation learners may be worthwhile to address the problem of inequality of access to medicine courses. Such policies would also improve the availability of health professionals from varied socio-religious backgrounds which would play an instrumental role in ensuring better access to healthcare services for patients from underprivileged communities.

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Addressing Hegemony within the System of Medicine for an Inclusive and Sustainable Health System: The Case of Traditional Medicine in India

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Abstract

There is growing interest and belief in the effectiveness and efficacy of the traditional system of medicine and its sustainability within the health system. The domination and superiority of biomedicine over traditional medicine have been visible from postcolonial time to till date. At the same time, there is also an increased attempt to streamline and harmonize the diversity of the traditional system of medicine with the modern system of medicine. However, it has often resulted in detrimental outcomes for many traditional health practitioners, including the system of medicine they practice. The dominance and interplay of the power relationships and social structural inequalities are not discussed and deliberated extensively in the published literature as one of the crucial reasons for medical hegemony. Therefore, the essay's objective is to address the hegemony in traditional medicine regulation, professionalization, commoditization and intellectual property rights. In doing so, an attempt has been made to argue for the traditional care providers such as bonesetters and *Dais* (Traditional Birth Attendants) whose services remain undermined due to their social identity, often overlooking the difficult conditions in which they provide care. This may give us a more inclusive and sustainable health system perspective. The traditional medicine system and the care providers, deserve the long denied respect from the medical care and health science community; and better recognition, preservation and protection of their skills.

Keywords

System of medicine, hegemony, traditional medicine, biomedicine, regulation, professionalization, commoditization, intellectual property, traditional knowledge, marginalisation

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Introduction

Globally the health system is dominated by the experimental concepts of the biomedical system of medicine, which is often called modern western scientific medicine, allopathic medicine, and conventional medicine. It explains health in terms of biology and attaches importance to learning about body structure (anatomy) and systems (physiology). It has brought innovations with consistent research and updating knowledge. The infectious diseases that were the primary cause of high mortality are now conquered. Management of high-risk cases, surgical interventions, etc., has brought in marvels in the health sector.

Nevertheless, the presence of a traditional system of medicine is equally undeniable, even though the domination of biomedicine can be seen in all spheres of the health sector, from primary to tertiary levels of care. The traditional system of medicine (TSM) explains health in terms of ecosystem and community-specific health practices, approaches, knowledge and beliefs, which are embedded in the community worldviews and value systems. The knowledge incorporates to plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises. The medical application may be singular or in combination to treat, diagnose and prevent illnesses or maintain well being.

Going by the World Health Organization (WHO) estimation, it is estimated that 80 per cent of the population depends on TSM in certain African and Asian countries. Further, WHO stated two critical goals in its newly published Traditional Medicine Strategy 2014–2023. The first goal is to support the Member States in harnessing the potential contribution of traditional medicine to health, wellness and people-centred health care. The second is to promote traditional medicine's safe and effective use by regulating products, practices, and practitioners (World Health Organization, 2013). The stated goals echoed the ethos of sustainable health in tune with the sustainable development goals of reaching the last mile, where no one is left behind in achieving health for all.

At the same time, sustainability of health is all about the availability, accessibility, and affordability of health services through different medical and health care systems. However, the differential in access to health care and systems of medicine produces health inequality and inequities when there is a barrier in access to resources and services. Studies and writings on the genesis of modern public health amidst the industrial revolution and colonial past informed us that TSM was prominent in knowledge domains and commercial purposes. Various disciplines such as Sociology, Medical Geography, Anthropology, Ethnobotany, Pharmacology and industry—the pharmaceutical industry have engaged with the question of traditional medicinal knowledge and traditional healing within medicine. While there is acceptance and acknowledgement of TSM globally, there has remained a sense of undermining their importance in more than one way. For instance, an increased attempt to streamline the diversity of TSM has often resulted in detrimental outcomes for many practitioners.

In the study by Guite and Reddy (2021),[1] it was found that there have not been any schemes for the upliftment of the skills of traditional healers and practitioners. When the interviews were done with the modern health care workers, they discourage mothers to utilize the traditional birth attendants (TBAs) for child delivery. According to one medical officer, "even though the TBAs might have abilities and experience in helping to give birth but they are not well equipped for emergencies", she mentioned, "if a mother suffers from postpartum haemorrhage then there is 90% chance the mother will die in the hands of TBAs, which can easily be treated in the hospital". According to some traditional healers, there have also been instances where they were given a warning not to continue their practice of healing by the health care workers. Such incidences and situations highlighted why WHO proposed training the TBAs in developing skills and understanding the mechanism to reach the hospital.

Further, the ever-decreasing power of the traditional healers and practitioners in their medical practices can be seen throughout the evolution of TSM from postcolonial to globalization in India. For instance, the traditional healers in the study (Guite and Reddy, 2021) also shared that they have expectations from the government. They believe that they have been neglected. They are not allowed to make use of their potential. They expect the government to provide life skill programs to the healers to enhance their capability, provide incentives to the certified healers to make them effectively work and help them effectively make full use of their potential. Therefore, as informed by the study, one can conclude that the dominance and interplay of the power relation and social structure within the system of medicine are there but not discussed and deliberated extensively in published literature. Therefore, the objective of the essay in addressing the hegemony in traditional medicine regulation, professionalization, and commoditization and intellectual property rights is to have a more inclusive and sustainable health system.

Hierarchies within the System of Medicine

The colonization period in India by the Britishers saw an increase in interactions of TSM and Biomedicine. It resulted in the propagation of scientific rationalization and obstruction of TSM by the British colonizers. It further weakens the power of the TSM medical practitioners in folk and spiritual medicine, whose practice is considered irrational and therefore disregarded. On the other, it textualized and standardized classical medicine, such as Ayurveda and Unani (Wujastyk, 2008), as they saw classical medicines as more reliable, with rational, central, discrete theories (Prakash, 1999).

Analysis of research writings on medical hegemony and hierarchies within the system of medicine, reveals that there is the dominance of biomedicine over classical medicine and the classical over folk and spiritual medicine. Majority of the folk and spiritual medicinal care providers are affected by their individual and

[1]"Traditional Healing Practices and Health care Utilization Among Mother and Children: A study of four North-eastern States of India", Major Research Project funded by ICSSR (Ministry of Human Resource Development), New Delhi. 2021.

group's identity which is more often than not, at the lower social rank, in addition to the medical hegemony and hierarchy. While the Government of India has made efforts in the last three decades to bring TSM into the central fold of health care provisioning by creating separate departments and then ministries within the health and family welfare ministry, there is a clear hierarchical position of one over the other. For example, the state patronage of biomedicine followed by the recent AYUSH Ministry giving importance to the centuries-old codified and classical systems like Ayurveda, Yoga, Unani, Siddha and Homeopathy and down below is the lesser-known but widely prevalent non-codified folk traditions (National Policy on Indian Systems of Medicine and Homeopathy, 2002). The folk and local healing systems serve the most marginalized who cannot afford private care or reach inaccessible public health services and non-functional primary level care in a few places. They depend solely or partially on the folk healers, who do not charge the patients much. For generations, the folk healers have served the community at doorsteps with utmost humility and generosity. The state now recognizes their wisdom and abundant knowledge of flora/fauna. AYUSH is documenting the folk practices, but anxiety and mistrust are building among the healers who are not benefiting from sharing their knowledge. The advent of allopathic medicine created distrust in TSM and accentuated the gap between western and traditional medicine. It also left many without care due to inaccessible regimes as far as the western systems of medicine were concerned. The notion that what was 'local' needed to be ratified by the 'global' pushed the TSM to the periphery thereby paving way for certification.

Certification has enhanced the utilization of the care services, as evident from government reports. However, the question is certifying whom? Do we need to certify a knowledge system, which has existed for generations, by much recent history, and much shorter training span system of medicine? Therefore, an enquiry into the fundamental causes of the inequities created in the system of medicine needs to be highlighted. When it comes to explaining social inequalities and health outcomes, various theoretical points of view ranging from structural to cultural and behaviour explanations have been approached to answer questions about why gender, class, race, and caste-based differences produce and treat health inequalities as an artefact. Similar arguments are put forward to question the existing power relations in the study of the system of medicine as an artefact. Why is one system of medicine considered superior, rational and scientific to the other? Is the inequality natural or manufactured? Alternatively, this has to do with the social and economic background of the medical practitioners in a given system of medicine. Are the disparities in the differential social identities the culprit? Is it because their position in the social ranking laying at the lower end, renders them devoid of the kind of power available to the other system of medicine? Is it the power dynamics between the traditional healers and the western allopathic care providers (and users)? Or, because 'knowledge' has remained the preserve of the few at the higher social rung, the advent of the western allopathic healing system provided space for usurping the 'knowledge' from those to it belonged? Perhaps these questions are struggling to seek answers from various

quarters, especially those who claim concerns about traditional medicinal knowledge and healing traditions. Let us explore pertinent issues of concern which lead to some challenging questions in harmonizing modern and traditional systems of medicine.

Regulation and Marginalization

The official and legal recognition of the traditional system of medicine in the Indian health care system is an attempt to create national ownership by including and excluding certain forms of traditional medicine. In this process, the healers or traditional medical practitioners who are not registered with the respective national medical councils are not legally allowed to practice. This means that only those practitioners with certification by the Central Council for Indian Medicine can practice. For example, under the officially legalized "Indian medicine," only *vaids* and *hakims* with government certificates are certified to practice (Berger, 2013). Marginalization of certain traditional medicines is also observed in the list of medicines approved as national medicine in India. The Government showed support only for scientific forms of traditional healing (Habib and Raina, 2005), following the legacy of the colonizers as power was in the hands of people who were educated under the colonial system. Marginalization of local health traditions such as folk and spiritual medicine is done in the name of being unscientific and irrational. The Indian Systems of Medicines (ISM) under the Ministry of AYUSH, recognizes seven traditional systems of medicine—Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa rigpa, and Homeopathy. The diversity of traditional medicine is altered by officially adopting national medicines, thereby creating a barrier and thus marginalizing certain medicines. Even though Folk medicine was recognized and endorsed as mainstream traditional medicine for the first time in the National Policy on Indian Systems of Medicine and Homeopathy by the Indian Government in 2002 (Payyappallimana, 2010) there are specialist traditional medical practitioners such as bonesetters, massage therapist (for muscle and nerves problems) who were still marginalized as their knowledge was not textualized (Lambert, 2012). Similar is the case with *Visha* (poison) healers and folk psychiatric healers. They are excluded from the Indian Systems of Medicine because of their oral-only and regionally diverse traditions. The situation of the dais (midwives) is no better. They are neither traditional practitioners nor skilled birth attendants. They are still marginalised even if they are the ones who attend emergency child deliveries in remote rural regions where there is the absence of modern medically trained gynaecologists or midwives. A study by Guite and Reddy (2021)[2] highlighted the hardship and marginalisation faced by the dais and healers in north-eastern states of India. The Quality Control of India (QCI) with the help of AYUSH has been certifying the competent healers and North East Christian University (NECU), Dimapur, Nagaland acts as the third party facilitator by facilitating the certification process. There are two steps in certifying the healers,

[2]"Traditional Healing Practices and Health care Utilization Among Mother and Children: A study of four North-eastern States of India", Major Research Project funded by ICSSR (Ministry of Human Resource Development), New Delhi. 2021.

first, the healers are interviewed on their knowledge and abilities of healing and the next step is the healers are made to show the demonstration of their healing process and if AYUSH finds them competent enough, then they are certified. Many traditional healers are made aware of NECU and QCI certification but still many are unaware of it, therefore if awareness and widespread seminars can be made for the healers so that all the healers' capabilities can be enhanced and they can work more effectively. The study also found that after 2005 a Dai training programme was created in certain states to bring midwives into mainstream modern health services (Sadgopal, 2009).

Professionalization in Public Health

Professionalization in public health refers to establishing suitable educational and professional standards for medical practitioners of a different system of medicine. This is done basically to protect the public against unqualified practitioners by establishing qualifying boards. Professionalization in public health reflects broader institutional, social and political forces. The Government of India set up systems to professionalize them through universities, allowing direct control over medical practitioners and ownership of traditional medicinal knowledge. Universities and Institutions were created to train, educate, conduct research and provide a degree in the classical system of Indian Medicine. For instance, the National Institute of Ayurveda, Homoeopathy, Unani, Siddha, Yoga, Panchakarma, and Naturopathy were set up by the Indian Government. The council for scientific, industrial research (CSIR) and the Ministry of Health and Family Welfare collaborated to set up the Traditional Knowledge Digital Library (TKDL) in 2002 on codified traditional knowledge to preserve knowledge and counter biopiracy (http://www.tkdl.res.in/accessed on 14 May 2022). The professionalization process adopted pulled power away from the local indigenous practitioners and demonstrates the heavy influence of biomedicine in all spheres. The social and economic backgrounds of the traditional medicine health practitioners were not considered in the whole process of professionalization. The institutions and universities created were not inclusive in their approach and pedagogy. Besides the marginalization and exclusion of traditional health care providers, there was a realization that the dominance of biomedicine continues in the curriculum and in understanding the cause and nature of diseases. The unique holistic characteristics of understanding health and illness were diluted in the name of science. The dominance of biomedicine was acknowledged in the 2002 National Policy on Indian Systems of Medicine and Homeopathy. It stated that the "component of modern medicine should be reduced, and study of Sanskrit in Ayurveda discipline and Urdu and Persian in Unani discipline should be incorporated in the curricula" (National Policy on Indian systems of medicine and homeopathy-2002). Professionalization and regulation of the traditional system of medicine should therefore be inclusive and be modified to allow culturally sustainable and its niche in public health.

Globalization and Commoditization of Traditional Medicine

The nature of traditional medicine is characterized by the inclusion of the social and the natural sciences. Anthropological studies and field observations describing the local use of nature-derived medicines are the basis of multidisciplinary scientific enquiries. It helps sustain local health care practices and demonstrates relevance in modern societies with therapies related to ageing, and chronic and infectious diseases. However, the intensified globalization and economic liberalism, which allows the interchange of knowledge and easy access via international trade using different communication and technology platforms, further excluded and marginalized the traditional health care providers, who do not have access to modern technological communication. So globalization led to another trajectory of reducing power from the traditional practitioners.

The state regulatory mechanism for streamlining the trade of herbal, aromatic and medicinal plants is weak due to the trade secrets involving forest officials, dealers and pharmaceutical companies. The traditional health providers were restricted from accessing the community forests due to improper extractions and extinctions of certain plant species of high international trade value. They are blamed for all the ecological imbalance and destructions because they are easy targets to cover up the nexus between forest officials, private dealers, and pharma companies (both national and international) involved in mass extractions from the wild (Guite, 2014). The profit from the selling of traditional medicine and indigenous medicinal knowledge is not shared with the local traditional health providers, even though they are the health care custodians and primary care providers to the community people who have no access to modern health services. The commodification of traditional medicine, information sharing and straightforward marketing strategy of herbal, aromatic and medicinal plants brought about by globalization further excluded traditional health care providers socially, institutionally and politically. The era of globalization also witnesses the rise in consciousness among the local traditional health providers and the formation of professional bodies and associations to fight for their right to ownership of knowledge and benefit-sharing. The era also led to discussions of different aspects of traditional medical knowledge in several international forums, including WHO[3] and the WTO (World Trade Organization).[4]

Intellectual Property

The outcome of globalization is the commodification of traditional medical knowledge, and growing commercial and scientific interest. As discussed earlier, the

[3]WHO (World Health Organisation) promotes the use of traditional medical knowledge for health care. See WHO Fact sheet No. 134 "Traditional Medicine", www.who.int/mediacentre/factsheets/fs134/en/.accessed on 14 May 2022

[4]The WTO's work on access to medicines and IP issues relating to public health is guided by the Doha Declaration on the TRIPS Agreement and Public Health; this clarifies the flexibilities in IP rules available to governments under the WTO's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). See www.wto.org/english/tratop_e/trips_e/who_wipo_wto_e.htm. accessed on 14 May 2022

modern system of medicine derived drugs and vaccines based on natural resources and associated knowledge. On the other hand, traditional medicine and its related knowledge are authentic to the specific social and cultural context of the indigenous communities. However, the growing commercial and scientific interest in traditional medicine systems calls for respect from the medical science community, better recognition, preservation and protection.

In traditional medical knowledge, medicinal use of herbs is often associated with genetic resources. For instance, the Kani tribe of South India has shared their knowledge of the medicinal plant '*arogyapaacha*' for a sports drug (World Bank, 2004; WIPO, 2004; WIPO, n.d). The existence of genetic resources is in nature and not the creations of the human mind. Therefore they cannot be directly protected as intellectual property as the knowledge is in the public domain. They are, however, subject to the access and benefit-sharing regulations under international agreements (WIPO, 2004). In order to prevent erroneous patents on traditional medicine, various international and national initiatives were sought. The World Intellectual Property Organization (WIPO) is primarily concerned with the "protection" of the intellectual property of traditional medical knowledge. It means protection against unauthorized use by third parties. The WIPO Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore (IGC) seek to develop an international legal instrument that would provide adequate protection of traditional cultural expressions/folklore and traditional knowledge (including traditional medical knowledge) and address the IP aspects of access to and benefit-sharing of genetic resources.

One key example is the Traditional Knowledge Digital Library created by the Council of Scientific and Industrial Research (CSIR), the Ministry of Science and Technology, and the Ministry of Health and Family Welfare in India (Ministry of DST and Ministry of AYUSH 2022). The Library documents traditional medicinal practices in India. It presents the information to be checked by international patent offices, thereby preventing the granting of erroneous patents on traditional medicines. However, not all the traditional medical knowledge could make it to the digital library. The knowledge holders face social, educational, economic and infrastructure barriers. They are pushed to the periphery in commoditization in our global economy, which further reduces the power of traditional practitioners. Often, local practitioners using traditional medicine knowledge are not given their due credit (Reddy, 2006). While it is essential to place traditional medicine globally, local medicinal practitioners should be given deserved credit and financial benefit for their work.

Conclusion

As the world moves ahead in the twenty-first century, we must take a balanced and inclusive approach. Let us acknowledge that the traditional system of medicine and its medicinal knowledge provides a pathway to social and economic development. The marginalization of the traditional system of medicine and its practitioners, in the name of regulation, professionalization, commodification and intellectual property

has to be stopped. The manifestation of social structural inequalities in the system of medicine and its providers is visible. We need to work in line with positive discrimination to bring about equality in the system of medicines. The knowledge possessed by traditional health practitioners deserves to be protected, promoted, and strengthened like modern health practitioners. Inferiority and superiority status based on science and rationality of a system of medicines are manufactured and can be prevented and avoided. The ancestral knowledge of the indigenous communities and traditional healers or practitioners can be explored to inculcate the ethos in multiple disciplines. This would most certainly bring the much-needed balance in achieving the United Nations Sustainable Development Goals, which aim to *leave no one behind*. Where the world is fast losing its natural resources, promoting traditional knowledge (TK) could become an initiative for its reconstruction in post-COVID 19 scenarios.

The Traditional Knowledge (TK) is in the discourse not only in medicinal knowledge but also in international discussions on a host of issues—food and agriculture; biological diversity, desertification and the environment; human rights, especially the rights of indigenous peoples; cultural diversity; trade and economic development. The TK has also moved towards the centre of policy debate about intellectual property (IP). This also leads us to some challenging questions. Is the IP system compatible with the values and interests of traditional communities and their system of medicine, or does it privilege individual rights over the community's collective interests? Is there the uneven power dynamics playing up too? These are pertinent questions to be addressed for bringing the due acknowledgement to the traditional health systems and its practitioners.

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Caste and Socioeconomic Inequality in Child Health and Nutrition in India: Evidences from National Family Health Survey

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Abstract

This study is on caste inequality in child health outcomes: mortality, malnutrition and anaemia for the year 1998/99 to year 2019/21 and examines the association of socio-economic factors with outcomes. Disparity ratio (DR) and Concentration Index (CI) are computed to examine inequality in outcomes. The association of socio-economic factors was modelled using logit regression. The study finds marginalised group were more likely to have poor health outcomes. The disparity ratio found increased among SC and ST compared to *Others* during 1998-99 and 2019-21. The value of the concentration index was found high on U5MR among SC and ST. Among SC and ST, the child health outcome greatly varies for poorest and richest. Odds ratio is 40-60 per cent higher for SC and ST compared to children belonging to *Others.* On socio-economic factors; land ownership and wealth status contribute significantly but house ownership not so. Caste-based inequality is still impacting health and nutrition of children in the country. The more focused inclusive policy and clustering of marginalised groups at regional level can be helpful in improving health and nutrition of marginalised children concentrated in different regions with equity lens to push the SDG Goals.

Keywords

Caste, land, mortality, malnutrition, SC/ST, SES

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Introduction

Inequities in health constitute one of the main challenges for public health globally. Globally, socioeconomic status (SES) or social position as measured by social determinants; such as education, income or occupations having association with a wide range of health indicators (Braveman & Gottlieb, 2014; Darin Mattsson et al., 2017; Feinstein, 1993; Wilkinson, 2002; Williams, 1990). In the Indian context, socioeconomic status is a reflection of social stratification manifested through the caste system (Mishra, 2006) and caste has been considered broadly as a proxy for socio-economic status and poverty (Borooah, 2012; Childers & Chiou, 2016; Kulkarni et al., 2020; Subramanian, et al., 2006). In India, within the axis of socioeconomic and cultural dimensions, ethnicity is studied widely through social/caste groups, which play a significant role in shaping health outcomes (Acharya, 2013; Baru et al., 2010; Bora et al., 2019; Borooah, 2010; Nayar, 2007; Raushan, 2020; Raushan & Mutharayappa, 2014; Raushan & Prasad, 2017). Poor social and economic status of those castes lower on the caste hierarchy is bound to have an influential effect on health (Dommaraju et al., 2008; Kulkarni et al., 2020; Mohanty, 2011; Thorat & Madheswaran, 2018). It also causes depletion to the developmental aspects of the country's health policy.

Caste-based inequalities in health have two broader perspectives: First, caste-based social and economic deprivations regulate health outcomes of different castes like SC/ST and place them at the bottom of the caste ladder and *Others* caste on the top. Scheduled Caste, Scheduled Tribes and in some cases the Other Backward Classes are considered as poor and socially disadvantaged groups (Acharya, 2013; Nayar, 2007; Raushan, 2020; Raushan & Acharya, 2018; Thorat & Neuman, 2012). Second, disadvantage and discrimination endured by the low and poor caste keep them away from the mainstream and dissuades them from availing health and healthcare facilities and impedes their responses to health and healthcare ultimately leading to poor health outcomes (Acharya, 2013; Baru et al., 2010; Borooah, 2010; Raushan, 2020; Raushan & Acharya, 2018).

Most of previous studies have divided caste groups into SC/ST and non-SC/ST except few which considered each social group as a separate group (Raushan & Acharya, 2018; Raushan & Mutharayappa, 2014; Subramanian, et al., 2006). Importantly there are emerging trends of caste-based studies on health outcomes getting noticed (Bora et al., 2019; Prasad & Raushan, 2020). SC and ST are not the homogenous groups and have their own cultural traits (although within the group there is heterogeneity) but the case may be the same for OBC and forward caste. Even within a group like ST, which is located in central India may be different from ST of north-east, west or south India which needs separate investigation considering a different approach to generate policy-level evidence.

Improvement in child health is a key indicator on progress towards the third goal of the United Nations' Sustainable Development Goals: A universal guarantee of a healthy life and well-being at all ages. Among them; mortality, malnutrition and anaemia are the key indicators. Mortality as a negative outcome has been used as an indicator to measure the status of child health and also the overall health status of the country. The association between caste and child mortality is well documented across literature (Bora et al., 2019; Deshpande, 2002; Mohindra et al., 2006; Nguyen et al., 2013; Ram et al., 2016; Raushan et al., 2016; Sahu et al., 2015; Subramanian, et al., 2006; Vikanes et al., 2010). Studies discuss malnutrition at early ages leads to poor child growth and development (Walker et al., 2005) on the one hand and a higher incidence of morbidities and mortalities on the other hand (Walker et al., 2007).

Malnutrition is responsible for nearly half of all deaths among children under five years, and together with poor diets, is a major driver of the global burden of disease. At least 57 countries are experiencing serious effects of both under nutrition, including stunting and anaemia, and adult overweight and obesity (Haddad et al., 2015). Anaemia in young children is a serious concern because it can result in impaired cognitive performance, low behavioural and motor development, coordination, language development, and scholastic achievement, as well as increased morbidity from infectious diseases. Iron deficiency anaemia used to be regarded as one of the 'Top Ten Risk Factors' for death (Dubey et al., 1994). During the first decade of twenty-first century, India was the largest contributor to child anaemia among developing countries (Pasricha et al., 2010).

Several studies have discussed that socio-economic status of a household is one of the factors responsible for high mortality, malnutrition and anaemia among children. Studies have found that caste differences in infant and child mortality are substantially reduced when parental socio-economic characteristics are held constant (Ram et al., 2016). Dommaraju et al. (2008) has found a complex relationship between caste and child mortality and postulated that although there are inter-caste inequality but it does not mean that there are no differences within the lower caste groups and those differences can be explained by the disparity in economic positions occupied by the group (Dommaraju et al., 2008). Household income, poverty, and mother's education are the strongest factors that influence child nutrition in developing countries (Glewwe, 1999).

Association of caste and child health inequality has been found significant in many studies (Borooah, 2004; Nayar, 2007; Prasad & Raushan, 2020; Ram et al., 2016; Saikia et al., 2019; Subramanian, et al., 2006) and require further investigation with a new approach. Previous studies have provided ample evidences of poor outcome on many health and healthcare indicators among SC/ST than the rest (Nayar, 2007; Prasad & Raushan, 2020) but the progress and current scenario of child health inequality along caste and socio-economic lines is missing. Hence, this study is framed

to examine the inequality in child health and malnutrition and its linkage with socio-economic factors that alter child health in the country. It is important for policy drive that includes the development and wellbeing of every individual as persisting disparity and inequality have remained issues of concern in the policy domain.

Data and Methods

The data used in the study is the latest available Indian version of demographic and health survey data i.e., National Family Health Survey (NFHS)-5 collected during 2019/21. However, the previous three rounds of NFHS-2: 1998/99, NFHS-3: 2005/06 and NFHS-4: 2015/16 is also used in the study. Internationally, NFHS is Demographic Health Survey (DHS) version for India; a large-scale cross-sectional survey that provides estimates from demographic and health parameters at national and state levels. However, for the first time, NFHS-4 had provided estimates at the district level for some of the selected demographic, health and healthcare indicators. NFHS-5 also adopted a two-stage sample design. Details of the sample size, design, and sample weight can be obtained from the NFHS reports (IIPS & ICF, 2022).

NFHS-5 collected data from a total of 6,36,699 households. The study is based on health, nutrition and anaemia among the children born in the last five years at the time of the survey during 2019/21. In NFHS-5, there were a total of 2,32,920 children under five years of age. Of those; 47,848 are from SC; 47,118 from ST; 89,093 from OBC; 36,573 from *Others* and the remaining 12,228 either don't know their caste identity or information is missing. Hence, the caste group specific analysis is restricted to 2,20,632 children for this specific study.

Outcome Variables

The outcome variables are child health and nutrition indicators. Globally, mortality is used to evaluate progress on health status whereas stunting, underweight and anaemia are considered to evaluate the nutritional status of children. On Nutrition; stunting reflects the inability to receive adequate nutrition over a long period of time and is also marked by recurrent and chronic illness. Underweight is a composite index of height-for-age and weight-for-height. It takes into account both acute and chronic malnutrition. Iron deficiency is one of the leading causes of disability in developing as well as developed countries , well known as anaemia.

For the purpose; on mortality-neonatal mortality rate (NMR), infant mortality rate (IMR) and under five mortality rate (U5MR) is considered. On nutrition; underweight, stunting and anaemia is considered. Mortality rate is calculated per 1000 live births whereas malnutrition is calculated on proportion of children having specific kind of

malnutrition. As per the world health organisation, recommended cut off points of less than minus two standard deviations is considered for underweight and stunting (WHO, 2006). For anaemia, the Hb level below 11 g/dl is considered as anaemic (IIPS & ICF, 2022).

Exposure Variables

The independent variable is caste groups- Scheduled Caste (SC), Scheduled Tribe (ST), Other Backward Classes (OBC) and *Others,* as per Govt. of India classification of caste into four broader social or caste groups. The Scheduled Caste (SC) and Scheduled Tribe (ST) are among the most disadvantaged caste groups having poor to poorest socio-economic development. The OBC are considered low in the traditional caste hierarchy. Whereas *Others* is the caste category which have higher social status and are well-off on socio-economic development (Raushan, 2020). Indicators pertaining to economic status and educational level are considered for the reflection of socio-economic status. For economic status; own land, housing and wealth index is considered. Mother's education is considered for level of education variable.

Statistical Analysis

Univariate, bivariate and multivariate methods is performed to find the factors associated with caste and socio-economic inequality in child health. Progress on health outcomes and disparity ratio (DR) across the social groups is calculated for the selected variables at four different time points: 1998/99, 2005/06, 2015/16 and 2019/21 considering the last two decades. State level map provides areas of high mortality at regional level for U5MR among SC and ST. However, some states and UTs have been dropped where sample children of ages below five years born in the last five years were less than 30 for a specific caste group. Based on the latest round of data, a total of 20 interaction groups considering caste and wealth index is constructed to understand socio-economic differentials in child health indicators.

Further, income-based inequality for SC and ST children are measured on Concentration Index (CI) and Concentration Curve (CC). Finally, logit regression is performed, first only with social groups and then independently for land, housing and wealth index to understand the differential risk of each factor on poor health outcomes. Finally full model is employed considering gender and mother's education, other than indicators of economic status as discussed previously. The results of logit regression are presented through odds ratio at five per cent significance level. Somewhere, 10 per cent significance level is considered and appropriate justification is provided for the same.

Concentration Index

Income-related inequality in child health and malnutrition using wealth score as the economic indicator is calculated using concentration index (CI) and the concentration curve (CC), and a binary outcome variables. In the study, wealth score is used as a proxy of income widely used in health studies across the world. The concentration index is defined as twice the area between the concentration curve and the line of equality. The concentration curve is obtained by plotting the cumulative proportion of outcomes against the cumulative proportion of the population ranked by the economic indicator (World Bank, 2008). It can be written as,

$CI = 2*cov W (Y_i, R_i)$

Where,

Y_i = outcome of the 'i'th individual

R_i = Fractional rank of the 'i'th individual (for weighted data) on HH economic status

'*cov*W' = Weighted covariance.

The value of CI quantifies the extent of inequality and varies between +1 and -1. A negative value indicates concentration of specific outcome among poorest/poor and the curve lies above the line of equality. In case of positive value, the opposite happens. The larger the absolute value, the greater the inequalities. Index value zero reveals absence of socio-economic inequality.

Logistic Regression

The association of socio-economic factors are regressed on binary logistic regression. Logit regression models relationship between a binary response variable (P) and one or more explanatory/predictor variables (X). The model is like as follows:

Logit (P) = Log {P/ (1-P)} = $\alpha + \beta X$; where, X is explanatory or predictor variable of P.

Or, Logit (P) = $b_0 + b_1X_1 + b_2X_2 + \text{---------} + b_kX_k$

Or, Log (P/1-P) = $b_0 + b_1X_1 + b_2X_2 + \text{---------} + b_kX_k$.

Where, X_1, X_2, ------X_k are predictor variables and (P/1-P) is the Odds.

Odds ratio is used to compare the odds for two groups, in the same way that the relative risk is used to compare risks (Westergren et al, 2001) and it can be understood as

$$\text{Odd Ratio} = \text{Odd Ratio} = \frac{p/(1-p)}{q/(1-q)}$$

Where, p and (1-p) is the probability of occurring and not occurring for the first group, and

q and(1-q) is the probability of occurring and not occurring for the second group.

Results of the Study

Progress on Child Health Outcomes

In India, progress on child health outcomes have been widely accepted and are the reflection of various programme and policy interventions during the last two decades. Looking at indicators like mortality, malnutrition and anaemia; continuous decline has been observed. However in case of anaemia, an increase is also observed as reflected from 2019/21 NFHS data. Across caste lines, continuous decline except for anaemia has also been observed for all the groups between 1998/99 and 2019/21. However, marginalised caste groups like Scheduled Caste and Scheduled Tribe continue to have the highest rates of mortality and malnutrition.

Looking at mortality, SC children have the highest neonatal death per 1000 live births across all the groups. However; on malnutrition and anaemia, the highest prevalence is found among ST children throughout the study period. It is also observed that there is no much difference between SC and ST children on the said indicators. Like in 1998/99; NMR, IMR and U5MR is found 53/1000, 83/1000 and 119/1000 among SC whereas it was 53/1000, 84/1000 and 127/1000 among ST children. In 2019/21 it is declined to 29, 41 and 49 per 1000 for SC to 29, 42 and 50 per 1000 for ST children respectively. Same is found for malnutrition and anaemia is pervasive from figure 1 and appendix table 1.

Caste Disparity in Health Outcomes

The persisting disparity and differentials in child health of marginalised and better-off groups have remained issues of concern in the policy domain. Here, Disparity Ratio (DR) has calculated for SC and ST children at four time points spanning over two decades is presented in table 1. On all the indicators under study; the DR is found high for SC and ST at all four time points, with exception for NMR among ST during 2005/06. Another interesting point is that the disparity ratio on all the three indicators of mortality has increased over the period for both SC and ST compared to *Others*. Among SC for NMR, the DR is increased from 1.31 in 1998/99 to 1.42 in 2005/06 and 1.50 in 2019/21. For IMR and U5MR it is found increased from 1.34 to 1.41 to 1.45; and 1.44 to 1.45 to 1.49 respectively. Among ST; DR for NMR also found increased from 1.31 to 1.35 to 1.48; for IMR it increased from 1.36 to 1.38 to 1.49; and for U5MR, it remained 1.53 in 1998/99 and found same as in 2019/21.

On underweight and stunting, the DR is found highest for SC and ST to *Others* in 2005/06. However over the last two decades, DR has been found either to decline or remained same as of the previous round. The same has been found in the case of anaemia. It is noted that the DR for anaemia is found almost same in 2019/21 compared to 1998/99 for both the SC and ST to *Others* children. But, we can't clearly pose here that the pattern of disparity ratio is same, either for SC or ST and consistent on all the indicators under the study. Even DR for indicators of malnutrition and anaemia among ST to *Others* is found more than SC to *Others* over the study period.

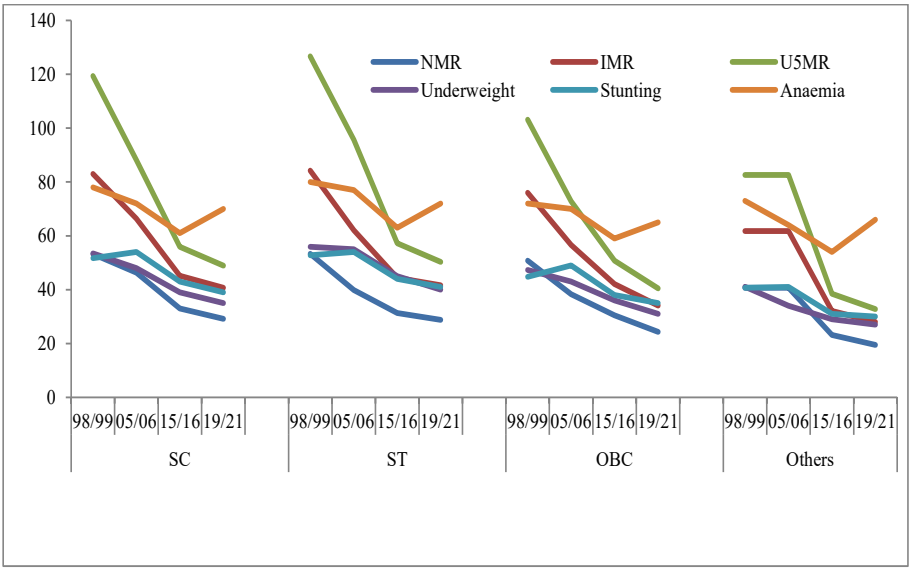


Figure 1: Progress on mortality, malnutrition and anaemia among children: 1998/99 to 2019/21

Source: Calculated by authors using various round of NFHS data

Table 1: Disparity ratio in outcomes among SC and ST in India (with respect to Others): 1998/99 – 2019/21

	NMR	IMR	U5MR	UWT	STN	ANE
SC to Others						
1998/99	1.31	1.34	1.44	1.30	1.27	1.07
2005/06	1.14	1.07	1.07	1.41	1.32	1.13
2015/16	1.42	1.41	1.45	1.34	1.39	1.13
2019/21	1.50	1.45	1.49	1.30	1.30	1.06
ST to Others						
1998/99	1.31	1.36	1.53	1.36	1.30	1.10
2005/06	0.98	1.00	1.16	1.62	1.32	1.20
2015/16	1.35	1.38	1.49	1.55	1.42	1.17
2019/21	1.48	1.49	1.53	1.48	1.37	1.09
UWT: Underweight, STN: Stunting, ANE: Anaemia						

Source: Calculated by authors using various round of NFHS data

Socio-Economic Inequality in Health Outcomes

Inequality in health outcomes constitutes a major policy challenge and a widely used measure is socioeconomic status (SES) measured usually on social determinants like education, caste, income or occupation. As in the case of India, caste and economic status plays a major role in shaping the outcomes, but how it contributes within specific caste group is less studied. Hence, how economic status makes a difference

within the SC and ST groups, are central to this section. With the increasing economic status irrespective of the caste group affiliation, the health outcomes improve. Like among SC; the NMR is almost 2.5 times lower among richest compared to the poorest, it was 2.5 times and 2.8 times low for IMR and U5MR. The pattern is found consistent among ST also with 2-2.5 times lower among richest than the poorest. The same has been found in the case of underweight and stunting among both SC and ST as close to two times differences between the poorest and richest but in case of anaemia, it is found 1.1 times less among SC and 1.2 times less among ST. Details on prevalence are provided in Table 2.

Table 2: Socio-economic inequality among SC and ST on health and nutrition in India, 2019/21

	Per 1000			Per cent		
	NMR	**IMR**	**U5MR**	**UWT**	**STN**	**ANE**
SC						
Poorest SC	39	52	70	44	49	73
Poorer SC	31	44	54	37	41	71
Middle SC	23	36	43	31	37	70
Rich SC	24	32	40	27	31	67
Richest SC	16	21	25	21	26	67
ST						
Poorest ST	32	46	56	45	45	77
Poorer ST	30	42	53	38	40	73
Middle ST	22	35	40	34	36	73
Rich ST	18	24	27	27	29	67
Richest ST	15	22	22	25	21	63
India	25	35	43	32	36	68

Source: Calculated by authors using fifth round of NFHS data

Another inequality measure, Concentration index (CI), is also widely used and pervasive to reflect the concentration of inequality. CI is calculated for SC and ST on selected indicators and provided in Table 3. The convention is that the index value takes a negative sign when curve lies above the line of equality, indicating disproportionate concentration of the health variable among the poor. Here, for all the indicators, the generated sign is negative for SC and ST reflects the concentration of high mortality, malnutrition and anaemia among the poor children. Among the SC, the inequality is higher for under five mortality, lower for underweight and stunting to lowest for anaemic children. Among ST, the inequality is observed high for under five mortality to lower for underweight and anaemia and lowest for stunting. Based on these two groups, it can be added here that that the inequality is high among SC children compared to the ST children (Figure 2).

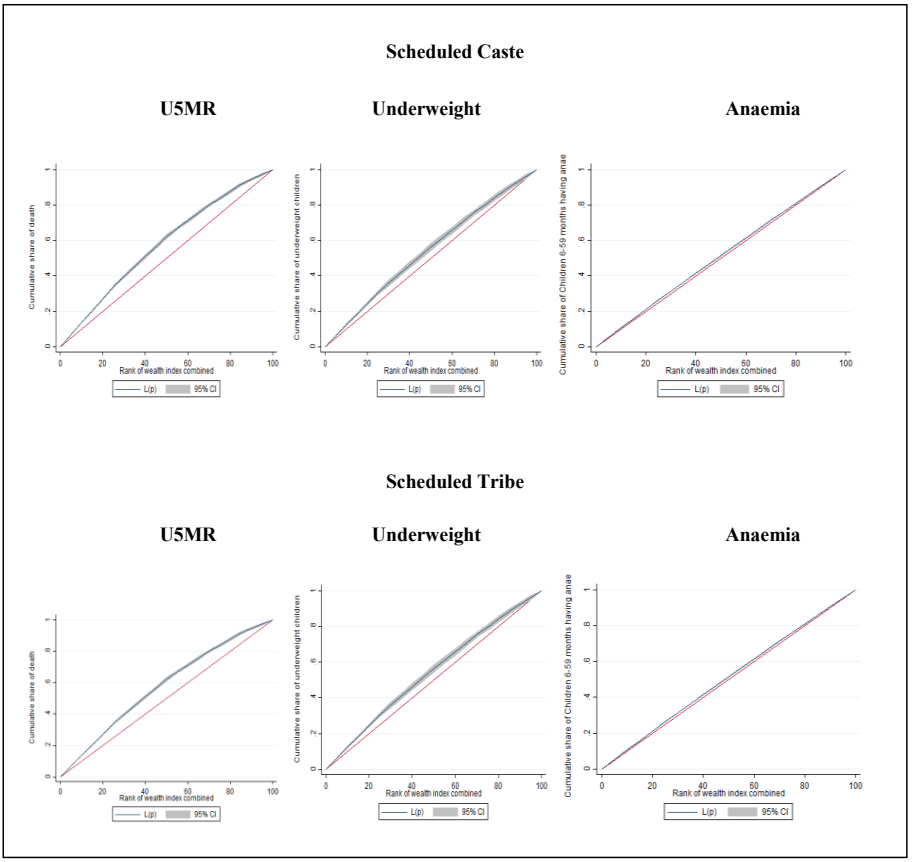


Figure 2: Concentration curve for mortality, malnutrition and anaemia among SC and ST children in India, 2019/21

Source: Calculated by authors using fifth round of NFHS data

Table 3: Concentration index for mortality, malnutrition and anaemia: 2019-21

	U5MR		Underweight		Stunting		Anaemia	
	CI	Std. Error	CI	Std. Error	CI	Std. Error	CI	Std. Error
SC	-0.139	0.012	-0.079	0.022	-0.052	0.015	-0.018	0.002
ST	-0.092	0.012	-0.074	0.019	-0.003	0.013	-0.022	0.002
India	-0.172	0.006	-0.092	0.011	-0.045	0.007	-0.029	0.001

Source: Calculated by authors using fifth round of NFHS data

Results of Logistic Regression Analysis

In this section; results of U5MR, underweight, stunting and anaemia based on logit regression analysis is presented. The risk of poor health and nutrition is presented using odds ratio at five per cent significance level. However, for some economic variable

especially for land, significance level is considered at 10 per cent. This can be found in Table 4-6. The risk of poor health and malnutrition across caste groups is presented in Table 4. The relative risk is found highest among SC followed by ST with reference to *Others* caste children. For instance, SC and ST children carry 51 per cent (OR: 1.51, p<0.001) and 30 per cent (OR: 1.30, p<0.001) more risk of under five mortality than the *Others* caste children. In case of underweight and stunting it is 65 per cent and 48 per cent more among SC (p<0.001), and 61 per cent and 58 per cent more among ST children with reference to *Others* caste children. Significantly, there were 25 per cent more anaemic children among SC. Although, there was 3 per cent less anaemic children among ST compared to *Others* caste children but not extracted significant.

Table 4: Odds ratio of child health and nutrition in India, 2019/21

	U5MR N=220632		**Underweight N=200319**		**Stunting N=199760**		**Anaemia N=173919**	
	OR	**P>z**	**OR**	**P>z**	**OR**	**P>z**	**OR**	**P>z**
Social groups (ref=*Others*)								
SC	1.51	0.000	1.65	0.000	1.61	0.000	1.25	0.000
ST	1.30	0.000	1.48	0.000	1.58	0.000	0.97	0.121
OBC	1.26	0.000	1.47	0.000	1.37	0.000	1.07	0.000
Cons	0.03	0.000	0.32	0.000	0.42	0.000	1.91	0.000

Source: Modelled using fifth round of NFHS unit level data

Table 5: Odds ratio of child health and nutrition regressed on own land, housing and wealth index in India, 2019/21 (Controlled on social group)

	U5MR		**Underweight**		**Stunting**		**Anaemia**	
	OR	**P>z**	**OR**	**P>z**	**OR**	**P>z**	**OR**	**P>z**
Land and House (ref: No)								
Own land in rural	0.81	0.001	1.05	0.079	1.05	0.089	1.02	0.582
Own house in urban	1.24	0.160	1.04	0.518	1.05	0.380	1.02	0.718
Own land and house- total	0.90	0.052	1.07	0.007	1.06	0.013	0.98	0.383
House but no land in urban	1.42	0.092	0.93	0.437	1.03	0.691	0.87	0.078
House but no land-total	0.99	0.918	1.01	0.849	1.03	0.456	0.83	0.000
Wealth Index (ref: Poorest)								
Poorer	0.81	0.000	0.71	0.000	0.77	0.000	0.84	0.000
Middle	0.63	0.000	0.58	0.000	0.63	0.000	0.81	0.000
Richer	0.55	0.000	0.46	0.000	0.49	0.000	0.73	0.000
Richest	0.38	0.000	0.34	0.000	0.38	0.000	0.68	0.000

Source: Modelled using fifth round of NFHS unit level data

In table 5, results of logit regression is presented for the economic variables modelled on different dependent variables. The odds ratio is presented for such economic variables like own land, own house and wealth index. It can be understand that each variable is controlled independently in separate model for the respective dependent variable. For land and housing, the mix picture emerged. In rural areas having own land reduces the risk of under five mortality by 19 per cent ($p<0.001$) whereas on malnutrition and anaemia it increases the risk by 2-5 per cent at 10 per cent significance level. Whereas having own house in urban areas although contributes high in case of under five mortality and revealed 25 per cent more death but found insignificant. For other dependent variables also, own house in urban areas does not have much impact in altering the health and nutritional status. There is the possibility that quality of housing in urban areas may trigger the impact in the opposite direction. When considering own land and housing, the risk of under five mortality is found 10 per cent less but for rest of the variables it appears as it was expected. Considering own house but no land in urban areas increases mortality by 42 per cent ($p<0.10$) but found 13 per cent less on anaemia at 10 per cent significance level. However, those having own house but no land irrespective of rural or urban, having 17 per cent reduces risk of anaemia significantly (OR: 0.83, $p<0.001$). On wealth index; with increase in wealth status; the level of mortality, malnutrition and anaemia reduces. It is found highly significant across all wealth categories on all the dependent variables (Table 5).

Table 6: Results of logit regression on child health, malnutrition and anaemia in India, 2019/21

	Death		Underweight		Stunting		Anaemia	
	N=33381		N=30617		N=30518		N=26587	
	OR	P>z	OR	P>z	OR	P>z	OR	P>z
Social Group (ref=Others)								
SC	1.14	0.183	1.35	0.000	1.33	0.000	1.18	0.000
ST	0.93	0.509	1.05	0.258	1.08	0.086	0.83	0.000
OBC	1.10	0.317	1.29	0.000	1.20	0.000	0.97	0.492
Sex (ref=Male)								
Female	0.84	0.003	0.89	0.000	0.87	0.000	0.98	0.401
Own Land (ref=No)								
Yes	0.85	0.077	1.04	0.350	0.99	0.879	1.18	0.000
Own House (ref=No)								
Yes	0.98	0.808	1.00	0.955	1.04	0.376	0.86	0.000
Wealth Index (ref=Poorest)								
Poorer	0.85	0.025	0.72	0.000	0.81	0.000	0.88	0.002
Middle	0.63	0.000	0.66	0.000	0.69	0.000	0.86	0.000
Richer	0.52	0.000	0.53	0.000	0.57	0.000	0.81	0.000
Richest	0.44	0.000	0.43	0.000	0.49	0.000	0.76	0.000

	Death		Underweight		Stunting		Anaemia	
	N=33381		N=30617		N=30518		N=26587	
	OR	P>z	OR	P>z	OR	P>z	OR	P>z
Mother's Education (ref=No Education)								
Primary	0.77	0.005	0.85	0.000	0.90	0.013	0.90	0.020
Secondary	0.76	0.000	0.76	0.000	0.76	0.000	0.80	0.000
Higher	0.48	0.000	0.55	0.000	0.58	0.000	0.66	0.000
Constant	0.08	0.000	0.72	0.000	0.91	0.038	2.88	0.000

Source: Modelled using fifth round of NFHS unit level data

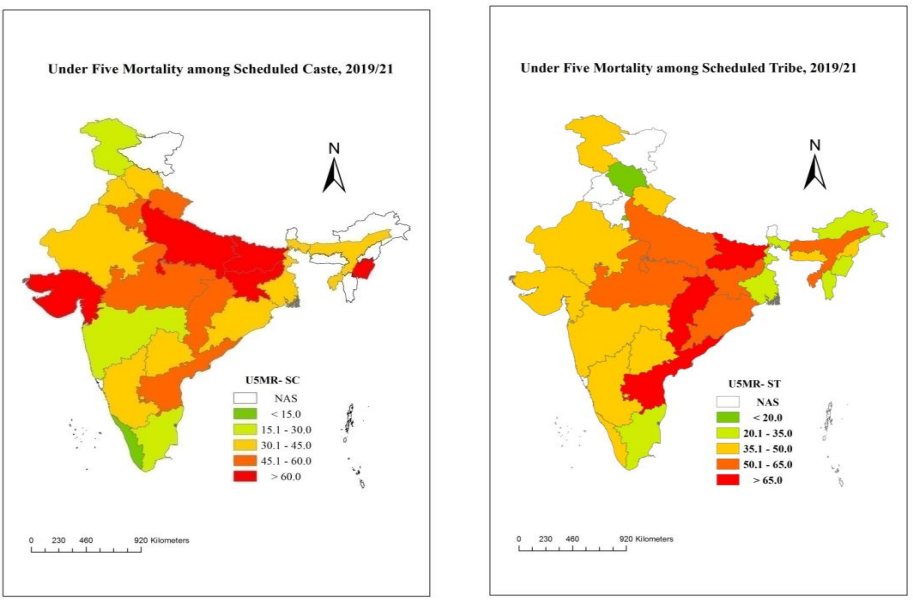
Table 6 presents full model on selected dependent variables controlled on variables of economic status and mother's education level. The socio-economic factors, especially wealth index and mother's education contribute significantly among caste groups on all the selected dependent variables but not the land and housing for all dependent variables. Executing the anaemia level differences along different levels of wealth and education are found large. Like, on under five mortality richest households having 56 per cent less deaths with reference to poorest households ($p<0.001$). This has been found to be 57 per cent, 51 per cent and 24 per cent in case of underweight, stunting and anaemia. On gender, females have significant advantage of 11-16 per cent less mortality and malnutrition. Own land is found significant only on under five mortality (OR: 0.85, $p<0.10$) and anaemia (OR: 1.18, $p<0.001$). Whereas own housing is not found significant excluding for anaemia. Here, it can be added here that along the different indicators of economic status, wealth index seems robust indicator reflecting the significant factors across all the dependent variables like mortality, malnutrition and anaemia in this study. However, more studies pertaining to land and housing can strengthen the caste based inequality in health and malnutrition in India.

Discussion and Conclusion

The country development on human and socio economic indicators especially on the health front is well recognised in terms of declining mortality and increasing longevity. The global concerns for equality and equity as manifested since Alma Ata Declaration to Sustainable Development Goals (SDGs) have pushed it further. Despite the positive changes, there have been noticeable differences on health outcomes other than access to healthcare services along caste and socio-economic line as evident from the studies (Acharya, 2013, 2018; Baru et al., 2010; Bora et al., 2019; V. Borooah, 2010; Childers & Chiou, 2016; Kulkarni et al., 2020; Nayar, 2007; Prasad & Raushan, 2020; Raushan, 2020; Raushan & Acharya, 2018; Raushan & Mutharayappa, 2014; Raushan & Prasad, 2017; Subramanian, et al., 2006). This paper examined progress on child health indicators among different caste groups. Magnitude of disparity, socio-economic inequality to differential effect of socio-

economic factors such as land, house ownership and wealth index including education remained major concerns of this paper.

It is the first of its kind of study that included a wide range of child health indicators and examined along the caste lines. Novelty of the study is that the disparity ratio for SC and ST is calculated at different points of time over 1998/99 to 2019/21 for the first time and brings out the regional level concentration of U5MR among SC and ST at the state level (Map 1). Using the latest data, economic inequality is measured for each caste group. Economic factors- own land, own house and wealth index is modelled independently with caste group and extracted the differential effects of each factor on child health and malnutrition.



Map1: State level disparity in under five mortality (U5MR) among SC and ST in India, 2019/21 (per 1000)

Note: NAS: Not adequate sample to calculate U5MR

The findings of the study are robust and revealed that even after consistent efforts towards pushing to equity through national level policies, programme and intervention; marginalised groups are bearing the increased burden of child mortality, malnutrition and anaemia during the study period- 1998/99 and 2019/21. The previous studies had come up with more or less similar findings but those studies were cross sectional in the nature (Acharya, 2018; Bora et al., 2019; Childers & Chiou, 2016; Deshpande, 2002; Prasad & Raushan, 2020; Raushan, 2020; Raushan & Acharya, 2018). Although there is a continuous decline except for anaemia evident across the caste group, SC and ST children still have the highest rates of mortality and malnutrition. It is also noted that there is not much difference between SC and ST children on those indicators. To deepen the concentration of death among SC and ST at regional

level, U5MR is calculated. More or less a high U5MR is found to be similar in states of central and eastern India with some limitations as evident from Map 1. The findings are in the line of previous studies and strengthen the findings of the study (Saikia et al., 2019).

Emerging evidences reveal that disparity ratio (DR) seems high for SC and ST during 1998/99 to 2019/21. Notably, disparity ratio was found increased for NMR, IMR and U5MR for both SC and ST to *Others* during the period. On underweight and stunting, the DR is found to be highest for SC and ST to *Others* in 2005/06. Throughout, the DR on malnutrition and anaemia among ST appears more than SC. Although, DR has found to be either declining or remained similar like as the previous round on malnutrition and anaemia. However, we cannot clearly pose a statement that the pattern of disparity ratio remained consistent for SC or ST, needs careful interpretations.

As assortment of studies have finds that socioeconomic status (SES) plays a major role in shaping inequality in health outcomes (Braveman & Gottlieb, 2014; Darin Mattsson et al., 2017; Dommaraju et al., 2008; Kulkarni et al., 2020), we constructed socio-economic groups based on caste and wealth index, is an addition. It brought out that with increasing economic status irrespective of caste group, the health status improves. Notably within SC and ST; poorest than richest are having two to three times high mortality and malnutrition. The inequality based on CI value that was found negative for SC and ST on all the selected indicators reflects the concentration of high mortality, malnutrition and anaemia among poor children (Glewwe, 1999; Nguyen et al., 2013; Subramanian, et al., 2006). However, among SC and ST, the inequality is high on under five mortality and low on underweight and stunting to lowest for anaemia. Even within these two caste groups, inequality seems more among SC compared to the ST children.

Further, different indicators pertaining to economic status like land, housing and wealth index is modelled independently and revealed a mixed picture. In rural areas having own land reduces the risk more for mortality than the malnutrition and anaemia significantly (Rammohan & Pritchard, 2014; Vu et al., 2021). Whereas having own house in urban areas does not have a greater impact on turning down mortality and malnutrition. There is the possibility of structure, location and quality of housing in urban areas triggering the impact in opposite direction (Thomson et al., 2013).

As there is evidence that although marginalised people have own house in urban areas but for most of them it's just like a shelter and in many cases it cannot be compared with own housing facility of better-off households in urban areas (Vaid & Evans, 2017; Nix et al., 2020). In case of wealth index, with improving levels, the level of mortality, malnutrition and anaemia reduces. It is found highly significant across all the levels for all the dependent variables in the study (Braveman& Gottlieb, 2014; Childers & Chiou, 2016; CSDH, 2008; Darin Mattsson et al., 2017; Dommaraju et al., 2008; Kulkarni et al., 2020; Subramanian, et al., 2006) and validating the findings

of the previous studies. Here, it can be added that along the different indicators of economic status; wealth index seems a robust indicator altering mortality, malnutrition and anaemia among children significantly in the study.

The study contributes to the persisting disparity and inequality in child health and nutrition in India across caste lines with a high burden among SC and ST even though progress is emancipated among such groups. Along the socio-economic inequality among caste groups in India, the finding of the study made significant contributions and strengthen the previous studies (Acharya, 2013, 2018; Baru et al., 2010; Bora et al., 2019; Borooah, 2010; Childers & Chiou, 2016; Raushan & Acharya, 2018; Subramanian, et al., 2006). In rural areas, having land pushes one to positive change, but having housing in urban areas needs deeper investigation with structure, location and quality of housing and linkages with health outcomes. The effect of education is also found significant across all the indicators under the study and consistent with other studies (CSDH, 2008). However, more studies pertaining to land and housing can strengthen the caste-based inequality in child health and malnutrition in India. Finally, caste-based inequality is the reality of India impacting the health of the people. An inclusive policy needs to be more focused at regional levels where such marginalised groups have high concentration and poor outcomes along with poor socio-economic development (Raushan & Acharya, 2018).

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Appendix Table

Table A1: Progress on mortality decline between 1998/99 to 2019/21, India

Caste Group	Year	NMR	IMR	U5MR	UWT	STN	ANE
SC	1998/99	53.2	83	119.3	53.5	51.7	78
	2005/06	46.3	66.4	88.1	48	54	72
	2015/16	33	45.2	55.9	39	43	61
	2019/21	29.2	40.7	48.9	35	39	70
ST	1998/99	53.3	84.2	126.6	55.9	52.8	80
	2005/06	39.9	62.1	95.7	55	54	77
	2015/16	31.3	44.4	57.2	45	44	63
	2019/21	28.8	41.6	50.3	40	41	72
OBC	1998/99	50.8	76	103.1	47.3	44.8	72
	2005/06	38.3	56.6	72.8	43	49	70
	2015/16	30.5	42.1	50.8	36	38	59
	2019/21	24.3	34.1	40.5	31	35	65
Others	1998/99	40.7	61.8	82.6	41.1	40.7	73
	2005/06	40.7	61.8	82.6	34	41	64
	2015/16	23.2	32.1	38.5	29	31	54
	2019/21	19.5	28	32.8	27	30	66

Source: Calculated by authors using various round of NFHS data

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Health Investments to Reduce Health Inequities in India: Do We Need More Evidence?

Indrani Gupta[1] and Avantika Ranjan[2]

Abstract

Large inequities in health outcomes and treatment-seeking behaviour continue to exist in India, across households, states and residence. A few large populous states continue to contribute the most to multi-dimensional poverty, including indicators for health outcomes. A significant contributor is the high out-of-pocket spending that continues to be a key feature of India's health sector, accompanied by one of the lowest levels of public investment on health. The COVID pandemic has brought out sharply the lack of preparedness of the country and its states to face a catastrophe of this kind. A resilient health sector can only be built by bridging the various gaps in key inputs into the sector – infrastructure, personnel, supplies and training. This investment is likely to bring down the demand for health services in the private sector and reduce spending on health services by households by making these affordable and accessible. A quantum jump in investment would also be required to offer health coverage that is truly universal in scope and coverage. Unless that happens, India would remain unprepared for the next calamity and continue with significant inequalities in health outcomes and access to services.

Keywords

Poverty, inequality, out-of-pocket spending, health outcomes, health financing

Introduction

The COVID pandemic has again highlighted the harsh truth about India: that there remains a huge socio-economic divide across groups based on residence, geography, class, caste, education and a whole host of other factors. Among the many heart-wrenching visuals that marked the highlights of the COVID period, two sets would remain etched in the minds of Indians: migrants walking hundreds of miles to reach

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their homes, hungry, ill and tired, and citizens scampering around desperately to get their sick relatives admitted to hospitals and procure oxygen cylinders.

While the two may seem unrelated, they are not. Though the COVID infection itself did not generally distinguish between the poor and the non-poor, the latter were better equipped to negotiate the system and had a higher probability of garnering resources for health as well as non-health requirements. Though many households were hit by loss of earning and employment, the poor remained the most vulnerable due to lack of social and health security.

While official estimates of poverty have not been brought out since 2011, other estimates indicate that about 28 per cent of Indians lived in multidimensional poverty in 2019 (United Nations Development Program [UNDP], 2019).

The report on multi-dimensional poverty (MDP) based on the fourth round of the National Family Health Survey (NFHS) for the years 2015-16 indicates that 33 per cent and 9 per cent of rural and urban Indians live in multidimensional poverty (National Institute of Transforming India [Niti] Aayog, 2021).

Given the decline in GDP and increase in unemployment during the pandemic, it is evident that poverty could only have increased and inequalities widened. A very recent statement by the RBI Governor indicates that growth rate of GDP for 2022-23 would be lower than initially estimated by the Finance Ministry, due to private consumption and contact-intensive services remaining below pre-pandemic levels (The Economic Times, 2022).

While one has already witnessed the education system falling apart and huge inequalities inserted among students due to the digital divide, the story would be similar for the health sector as well. Unfortunately, data remains unavailable to estimate the impact of the pandemic on the health sector and health-seeking behaviour of individuals. While the pandemic caught most countries off guard, the resilience of health systems determined to a large extent the impact of the pandemic and the ability of countries to reduce illness and death from COVID.

In India, there are large inequalities among states on various socio-economic indicators, including health outcomes. Southern states like Kerala and Tamil Nadu (TN) are considered much ahead of the other states in terms of health and educational outcomes. On the other hand, a group of states labeled as Empowered Action Group or EAG states comprising eight states[1] have often been the focus of government programmes and interventions due to their continued vulnerability status. Often, Assam is added to the EAG group for policy purposes. In this essay, we attempt to analyse why the pandemic might have seriously exacerbated the existing health inequalities in the system, requiring a rebooting of the health sector. We present evidence for the country as a whole, and also on the vulnerable states, especially Bihar and UP and take Tamil Nadu as a comparator, to understand the aspirational directions policies could take in the near future. A key policy knob—health financing—is analysed in detail, and we present our prognosis and recommendations about the future of health sector policy in India.

[1]Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh

Inequities Across States in Health Dimensions

There is already a large volume of literature about EAG states and their relative positions across a number of indicators. Government of India (GOI) has been initiating numerous programmes and schemes for making the EAG states come out of their backward status and catch up with the rest of the states. However, despite such efforts, we continue to see huge inequities between EAG and non-EAG states in health outcomes. Table 1 presents data on multidimensional poverty for EAG states,[2] and Kerala and Tamil Nadu as well for comparison.

Table 1: Multidimensional poverty, EAG states including Assam, Kerala & Tamil Nadu, 2015-16

States	Multi-dimensionally poor (%)	Percentage of total population who are multi-dimensionally poor and deprived in each indicator (%)		
		Nutrition	Child & adolescent mortality	Maternal health
Bihar	51.2	41.6	3.9	36.5
Jharkhand	42.2	34.4	2.7	26.5
Uttar Pradesh	37.8	30.5	3.8	25.3
Madhya Pradesh	36.7	29.0	2.7	20.1
Assam	32.7	25.5	2.2	17.8
Chhattisgarh	30.0	24.0	2.3	17.0
Rajasthan	29.5	23.3	2.1	17.1
Odisha	29.3	22.4	1.5	12.7
Uttarakhand	17.8	14.7	1.6	13.0
Tamil Nadu	4.5	3.6	0.3	1.7
Kerala	0.7	0.6	0	0.2

Source: Niti Aayog 2021

Among the major states, Bihar has 52 per cent of its population who are multi-dimensionally poor, followed by Jharkhand (42 per cent) and Uttar Pradesh (UP) (38 per cent) respectively. In the three health domains—nutrition, child & adolescent mortality and maternal health—most of the EAG states, but especially Bihar and UP, continue to be in the group that performs the worst. TN and Kerala, on the other hand, have very little MDP in comparison. The Niti Aayog also brings out an annual Health Index which is a weighted average of various indicators that attempts to measure the state of health, and tracks the overall and incremental changes across all states and Union Territories (UT). The latest report with 2018-19 as the base year and 2019-20 as the reference year indicates that among the larger states, Kerala, Tamil Nadu and Telangana were the three best performers in terms of overall performance (Niti Aayog, 2021). The worst performer was UP, with Bihar also in a similar situation in overall score. However, unlike Bihar, UP's incremental performance was quite good.

The same report indicates that states performed differently in the three main domains that went into constructing the health index—health outcomes, governance & information, and key inputs & processes. In the health outcomes domain, most of

[2]We include Assam in discussions on EAG states

the EAG states do very poorly, with Bihar and UP as the worst performers and Kerala at the top. For the domain on governance and information, the picture is somewhat mixed, with Assam doing very well, ahead of Kerala. Jharkhand is the worst performer in this group. Finally, for the domain on key inputs and processes, Tamil Nadu is at the top with Bihar at the other end.

For all the states and UTs, the MDP proportions are much higher for rural areas than urban areas: for example, for Bihar, the rural-urban numbers are 56 per cent and 24 per cent respectively.

Clearly, health inequalities persist in all dimensions within states, between rural and urban areas, and as the report also indicates across districts.

The contribution of health indicators in total MDP is shown in Figure 1 for the EAG states and for Kerala and TN.

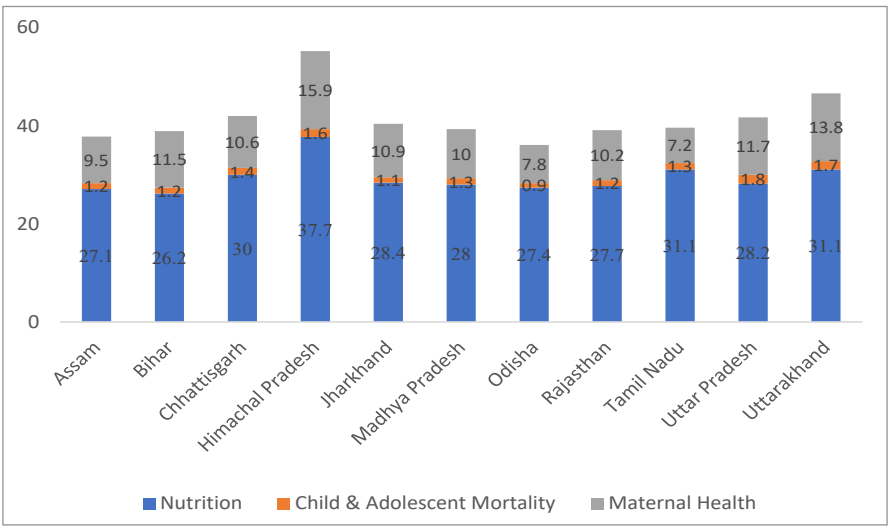

Figure 1: Contribution of each indicator to MPI score (%)

Source: Niti Aayog 2021

For all the states, including Kerala and TN, nutrition contributes the most to MDP, followed by maternal health. For more evidence on what literally ails the various states, Table 2 indicates the top 5 diseases that contribute to total disease burden in each of the states and for India. We now focus only on the two most vulnerable states—Bihar and UP—and TN, since TN and Kerala have similar trends.

The Global Burden of Disease (GBD) data for India indicates that both Bihar and UP continue to have maternal, neonatal and nutritional diseases as the top cause of disease burden (GBD, 2019). For TN, the top cause is cardiovascular diseases which is also the case for all-India. In fact, for TN, all the 5 top diseases contributing to total disease burden are non-communicable diseases and injuries (NCDI). For both Bihar

and UP the set of diseases classified as communicable continue to impose the most disease burden, indicating that these states need a public health approach to reduce their disease burdens.

Table 2: Global burden of diseases: Top 5 shares in terms of disease burden, 2019

Top 5 Diseases	Bihar	Uttar Pradesh	Tamil Nadu	India
1	Maternal, neonatal & nutritional diseases (13%)	Maternal & neonatal & nutritional diseases (14.1%)	Cardiovascular diseases (19.6%)	Cardiovascular diseases (13.9%)
2	Cardiovascular diseases (11.3%)	Respiratory infections & TB (10.4%)	Diabetes & CKD (9.1%)	Maternal, neonatal & nutritional diseases- (9.9%)
3	Enteric infections (9%)	Cardiovascular diseases (9.5%)	Neoplasms (6.2%)	Respiratory infections & TB (7.7%)
4	Respiratory infections & TB (8.8)	Chronic respiratory (7.7%)	Unintentional injuries (5.7%)	Chronic respiratory (6.3%)
5	Other non-communicable (5.7%)	Enteric infections (7.4%)	Musculoskeletal disorders (5.6%)	Neoplasms (5.8%)

Red: Communicable, maternal, neonatal and nutritional diseases
Blue: Non-communicable diseases
Green: Injuries
Source: IHME GBD India 2019

Most of the burden of communicable diseases, continues to fall on the poorest sections of the population in any developing country, and India is no exception. Moreover, with changing disease profiles, there is increasing evidence that poverty also increases risk of death and disability from NCDIs as well (Johns Hopkins, 2018).

This short summary indicates that health outcomes for the poor remain a cause of concern, with a two-way relationship between poverty and disease occurrence.

Treatment-seeking Behaviour and Out-of-pocket Expenditure

National Sample Survey (NSS) 75th round enables us to understand treatment-seeking behaviour of households including out-of-pocket spending (OOPS) and allows additional insights into possible sources of health inequities across states.

Table 3 presents the self-reported out-patient (OPD) and inpatient or hospitalization (IPD) rates from the NSS and indicates that care increases with increases in income. So, while 5 per cent from the lowest quintile sought care for OPD in rural areas, more than 10 per cent sought care in the richest quintile. While this could be because of higher morbidity rates among the relatively well-off, evidence suggests otherwise, and indicates that economic means could be a major constraint in treatment-seeking behaviour.

Table 3: Demand for care across quintiles, NSS 75th round

Quintile	OPD (%)		IPD (%)	
	Rural	Urban	Rural	Urban
1	4.8	6.5	1.7	2.8
2	5.4	8.6	1.8	3.2
3	6.4	9.0	2.4	3.7
4	7.0	10.4	3.0	3.6
5	10.4	10.9	4.1	3.8
All	6.8	9.1	2.6	3.4

Source: NSS 75th round

Figure 2 shows where respondents went for hospitalization and the out-of-pocket spending incurred by them, in public and private facilities.

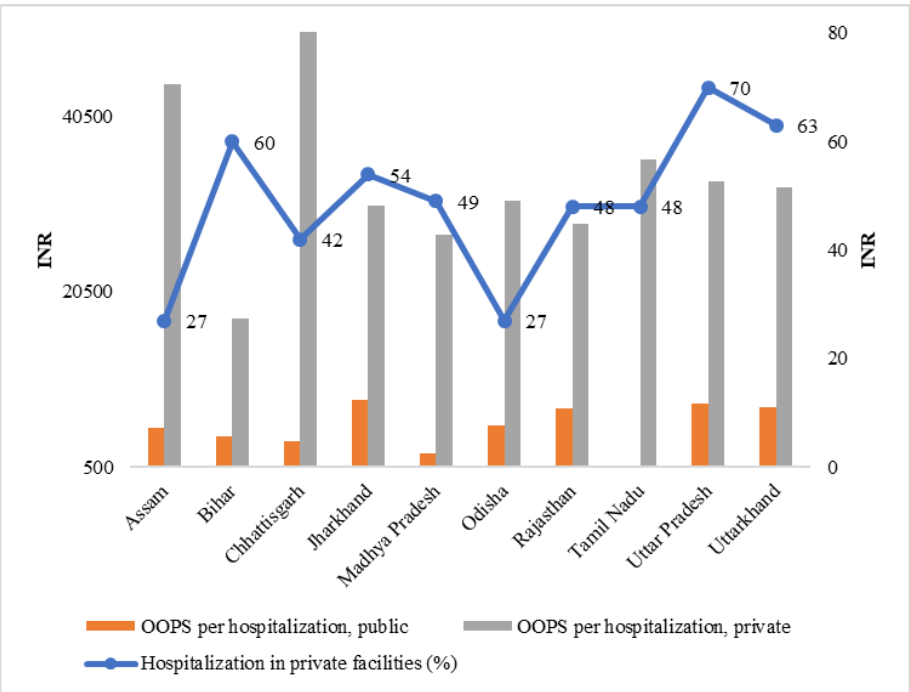

Figure 2: Out-of-pocket spending on hospitalization and % seeking private hospitals

Source: NSS 75th round

The first point to note is that a high proportion of respondents sought care from private facilities for hospitalization. In UP, 70 per cent of those needing hospitalization went to a private facility. Even TN, the comparator, had 48 per cent seeking care in private facilities. The result of these patterns of treatment-seeking behaviour is felt on respondent's out-of-pocket spending (OOPS) on hospitalization. The difference between OOPS between private and public facilities is substantial in almost all the states, including TN, though for TN and Madhya Pradesh (MP) respondents paid very

little while seeking care in public facilities. The difference is highest for Chhattisgarh and Assam.

While TN also shows the maximum difference between public and private OOPS, we need to understand to what extent such high expenditure might impact households.

When we look at the percentage break-up of ailments treated on medical advice by healthcare service provider, we find that in TN, only 8.8 per cent and 13 per cent went to private doctors or private clinics in rural and urban areas respectively; most of the respondents chose government hospitals for seeking medical advice, and this percentage was much higher for rural areas (63 percent) compared to urban areas (41 per cent). In Bihar and UP, this was just the reverse: for both rural and urban areas, medical advice was sought at private clinics and from private doctors by more than 60 per cent of the people seeking care.

The OOPS in per capita household consumption indicates how much households pay for health care out of their total consumption expenditure. Figures 2a and 2b present the ratio of average household consumption on health (OPD plus hospitalization) for each quintile between the two health NSS rounds for rural and urban areas separately, for the country as a whole.

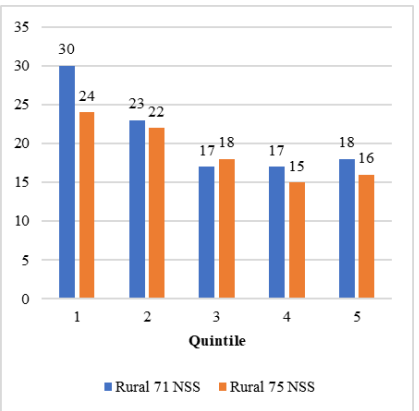

Figure 2a: Share of per capita consumption on health in household per capita total consumption (%)

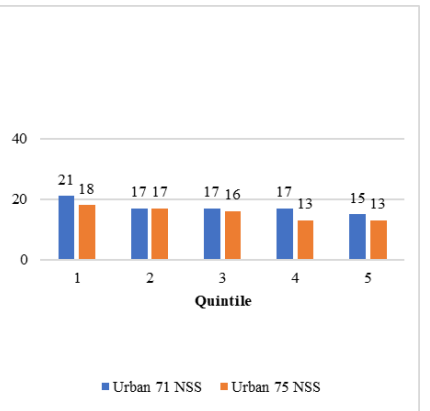

Figure 2b: Share of per capita consumption on health in household per capita total consumption (%)

Source: NSS 71st and 75th round

The first point to note is that the rural areas are spending more on health than urban areas. For both the rounds, lowest quintiles in rural areas spend more than the lowest quintiles in urban areas. The second point is that lower quintiles spend more than upper quintiles on health—the ratio declines in the upper quintiles. Finally, and which is a positive development, the share of health in total consumption has gone down marginally for all the quintiles between the two rounds.

The existence of inequality in the burden of health care among rural residents and lower quintiles continues to be one of the most inequitable features of the health system in the country.

Explaining Treatment-seeking Behaviour

a. Infrastructure and Personnel

The choice of providers in Bihar and UP is easy to explain if one looks at the state of infrastructure and health personnel in these states, compared to TN. Figures 3, 4a and 4b indicate the shortfalls in these two variables in the three states.

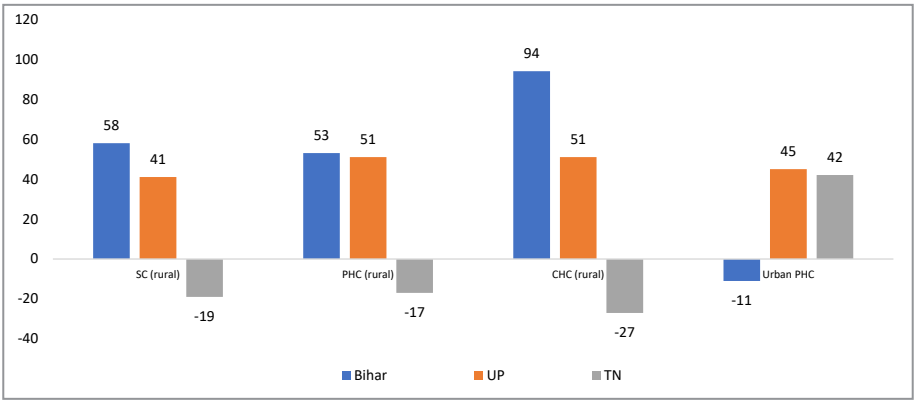

Figure 3: Shortfall in Health Facilities (July 2020)

Source: Rural Health Statistics 2019-20

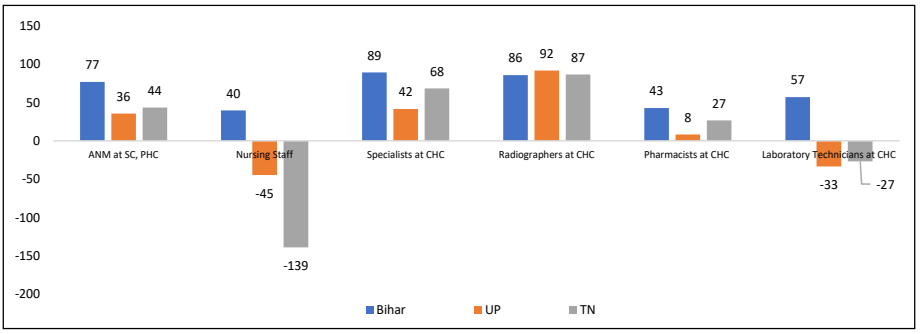

Figure 4a: Shortfall in Health Personnel (Urban) - July 2020

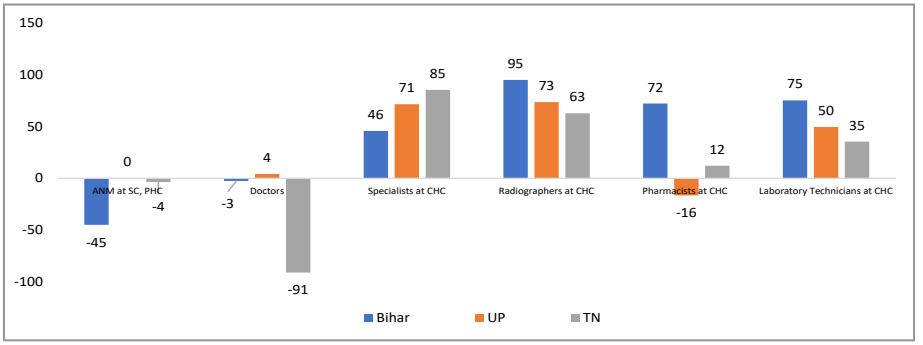

Figure 4b: Shortfall in Health Personnel (Rural) - July 2020

Source: Rural Health Statistics 2019-20

Both Bihar and UP show serious shortfalls in Sub-Centres (SC), Primary Health Centres (PHC), Community Health Centres (CHC); in contrast, TN has already achieved surplus infrastructure, explaining the high visits to government facilities in this state and very low visits in the other two.

The picture for health personnel is slightly different. TN also shows shortfalls in Auxiliary Nurse Midwives (ANMs), specialists, radiographers etc., but Bihar does much worse than UP in terms of government health personnel. UP has recently made up for lack of ANM and nursing staff and shows a much better situation compared to Bihar, especially for urban areas.

The missing health infrastructure and personnel in the government sector continues over the years, and contributes to high burden of OOPS on households, who are forced to visit private providers and facilities.

It should be pointed out that the TN numbers may be somewhat misleading since TN has arranged its health system in a much more efficient manner with superior outcomes. Tamil Nadu has a distinctive public health cadre in the district level, has a separate body for regulating procurement of drugs and has been implementing very efficiently the TN Health Systems Project over the years (Parthasarathi and Sinha, 2016). The quality and efficiency of public health services continue to be far better than many other states, and TN health services utilization are generally considered pro-poor, though there is some evidence that recently, the proportion of those in the poorest quintile using public facilities has gone down (Vaidyanathan, Muraleedharan, Sundararaman et al., 2022). This is probably also the reason why in the Niti Aayog estimates, TN does very well on key inputs and processes.

b. Health Coverage in EAG States

The key to avoiding high OOPS is through health coverage, and India—like many other countries—has been trying to move towards Universal Health Coverage (UHC). The health coverage has to be highest for the lowest quintiles and those living in rural areas, who are experiencing relatively higher burden of OOPS. The most recent initiative of the government towards this has been the launch of Ayushman Bharat (AB), which has essentially two arms: one to strengthen primary care through Health and Wellness Centres (HWCs) and the other is the health coverage scheme for the most vulnerable called the Prime Minister's Jan Arogya Yojana (AB-PMJAY). Most of the states have been running their own schemes for hospitalization which have since been merged with AB-PMJAY with a few exceptions.

Table 4 indicates the status of health coverage in rural and urban areas as reported in the 75th round of the NSS, and indicates that residents in EAG states are mostly not covered by any health coverage programme. The other notable point is that those in the top quintile in urban areas are much better covered compared to their rural counterparts, and in general urban non-coverage numbers are better than rural non-coverage numbers. However, there are exceptions. Chhattisgarh and Rajasthan seem to have done much better among the EAG states, and their rural non-coverage numbers are better than the urban ones. Finally, the non-coverage numbers for Tamil Nadu are

comparable to the EAG states, with the exception of urban top quintile, who are best covered in the state.

Table 4: Health coverage by quintiles, Rural & Urban

State	Not covered by coverage scheme (%) 1st quintile		Not covered by coverage scheme (%) 5th quintile	
	Rural	Urban	Rural	Urban
Assam	96.2	96.1	95.6	83.1
Bihar	99.7	98.9	97.3	85.9
Chhattisgarh	32.3	40.2	40.9	60.3
Jharkhand	99.9	99.2	99.8	86.6
Madhya Pradesh	99.8	98.7	99.0	84.8
Odisha	80.5	92.3	95.6	90.1
Rajasthan	56.6	74.6	63.4	71.5
Tamil Nadu	98.0	89.8	81.2	64.9
Uttar Pradesh	99.8	99.2	98.4	72.1
Uttarakhand	99.8	99.6	92.4	62.4
All India	89.8	90.2	78.1	66.9

Source: NSS 75th round

It is difficult to predict the coverage numbers during the pandemic years – most programmes had to be halted or were slow to progress, and it remains to be seen if the health coverage has improved and OOPS has declined for the most vulnerable.

Resource Allocation for Addressing Inequities in the Health Sector

The poor infrastructure and personnel situation, and low health coverage explains well, the high OOPS expenditure of households that are likely to disproportionately impact the poor and the vulnerable across the country, but mostly in the EAG states. How could this have been avoided?

The most important policy knob is health financing. There is now solid evidence that health outcomes are better in countries with better public health financing, and low OOPS.

A recent study (Owusu, Sarkodie & Pedersen, 2021) examined the influence of health expenditure on infant and maternal deaths for the period 2000–2015 across 177 countries and found a negative effect of health expenditure on mortality across all percentiles. The study concludes that to attain Sustainable Development Goals (SDG)- 3, there is a need to increase health spending in especially lower middle-income countries. This finding corroborates earlier such findings (Boachie, Polajeva, & Frimpong, 2020), (Kiross, Chojenta, Barker et al., 2020) on the direct link between health outcomes and health financing.

India's low level of spending on the health sector is now also widely known and numerous articles have been written on the inability of the country to move out of the trap of low health spending. While the total health spending is slightly above 3 per cent (National Health Accounts [NHA], 2021), government health spending is only slightly

more than 1 per cent currently. Table 5 brings out the comparatively poor performance of India globally in its ability to raise resources for the latest comparable year, 2018.

Table 5: Domestic government health spending in GDP (%)

Income Categories of Countries - World Bank	Government Health Spending as a % of GDP (2018)
High income	7.7
Upper middle income	3.3
Middle income	2.8
Low & middle income	2.8
Lower middle income	1.5
Low income	1.1
India	1.0

Source: World Bank Open Data

While high-income countries spend on an average more than 7 per cent, this goes down with income levels to 1.1 per cent for low-income countries. India's spending of 1 percent of its GDP is lower than the average of the group it belongs to—lower middle-income countries.

In general, the higher is government spending on health, the lower is OOPS. Figure 5 uses World Bank data to plot government spending of countries out of their GDP with OOPS in current health expenditure. While the fit is not as close as one would hope, it still is a strongly negative one, indicating a fairly tight relationship between the two variables. India can only hope to reduce OOPS if it starts increasing its total government expenditure on health.

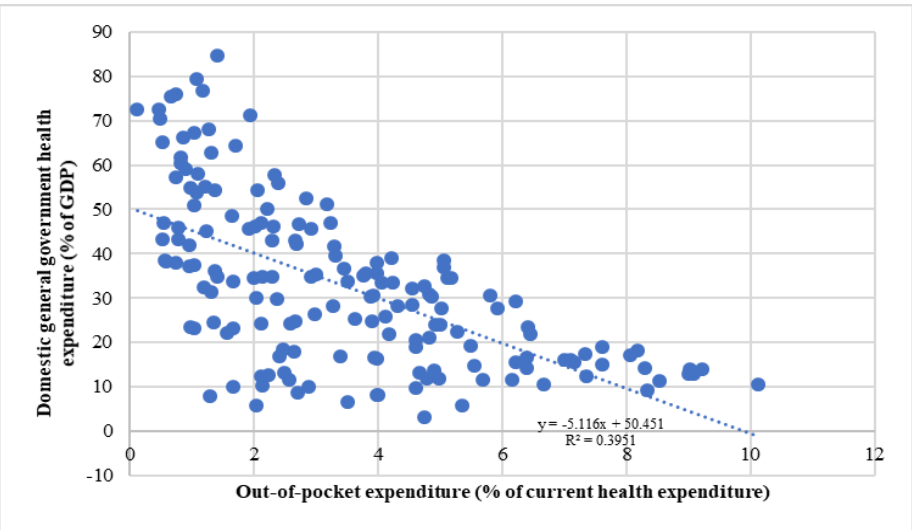

Figure 5: Govt expenditure and out-of-pocket spending across countries

Source: World Bank Open Data

High OOPS and low coverage indicates the ever-present challenge of the Indian health system—raising resources for building a resilient health sector and

offering financial protection to its citizens from health shocks. The COVID-19 pandemic brought out clearly the urgent need to revive and strengthen the health sector (Gupta, 2020). A pandemic like COVID could have been dealt with more efficiently, with better overall allocations, and strengthening key components like public health investment.

While the health sector budget is key for investment on infrastructure and personnel, the public health component largely comprises drug control, food safety and standards, manufacture of vaccines, prevention and control of diseases, prevention of food adulteration, public health education and public health laboratories. Public health interventions have been universally successful in dealing with the threat of communicable diseases. So, it can be expected that states in the initial stages of epidemiological transition would direct more resources towards public health within a modest to high total public financing of the sector.

We analyse some of these parameters for Bihar, UP and Tamil Nadu (TN).

Table 6 presents the real per capita total health expenditure by the respective state governments over the last six years between 2014-15 and 2019-20. These numbers are derived from the state Demand for Grants.[3]

Table 6: Per capita real total expenditure (INR), Dept. of Health & Family Welfare

States	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Compound growth rate (%)
Bihar	265	318	363	392	445	448	11
UP	442	455	509	526	546	554	5
TN	714	817	862	816	968	1092	9

Source: Author's calculations based on state Demand for Grants, Health & Family Welfare

Over the six years, Bihar showed the highest compound growth in per capita real total expenditure, followed by TN, while UP's growth was the lowest. However, Bihar's per capita real total expenditure on health in 2019-20, was a mere INR 448 compared to INR 1092 for TN. UP's was only marginally better at INR 554 and its growth rate was also much lower. Clearly, to catch up with TN, both the states have to increase their growth rates to much higher levels.

Real per capita expenditure on the public health component is a critical sub-category under total health expenditure, especially where the burden of communicable disease is very high. Both Bihar and UP have a disproportionate burden of communicable diseases. In 2019, Communicable, Maternal, Neonatal and Nutritional Diseases comprised 40 per cent, 40 per cent and 17 per cent of total disease burden (Disability Adjusted Life Years or DALYs) in Bihar, UP and TN respectively (GBD, 2019) indicating that states like Bihar and UP must continue to focus on preventable and communicable diseases. In the background of the pandemic, this becomes a greater priority.

[3]Demand for Grants are budget documents for each Ministry and Department within the Centre and State governments. These documents give the budget estimates of spending of all line-items for the upcoming year, revised estimates for the previous year and actual spending incurred for the year before last.

Table 7, however, indicates the low prioritization of public health in total health expenditure of the governments of Bihar and UP. In 2019-20, these states spent INR 9 and INR 17 respectively on per capita real expenditure on the component public health, compared to INR 55 for TN. Investment on public health laboratories takes place under this head of expenditure, and indicates poor investment on diagnostics and laboratories, two areas of critical importance during outbreaks and pandemics.

Table 7: Per capita real expenditure (in INR) on the public health component

States	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Bihar	5	5	5	6	6	9
UP	16	16	15	20	18	17
TN	46	50	51	53	56	55

Source: Author's calculations based on state Demand for Grants, Health & Family Welfare

While raising total resources and investing in critical areas like public health is going to remain the most important policy knob, it is also important to guard against inefficient spending, which will only waste precious resources.

Figure 6 plots Infant Mortality Rate (IMR) against per capita health expenditure for the various states for 2019-20. The figures shows that states do get different outcomes from the same level of spending, indicating the possibility of different efficiency in their health spending. For example, Tamil Nadu (TN), Haryana (HR), Odisha (OR) and Chhattisgarh (CG) have similar per capita spending, but very different outcomes in terms of IMR. Also, Kerala (KL) and Goa (GO) have both performed well and have almost similar IMR. However, Kerala is able to achieve good results with much lower per capita health spending.

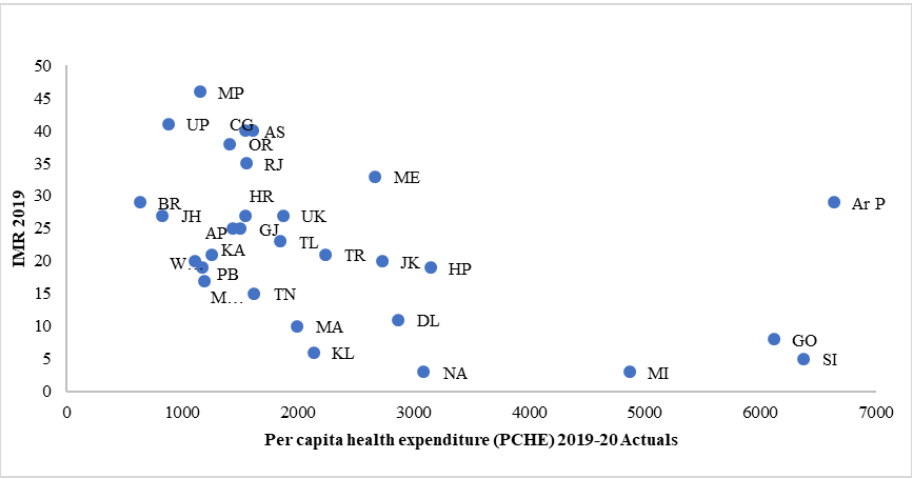

Figure 6 : Per capita health expenditure and IMR across states

Source: Authors calculations based on state Demand for Grants, Health & Family welfare 2021-22, SRS Bulletin 2019

The discussion above clearly brings out the need for a quantum jump in spending on health in the country. The National Health Policy in India (NHP, 2017) recommends spending 2.5 per cent of GDP, but at this point even this seems too inadequate. Most countries with UHC have been able to spend more than 3 per cent of their GDP on health. The COVID-19 experience has brought to the fore again the urgent need for a quantum jump in health financing. The resilience of the health sector hinges on how much a country prioritizes health by putting in adequate finances. Also, since India is now also supposedly on the path of UHC, its current level of spending is totally inadequate to move it towards UHC.

Table 8 indicates the levels that would be required if India truly wants to move towards UHC. While European countries like Norway and Germany spend almost 1/10th of their GDP on health, even countries in Asia like Thailand, China and Sri Lanka are able to do much better than India in terms of per capita spending as well as level of government spending out of GDP. Rwanda has made rapid progress towards UHC, and while its per capita spending is low, it is able to spend 2.6 per cent of its GDP on health.

Table 8: Health financing indicators for countries with significant UHC

Countries with significant UHC	Domestic Government Health Expenditure Per Capita, PPP (current international $), 2019	Domestic Government Health Expenditure (% of GDP), 2019
Norway	6194	9.0
Germany	5238	9.1
France	4137	8.3
Japan	3847	9.0
Turkey	925	3.4
Brazil	610	3.9
Thailand	524	2.7
China	493	3.0
Sri Lanka	269	1.9
India	69	1.0
Rwanda	58	2.6

Source: World Bank Open Data

A recent World Health Organization report (WHO, 2020) indicates that health financing vulnerabilities that existed prior to 2020 will also affect health spending in the coming years post COVID. The report points out that countries like India that rely heavily on OOPS and are facing large economic contractions will find it hard to sustain their current levels of financing and address equity in health services. While OOPS may not increase substantially, that is mainly due to foregone care due to loss of income as well as lockdown, rather than a real drop in OOPS. The report also warns that such foregone care is likely to hit the poor much harder than others.

Clearly, India and its states need to not only defend their current levels of spending but increase spending substantially if inequities are to be addressed.

While the National Health Mission (NHM) and the Ayushman Bharat are two major landmark initiatives in the health sector, it is not clear whether the benefits have trickled down enough to make a major difference in inequities. The NHM was launched to make a difference to the way government health services—especially maternal and child health care services—are provided in the rural areas, including improvements in infrastructure. The NHM has been an important initiative of the government, which should be strengthened.

A Benefit Incidence Analysis (BIA) using 2014 NSS (Bowser, Patenaude, Bhawalkar et al., 2019) shows that government spending on public health care has not resulted in significantly pro-poor services, and that in-patient services are in particular not pro-poor, and there are significant disparities across states. A recent study (Selvaraj, Karan, Mao et al. 2021) uses two waves of the NSS and also employs BIA to find that NHM did benefit the poor, but in terms of health subsidies received forutilization of inpatient and outpatient services, the rich benefitted more. The study also finds that inequalities persist across all healthcare services in the private health sector.

Nonetheless, NHM remains an important programme with a huge potential to make further difference to the lives of millions of Indians living in rural India. Similarly, there are other programmes of the government on Tuberculosis (TB), non-communicable diseases, HIV/AIDS that yield direct benefits to people if scaled up and done well.

The PM-JAY for hospitalization coverage for the 40 per cent of the vulnerable population of the country also requires huge finances, which has not been forthcoming (Gupta & Roy, 2019).

In a meagre total allocation for health, it stands to reason that the allocations under specific heads will be in turn very small.

There have been studies that have indicated how much India should be spending on disease control programmes; some of those calculations yield numbers that are impossible to attain. The synergies in health sector programmes need to be exploited, so that separate allocations can be manageable and realistic. Thus, while India has been able to increase spending on TB prevention and control, OOPS on TB remains about half of the total expenditure in the country on TB (Su, Baena, Harley et al., 2020). Malaria has a similar story, possibly worse than that for TB, in that OOPS in malaria prevention and control remains high (Haakenstad, Harle & Tsakalos, 2019). If one takes spending on non-communicable diseases and injuries (NCDI), the total government spending remains very low at less than half a percent of GDP (Gupta & Ranjan, 2019). The COVID calamity has brought to the fore the need for health systems strengthening (HSS) which runs common across all disease control programmes; HSS would require funding and filling the various personnel, infrastructure and supply gaps and make all the existing disease control programmes much more efficient.

In India, health being a state subject, health spending is majorly done by the states, at two-thirds of the total health spending (National Health Profile, 2021). Therefore, merely increasing funds in the Central government is not enough if correspondingly state governments are not able to raise resources for health. In any case, the last two Union budgets indicate that core health allocations of the MOHFW have been static or declining, and some major programmes like NHM are not getting adequate funding. While the 2021-22 budget expanded the scope of what was defined as "health and well-being", and included water, sanitation and nutrition, a detailed analysis revealed that core health sector allocations actually did not increase and in fact went down slightly. The same happened in the subsequent 2022-23 budget, though the definition reverted to the earlier one and health sector allocations of the Union government went down slightly.

Looking Ahead

Significant inequities in health outcomes and access to services continue in the country. The brunt of these inequities continue to fall on a few large populous states with large numbers of poor and significant inequalities between rural and urban areas. These states will be unable to come out of this low-level equilibrium without a significant shift in priorities. The health sector has yet to be prioritized in the country and the COVID pandemic has once again indicated the pitfalls of continuing with a weak health sector. The lack of investment in the health sector has translated into a weak government health system, with missing infrastructure, personnel and medical supplies. The resultant shift of care to the private sector has come at a high cost and India continues to report one of the highest OOPS among countries that are supposedly on the path of UHC. It is not necessary to launch large programmes of coverage that are neither universal in definition nor in coverage. Instead, it might be much better for the government to focus on the infrastructure the country created, that was to serve its people adequately. Either way, government investments have to increase—not incrementally—but with a quantum jump. That is the only way to improve equity in the health sector.

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Social Inequities in Private Health Sector Workforce in India: Religion, Caste, Class, and Gender

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Abstract

The health workforce is hierarchical in structure in terms of skill mix and social composition. Most of the studies on the health workforce are focused on the number of personnel in the public sector. The private sector that has a large presence employs a significant percentage of the total health work force but there is little reliable data on the numbers involved. This is largely due to the lack of regulation of the private health services. Apart from the numbers involved in both the sectors, a few studies have shown the relationship between the work and social hierarchy in health services. While the public sector has a more diverse mix of social backgrounds due to affirmative policies, the private sector ownership is mostly dominated by an upper and middle caste-class combine. There is an under-representation of minorities and women as owners of private health services. The gendered nature of work is visible with the middle and lower rungs constituted by mostly women and men from lower caste-class combine. The terms of work, working conditions and wages paid for this category of workers amounts to exploitation with no forum for redressal. This essay draws together some primary work and references to secondary research and anecdotal evidences to build the scenario of social inequities among the workforce in the private health services.

Keywords

Health personnel – doctors, nurses, paramedics; permanent and temporary workers; occupational hierarchy; social inequity; caste; class; gender; religion; private health care

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Introduction

The estimates of healthcare workforce, from all past censuses and surveys has drawn attention to a significant deficit in all categories of workers, and a substantial urban bias in their geographical distribution. The analyses of these data sets have mainly focused on the public sector. Since the launch of the NRHM in 2005, the Indian government has engaged in increasing the training institutions for all categories of health personnel—doctors, nurses, technicians and other paramedics to close this gap. In order to increase supply of health personnel there has been an effort to establish medical, nursing and allied disciplines with the involvement of both the public and private sector. Recent data shows that the public to private ratio of medical colleges is almost equal at the all India level but there are state variations. The south and west states have a higher proportion of private medical colleges while the east and some north states have a higher proportion of public medical colleges (Baru and Diwate, 2022). However, all other categories of the health workforce are trained in private colleges across the country. The privatisation of nursing, technical, paramedical and allied health disciplines is widespread in India. There is however little effort for regulating the quality of those who are being trained. The gap in terms of self-regulation, accreditation and quality assurance is glaring for private medical, nursing, technical, paramedical and allied health disciplines that requires serious study and policy engagement.

However despite these efforts, recent research presents a rather grim picture on both the quantity and characteristics of healthcare workers in India. K D Rao employs three macro data sets to arrive at estimates of the different cadre of health workers. These include the Census, NSSO and Professional Councils. His analysis points to considerable variation in the availability and distribution of doctors and other cadre of health workers across states in India (Rao et al., 2011). A larger proportion of them are in the private sector across cadres (See Figure 7 as cited in Rao et al., 2014). Apart from a significant shortage in many categories of workers, a considerable proportion of personnel are unqualified, especially within the private sector and rural areas. Baru (2004) finds the private sector often hiring poorly qualified staff at paramedic levels who can be paid less, in order to contain costs. Even doctors with BAMS degrees are preferred over MBBS because they can be paid lesser salaries (Baru, 2004).

India has one of the most highly privatised healthcare systems in the world—both in terms of finance and delivery. In 1996, the private sector accounted for 54 per cent of rural hospitalization and 70 per cent of urban hospitalization. By 2000 the private sector included as much as 93 per cent of all hospitals and 64 per cent of all beds nationwide (Radwan, 2005). The private health sector is highly heterogeneous in nature with providers ranging from qualified specialists to unqualified persons and quacks, practicing different systems of medicine and healing forms, in highly diverse organisational setups (Baru, 2005). Early scholars documented concerns on the poor quality of care in the private sector. There were problems with diagnostic and treatment practices, inadequate facilities and equipment, malpractices like over prescribing and

unnecessary investigations, exorbitant charges, etc. (Nandraj et al., 2001). However despite the size and scale of the private sector, data on the private health sector and the personnel remains fragmented and under reported. Government sources record data for public sector personnel, but not for the private sector. Records for health personnel from other systems of medicine, like AYUSH also are also inadequate and largely self-reported. As a consequence, little is known about the structure and dynamics of the health workforce.

This essay seeks to pull together the magnitude, social characteristics and working conditions of healthcare employees in the private sector, through an extensive review of literature, primary data, relevant reports of civil society organisations and newspaper reports.

Methodology

The essay is based on an extensive literature review on the condition of health workers employed within the vast private health sector in India. The essay employs both secondary data and anecdotal evidence arising from primary studies conducted within private sector settings on the conditions for work. Owing to a dearth of data and information on the private health sector, the authors piece together evidences from small sample studies to arrive at a meaningful analysis. The study strives to understand these findings on the private sector work conditions along two axes—first, the work conditions within the public health sector, and second, the social background of these workers. A juxtaposition of the occupational hierarchy within health services along with the social hierarchy in terms of their religion, class, caste and gender of the workers, and the resultant dynamics of healthcare work in the private sector.

The sources of data for the essay are government reports, research publications, reports of civil society, e-newspapers, journals and periodicals. For newspaper reports and other published data, Google search engine, with specific search words like: "private sector staff India", "caste and class of health workers in private hospitals," "nurses in private hospitals", "dearth of staff in Hospitals", "nurses strikes in India", "harassment in hospitals", "caste background of nurses", "ward boys and cleaning staff", etc., were done. Search engines of few newspaper websites like the Times News Network, The Hindu, The Indian Express, The Hindustan Times were also used to locate older news clippings. The authors focussed on news articles published in the period post 2000. Further Digital library platforms offered by JSTOR and Google Scholar were used to derive research papers that engaged with facts and descriptions on work in the private sector. Apart from these two sources, Government of India Reports on Indian health workforce—like Census and NSS survey data was also utilised. WHO reports and papers were also consulted. Data collection from all these sources was conducted between 14 June 2021 and 31 January 2022.

Data and research on the private health sector in India has always been scanty. Not only is data not recorded, there is also a considerable effort from the private players to not share vital information about their services, protocols, processes, user charges,

number of service providers, etc. Accountability and monitoring mechanism by the government have been very weak. Efforts from private organisations and individual researchers to conduct studies and collect data from the private health sector are almost always met with considerable opposition and hindrance. As a consequence, very little information and data is available on private healthcare sector in India.

The studies on health workers in general are biased for the excessive representation of doctors and nurses. While studies on private sector employees are anyway very few, the existing work focuses primarily on doctors and nurses and does not pay adequate attention to allied staff that comprise technicians, physiotherapists, laboratory workers, pharmacists, nursing orderlies, cleaning and sanitation staff. The views and perceptions of these paramedics and ancillary workers are rarely recorded. Work on gender also omits another category of women workers consisting of helpers and ayahs. This comes as a serious drawback, as the authors found it very difficult to make an assessment on the caste and class background, and dynamics of working conditions of these health workers within the private sector.

The following paper discusses the dominant themes that emerged out of the literature review—namely a low density of qualified workers, the caste and class background of health personnel, low remuneration and forms of employment for different categories of health staff, feminisation of low paid work, sexual harassment at workplace, and weak unionisation of private sector employees.

Health Personnel in the Private Health Sector in India: Present Scenario and Concerns

Low Density of Qualified Health Workers

Authors Rao et al. (2016) quote data from a study using Census 2001 data which has estimated "the density per 10,000 population of all health workers as 20.1 (4.7 qualified), of allopathic doctors as ranging from 6.1 to 8.0 (2.6 qualified) and nurses and midwives as 6.1 (0.6 qualified)" (Anand S, Fan V. 2016 cited in Rao et al. 2016).[1] Comparing these figures with 2011-2012 NSS estimates, the authors found a density of 20.9 health workers per 10,000 population. The estimated densities by cadre were as follows: allopathic doctors as 5.8 (3.3 qualified); nurses and midwives as 7.6 (3.1 qualified); dentists as 0.4 (0.3 qualified); AYUSH practitioners as 1.3 (0.6 qualified); health associates[2] as 5.8 (1.8 qualified); and traditional practitioners as 0.1 (0.0

[1]Authors Sudhir Anand and Victoria Fan (2016) provide data on health care personnel from Census 2001 using 'density per lakh population'. Authors KD Rao, et al. (2016) convert the figures to 'density per 10,000 population in order to facilitate comparison with other studies.

[2]The category of workers - health assistants and associates are engaged in administrative, managerial and other support activities. Health associates and assistants directly support other health workers involved in service delivery. This group (0.81 million as of January 2016) included health assistants, sanitarians, dieticians and nutritionists, optometrists and opticians, dental assistants, physiotherapy associates, pharmacist assistants, and so on. A second group – other support staff (1.25 million) included clerks, cashiers, tellers, housekeeping and restaurant

qualified) (Rao et al., 2016). A more recent study using NSSO 68th round data (July 2011-June 2012) estimated the density as 29 health workers per 10000 population. With educational adjustments this figure reduced to 16 per 10000 populations (Karan et al., 2019).

In a 2021 published study, Karan et al. use data from National Health Workforce Account (NHWA) 2018 and Periodic Labour Force Survey 2017–2018 of the National Sample Survey Office (NSSO) to find that

> "stock density of doctor and nurses/midwives are 8.8 and 17.7, respectively, per 10,000 persons (all India). Adding the stock of dentists and traditional medicine practitioners to this gives a total stock density of 34.6 doctors per 10.000 persons for India. However, density of active workers (as estimated from the NSSO) of doctor and nurses/midwives (without adjusting for adequate qualification) is estimated to be 6.1 and 10.6, respectively. The density further drops to 5.0 and 6.0, respectively, after adjusting for the adequate qualifications. Total active worker density is estimated to be 26.5 and 16.7, respectively, before and after adjusting for qualifications." The authors also add that "the density of allopathic doctors and nurses who are active in labour market are as low as 6.1 and 10.6, respectively, per 10,000 persons (16.7 in total), which is well below the WHO threshold of 44.5 doctors, nurses and midwives per 10,000 population." (Karan A et al., 2021)

The health personnel data with its education adjustments highlighted the large presence of unqualified providers in India's health workforce. Overall, there are 1.4 million unqualified health workers in India, representing 56.4 per cent of the health workforce. By cadre, this meant: 42.3 per cent of allopathic doctors, 58.4 per cent of nurses and midwives, 27.5 per cent of dentists, 56.1 per cent of AYUSH practitioners, and 69.2 per cent of health associates did not possess the necessary qualifications. Further, the presence of unqualified health workers is higher in rural (71.2 per cent) compared to urban (48.8 per cent) areas.[3] The distribution of qualified health workers was also skewed towards urban areas; 77.4 per cent of all qualified workers were in urban areas, even though the urban population accounted for only 31 per cent of the total population (Rao et al., 2016).[4]

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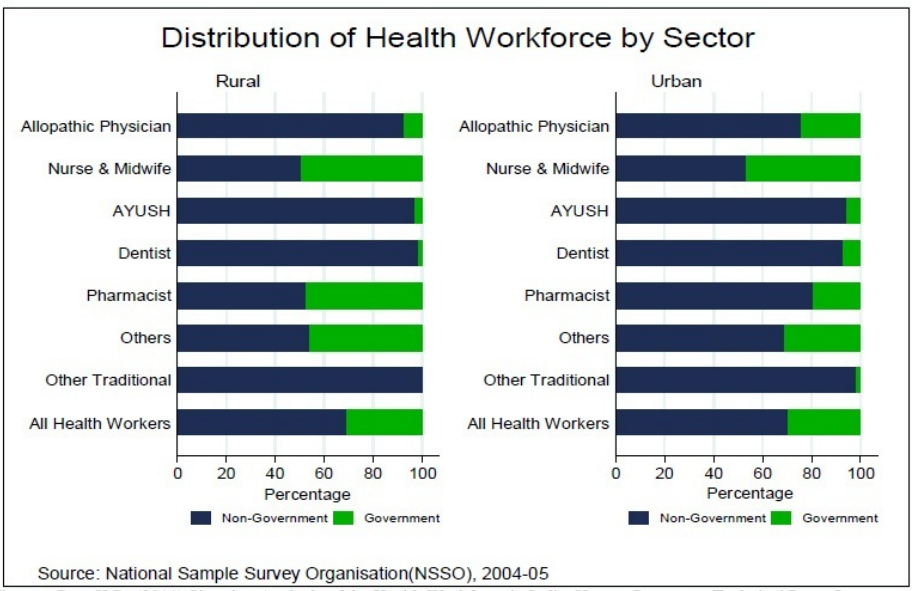
service workers, personal care, protective service staff, garbage collectors, other sanitation workers, and so on. These support staff perform crucial roles which are imbedded in the overall health service delivery.

[3]The weighted estimates for unqualified health workers in rural India were: 69.1 per cent of allopathic doctors, 68.2 per cent of nurses and midwives, 62.9 per cent of dentists, 74.3 per cent of AYUSH practitioners, and 75.8 per cent of health associates. Qualified female health workers constitute almost half of the qualified health workforce.

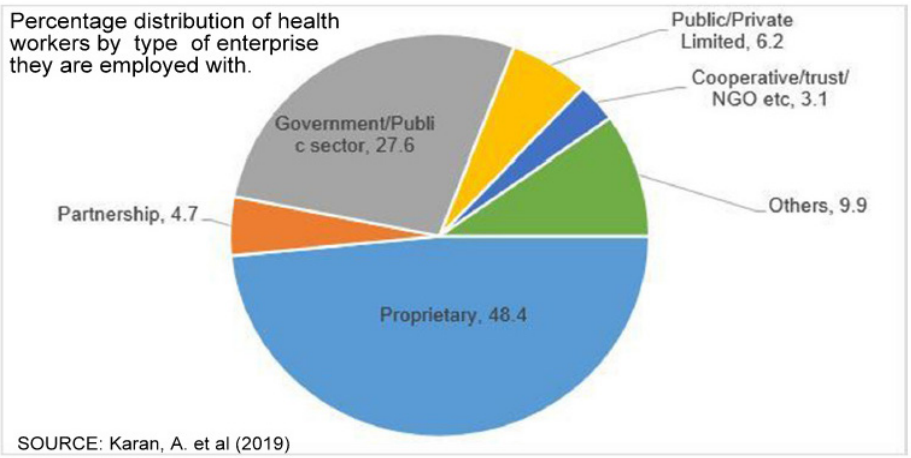
[4]The density of qualified health workers was 22.7 per 10,000 population in urban areas, as compared to 3.0 per 10,000 population in rural areas. The maldistribution was higher for allopathic doctors (density 11.4 times higher in urban areas), as compared to nurses and midwives (5.5 times higher in urban areas). Almost all the dentists were in urban areas.

While the above statistics are cumulative that includes the public and private sectors, available estimates show that the situation of private health sector is much worse. In both rural and urban areas, around 70 per cent of the health workers were privately employed in the nongovernment sector (rural, 67.0 per cent; urban, 74.0 per cent). More than 80 per cent of allopathic doctors in urban (87.1 per cent) and rural (83.5 per cent) areas were engaged in private employment. Similarly, more than 90 per cent of dentists (rural, 96.7 per cent; urban, 91.9 per cent) and AYUSH practitioners (rural, 95.5 per cent; urban, 93.9 per cent), and around 70 per cent of health associates in both rural (68.3 per cent) and urban (75.5 per cent) areas were working in the nongovernment sector. However, among nurses and midwives, 48.8 per cent of those in rural and 59.8 per cent of those in urban areas were privately engaged (Rao et al., 2016).



Source: Rao, K.D. (2011) Situation Analysis of the Health Workforce in India. Human Resources Technical Paper I. Public Health Foundation of India. New Delhi

In both rural and urban areas, around 70 per cent of the health workers were privately employed in the nongovernment sector (rural 67.0 per cent; urban 74.0 per cent) (Rao et al., 2016). Occupation-wise, the proportion of doctors employed in the private sector is far higher compared with nurse and midwife and other health workers. For AYUSH and dental practitioners, their share in the public sector is less than 10 per cent. However, approximately 45 per cent of trained nurses and midwives are employed in public sector institutions (Karan et al., 2019). The authors further elaborate on distribution of all health workers by types of institutions and find more than half (53 per cent) of workers are self-employed in sole proprietorship or partnership entity; and only 6 per cent in big corporate companies with public or private limited status (See chart) (Karan et al., 2019).



The macro analysis of big data sets does not provide insights into the structure, dynamics and the social composition of health workers in the private sector. The essay draws on small studies on the private sector to get a better understanding of the conditions of workers.

A study of private hospitals in Chennai highlighted the poor adherence to norms—both in terms of infrastructure and staff composition. The study pointed to a dearth of staff at all levels of the work hierarchy. It also highlighted the strong dependence of private hospitals on government doctors with a significant percentage of the latter acting as consultants in the former (Muraleedharan, 1999). An earlier study of private nursing homes in Hyderabad also showed the inter relationship between the public and private sector with a large proportion of government doctors acting as consultants in small and medium nursing homes. This resulted in diversion of patients from the public to private sector who had to pay for care (Baru, 1998). A study of 24 private hospitals in Mumbai (Nandraj, 1994) found that majority of hospitals employed unqualified staff. Only one had a postgraduate doctor, while ten hospitals had doctors trained in other systems of medicine (as quoted in Baru, 2004). Employing unqualified staff compromised the quality of care being provided in these hospitals. One would agree with Rao et al. (2016) who points to the dilemma of the complexity of dealing with unqualified providers. On the one hand they provide health care to populations that do not have access to qualified providers, while on the other hand, their lack of proper training becomes a source of concern.

Hierarchy in the Health Workforce in the Public and Private Sectors: Religion, Class, Caste and Gender

The available studies on the social characteristics of the workforce in health care are few and tend to provide a fragmented insight in both the public and private sectors. Analysing the World Health Survey (2003) by WHO and IIPS (2006) on Health Systems Performance Assessment, Duggal (2014) points out that while there is

some information on the class background of the households of physician, it does not provide information on religion or caste. The analysis of this data shows that the bottom or lowest three quintiles did not have a single physician whereas the top quintile accounted for 83 per cent of all physicians. When it comes to nurses, 61 per cent belonged to the top two quintiles while the bottom two quintiles had only 19 per cent. A higher proportion of the support health staff (37 per cent) belonged to the bottom quintile as compared to the physicians and nurses.

Duggal (2014) further examines 2001 census data for the caste background of health professionals, and finds that, "for physicians the variances from the proportion in the population for each social group is highly negatively skewed for the SCs and STs, the deficits being between 50 and 80 percent, but for the "Others" group it is in excess between 10 to 15 percent. Going down the hierarchy to nurses and paramedics the variances become narrower and one sees a few excess ratios for SC and ST, notably for the category of sanitarians and nursing/midwifery. For the ST, the nursing and midwifery categories surprisingly show a huge excess of over 100 percent. The author asserts that despite affirmative action policies the SC and ST have been unable to break the glass ceiling of the upper caste control over the health professions, especially physicians of all types." (Duggal, 2014).

Sobin George's study found that with the exception of associate professionals of nursing, midwifery and ASHAs, the share of Dalits among the hierarchy of work in the health sector is far below compared to other social groups. It is under-represented as a proportion to their total population in both rural and urban India. The health worker population ratio across social groups shows that only middle and upper caste has adequate and in some cases over representation among all health related professionals. These include general medical practitioners, specialists' doctors, trained nurses, technicians and associated health staff. While the upper and middle castes constitute a little less than 24 per cent of the population in rural India, their share is 40 per cent in the occupational category of health professionals, 70 per cent in nursing professionals, 34 per cent in health associate professionals and 26 per cent in nursing and midwifery associate professional (George, 2015).

The other side of the story is the underrepresentation of certain social groups, especially SCs and STs. While STs and SCs have a population share of 11 and 21 per cent respectively in rural India, their corresponding shares in the category of health professional are 1.3 and 16.5 per cent respectively. In rural India, the under representation of SCs is found to be the highest in the nursing profession. Urban India also follows a similar trend of under representation of STs in all categories. For SCs it was most pronounced in the category of general and specialist doctors in urban areas. While the population share of SCs in urban India stands at a little less than 15 per cent, their share in the category of general and specialist doctors is only 5.5 per cent (George, 2015). In short, the data indicates that there is visible

over representation of middle and upper caste groups and under representation of lower castes and scheduled tribes across the work hierarchy of care providers such as doctors and nurses. The all India averages mask interstate variations in terms of social composition of the health workforce.

A study on earnings of nurses in Gujarat provided some trends on the class background of nurses. "On an index of assets owned by their households, 26 per cent of nurses working in private hospitals fell in the lowest quintile of asset ownership, compared to 10 per cent of permanent public sector nurses and 22 per cent of temporary public sector nurses" (Seth, 2017). Her study also showed that nurses who were able to secure a permanent government job had a very low percentage of SC and ST nurses in comparison to the private sector. "A wide range of earnings reported by similarly qualified and practiced nurses in this study suggests the presence of multiple labour markets for nurses in India." (Seth, 2017).

While caste disaggregated data for other paramedics like technicians, nursing orderlies, pharmacists, ambulance drivers, etc., is very scanty, however, the above analysis shows how the health sector hierarchy mirrors the hierarchy in the social system, and there is a clear gradient in the entitlements and emoluments accessible to people from different castes and classes. The doctors belong to the upper and middle castes. Among the middle and lower rungs of the hierarchy consisting of nurses, paramedics and technicians is mostly dominated by middle castes in the public sector. However, one section of workers—whether in public or private sector is exclusively from the lower castes and marginalised groups, namely cleaning and sanitation work. A study by Society for Labour and Development with Delhi's public health service employees noted "the dominance of upper castes among the physicians, while the lower castes were concentrated among occupations such as ward boys, sweepers, security personnel, *chowkidars*" (SLD, 2015).

Understanding the religious composition of healthcare workers is another challenge as data on this aspect is non-existent. Studies by Oomen (1978) and Madan (1980) on the public sector in health found that doctors were mainly upper caste Hindus. Minorities like Muslims and Christians were very few among the doctors (as quoted in Baru, 2005). A study of the private healthcare sector in Hyderabad (1998), where there is a considerable proportion of Muslims, did not find any significant representation among doctors. Majority of doctors were upper caste Hindus (Baru, 1998). This was broadly in concurrence with the status of employment of Muslims in the economy and social sectors. The Sachar committee report 2006 showed an acute exclusion of Muslims from the formal economy. Using NSS 61st round data, the percentage of regular salaried or wage non-agricultural workers employed within government and large private sector for Muslims was lower than all other Socio Religious Categories, even lower than SCs/STs and OBCs among Hindus.

Table 1: Percentage of Regular Salaried/Wage Non-Agricultural Workers in each SRC Employed in Govemment/Public & Large Private Sectors: 2004-05

SRCs		All		Male		Female		Urban		Rural	
		Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd
All		34.2	13.1	34	13.8	35.1	10.2	31.5	14.6	39.2	10.5
Hindus	All Hindus	35.3	13.9	35.3	14.6	35.2	10.7	32.8	15.3	39.5	11.4
	SCs/STs	39.4	9.5	41.3	9.4	32.4	9.9	36.7	8.7	42.9	10.5
	OBCs	30.4	12.8	30.4	13.1	30.0	11.4	27.3	14.0	34.6	11.1
	UC	37.4	17.1	36.4	18.6	41.7	10.6	35.2	18.8	43.2	12.5
Muslims		23.7	6.5	23.0	6.5	29.4	6.8	19.4	7.4	33.3	4.8
Other Minorities		35.8	12.8	35.1	14.8	37.6	8.0	32.0	16.5	41.8	7.1

Source: NSS 61st round, Schedule 10

While their representation within the health sector workforce is not analysed, statistics on composition of occupational groups showed the domination of Hindus, followed by Muslims and then other Minorities for the category of 'Physicians and surgeons' in both urban areas and rural areas. However for the category 'Nursing and Other Technicians', the proportion of Muslims was far lower than other Minorities. This implies that the participation of Muslims in healthcare workforce fares worse than SCs, STs, OBCs and other Minority groups.

Table 2: Percentage Distribution of All (Principal & Subsidiary) Workers by TWo Digit Occupational Groups for Each SRCs, 2004-05

Occupational Group	All	Hindus				Muslims	Other Minorities
		All Hindus	SCs/ STs	OBCs	UC		
Urban Workers							
Physicians & Surgeons, (Allopathic, Dental & Veterinary Surgeons)	0.6	0.7	0.3	0.4	1.1	0.5	0.4
Nursing & Other Medical & Health Technicians	0.8	0.7	0.8	0.5	0.7	0.6	2.5
Rural Workers							
Physicians & Surgeons, (Allopathic, Dental & Veterinary Surgeons)	0.2	0.1	0.1	0.1	0.3	0.2	0.2
Nursing & Other Medical & Health Technicians	0.2	0.2	0.1	0.2	0.3	0.1	0.3

The representation of Christians in the healthcare workforce is also very limited. Christians formed the bulk of nurses in early years, when both Hindu and Muslim women did not enter the profession. However, the remuneration of these nurses was very low, and they belonged to the lower socio economic strata (Baru, 2005). The author notes "they were predominantly Christian and were motivated by the need to serve humanity. The proportion of Muslims, SCs and STs among nurses was indeed very small" (Baru, 2005). However in recent years, with better remuneration, the participation of Hindu women has increased. Lower caste Hindu women were always dominant among untrained caregivers. Using data from Enterprise Survey 1996, Baru notes that "females belonging to Scheduled Caste category dominate the individually owned enterprises in health in rural areas. These largely included trained and untrained workers like dais who are traditional birth attendants and other healers." (Baru, 2005).

Among ANMs, Iyer et al. (1995) note that two-thirds belonged to upper and middle class Hindus, while SC and STs constituted only one-fifth of workers. A very small proportion comes from Muslims and Christians (as quoted in Baru, 2005).

For other categories of workers, religion-based disaggregated data is unavailable. Yet, the above trends affirm that Hindus dominate the profession of doctors, nurses

and technical staff. Christians show a better representation among nurses but little among doctors, technical staff, and other paramedic workers. The Muslims have a very low presence among all categories of health workers, and data on private sector employees—who are temporary and untrained remains unavailable to analyse.

Underpaid and Overworked

The remuneration paid by the private health sector has no benchmarks or predefined standards. Different organisations pay different scales to the workers, which are very low in comparison to the scales paid by the public sector. The women in particular face discrimination and disadvantages in wage, due to hierarchical structures and gender stereotypes that shape occupational segregation (WHO, 2019).

Patil et al. (2012) study on working conditions in public and private hospitals of Satara city found significant disadvantages for the private sector workers. Data on salary drawn by public and private sector employees showed that for all categories of workers, the average salary drawn by private hospital employees was 4.56 times lower than average salary drawn by government hospital employees. While government employees were entitled to casual leave, sick leave, paid and maternity leave, none of these were available to the private sector employees. Provident fund, gratuity and family pension were benefits only accruing to government sector employees, and private sector had no such social security provisions.

A study of nurses in Gujarat reported that 49 per cent of nurses working in private hospitals and as temporary employees in public facilities—belong to the Scheduled Castes and Scheduled Tribes, and were estimated to earn 9 per cent less than similarly qualified and practiced nurses from general caste categories. Further 18 per cent of nurses working in private hospitals did not have formal nursing qualifications. And last, nurses working in private hospitals and as temporary employees in public facilities earned less than the minimum wage stipulated by the Government of India.

The same study also finds that "permanent public sector nurses were estimated to earn 105 percent more than private sector nurses with the same qualifications, years of work and caste background." (Seth, 2017) These findings resonate with the general trend of exploitation of workers within the private sector across the hierarchy, the lowest rungs suffering the most. Understaffing has direct implications on workload, and this coupled with being underpaid manifests in extreme exploitation of workers, especially within small hospitals and polyclinics. The corporate and bigger private hospitals still adhere to the minimum standards laid by WHO owing to better accountability from the government, and remuneration standards are much better. However, they represent a miniscule proportion of the private sector.

In 2010, nurses from top private hospitals in Delhi held protest strikes against their employer and the Government. This was against significant wage differentials in the public and private sector. "While the salary offered to a fresh nurse in a public sector hospital before the implementation of the Sixth Pay Commission recommendations was in the basic scale of ₹ 5,500, the total salary of a nurse in a private hospital

who has completed the general nursing-midwifery degree[5] (which takes 3 and half years after 10+2 years of schooling) ranges anywhere from ₹ 2,500 to ₹ 6,000. The difference is all the more glaring after the implementation of the Sixth Pay Commission recommendations in public sector hospitals, and has triggered the current wave of strikes" (Nair, 2010).

The for-profit private sector uses the strategy of paying lower incomes to staff in order to increase profits. In pursuit, practices like understaffing, replacing trained and qualified nurses with under-qualified personnel is common. Sreelekha Nair (2010) observes that many small private hospitals pay nurses less than the minimum wage and flout regulations regarding employment benefits and leave packages. Nurses are being replaced by nursing aides, auxiliary nurses and untrained assistants, who can be paid just ₹ 1,000 to ₹ 1,500 and are made to perform nursing duties including giving injections for which they are not trained. The working conditions for nurses can also be very challenging with adverse nurse-patient ratios of 1:30 to 1:50 in the private sector. Facilities like restrooms and changing rooms are also not provided in most private settings.

A nurse activist observes that "most of India's nurses work in private hospitals, which are largely unregulated and do not follow the norm of having nurse-patient ratios of one to every four. Nurses work 9 to 14-hour days, often doing double shifts. Many nurses are required to sign contractual bonds with their employers withholding their educational certificates as guarantee" (Mahindrakar, 2016). Withholding of certificates is a common practise in private hospitals to prevent the trained and qualified nurses from leaving the job, and treat them like bonded labour. Biju explains this practise often stems out of desperation to earn soon as many nursing students take loans to complete their education. With a decline in opportunities in the public sector, private hospitals have cashed in on the opportunity to adopt exploitative practices. They often ask candidates to execute service bonds and deposit ₹ 25000 – ₹ 75000 at the time of joining service. The management also impounds original certificates to prevent inter-firm migration. Often they are paid only part salaries which also is also given irregularly (Biju, 2013).

Thus, most nurses in the private sector have to contend with lower wage rates and a lack of job security. They are commonly employed on temporary contracts, which are renewed every time the contract expires. Such mechanisms allow the private hospitals to push these specialised and trained workers into the non-formal economy, devoid of rightful incomes and upward mobility. Legislative attempts to standardize private medical care have also been opposed by many states and powerful professional bodies, such as the Indian Medical Association. For instance, the Clinical Establishment Act of 2010—which prescribes minimum standards for services to be provided by a variety

[5]General Nursing and Midwifery (GNM) and Bachelor of Science in Nursing (BSN) are the two main nurse training programs in India, and their graduates are generally employed as A-grade staff nurses in hospitals. Auxiliary Nursing and Midwifery (ANM) is a shorter, 2-year certificate course whose graduates assist A-grade nurses in hospitals or work in public primary health facilities.

of clinical establishments and requires private clinical establishments to register with the state, maintain records of the care they provide and display rates of the services they offer—has only been adopted by few states (Seth, 2017). These practices are not restricted to small and medium nursing homes but it is also seen in the corporate hospitals across states.

Corporatisation and privatisation of healthcare has led to further exploitation of nurses and nursing ancillary staff. With international immigration, there has been a supply crunch in nursing labour. The scarcity of registered nurses, instead of valorising nursing labour, has led to an increase in the hiring of unregistered nurses, nursing aides and attendants. Whether it is the public or the private sector, there is a growing reliance on a pool of semi- or untrained labour that represents the most informal and casual end of the workforce. The nursing labour market is a pyramidal market with the bottom over-represented by female casual employees struggling with low wages and status, stigma, and no labour rights (Ray, 2020).

The condition of other workers like technicians, paramedics, cleaning and sanitation staff, ambulance drivers, among others is no better. They are hired as temporary workers, and paid a very low remuneration, irrespective of whether qualified and experienced. But more glaring are the consequences of understaffing, owing to which most of these staff are multi-tasking, and fulfilling any roles where a need is felt—whether or not they are trained. A newspaper report on shortage of paramedics revealed that a sanitation worker would bandage patients, plaster casts and even worked in the laboratory, besides his own cleaning work.

"It is not part of my duty, but a cleaner's work is not hectic. And there is a major shortage of paramedic staff, particularly at nights, so we help the doctors and laboratory staffs," he says (Singh, 15 January 2014).

The union of paramedics claim that although official data is missing, but approximately 70 per cent paramedics in the country are not trained for the jobs they do (Singh, 15 January 2014). "Such cases of multitasking by paramedics is a very common sight, and untrained workers are doing paramedics' work in most government and private hospitals in the country, in the words of union activists."[6] A survey by Health Ministry's National Initiative for Allied Health Sciences and the Public Health Foundation of India in December 2012 also highlighted the acute shortage of qualified paramedic staff in the country. Health activists and doctors blame the lack of a comprehensive Central legislation to monitor paramedics for the present situation. "They say in the absence of a Central law, there are no standard minimum qualifications for the appointment of paramedics such as nursing assistants, laboratory assistants, compounders, X-ray assistants, etc. To make matters worse, only five states have set up paramedic councils for drafting standards for education in the sector. Few among these are also very nascent. In such a scenario, it is left to health centres and laboratories to appoint paramedics and decide their qualifications." (Singh, 15 January 2014).

[6]Kaptan Singh Sehrawat, the then general secretary of the Joint Forum of Medical Technologists of India (JFMTI), an umbrella body of paramedics in the country, as quoted by Jyotsna Singh in 'Down to Earth' (2014)

But health activists also warn of the negatives of having a pool of qualified paramedics, because despite being qualified, it might not result in private hospitals and labs recruiting them. Singh's study quotes a union leader as saying: "What will the degree holders do if there are no takers? Those who are unskilled or less skilled are ready to work at a much lower wage, while the skilled demand more money. Recruiters, especially private bodies, do not care about skills" (Singh, 15 January 2014). Thus, it leads to greater frustration among the graduates and they are trapped in the cycle of exploitation and low remuneration. Owing to the significant outreach of the private sector, it has also led to mushrooming of ill-equipped private institutes across the country often on false promises of government jobs. This is also the case with nursing institutes and pharma courses. Non accredited institutes offer degrees which are not recognised, and their graduates are ineligible for work within any big hospital. They thus get employed at very low salaries by smaller hospitals and clinics, and with exploitative conditions. Regulating private institutes is also now an imminent challenge, but union activists say: "Steps to strengthen the education system will not help unless there are rules to govern recruitment." (Singh, 15 January 2014).

Similar ethos was seen in a study on motivational level of physiotherapists in four cities of north India. The two dimensions which had the highest scores were salary and job security. Two other interesting findings were greater satisfaction levels among male workers compared to women, and among higher qualified physiotherapists in comparison to others (Gupta et al., 2013). The study however failed to give any explanations for these differences, and comparison between public and private sector employees, despite having collected responses from both settings. The Pharmacist is another crucial worker in the health system who dispenses medicines, however this task is mostly done by a supporting person who is less qualified. Sabde's study on Private Pharmacies in state of Madhya Pradesh revealed interesting facts—one, only 12 per cent pharmacists had the minimum formal qualification; and two, 88 per cent of these qualified persons worked in urban areas. Sabde warns that poor education of dispensing pharmacists has been identified as a leading cause of irrational use of antibiotics. The prevalent perspective about pharmacists is never as health professionals, rather as traders (Sabde, 2011).

The situation of cleaning and sanitation workers, the nursing orderlies, and ambulance drivers (also referred as ancillary workers) are quite similar across both private and public sector owing to outsourcing. Even if the site of work is a public facility, the workers from these categories are supplied by a private contractor. This implies, almost all workers in these professions are engaged in the private economy. A report by Workers Solidarity (2000) on the private hospitals in Delhi noted the trend of hiring contract workers initiated by new private sector hospitals. The report also cautioned how the practise was also being emulated by older private hospitals, which until had offered permanent employment to Grade 4, namely, sweepers and security guards. The report noted that contracted staff were overworked—to the extent of doing 5 consecutive shifts owing to shortage of staff, poor salaries, constant job insecurity and no provisions for lunch time. The report also noted how contracted workers were fired

since they had complained to the Labour Commissioner. The contractors were reported to change the posting of these employees in order to prevent them from collectivising and forming unions (Worker Solidarity, 2000). A study on outsourcing within a tertiary public hospital in Kolkata, West Bengal showed the flouting of minimum wages by the contracting agency when remunerating cleanliness staff. The interviews also exposed delayed remuneration to these workers, and a denial of protective gear from infections owing to exposure of hospital waste (Roy, 2010).

Sexual Harassment and Feminisation of Work

The nurses form the largest category of hospital employees. Approximately 70 per cent of nurses, midwives and community health workers are female; the share of female doctors is much lower than a third. Female doctors comprise only 17 per cent of the doctors in the country (Rao, 2014). A WHO report records the adverse occupational gendering in healthcare: across countries, most physicians, dentists and pharmacists are men, while women are overrepresented in the ranks of nurses and midwives. The same report records that women health workers earn on an average 28 per cent less than men (Ray, 2020). The health sector is a highly gendered space, where women historically have been relegated to a secondary status. The realm of doctors, which is dominated by men, is seen as the 'cure' part, while nursing which is dominated by women, is seen as the 'care' aspect of healthcare practise. The task of nursing is usually seen as more caring than curing, an extension of stereotypical feminine qualities (Ray, 2020). Gender bias in healthcare is seen with respect to specialities like cardiology and surgery viewed as male bastions, while gynaecology and microbiology are regarded as more women-friendly. The private sector is mainly dominated by male doctors-turned-entrepreneurs. A study of private nursing homes in Hyderabad revealed that the medium and small nursing homes are promoted by spouses who are doctors. Here, again it is the husband who is the main owner while the wife occupies a secondary position in the partnership. The private and public limited enterprises are mostly promoted by male entrepreneurs. It is in only in family promoted enterprises where there are no male heirs, that daughters are allowed to manage the company as seen in the case of Apollo Hospital promoted by Dr Pratap Reddy.

The nursing profession on the other hand is dominated by women. The division between curing and caring is clearly gendered. The feminisation of the health workforce begins with the nurses and is seen in the lower rungs of the work hierarchy in both public and private hospitals. This hierarchical opposition reinforces a nurse's secondary role within health institutions. The secondary role is further reflected in the gendered wage gap and adverse working conditions. Stereotypes of nursing as natural female, caste norms and various stigma reinforce the low valuation of care work (Wichterich, 2020).

The historical and sociological literature suggests that the low wages nurses are paid in India might be a reflection of their low status in the health system and society. Studies conducted in other countries, such as Mexico, Bangladesh and the US, also document the prevalence of negative gender and class-based dynamics in the work

environment of nurses (Seth, 2017). Shelby Garner, et al. (2014) explain how historical religious and cultural factors have shaped the attitudes about nursing among society in India thus contributing to the limited nursing workforce capacity. The work of women outside of the home that involved touching strangers and exposing them to potentially infectious materials was viewed as "polluting within Hindu and Muslim Cosmology". As a consequence, nursing was relegated as a low caste position, and early nurses in India saw a predominance of Christian women.

Studies on the rise of nursing profession in India note that a shortage in the number of trained nurses was on account of a highly negative and sexualised image of the nurse. "In the beginning, a nurse was considered a prostitute or an assistant of a doctor in a clinic or a small hospital, expected to perform non-nursing duties, work that was menial and intensive physical work, including night duties, within unsatisfactory and crowded living conditions making it highly unattractive…low standards of education among those who went for a nursing job made it unattractive in the eyes of the educated. These notions culminated into a relatively low status of nurses in the health care hierarchy and the visible dominance and even harassment by power-wielding male doctors that have engendered a social stereotype of women who work as nurses" (Abraham, 2004). These stereotypes get reflected in workspace as well. Studies have shown that a high percentage of nurses in India are women who face sexual harassment and lack of physical safety as a part of the poor working conditions that they face (Seth, 2017).

Chaudhuri's study (2007) found sexual harassment routinised in the everyday lives of the women health workers, especially nurses. The women who had experienced harassment were reluctant to complain, fearing loss of jobs or being stigmatised, and most were not aware of formal channels for redress. The perpetrators could be anyone in the hospital—fellow male doctors, persons in administration, and even patients and their relatives. The author analysed such violence embedded in patriarchal gender inequities, which even superseded other power relationships, e.g. in the case of male patients or administrative staff harassing nurses, young male doctors harassing their female colleagues or non-medical staff such as stewards, sweepers, peons and ward boys harassing their female peers.

The study also highlighted that very few cases of sexual harassment were actually reported. Victims were scared to confront the system, since social norms inadvertently placed the blame on the victims. Further, recognition of power dynamics and the implications in terms of job security, loss of reputation and risk of dismissal also suppressed the women from seeking justice. This exposes the power imbalance even in spaces where numerically women are higher, and shoulder a significant responsibility. Respondents were well aware that if the perpetrator was a person in authority, action was unlikely to be taken against him. Many reported fear of dismissal, loss of income, blocking of promotion and victimisation in work assignments (for example, inconvenient duty hours). These fears are greatly magnified if the women worker is on temporary post or working on contract, unfortunately the norm in private sector.

Basu (2020) writes about the extreme exploitation of *aya*s—another category of care providers whose numbers have increased more than the nurses, however their remuneration and emoluments continue to be very low and exploitative. The study based on private health sector in Siliguri, West Bengal notes the transformation of nursing homes to limited companies owing to mergers and acquisitions by corporate giants, however, labour relations continuing to be informal especially for care workers who remain semi or unskilled. The remuneration paid to *aya*s was found to be determined by multiple stakeholders like the hospital management which fixed the wage rate, however, the amount was paid by the patients' families. The daily wage rate ranged between ₹ 150 to ₹ 170, with the exception of a super speciality hospitals where they received a monthly salary of ₹ 3200 (Basu, 2020).

Recent strikes and protests have been the only channel through which some benefits have accrued to these strata of workers. While unionisation of these workers was long non-existent. the nurses were earliest to collectivise, paramedics and outsourced staff have more nascent unions. Biju explains—as nursing services have been commercialised over the past two decades, thousands of nursing institutes emerged between 2002 and 2005, especially in the southern states. Many young nurses formed associations such as the Indian Professional Nurses Association, Delhi Private Nurses Association, and the United Nurses Association to demand better working conditions. In May 2015, there was attempt to unite all nursing associations of India (Biju, 2013). The unionisation of nurses in Kerala's private sector, and their subsequent success in increasing wages forced corporate hospitals in Delhi, Hyderabad and Chennai to announce new pay packages, in order to prevent the exodus of nurses back to Kerala. However union activities are never given space in the private sector, and many times workers had to face the brunt of organising protests. In December 2009, staff nurses of the Batra Hospital in New Delhi went on strike demanding basic facilities and minimum basic salary of between ₹ 10,000 and ₹ 15,000. They succeeded in getting the salary hike but those nurses at the forefront were fired on disciplinary grounds. In the public sector, nurses protesting working conditions are sometimes sent to difficult locations or may be refused leave (Mahindrakar, 2016).

A study of Delhi private hospitals showed that only 30 per cent of their expenditure was on salaries, while in public hospitals, it was close to 80 per cent. Even the meagre 30 per cent mainly goes to the consultants who have higher salaries in the private sector. The proportion of wages paid to consultants has shot up over the years, due to which adequate pay scales due to paramedic and support staff is not paid. And consequently much of the class 4 has been contracted out (Baru, 2004).

Conclusion

Drawing on a variety of research articles and primary work on the private sector, this essay has shown the complex intersection between the social and work hierarchy in secondary and tertiary health service institutions. The available studies on social background of health workers in public and private hospitals are few and mostly in

urban areas. While there is a recognition of the gender division in the hierarchy of work, there is little focus on religion, caste and class. Religious backgrounds are not foregrounded adequately especially with respect to representation of minorities. It is quite clear that majority of owners in the private sector are Hindus belonging to the upper and middle castes and male. However the nursing, paramedical and support staff constitute diversity in terms of religion, caste and class. The over representation of marginalised groups in these categories is higher in the private sector as compared to the public sector. This is largely due to the hiring of personnel who are semi or unqualified by the private sector as a means to save labour costs with exploitative terms of work. Poor wages, long hours of work, lack of secure employment, leave and pension benefits are glaring for the lower levels in the work hierarchy in the private sector. These practices amount to extractivism as discussed by Wichterich (2020). As she opines: "The notion of extractivism marks the intensified commodification and exploitation of the resource labour in social reproduction for the purpose of managing crises situations without burdening the state or the health industry with additional costs and responsibilities. It is a mode of accumulation in markets of social reproduction and health. While the deflated term exploitation highlights the offender–victim relationship, the concept of extractivism stresses the structural power relation in the political economy." (Wichterich, 2020). The term aptly defines the case with much of the private health sector in India that thrives on the vulnerability inflicting the majority of labour force, in addition to the nurses. Workers from lower caste and class background, who are often not adequately qualified, bear the brunt as they are deemed unfit for well remunerative jobs. Formal jobs in professions of paramedics (barring some nurses and few technician roles) are fast converting into contracted and non formal jobs, where an outsourcing partner hires the workers on temporary terms. The exploitation is higher is smaller cities and rural areas, where no alternatives for employment exist. This exploitative system thrives on non interference by the government agencies, particularly the health ministry, which should ideally be setting standards of workplace compliance and remuneration standards in accordance with qualifications. Far from any accountability and compliance system, the government has also adopted contracting in of health workers thereby displacing recruitment of permanent ones.

The Covid-19 pandemic has brought considerable focus on the further exploitation of health workers in both the public and private sectors. The role of the unions has been very prominent in speaking against the oppression within the system. There have been numerous attempts by nursing unions, unions of ambulance drivers, and paramedics to pressurize the governments in enforcing workers' rights for minimum wages, better working conditions and social security from the contracting agencies. The response from the government has been weak and half-hearted. Despite the Covid-19 pandemic the government's stance to improve working conditions and wages of the health workforce is wanting. A news article published in April 2021

reported that "private ambulance network StanPlus was reported to be handling ten times more volumes of work since the preceding month of March 2021 and could find only one trained personnel for every four open paramedic positions, and was hiring paramedics staff at almost 50 per cent pay hike." This demand surge came from more Covid care centres being commissioned and Home ICU setups being offered. (TNN, 30 April 2021)

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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

[1]Dalit 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

[2]The 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.

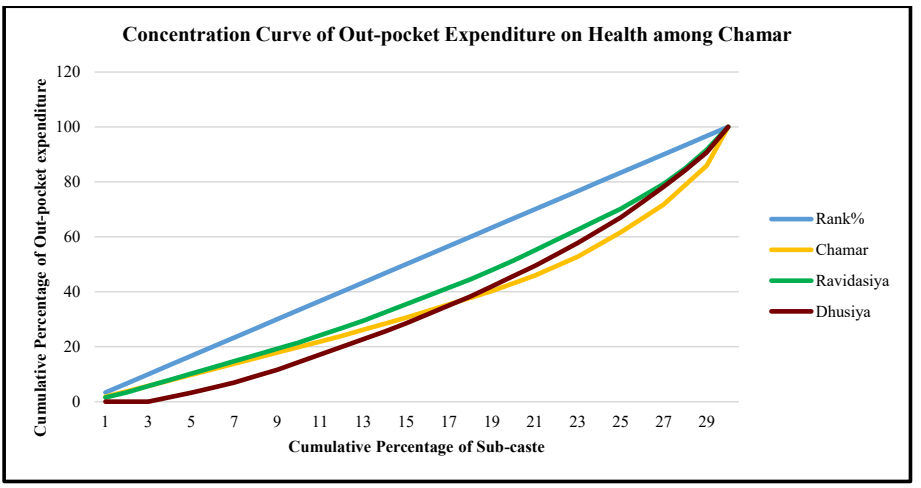

Figure 1: Out of pocket expenditure on health among Chamars

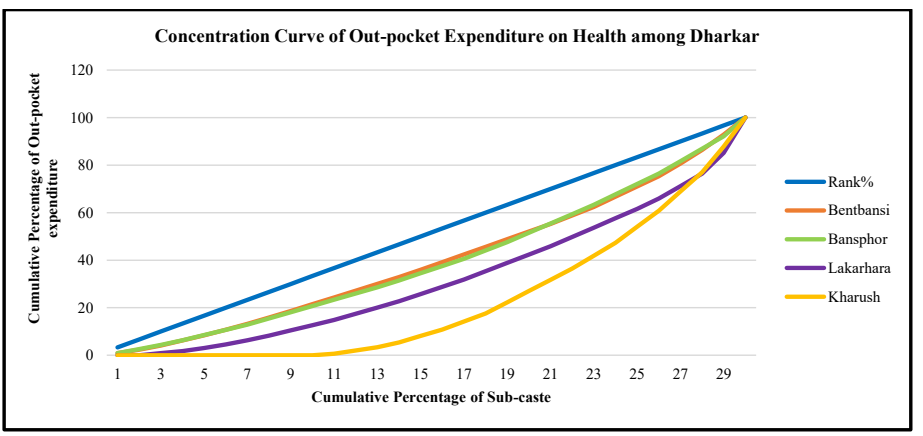

Figure 2: Out of pocket expenditure on health among Dharkars

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.

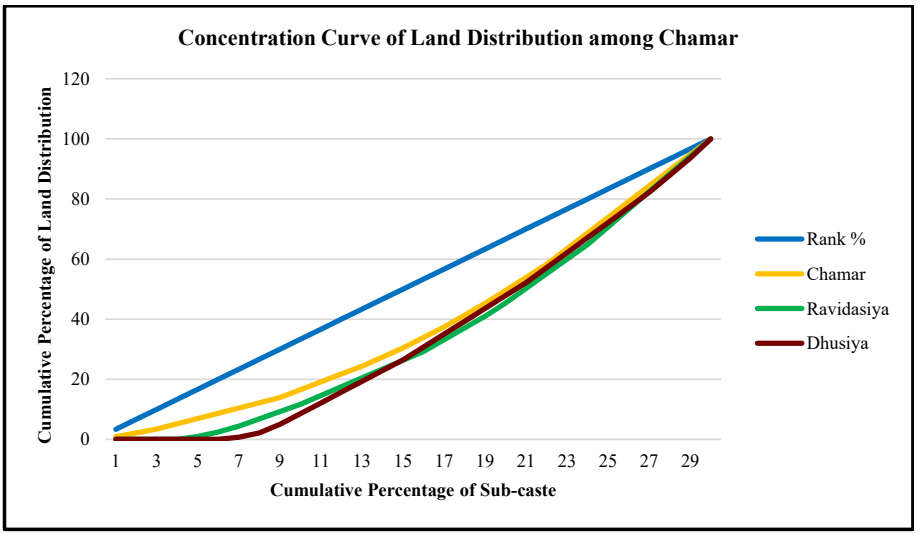

Figure 3: Land Distribution and Sub-caste level differences among Chamars

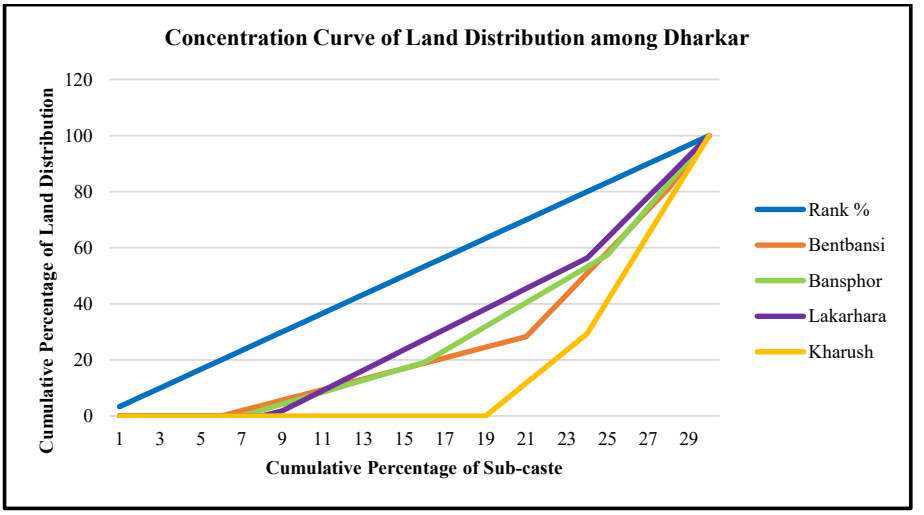

Figure 4: Land Distribution and Sub-caste level differences among Dharkars

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.

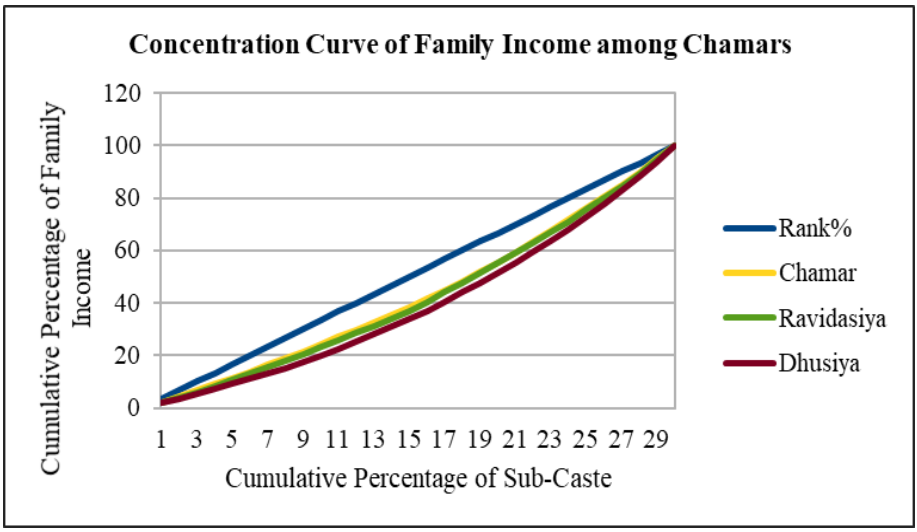

Figure 5: Concentration curve of HH Income of Chamar caste

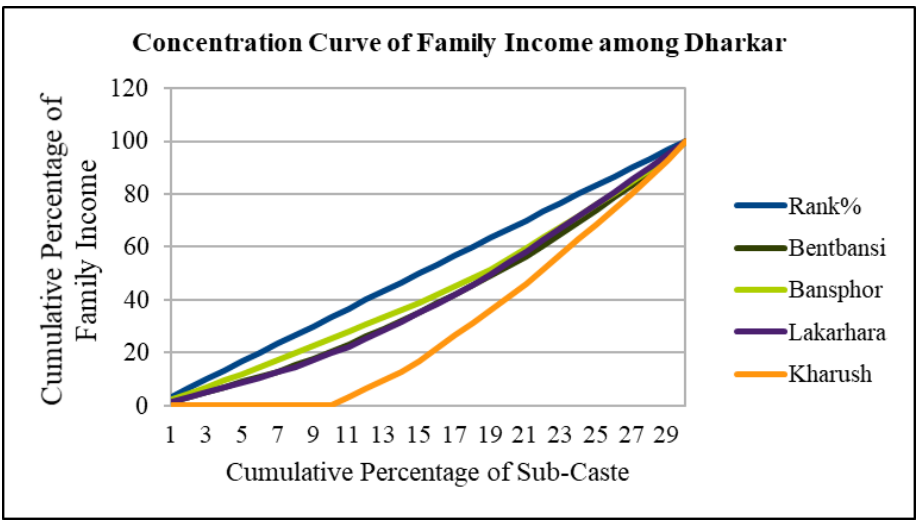

Figure 6: Concentration curve of HH Income of Dharkar caste

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 inqualities 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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Appearing in Court in India: Challenges in Representing the Marginalised

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Abstract

This article reflects on the challenges faced in the process of improving access to justice and representation of the marginalized communities in the legal system. The author has drawn reflections from his own career as a human rights lawyer. Explaining this, the author first highlights the barriers faced by marginalized communities in the legal system, and then narrates the challenges faced by those who seek to represent the marginalised or espouse their causes. The emphasis of the article is on understanding what it means to be a marginalised person facing the barriers of the system. Lastly, the article suggests institutional measures to approach the challenges thrown up in the process of representing the marginalised.

Keywords

Access to justice, representation, Ambedkar, marginalized, legal profession

Background

This article is an edited version of the lecture delivered by Dr. Justice Muralidhar (Chief Justice, High Court of Orissa) on 14 April 2022 as a part of CEDE's[1] Second

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[1]CEDE is a network of lawyers, law firms, judges, and other organisations and individuals, who are committed towards reforming the Indian legal profession. It was founded in April 2021 by Disha Wadekar (Lawyer, Supreme Court of India), Anurag Bhaskar (Assistant Professor, O.P. Jindal Global University, India), and Avinash Mathews (Lawyer, Supreme Court of India). Since its inception, CEDE has been organising annual Dr Ambedkar Memorial Lectures. The first inaugural lecture in 2021 was delivered by Dr. Justice DY Chandrachud (Judge, Supreme Court of India) on the topic "Why Representation Matters". The Editors of the Journal are grateful to CEDE team (Community for the Eradication of Discrimination in Education and Employment), for facilitating the process of publishing this article in the Journal.

Annual Dr Ambedkar Memorial Lecture on the topic "Appearing in Court: Challenges in Representing the Marginalised".

Introduction

It is a privilege to be invited to speak on the occasion of the birth anniversary of Dr. Ambedkar and the completion of one year of the launching of the Community for Eradication of Discrimination in Education and Employment (CEDE).

A year ago, three young lawyers Anurag Bhaskar, Disha Wadekar, and Avinash Mathews, came together to launch this self-empowering initiative, CEDE, which provides opportunities in education and employment to those belonging to the marginalized communities in India with special focus on Dalits, Adivasis, Other Backward Classes, and Indigenous communities.[2] One of the laudable objectives of CEDE is to increase the representation of the marginalized communities in the legal profession in India.

It is the last-mentioned endeavour that has prompted the choice of the topic for today's lecture. The many years of active practice as a litigator provided me with an opportunity to study the legal services delivery system from close quarters. Being a lawyer on the panel of the Supreme Court Legal Services Committee for close to 15 years, a member of the Committee for two terms, and an *amicus curiae* in a number of cases involving public interest and human rights, helped me understand the complexity of the issues that require to be addressed while discussing the theme of access to justice.

Representing many of the marginalised groups in Court made me ponder over questions for which there were no easy answers then. I doubt it is easier now, although the complexity of the issues is better acknowledged in the empirical and research work done in the past few years on the working of the Indian legal system. One such study is the report published in October 2021 by the American Bar Association Centre for Human Rights on "Dalit Justice Defenders in India" (American Bar Association, 2021, Chapter III). I will have occasion to refer to it later in this talk.

I seek to briefly set out what I propose to speak on. In the first part of the talk, I wish to add to our understanding of whom we consider to be a person in need of legal services and in that context whom we understand to be a 'marginalised' person. Next, I wish to focus on the barriers that a marginalised person encounters in the legal system and how the system has responded to the problem. I ask: Can we really understand what it means to be a marginalised person facing the barriers of the system? Third, and this is an important part of the talk, the challenges faced by those who seek to represent the marginalised or espouse their causes. The final part of the talk will dwell on how we should be approaching the challenges thrown up in the process of representing the marginalised.

[2]CEDE (Community for the Eradication of Discrimination in Education and Employment), https://www.cede.co.in/home

I. Who are 'Marginalized' in Justice?

At a very basic level, every person denied justice in the broadest sense of the term, and who has to perforce engage with the legal system for redressal, is in need of legal services. The Indian Constitution acknowledges persons who by birth, descent, caste, and class have been denied justice over generations.[3] It envisages the State coming up with affirmative action programmes and policies to redress such historic injustices.[4] These include those belonging to the Scheduled Castes (SC)/ Dalits, and Scheduled Tribes (ST)/ Adivasis, socially and educationally disadvantaged classes, economically deprived classes and a whole host of others including religious minorities, sexual minorities, differently abled, and children in conflict with the law. Then there are 'status offenders' like sex workers,[5] vagrants,[6] mentally ill,[7] and many others whose very existence and every activity is criminalised and therefore very often find themselves on the 'wrong' side of the law. Thus begging,[8] street dwelling,[9] prostitution,[10] wandering of mentally ill persons[11] and vagrants[12] are all treated as law-and-order problems and dealt with in the criminal justice system. It is a matter for concern that at least 20 states in India still have anti-beggary criminal laws (Scroll, 2017). Only in Delhi *(Harsh Mander & Anr v. Union of India*, AIR 2018 Del 188) and J&K *(Suhail Rashid Bhat v. State of Jammu & Kashmir* 2019 SCC J&K 869) have the laws been struck down by judicial verdicts. Then there are the de-notified tribes[13] who have, for long, been the victims of police atrocities. Those coming in conflict with the law in these situations

[3]Constitution of India 1950, art. 15. Article 15 of the Indian Constitution recognizes and secures the citizens from discrimination on grounds of religion, race, caste sex or place of birth.

[4]Constitution of India 1950, art. 38. Article 38 of the Indian Constitution recognizes that the importance of state in providing social, political and economic justice to its citizens.

[5]While the term sex workers are not defined, the term prostitute is referenced to the act of prostitution mentioned in Section 2(f) of the Immoral Traffic (Prevention) Act, 1956. Section 2(f) defines prostitution as any 'means for which the sexual exploitation or abuse of persons for commercial purposes or for consideration in money or in any other kind. It describes "prostitute' to be construed accordingly.

[6]The Bengal Vagrancy Act, 1943 describes 'vagrant' as a person found asking for alms in any public place or wandering about or remaining in any public place in such condition or manner as makes it likely that such person exists by asking for alms but does not include a person collecting money or asking for food or gifts for a prescribed purpose.

[7]Mental Illness is defined in Section 2(s) of the Mental Healthcare Act, 2017.

[8]Currently 20 state legislations criminalize begging and provides incarceration for those found to be begging. Some of these are 'The Andhra Pradesh Prevention of Beggary Act, 1977', 'The Assam Prevention of Begging Act, 1964' and 'The Bihar Prevention of Begging Act, 1951.'

[9]*Id* at 3. Immoral Traffic (Prevention) Act, 1956, s. 2(f)

[10]Immoral Traffic (Prevention) Act, 1956, s. 2(f). Section 2(f) defines prostitution as any '*means for which the sexual exploitation or abuse of persons for commercial purposes or for consideration in money or in any other kind.*

[11]*Id* at 5. Mental Healthcare Act, 2017, s. 100

[12]*Id.,* at 4.

[13]The tribes that were mentioned in the Criminal Tribes Act, 1871 were required to register with the local magistrate as per Section 8 of the said Act with any such required information. If such information was not specified as per notice mentioned in Section 9, such members of the tribes

are invariably those below the poverty line and a 'high risk group' for whom legal aid is an absolute necessity. They are to be acknowledged as unwitting consumers of legal services.

There is also problem with excluding certain categories of persons from the ambit of legal services. Early legal aid schemes statutorily sought to disqualify those arraigned in cases involving offences under the law prohibiting gambling, consumption of alcohol or the offences of defamation and adultery from receiving legal aid (Muralidhar, 2004, pp. 50, 60). Under Article 22 (3) (b) of the Constitution of India, the right available to every person who is arrested, to consult and be defended by a legal practitioner of his choice, is not available to a person who is arrested or detained under any law providing for preventive detention.[14] Consistent with this bar, S.11 (4) of the National Security Act, 1980[15] and S.8 (e) of the Conservation of Foreign Exchange and Prevention of Smuggling Activities Act, 1974[16] bar the right of a detenu to legal representation in proceedings before the Advisory Board which examines the need for continuing the detention. This to some extent has been addressed by Section 12 of the Legal Services Authorities Act, 1987 (LSAA), in terms of which every person who is in custody is entitled to legal aid. No exception is made for cases in which custody is by way of preventive detention. And yet, under Section 13 LSAA,[17] a legal aid functionary could refuse legal services in a criminal case on the ground that no prima facie case exists. Then we have the pernicious prospect of a bar association resolving that no member lawyer will defend a certain kind of 'accused': a person accused of committing what is termed a terrorist act (Press Trust of India, 2008). This despite the fact that the Supreme Court has outlawed it[18] (Press Trust of India, 2013).

ccould be penalized under provisions of the Indian Penal Code, 1860 This was replaced with Habitual Offenders Act, 1952 that de-notified these tribes of their criminality.

[14]Article 22 (3) is an exception to the provisions mentioned prior to it in Clauses (1) and (2) that protect the persons from arbitrary arrest and detention. Article 22(3)(b) mentions that such provisions are *not applicable to any person who is arrested or detained under any law providing for preventive detention.*

[15]Section 11(4) of the National Security Act, 1980 describes the procedure for advisory boards that "*shall entitle any person against whom a detention order has been made to appear by any legal practitioner in any matter connected with the reference to the Advisory Board; and the proceedings of the Advisory Board and its report, excepting that part of the report in which the opinion of the Advisory Board is specified, shall be confidential."*

[16]S.8 (e) of the Conservation of Foreign Exchange and Prevention of Smuggling Activities Act, 1974 refers to the advisory boards mentioned sub-clause (a) of clause (4), and sub-clause (c) of clause (7), of Article 22 of the Constitution that *" a person against whom an order of detention has been made under this Act shall not be entitled to appear by any legal practitioner in any matter connected with the reference to the Advisory Board, and the proceedings of the Advisory Board and its report, excepting that part of the report in which the opinion of the Advisory Board is specified, shall be confidential*;"

[17]Section 13(1) of the Legal Service Authorities Act, 1987 describes the criteria for entitlement of legal services. The provision mentions that '*persons who satisfy all or any of the criteria specified in section 12 shall be entitled to receive legal services provided that the concerned Authority is satisfied that such person has aprima facie case to prosecute or to defend.*'

[18]A.S. Mohammed Rafi Vs State of Tamil Nadu AIR 2011 SC 308. The court in the following case opined: *'It is against the great traditions of the Bar which has always stood up for*

The Indian criminal justice system provides, for those willing to see, a stark depiction of the intersection of law and poverty. Prof. Upendra Baxi states that the words 'poverty' and 'poor' suggest the passivity of the 'poor' (Baxi, 1988, p. 8). "Everything about the 'poor' and 'poverty'", he says, "is defined in terms of a lack: powerlessness, apathy, disorganization, alienation and anomie are some of the major attributes we use to define and describe the 'poor'. This cluster of attributes define the 'culture of poverty' which is a culture of multiple disabilities, and lacks, transmitted across generations" (ibid). Noted scholar Barbara Harris White prefers the term 'destitution' and its myriad forms to describe what those in poverty experience. She describes 'economic destitution' as "having nothing"; 'social destitution' as "being nothing" and "political and law induced destitution" as "having no rights and being wrong"; each of which results in denial of 'personhood' or 'full citizenship' (2002, p. 86).

While tabling the final draft of the Indian Constitution before the Constituent Assembly on 25 November 1949, Dr. Ambedkar reminded everyone that: "On the social plane, we have in India a society based on the principle of graded inequality. We have a society in which there are some who have immense wealth as against many who live in abject poverty" (Ambedkar, 1948). That scenario continues to plague Indian society even seven decades thereafter. He was also prophetic that despite independence, we could not call ourselves truly democratic unless we ensured 'social democracy'. He was not sanguine about this. He prophesied that "In our social and economic life, we shall, by reason of our social and economic structure, continue to deny the principle of one man one value" (Ambedkar, 1948). We are yet to dismantle the structures that marginalise a sizeable section of our population. Thus, we still have many among us who are engaged in manual scavenging, sewer cleaning, rag picking and in forced labour or begar, doing all our 'dirty work' at the cost of their dignity and right to life.

And then, poverty need not be understood only in economic terms. As the Allen Committee that was commissioned by Robert Kennedy, then the Attorney General, in 1960s in the USA to study poverty and the criminal justice system observed, poverty is also a "functional incapacity to obtain in adequate measure the representation and services required by issues, whenever and wherever they appear" (Attorney General's Committee,1963). Thus, a married woman belonging to the higher or middle-income group who is a victim of domestic violence and finding herself incarcerated in her marital home in an upper-class neighbourhood may still be deprived of legal services. The definition of 'marginalized' it would seem is thus not as simple as one might want to believe it to be. It is thus entirely possible that a person in India on account of her social or economic disadvantage is denied legal services. We may be creating a set of 'social' and 'economic' outcasts through law.

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defending persons accused for a crime. Such a resolution is, in fact, a disgrace to the legal community. We declare that all such resolutions of Bar Associations in India are null and void and the right minded lawyers should ignore and defy such resolutions if they want democracy and rule of law to be upheld in this country. It is the duty of a lawyer to defend no matter what the consequences, and a lawyer who refuses to do so is not following the message of the Gita';

II. Barriers for the Marginalized

The 'marginalised' enter the legal system in a variety of ways, very often involuntarily. They come in as victims of crime—crimes against humanity, mass crimes, hate crimes, caste (National Crime Records Bureau, 2020a, p. 34) and communal crimes (NCRB, 2020b, p. 33) and atrocities—as witnesses to crimes and atrocities, as complainants, as victims of forcible evictions, of neglect, of poverty, of natural and man-made disasters, of human conflicts including caste and communal riots. And of course, they come in as persons suspected of committing crimes. Twenty one per cent of the undertrial population of 3.72 lakhs (NCRB, 2020c, p. 68) and 21 per cent of the convict population of 1.13 lakhs belong to the SC. 37.1 per cent of the convicts and 34.3 per cent of the undertrials belong to the OBCs (NCRB, 2020d, p. 64). The corresponding percentages for Muslims is 17.4 per cent and 19.5 per cent respectively (NCRB, 2020e, pp. 63 and 67). And yet, these are the persons who are likely to find it difficult to come forward to fight for their rights.

Again, to quote Dr. Ambedkar:

> Ask those who are unemployed whether what are called Fundamental Rights are of any value to them. If a person who is unemployed is offered a choice between a job of some sort, with some sort of wages, with no fixed hours of labour and with an interdict on joining a union and the exercise of his right to freedom of speech, association, religion, etc., can there be any doubt as to what his choice will be. How can it be otherwise? The fear of starvation, the fear of losing a house, the fear of losing savings if any, the fear of being compelled to take children away from school, the fear of having to be a burden on public charity, the fear of having to be burned or buried at public cost are factors too strong to permit a man to stand out for his Fundamental Rights. The unemployed are thus compelled to relinquish their Fundamental Rights for the sake of securing the privilege to work and to subsist (Ambedkar, 1947, pp. 409–410).

The formal legal system in India is a legacy of the British legal system. For many a 'marginalised' person, navigating the formal legal system is a nightmare. Law Professor Stephen Wexler is fairly accurate when he says: "Poverty creates an abrasive interface with society; poor people are always bumping into sharp legal things" (Wexler, 1970, p. 1050). There are many barriers to accessing justice that a marginalised person faces. The laws, rules and processes are mystifying and befuddling even for an educated, literate person. The laws are themselves structured to discriminate against the poor. Specific examples are the anti-beggary laws that criminalise poverty,[19] the Immoral Traffic Prevention Act that criminalises sex

[19] *Id., at* 6. Other laws also include 'The Haryana Prevention of Begging Act, 1971', 'The Himachal Pradesh Prevention of Begging Act, 1979 and 'The Karnataka Prevention of Begging Act, 1975'

work,[20] the juvenile justice law that delivers the street child into the arms of the law[21], and even the municipal laws that criminalise acts of encroachment of public spaces[22] by street dwelling homeless persons and hawkers. The system works differently for the poor. The Beggars Courts, the Juvenile Justice Boards,[23] and the Mahila Magistrate Courts[24] are often the first points of encounter for the poor with the legal system. A visit to any of them in a metropolis in India will bear out the truism that the system works unequally for the poor and the rich. Many undertrials continue to remain in jail despite grant of bail because of their inability to arrange surety bonds (Singh, 2018).

For long, sexual minorities and *trans* persons have had to live in fear of the criminal law processes. Even after Section 377 IPC[25] was read down, first by the Delhi High Court in Naz Foundation (*Naz Foundation v Government of NCT of Delhi & Ors* (2009) 111 DRJ 1 (DB)) and later by the Supreme Court in Navtej Johar (*Navtej Singh Johar v. Union of India* AIR 2018 SC 4321), and even after the declaratory judgment of the Supreme Court in NALSA (*National Legal Services Authority v. Union of India & Ors* AIR 2014 SC 1863) in 2014 affirming the full citizenship and personhood of trans persons, it is a struggle on the ground for sexual minorities to cope with their daily lives. The changes it seems are happening 'with all deliberate speed',[26] a phrase that translates as 'very gradually'.

To tackle the inequality and inequity of the formal legal system, we have institutionalised the delivery of legal services through the LSAA.[27] We have a four-

[20]Immoral Traffic Prevention Act 1987, s.4. The provision mentions the punishment for those living on the earning of prostitution as '*any person over the age of eighteen years who knowingly lives, wholly or in part, on the earnings of the prostitution of any other person shall be punishable with imprisonment for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both, and where such earnings relate to the prostitution of a child, shall be punishable with imprisonment for a term of not less than seven years and not more than ten years*.'

[21]Juvenile Justice (Care and Protection of Children) Act, 2015, s. 2(14)(ii). Section 2(14) (ii) describes that a 'child in need of care and protection' *is a child who is found begging or living on the street'.*

[22]Delhi Municipal Corporation Act, 1957

[23]*Id.,* at 20, s.4 describes that Juvenile Justice Boards shall be established in every district responsible *for exercising the powers and discharging its functions relating to children in conflict with law under this Act.*

[24]Mahila Magistrate Courts are courts that deal exclusively with cases concerning offences against women in India. While at the sessions level they deal with cases concerning prostitution, kidnapping, rape and cruelty, these special courts at metropolitan level also deal with cases of domestic violence.

[25]Indian Penal Code, (1860), s. 377. The provision criminalised homosexuality as it mentioned '*whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with1[imprisonment for life], or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.'*

[26]Brown v. Board of Education of Topeka, 347 U.S. 483 (1954). The court concluded its judgement on desegregation to the lower federal courts to '*enter such orders and decrees consistent with this opinion as are necessary and proper to admit to public schools on a racially nondiscriminatory basis with all deliberate speed the parties to these cases.'*

[27]*Id.,* at 16

tier mechanism with the National Legal Services Authority (NALSA),[28] the State Legal Services Authorities,[29] the District Legal Service Authorities[30] and the Taluk Committees.[31] We also have a Legal Service Committee in every High Court. We have attempted providing not just legal representation but legal services as well.[32] Both at the pre-litigation and post litigation stages.[33] We have schemes that are meant to provide a complainant, a victim and a suspect legal assistance at every stage of the criminal justice process. And yet as Justice U U Lalit, Executive Chairperson of NALSA noted recently, "Only 1% of the total criminal cases heard in the courts of law get legal aid from the offices of Legal Services Authorities across the country" (Buradikatti, 2021). The two reasons he identified were (i) lack of awareness and (ii) more disturbingly "they don't perhaps have confidence in the set-up of legal aid" (Ray, 2021).

The fact remains that quality of legal aid is a concern. The marginalised who are the recipient of legal services do not really have a choice. This is a paradox because Article 22 talks of guaranteeing a person arrested with a lawyer of her choice.[34]

In the Constituent Assembly, while debating the wording of Article 15A (later to be Article 22 in the final draft), Dr. Ambedkar adverted to the suggestions made in regard to the right of an accused person to consult a legal practitioner. With a view to removing ambiguity, he said: "I am prepared to add after the words 'consult', the words 'and be defended by a legal practitioner' so that there would be the right to consult and also the right to be defended" (CAD, September 15, 1949). He also explained that the words "legal practitioner of his choice" had been deliberately used "because we do not want the government of the day to foist upon an accused a counsel whom the Government may think fit to appear in his case because the accused persons may not have confidence in him."[35]

This lack of confidence in the legal aid lawyer is a reflection of the general approach to 'welfare services' by the providers, and the perception that this is an act

[28]The Legal Service Authorities Act 1987, s.3. Section 3 mentions about the constitution of National Legal Service Authority to exercise all powers and necessary functions that are "*conferred on the Central Authority under the Act."*

[29]The Legal Service Authorities Act 1987, s.6. Section 6 mentions about the constitution of State Legal Services Authority to fulfill all functions and exercise all powers "*conferred on or assigned to the State Authority"* under the said Act.

[30]The Legal Service Authorities Act 1987, s.9. Section 9 mentions regarding the constitution of District Legal Services Authority to exercise all powers and necessary functions that are "*conferred on or assigned to the District Authority"*

[31]The Legal Service Authorities Act 1987, s.11A. Section 11A mentions regarding the constitution of The Taluk Legal Services Committee for every Taluk or mandal.

[32]The Legal Service Authorities Act 1987, s.4. Section 4 describes the various functions of the National Legal Services Authority in undertaking various schemes and establishing policies to provide legal aid, including but not limited to allocation of funds, organizing of legal aid camps, settlement of disputes.

[33]The Legal Service Authorities Act 1987, Chapter VIA. Chapter VIA recognizes the pre-litigation conciliation and the establishment and procedures for Permanent Lok Adalats.

[34]Constitution of India 1950, Art. 22.

[35]*Id.*, at 21

of 'charity' rather than the right of the person in receipt of such services. It impinges on the dignity of the person. I call it the 'ration shop syndrome'. The poor believe that if you are getting any service or benefit for free, or it is substantially subsidised, then you cannot demand quality. Beggars can't be choosers is the stoic response that keeps the poor going. In a critical study of the public defender system in the USA, Charles Silberman found that defendants, who were represented by legal aid lawyers, said 'He's not my lawyer, he is the legal aid', and that in the court "when judges ask who the lawyer is in the case at hand, legal aid lawyers typically answer, 'I'm standing up for this case,' not 'I'm representing this client,' let alone 'I'm representing Mr. Jones'" (Silberman, 1978).

The laws and the legal system also appear to work differently for the marginalised. Recently, a Supreme Court two-judge Bench of Justice DY Chandrachud and Justice B V Nagarathna noted that several members of the SC/ST community "face insurmountable hurdles in accessing justice from the stage of filing the complaint to the conclusion of the trial" and that they "specifically suffer on account of procedural lapses in the criminal justice system" (*Hariram Bhambhi v. Satyanarayan & Anr* AIR 2021 SC 5610). The press report of the hearing (that appeared in the Hindustan Times Delhi edition of 31 October 2021) quoted the Bench as saying that due to the fear of retribution from members of upper caste groups, ignorance, or police apathy, many SC/ST victims do not register complaints in the first place and even if they do "the victims and witnesses are vulnerable to intimidation, violence, and social and economic boycott" (Anand, 2021; Jyoti, 2021; Bisht, 2020). The Bench is reported to have noted that, "This results in low conviction rates under the SC/ST Act, giving rise to the erroneous perception that cases registered under the Act are false and that it is being misused. On the contrary, the reality is that many acquittals are a result of improper investigation and prosecution of crime, leading to insufficient evidence" (Anand, 2021; Jyoti, 2021; Bisht, 2020).

Indeed, the statistics put out by the NCRB on the conviction rates in SC/ST cases bear out these remarks. In 2020, the pendency of trials of offences under the SC and ST Act was 96.5 per cent (Jayati, 2021). Only 216 cases from the 50,291 crimes against SCs in 2020 resulted in convictions. 3,192 cases resulted in acquittals (Jayati, 2021).

The above scenario is equally true in cases of communal riots and mass crimes. Where the trial is able to be insulated from the local pressures, there is a greater chance of reaching the goal of justice. Illustratively, these would include the cases of burning of Dalit households in Mirchpur village in Haryana (where the trial was shifted to Delhi) (Hindustan Times, 2018a; Singh, 2018), or mass killings of Muslims in Hashimpura in UP by the PAC (again the trial was shifted to Delhi) (Hindustan Times, 2018b) or the case of rape and murder of a Bakkerwal girl in Kathua in Jammu (the trial was shifted to Pathankot) (Mahapatra, 2018) or the Gujarat riot cases (Best Bakery and Bilkis Bano cases, both shifted to Maharashtra) (Press Trust of India, 2004). In each of these instances, the trial itself had to be transferred to different states since there was no assured witness protection programme for the marginalised, who became soft targets for intimidation.

Then within the formal legal system there are the problems posed by 'hidden' and other 'costs' that have to be inevitably borne by recipients of legal aid. Here I have the unedifying task of quoting my own work "Law, Poverty and Legal Aid: Access to Criminal Justice":

One disincentive for a person to avail of legal aid offered is the problem of uncompensated costs that have to be incurred. Legal aid schemes do not account for the 'hidden' costs incurred by those brought involuntarily into the system either as victims or as accused. While the legal aid programme may pay for court fees, cost of legal representation, obtaining certified copies and the like, it usually does not account for the bribes paid to the court staff, the extra fees to the legal aid lawyer, the cost of transport to the court, the bribes paid to the policemen for obtaining documents, copies of depositions and the like or to prison officials for small favours. Legal aid beneficiaries do not get services for 'free' after all. At the end of a long litigation, where the person emerges innocent, he is not awarded the costs of the litigation. Thus, the amount of time and money spent on establishing innocence remains unrecoverable and non-compensable. Equally it is a loss to the victim of the crime and to the taxpayer whose money has gone into funding the entire prosecution exercise. (Muralidhar, 2004)

Law Professor Deborah Rhodes (2009) in her piece titled "Whatever Happened to Access to Justice" has this to say:

> …not all barriers to justice are in the judicial system; some are part of a larger problem of economic disadvantage (Massachusetts: Access to Justice Commission, 2007). Many factors affect the justness of the legal process apart from the adequacy of legal assistance: the substance of legal rights and remedies; the structure of legal processes; the attitudes of judges and court personnel; and the resources, expertise, and incentives of the parties (Engler, 2006). On almost all of those dimensions, as law professor Marc Galanter famously put it the " 'haves' come out ahead" (Galanter, 1974).

Studies abroad have shown, and this is true to a large extent in India as well, that there is a parallel system involving the police and the mafia that derives benefits from the activities of criminalizing prostitution, beggary, and other activities of the marginalised (Frey, et al., 1981, pp. 239–249). There exists a system of pre-paid legal services for those involved in organized crime rackets and other criminalized activities (Campana, 2017). Professional criminals are able to engage lawyers and obtain bail for those made to beg by them. They are also able to arrange sureties and professional bonds. In the context of sex work, the recent Sanjay Leela Bhansali film 'Gangubhai Kathiawadi' (Bhansali, 2022) starring Alia Bhat focuses its lens on the nexus between the brothel owners, the political class and the police. This is a vicious quagmire that the marginalised are unable to liberate themselves from.

Are the Alternate Dispute Resolution (ADR) systems within the formal legal systems a solution to the problems of the marginalised? As they presently stand, the

options of mediation and arbitration do not seem to be available to the poorest among the litigants particularly since they find themselves ensnared in the criminal justice processes or face forced evictions, homelessness, displacement, and a myriad issues in confronting the State. They, however, do feature largely in Lok Adalats with their claims for either motor vehicle or land acquisition compensation and are asked to 'settle for less' as it were. Legal scholars Marc Galanter and Jayanth Krishnan term this phenomenon as 'bread for the poor' (Galanter & Krishnan, 2004, p. 789). The marginalised also feature in 'jail adalats' where they have the Hobson's choice of longer periods of incarceration as opposed to admitting to guilt in petty offences for a premature release but with the tag of a 'previous conviction' (Paliath, 2020; Commonwealth Human Rights Initiative, 2009). There do not appear to be dignified spaces rendering complete justice to the marginalised litigants in the ADR arena, as yet. That may be an area that needs further exploration.

Non-formal systems are perhaps the first choice for the rural and urban poor, deterred as they are by the prospect of having to engage with the formal system. But here again while the caste panchayats might offer solution to some civil disputes, it is doubtful that they are truly representative institutions when it comes to some of the critical issues concerning the marginalised (Inabanathan & Sivanna, 2010). Particularly, when it comes to cases of crimes against women, caste-based discrimination and violence, cases of inter-caste runaway couples, the track record of the informal systems has not been encouraging.[36] For the marginalised, traversing the legal system whether formal, alternate or non-formal, is a daunting task, full of uncertainties and perils.

III. Challenges in Representing the Marginalised

I will now explore what representing the marginalised in Courts entails. That takes me to understanding how the 'Bar' is organised. Is the Bar democratic? Is it a place of 'equal opportunity'? Is it diverse? Or does it mirror to a large extent the social and economic inequalities that are ubiquitous in Indian society, and home to the biases that plague social life (Ahmed & Suryam, 2021).

The study on "India's Grand Advocates" by Marc Galanter and Nick Robinson is fairly well known in legal circles (Galanter & Robinson, 2013). These two legal scholars have stated that "despite repeated inquiries" they could not identify any Scheduled Castes, Scheduled Tribes and Other Backward Class advocates, who are regarded as part of the elite strata of lawyers (Galanter & Robinson, 2013, p. 16). I suspect that the legal service institutions may not be faring any better. Do we know how

[36]In Re vs. Indian Woman Says Gang-raped on Orders of Village Court Published in Business & Financial News Dated 23.01.2014, (2014) 4 SCC 786. Also note, Shakti Vahini v Union of India (2018) 3 SCC 1 , the court issuing directions to state governments and law enforcements in prevent honour killings observed that *"Once the fundamental right is inherent in a person, the intolerant groups who subscribe to the view of superiority class complex or higher clan cannot scuttle the right of a person by leaning on any kind of philosophy, moral or social, or self-proclaimed elevation"*

many of the legal aid panel advocates are Dalits? What percentage of the arbitrators, mediators, counsellors, conciliators do they constitute?

The study I referred to, to begin with, on 'Dalit Justice Defenders in India' makes an important contribution to our understanding of the lack of diversity in the Bar (ABA, 2021, p. 12). After conducting interviews with lawyers, former and current judges, academics and others that in the High Courts, the study concludes that "the bar is dominated by lawyers of upper castes and well to do families with a network of connections" (ABA, 2021, p. 15). Some of the respondents admitted that "in lower Courts, caste plays a role in getting clients" (ABA, 2021, p. 16). One of the conclusions drawn from the interviews conducted was that "structure of the legal profession is based on the ability of an individual to secure references, resources and have a network, all of which are difficult in an environment with caste discrimination." The study also reveals very tellingly that Bar Associations have historically been dominated by upper class males (Jain & Tripathy, 2020, p. 11). The lawyers belonging to marginalized have experienced indirect discrimination, being asked to perform relatively unskilled tasks in law offices. There is also tendency to type-caste lawyers from Dalit and other marginal groups. A woman lawyer, who described herself as "the first generation bahujan lawyer" without any caste networks of financial support, found the journey to be a "lonely experience" and found the attitude of senior counsel as patronizing and loaded with notions of charity (Jain & Tripathy, 2020 p. 21). She was treated as "a token or diversity candidate" and importantly, she stated that "the dignity of being a colleague was missing." The study found that lawyers belonging to Dalit and Adivasi communities working on human rights cases risk being labelled as 'Maoist' or 'Naxalite lawyers' (Jain & Tripathy, 2020 p. 21).

The same study mentions a positive development that has taken place in the form of the National Dalit Movement for Justice (NDMJ) which has brought Dalit and Adivasi Advocates together on a platform for intervening in Dalit atrocities cases in Court (NDMJ, 2020). The NDMJ claims to have trained 2000 lawyers across the country so far (NDMJ, 2020, p. 22). I am aware that the Centre for Social Justice in Ahmedabad too has done considerable work in this area. These are not one-off initiatives. Several individual lawyers and smaller groups and organisations are confronting these challenges on a daily basis.[37] However, all of this is not yet enough. The legal profession as it is presently structured does not necessarily provide a level playing field to all those entering into the system in various capacities: as a litigant, as a suspect in a criminal case, as a victim of crime, as a person denied justice, as a witness and accused, as a lawyer and even as a judge. The legal profession to a large extent mirrors the inequalities and the biases of the society.

The cab rank rule[38] by which the legal profession purportedly operates, does not work for those who cannot afford cabs in the first place. The marginalised, to use a

[37]Some of the organisations working on representation of Dalit, Adivasi and other marginalized communities are All India Dalit Mahila Adhikar Manch, Human Rights Law Network, All India Democratic Women Association, Lawyers Collective and Project 39A.

[38]Cab rank rule oblige a lawyer to accept any cases appropriate to their experience in the field of practice void of the nature of case, identity of the client or any other factors that might

rough analogy, traverse the legal system by foot or in overcrowded buses or trains, very often at personal risk to their life and safety. The luxurious sedan that charges a higher tariff is largely out of reach, even when infrequently they do get a 'token' joy ride. Occasionally, you will have a top-notch senior lawyer do a case or two completely pro bono, and with positive outcomes (Sharma, 2009; Anand, 2019; Live Law, 2021). But for most other cases in the Indian subordinate courts, where the marginalised largely meet their destiny with choice less stoicism, the informal rules by which the Bar functions are dictated largely by a supply and demand situation: where competent lawyers are in short supply and therefore, they are in great demand. In almost every rung of the structured hierarchy of the legal profession, more than 80 per cent of the work is controlled by less than 20 per cent of the lawyers who are usually referred to as the 'active practitioners' of any Bar. These active practitioners would have their own class and caste biases in how they approach cases, in how they prioritise their work and how they treat their clients. More than a century ago, Gandhiji commented that the law courts in India are perhaps the most "extravagantly run" (Sharma, 2019; Gandhi, 1962). He noted that "several thousand rupees had been known to be to have been charged in India. There is something sinful in a system under which it is possible for a lawyer to earn from ₹ 50,000/- to ₹ 1,00,000/- per month. The legal practice is not – and ought not to be – a speculative business. The best legal minds must be available to the poorest at reasonable rates" (Hindustan Times, 2018b).

In a documentary titled 'All Rise for your Honour", the Director Sumit Khanna depicts the plight of an elderly rural woman trying to get an affidavit that she needs in a civil dispute, signed by her son who is lodged in a jail in Varanasi.[39] Even with the help of the film maker, and all of this on camera, a sum of ₹ 1500/- has to be spent just on getting the affidavit attested by a notary magistrate who travels with them to the jail to get the affidavit signed by the prisoner in his presence. All this only to be told later that it was not necessary at all. It is a telling commentary on the way the legal system in the courts is plagued by the ignorance of laws and procedures among lawyers, which works to the disadvantage of those already marginalized.

Self-representation, i.e. the litigant appearing in person, is not really an effective alternative. They often face the seemingly insurmountable barriers of legalese and court etiquette, which are tools of persuasion cultivated by the Bar over the years. On a lighter note, in an episode involving an elderly litigant appearing in person in court, during abstention from work by the bar, the judges interrupt his submissions saying: 'Babuji, aap jo keh rahe hain, ham samajh nahi paa rahen hain. Aap vakil rakh lo". To which the elderly litigant responds: "Kamaal hai, samajh aap ko nahi aa rahi hai aur vakil mujhe rakhna hai?"

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discriminate against the client. This promotes access to justice and interest of the client by providing them an appropriate opportunity to be defended.

[39]All Rise for your Honour, PBST India, *Youtube*<https://www.youtube.com/watch?v=wmEVNo9ssG4> accessed on 20th April 2022

But occasionally you do have the type of dedicated and conscientious lawyer that we saw Naseeruddin Shah play in Govind Nihalani's 'Aakrosh',[40] Rajkumar Rao play in Hansal Mehta's 'Shahid',[41] and southern star Surya play Chandru in Gnanavel's 'Jai Bhim'.[42] The lawyers in those stories are the ones that we must get the young entrants to the Bar have as role models. And, among the younger generation of lawyers that I see in Courts I do come across one or two that have that potential.

Such lawyers at present are a small number and in great demand. They too are stretched beyond their resources, and at times this dilutes their efficacy. Unfortunately, there is a tendency of late to view appearing for the marginalised as making a political choice. These decisions have the potential of marginalizing those representing the marginalized. They are not the high-flying ambitious career-oriented lawyers. They plug away at cases knowing that the system is weighted against their clients. The lawyer Vinay Vora (played by actor Vivek Gomber) in the Marathi film 'Court' by Chaitanya Tamahane is one such.[43] Yet, some of them who stand up for 'unpopular' causes that don't meet the approval of the dominant voices in society, face stiff resistance: they face threats to their lives, boycotts and expulsions by the Bar Associations, and even unwanted intrusions by law enforcement agencies. However, their presence in the court does lend legitimacy to the legal system which is essential for upholding the rule of law.

There are also the civil society groups that have for many years been working with the marginalised—with the homeless,[44] the sex workers,[45] the children in conflict with the law,[46] the slum dwellers,[47] the rag pickers,[48] the manual scavengers[49] and sewer cleaners—helping them organise, question state and police excesses, demand protection and enforcement of rights. There are also para legal workers that help the marginalised avoid or exit institutionalisation by their interventions. The system needs all of them for its legitimacy. The marginalised need them for their survival. A larger and less intimidating space has to be provided for these non-state players in the system.

[40]Govind Nihalani's 'Aakrosh (1980)

[41]Hansal Mehta's 'Shahid' (2012)

[42]TJ Gnanavel 'Jai Bhim' (2021)

[43]Chaitanya Tamahane 'Court' (2014)

[44]Some civil society organizations working for the homeless persons include Aashray Adhikar Abhiyan, Rainbow Homes, Butterflies and Udayan Care.

[45]Some civil society organizations working with the sex workers are Durbar Mahila Samanwaya Committee, Kat-Katha and Saheli Sangh.

[46]Healing Dove Foundation supports rehabilitation of juvenile delinquents into the mainstream society. https://healingdovefoundation.org

[47]Some of the civil society organizations supporting slum dwellers are Youth for Unity and Voluntary Action (YUVA) and Humane Universal Good Deeds Network. Other organizations also include Center for Sustainable Development (Nagpur), Uday Foundation, Goonj and Give India.

[48]Some of the civil society organizations supporting the rag pickers are Arunodhaya, Atmashakti Trust and Toxics Link.

[49]Some of the civil society organizations working with manual scavengers-Safai Karmachari Andolan, Association for Rural and Urban Needy (ARUN), Sulabh International Social Service Organisation, and Jan Sahas.

IV. Addressing the Challenges

Finally, I come to the question: How do we enable the marginalised to meet the challenges?

First, we need to acknowledge that the marginalised largely view the legal system as irrelevant to them as a tool of empowerment and survival. Their experience tells them that it operates to oppress, and that they have to devise ways of avoiding it rather than engage with it. Without fundamental systemic changes that enable erasing to some extent this negative perception of the legal system, and the legal profession in particular, mere changes in the system of legal services delivery by themselves may not enthuse greater engagement with the system, however promising the results may seem. It is bound to be viewed with suspicion. To begin with we need to revive the discussions around de-criminalising many of the survival activities of the poor including pavement dwelling, encroachment, hawking, begging, sex work. We have to act more on legal institutional reforms. For e.g., finding alternate, less coercive ways of running *nariniketans* (Singh, 2015), observation homes for boys and girls, beggars' homes instead of modelling them on the penal custodial institutions (Aidasani, 2021).

Prof. Deborah Rhodes highlights for us the kind of questions we might want to ask in our approach to reforming the legal services delivery system. "Should individuals be entitled to assistance on all matters where fundamental rights are at issue, or only where their claims seem meritorious? When should they receive lawyers' help, and when would other forms of aid be sufficient? How should legal aid providers allocate assistance between individual representation and collective impact work such as lobbying, organizing, and test-case litigation? And most important, how should those decisions be made?" (Rhodes, 2004).

Test-case litigation can be an effective tool for bringing about systemic changes. There are lessons to be learnt from the manner in which the civil rights movement in the USA went about litigating the issues of discrimination. Professor Charles Ogletree's seminal work titled *All Deliberate Speed* (Ogletree, Jr, 2005) describes in detail how the early work of test-case pioneer Prof. Charles Hamilton Houston for the NAACP[50] to seek parity in payment to white and black teachers in public schools, paved the way for later litigators like Thurgood Marshall, who went on to become a Judge of the Supreme Court of the USA, to bring forth simultaneously in a range of courts spread across states, cases concerning segregation in public transport, public facilities, universities, schools and so on. *Brown v. Board of Education* did not happen overnight.[51] It was a culmination of many years of patient struggle and perseverance

[50]National Association for Advancement of Colored People

[51]Brown v. Board of Education emerged from 5 cases concerning racial segregation in schools in the United States and clubbed as a national issue before the Supreme Court of the United States in 1952. These 5 cases argued before the representative state Court of Appeals were Belton (Bulah) v. Gebhart [1952, Delaware], Bolling v. Sharpe [1952, Washington D.C], Briggs v. Elliott [1952, South Carolina], Davis v. County School Board [1952, Virginia] and Brown v. Board of Education [1952, Kansas]. Out of the 5 cases, Belton (Bulah) case achieved substantial claim for the plaintiffs as it allowed the 11 school children to be admitted to all-white school.

with conviction and painstaking fact-gathering for presentation in the court. Basically, a lot of hard work. And then, there has been a constant struggle to get the tangible results of such test litigation realised in the succeeding years without diluting *Brown*. The follow up order in *Brown* that the US Supreme Court handed down in September 1955 (*Brown v. Board of Education* 349 U.S. 294 (1955)), one year after *Brown*, basically permitted the consequential changes of desegregation to be only gradually implemented. It used the phrase 'with all deliberate speed.' The NALSA judgment of the Supreme Court of India (*National Legal Services Authority v. Union of India &Ors* AIR 2014 SC 1863) that recognises the full citizenship and personhood of transgenders is another such test-litigation that is yet to witness the tangible effects on the ground. Prof. Ogletree himself spent a large part of his early professional life honing his lawyering skills with the Public Defender Service in Washington DC. He emphasises that if any system of Public Defender has to be effective, there can be no compromise on the quality of professional competence of its lawyers (Ogletree, Jr, 2005, p. 90). In more contemporary times, the pro bono work of lawyer Bryan Stevenson in the USA, devoting his energies to getting innocent black convicts released from death row is inspiring. In his book, *Just Mercy*, Bryan tells us how a conscientious lawyer handling cases of the marginalised needs to be emotionally and mentally strong, politically aware, professionally competent and be prepared to take on a hostile system with calm and fortitude (Stevenson, 2014).

How do we improve the quality of legal services here in India? To begin with, we need to attract the better if not the best available legal talent for legal services. Since fees is such an important incentive for a lawyer to take up a case, it is necessary to ensure that the fees paid to the legal aid counsel representing indigent accused, in criminal trials involving grave offences, is the same as is paid to the prosecutor. The fact is that there is no scarcity of financial resources with the legal services authorities. It is the distribution of the resources that needs paying attention to. Even if it is a salaried system, the salary must be commensurate with what the lawyers would usually and reasonably charge private clients.[52] Here we cannot pick the high end of the tariff but the 'mean' to ensure that the legal aid lawyer does not lose out for taking up a legal aid case. To expect Senior lawyers to take up the cases as 'pro bono' would not be doing justice to the clients. They would always be made conscious that they are recipients of 'charity' or 'beneficial treatment' which does not respect their dignity and enable them to demand accountability from the counsel. For trials involving complex issues and tasks, the services of a combination of a senior and junior lawyer should be able to be offered.[53]

[52]National Legal Services Authority (Free and Competent Legal Services) Regulations, 2010, s. 8(12). The provision mentions minimum honorarium to be paid to retainer lawyers in different legal services committee. Further note 'Recommendation of NALSA about minimum fee payable to panel lawyers', https://nalsa.gov.in/acts-rules/guidelines/minimum-fee-recommended-by-nalsa-for-panel-lawyers accessed on 21st April 2022

[53]Justice U.U. Lalit interview with Hindi Hindustan Shashi Shekhar and Shyam Suman noted in Good quality legal aid possible only if senior lawyers join outreach drive': SC judge justice Uday U Lalit, *Hindustan Times* (November 14, 2021)https://www.hindustantimes.com/india-

Second, and important, we need to ask how do we orient the lawyer to take up the cases of the marginalized? How do we get the lawyer to understand what it means to be a marginalised person having to navigate an intimidating and alienating legal system? Can we get the lawyer to truly understand how the marginalised person feels and thinks? How do we ensure that the legal aid lawyer is thoroughly professional in understanding all the nuances of the law and is able to match the opponent in terms of competency?

The legal aid lawyer would do well to remain aware that legal aid is not charity: it is the basic right of the marginalised. The consumers of legal services must be consulted at every stage of the case. They should be patiently listened to. They cannot be made to lose control over their case. They must have a say about the course of action or strategy to adopt. If pleadings are in English, and the client cannot understand that language, it has to be read over and explained in the language that they understand. Offering services pro bono or at state expense does not entitle the lawyer to make concessions and statements in Court, that do not correctly reflect the client's position or ends up compromising their position. It could be a political position, it could be a position on facts. At all times, the persons for whom one is representing must be kept in the loop and informed about everything that is happening in the Court. Nothing must be done in the Court without their consent. Also, there can be no room for cynicism. If the system appears broken, we are part of it and we need to do our bit to fix it. When the marginalised still have hopes of the system, lawyers who care can hardly afford to give up hope.

Last, to increase representation of the underprivileged and marginalized in the legal profession one has to begin early. One has to begin with law colleges. Initiatives like IDIA (Increasing Diversity by Increasing Awareness),[54] the brainchild of late Prof. Shamnad Basheer, are indeed welcome. The presence of the underprivileged in law colleges is by itself not enough. They need to be handheld through the law course and thereafter till they are placed with seasoned lawyers or law firms.[55] The Bar Council and Bar Associations need to emulate the IDIA model on a larger scale. There has to be mentoring of young lawyers belonging to marginalised groups by the more seasoned lawyers. The Bar Council of India can float a scheme offering stipends to promising young lawyers for the first two years of such mentorships, to help them find their feet in the profession.

There is much to be done. And it needs to be done now. We have the resources. We must find the will.

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[54]'Increasing Diversity by Increasing Access', https://www.idialaw.org accessed on 19th April 2022

[55]Increasing Diversity by Increasing Access offers mentorship opportunities to underprivileged law students and trains them with soft skills and access to internship opportunities, https://www.idialaw.org/idia-programs/ accessed on 21st April 2022

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Manifestations of Academic Untouchability in India: Exclusionary Practices that Subvert Reservations in Admissions in Higher Education

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Abstract

The notions of ritual purity and pollution hierarchically grades people according to their castes, and this hierarchy is socially expressed in terms of unequal rights to space, and the idea of 'untouchability' is socially realized either in terms of a complete denial or the most inferior participation. As a corrective measure of the historical injustices to certain sections of the society, the state and union governments in India have enacted reservation policies in education and employment. Nevertheless, the administrators of several institutions show reluctance in implementing reservations in letter and spirit, despite the fact that the University Grants Commission has emphasized about proper implementation of reservations at various points in time. The demand for proper implementation of Central Educational Institutions (Reservation in Admission) Act, 2006, subsequently amended in 2012, in Pondicherry University exposes how an ambiguity inherent in the act's amended version has been used to justify the systematic exclusion of Scheduled Caste and Scheduled Tribe doctoral aspirants in several departments of the university. Based on interactions with the university administration, the essay attempts to understand the politics behind the method of implementing reservations in admissions in higher education. It emphasizes that the bodies governing higher education should provide proper directions in regard to the implementation of the act. It further calls for the establishment of administrative mechanisms, directly under the apex regulatory bodies, to oversee implementation of reservation policies in all the government educational institutions.

Keywords

CEI Act 2006, CEI Amendment Act 2012, reservation, roster, Scheduled Castes,

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Scheduled Tribes, Other Backward Classes

The Context

Given the structural inequalities in Indian society, education has been the only hope for upward mobility for people belonging to socio-economically and culturally oppressed communities. The reservation policies enacted by the union and state governments in India are intended to facilitate educational opportunities for people from socially vulnerable backgrounds. In May 2016, a student belonging to the Scheduled caste (SC) category had applied to the PhD programme in mass communication in Pondicherry University and had secured the fourth place in the all-India entrance examination conducted by the university. There were two seats in the PhD programme in mass communication, and having secured the fourth rank this candidate should have been called for an interview. But the university called three students from the unreserved category who had secured the first three ranks and three Other Backward Classes (OBC) students. When the Scheduled Caste (SC) candidate sought a clarification, he was told that since there were only two seats in the mass communication programme, one seat had been allotted to a general category candidate and the other to an OBC candidate. Since no seat was allotted for SCs that year, he was not called for an interview.

The department of electronic media and mass communication in Pondicherry University has eight faculty members and offers PhD programmes in electronic media and in mass communication. Five out of the eight faculty members guide doctoral students. In 2016, there were 14 PhD scholars enrolled in the PhD programme in electronic media and 21 in the mass communication programme. Among these scholars, two were SC and one ST, and all three had been granted the Rajiv Gandhi National Fellowship even before they had been admitted to the course. Also, these SC and ST students were admitted under the general category. According to the rules, three seats in electronic media and five seats in mass communication programmes should have been reserved for students from SC and ST categories. This means that the university did not allot seats to SC and ST candidates under the reserved categories.

This is the reality in many departments where the number of faculty and the number of eligible guides is less than 10. The minimum period of completion of a PhD degree is three years, and it is very common to see PhD scholars taking twice as many years to complete their doctoral research. Therefore, PhD vacancies may not arise in departments as regularly as in the case of postgraduate or undergraduate courses. When the intake is less, and this continues for a few years, then it will amount to a systematic exclusion of SC and ST communities as it has been the case in many departments of Pondicherry university.

The student representatives and faculty members of the Pondicherry university raised concerns regarding this matter in a meeting with the administration in February 2016.[1] The authorities agreed that the existing reservation policies were unjust in

[1]In February 2016, the students organised a protest and raised several demands, including the lack of certain basic amenities, following which they were invited for a meeting. Several demands, including the provision of three months' time for students belonging to the SC and

regard to the SC and ST communities and added that the administration was only implementing the existing policies, and that any changes to these could only be carried out by the Parliament. While initiating the process for a policy change would be time consuming, the adoption of the roster system could accommodate the SC and ST students in research programs under the existing policies. Reservation roster is a method to allocate an emerging position in a particular cadre by considering the existing number of posts and allocations already made to different categories of the reserved/unreserved depending upon proportional reservation.[2] This system was suggested with a view that, social groups which could not be allotted seat(s) in a particular year can be allocated seats in the subsequent admissions. However, the Pondicherry University administration replied that there was no rule that directed the university to follow the pointwise reservation roster in admissions.

With changes in reservation policies and other relevant communications not being placed in the public domain, the stakeholders—that is, faculty members, students, and the faculty, non-teaching, SC-ST employees or students' associations—are ignorant of the rules. This ignorance makes them accept the oral replies from the administration personnel at face value. The possibility of reserving seats for SC and ST categories when the vacancies are less than eight remain bleak. Therefore, this essay attempts to understand the politics behind the method of implementing reservations in admissions in higher education, especially in PhD programs, based on the interaction with university administration.

Understanding CEI Act, 2006 and Amendment Act, 2012

The University Grants Commission (UGC) has time and again emphasised upon the strict implementation of reservation rules. In a letter dated 23 March 2016, the UGC undersecretary stated:

> I am directed to inform you that it has been observed that some of the Central Universities have not maintained the point wise reservation roster. Therefore, it is to inform you to frame the point wise reservation roster as per rules framed by the Govt. of India. Further, it is also to inform you that as per instructions of Govt. of India/UGC, the educational institutions receiving grant-in-aid from Central Government have to follow the prescribed percentage of Reservation i.e. 15 per cent for SCs, 7.5 per cent for STs and 27 per cent in OBCs in the matter of teaching and non-teaching posts as well as in admissions to various

ST communities facing financial difficulties to pay their fee, were discussed in the presence of the then registrar (i/c) and the vice chancellor (i/c). As the finance officer, deputy and assistant registrars were also present in the meeting, the feasibility and modalities of implementation were immediately discussed, and two demands were met by the authorities. Incinerators were installed in the women's hostels to dispose of sanitary napkins, and the SC and ST students who were admitted in 2016–17 were exempted from paying the fees immediately, and could pay within three months.

[2]For a detailed explanation about rosters, see https://persmin.gov.in/DOPT/Brochure_Reservation_SCSTBackward/Ch-05_2014.pdf

> courses except Minority educational institutions under Article 30(1) of the Constitution. (UGC 2016a)

The UGC joint secretary, in a letter dated 3 June 2016, directed the universities to follow the provisions of the Central Educational Institutions (Reservation in Admission) Act, 2006 (hereafter, the CEI Act) and the Amendment Act, 2012 in admissions along with directions regarding reservations in non-teaching and teaching positions (UGC 2016b). Section 3 of the CEI Act, 2006 states that:

> 3. Reservation of seats in Central Educational Institutions: The reservation of seats in admission and its extent in a Central Educational Institution shall be provided in the following manner, namely:
> (i) out of the annual permitted strength in each branch of study or faculty, fifteen per cent seats shall be reserved for the Scheduled Castes;
> (ii) out of the annual permitted strength in each branch of study or faculty, seven and one-half per cent seats shall be reserved for the Scheduled Tribes;
> (iii) out of the annual permitted strength in each branch of study or faculty, twenty-seven per cent seats shall be reserved for the Other Backward Classes;"[3] (GoI, 2007).

All the policy documents on reservation call for reservations in the following order: 15 per cent for SCs, 7.5 per cent for STs and 27 per cent for OBCs. The implementation of reservation policy based on percentages alone may be acceptable in cases where the number of available seats is more than eight, as each of the categories would get their share as per the proportions prescribed by the CEI Act. For example, if there are two seats in a particular department, 50 per cent of these have to be kept unreserved. Therefore, only one seat will be available for the general category and one would be reserved. When the proportions are applied, 0.54 seat (27 per cent of two) will be due to OBCs, O.3 for SCs, and 0.15 for STs. Since the share of OBCs exceeds 0.5, the first reserved seat will be allotted to an OBC candidate. Therefore, one seat will be reserved for a SC candidate only when there are four seats in a course (15 per cent of four is 0.6) as the share of SCs is more than 0.5. In the case of STs, their share will cross the 0.5 mark only when there are seven seats. But given the 50 per cent capping on reservation, four will have to be kept unreserved, two seats will be allotted to OBCs and one seat to SC. Hence, one seat is allotted to STs only when there are eight seats available in a particular course or department in an academic year (Pondicherry University 2016b, 2016c).

Therefore, if a department continues to admit three candidates for ten consecutive years, approximately twenty students would have got admission under the unreserved (general) category, ten or more students would be admitted under the OBC category, and no seats would be allotted to candidates belonging to the SC or ST categories. This might be true in departments where there are fewer number of eligible research

[3]This was duly communicated to registrars of all central universities by the UGC No F 36-2/2003 (CU) dated 8 January 2007.

supervisors.[4] Therefore, it can be said that, the method of allocating seats based on percentage prioritises reservation of the socially dominant over that of the oppressed. This method becomes a serious problem in cases where the annual intake is less than eight seats.

However, some sections of the CEI Act, 2006 were amended in 2012 and the following provisions were added to Section 3 of the principal act:

> Provided that the State seats, if any, in a Central Educational Institution situated in the tribal areas referred to in the Sixth Schedule to the Constitution shall be governed by such reservation policy for the Scheduled Castes, the Scheduled Tribes and the Other Backward Classes, as may be specified, by notification in the Official Gazette, by the Government of the State where such institution is situated:
>
> Provided further that if there are no State seats in a Central Educational Institution and the seats reserved for the Scheduled Castes exceed the percentage specified under clause (i) [Section 3 of the principal Act] or the seats reserved for the Scheduled Tribes exceed the percentage specified under clause (ii) [Section 3 of the principal Act] or the seats reserved for the Scheduled Castes and the Scheduled Tribes taken together exceed the sum of percentage specified under clauses (i) and (ii), but such seats are-
>
> (a) Less than fifty per cent of the annual permitted strength on the date immediately preceding the date of commencement of this Act, *the total percentage of the seats required to be reserved for the Other Backward Classes under clause (iii) shall be restricted to the extent such sum of percentages specified under clauses (i) and (ii) falls short of fifty per cent of the annual permitted strength*;
>
> (b) More than fifty per cent of the annual permitted strength on the date of immediately preceding the date of commencement of this Act, in that case *no seats shall be reserved for the Other Backward Classes under clause (iii) but the extent of the reservation of seats for the Scheduled Castes and the Scheduled Tribes shall not be reduced in respect of Central Education Institutions in the specified north-eastern region*.[5] (Emphasis added) (GoI, 2012).

The provisions quoted above attempt to provide a solution when the number of seats reserved for the SCs and STs exceed the stipulated 15 per cent, and 7.5 per cent, or 22.5 per cent if both taken together. Clause (a) of the amended Section 3 discusses the

[4]It is also not clear whether the UGC/ the Ministry of Human Resources Development (MHRD) obtain and maintain department wise annual admission data from all the universities so that they can oversee the proper implementation of the reservation policy. Even if the universities include this data as a part of their annual report, it is not clear whether the UGC has a mechanism to check how effectively the policy has been implemented. Also, the question that needs to be looked into is what kind of administrative penalties are imposed on universities/departments/ authorities that do not implement the reservation policy in each department.

[5]This was amendment was duly communicated to registrars of all central universities by UGC letter F. No 35-19/2008/CU dated 28 September 2012.

scenario where seats reserved for SCs and STs exceed 22.5 per cent but are less than 50 per cent. It suggests that given the 50 per cent cap on reservation, the percentage of reserved seats remaining after allotments to SCs and STs shall be given to the OBCs. This clause does not say that the reservations for SCs and STs shall be made after ensuring reservations for OBCs. Rather, it says that the reservations for OBCs shall be made only after ensuring reservations for SCs and STs. If the percentage of seats reserved for SCs and STs exceed the stipulated 15 per cent and 7.5 per cent, respectively, the number of seats "required to be reserved" for the OBCs shall be restricted. Therefore, it is clear that reservations for SCs and STs are prioritized over the reservations for OBCs. Since reservation is a social justice mechanism devised by the government, such a prioritization has serious socio-economic, political and historical reasons behind it.

However, there is a possibility of confusion when one reads Clause (b) of the amended Section 3. The clause states that in case the reservations for SCs and STs exceed 50 per cent no seats shall be reserved for OBCs. It further states that the number of seats reserved for SCs and STs shall not be reduced in respect of central educational institutions in North-East India. Since Clause (b) has to be read in conjunction with other paragraphs of the amended Section 3 quoted above, that define the context, there are two ways in which the clause can be interpreted. First, the jurisdiction of the amended Section 3 may be understood as pertaining only to central educational institutions in the North-eastern region. Second, the said clause can also mean that the number of reserved seats for SCs and STs shall be reduced in central educational institutions in all other regions except the North-East.[6]

Further, it can also be stated that, the jurisdiction outlined in Clause (b) could very well be used to deny the prioritisation of reservations for SCs and STs provided in Clause (a), saying that the amendment pertains only to the North-eastern region.[7]

[6]The personnel in administration have a peculiar way of reading laws/policies/statutes and have enacted these according to their convenience. Here, their interpretation is that the Amendment Act, 2012 does not say that the seats reserved for SCs and STs shall not be reduced in the entire country. Rather it only specifies that the seats reserved for SCs and STs shall not be reduced in the central educational institutions in North-East India. So, reducing the percentage of seats allotted to SCs and STs in rest of the country is not wrong.

[7]It is worthwhile to note here that during our discussions with the administration regarding adopting roster system in PhD admissions, the administration said that there is no rule that compels the university to adopt it. When it was specifically asked if there is any rule that prevents its adoption in admissions, the deputy registrar (Academic) responded that has not been adopted since there is no rule mandating the university to follow it in admissions. However, neither the officers concerned, nor the students and other faculty members were aware of the CEI Act 2006, or its 2012 amended version during that meeting. While the personnel in administration look for clear rules to facilitate admissions of the oppressed, the ambiguity that arises due to the lack of clarity is always used to the advantage of the socially dominant. The very act of allocating the first reserved seat to the OBCs without any direction is an evidence for this.

This ambiguity was exploited by the Pondicherry University administration to justify their exclusion of SC and ST candidates in PhD admissions when the intake was less than four and eight, respectively in a reply dated 25/11/2016 to National Commission for Scheduled Castes (NCSC).[8]

In response, the Pondicherry University administration stated in paragraph 21 that "The University has strictly implemented CEI Act 2006 and is following reservation percentage as prescribed in it. The CEI amendment 2012 cannot be implemented in the rest of India and the extent of its application is only for those North Eastern Region specified in it."[9] It is worthwhile to note here that Section 4 of the CEI Act, 2006 which includes the list of all institutions exempted from this act does not include Pondicherry University, and this clause has not been amended thereafter (GoI, 2007).

Given the inherent ambiguities in the Amendment Act, 2012, the entire claim of the stakeholders belonging to SC and ST communities was seen by the Pondicherry University administration as "totally false, misconstrued and illogical."[10] Nonetheless, the Two Hundred Thirty Fourth Report on the Central Educational Institutions (Reservation in Admissions) Amendment Bill, 2010 (henceforth, the 234th report), which examined the Amendment Bill, provides a better insight (GoI, 2011).[11]

> 3.3 b. more than fifty per cent of the annual permitted strength on the date immediately preceding the date of commencement of this Act, in that case no seat shall be reserved for the Other Backward Classes under clause (iii) and the extent of reservation of seats for the Scheduled Castes and the Scheduled Tribes under clauses (i) and (ii) shall, notwithstanding anything contained in section 6, be-

[8]The author had represented this issue of non-implementation of reservations as per CEI act and denial of reservations for SC and ST in PhD admission to the National Commission for the Scheduled Castes, and this is quoted from the University's response to the author's complaint "Para wise remarks on the petition filed by (…) to National Commission for Scheduled Caste (NCSC)," PU/DR/Aca2/2016-17/295 dated 07/12/2016.

[9]Paragraph 21 of the "Para wise remarks on the petition filed by (…) to National Commission for Scheduled Caste (NCSC)," PU/DR/Aca2/2016-17/295 dated 07/12/2016. The deputy registrar stated that "Further, he (…) has no right or business to make his own interpretation and ask the University to reduce the reservation percentage to OBC which is also a statutory right given by GOI to a particular sector of people." It is clear from their communication that the university administration has twisted the demand to ensure reservations for SC and ST as a demand to reduce the reservations for OBC. This way of posing the demands raised on behalf of one social group as motivated against another social group and thereby deny reservations to SCs and STs only endorses the concerns raised by this article. It is to be noted here that the authorities involved in the preparation this reply to the NCSC and those who endorsed and forwarded are neither SC nor ST.

[10]Para 21 of "Para wise remarks on the petition filed by (…) to National Commission for Scheduled Caste," letter PU/DR/Aca2/2016-17/295 dated 07/12/2016.

[11]Two Hundred Thirty-Four Report on the Central Educational Institutions (Reservation in Admissions) Amendment Bill, 2010 was presented to the Rajya Sabha on 25 February 2011 and to the Lok Sabha on 25th February 2011) by the Rajya Sabha Department Related Parliamentary Standing Committee on Human Resource Development.

> *(I) reduced to fifty per cent of the annual permitted strength in the academic year immediately succeeding the commencement of the Central Educational Institutions (Reservation in Admission) Amendment Act, 2010, in respect of a Central Educational Institution situated in any area other than the specified north eastern region;*
> *(II) not reduced in respect of a Central Educational Institution situated in the specified north-eastern region.* (Emphasis added) (GoI, 2011).

The Amendment Act, 2012 retained the first three paragraphs of Section 3 contained in 234th report, including Clause (a). But Clause (b) of the amended act does not include the sub-clauses (I) and (II) as mentioned in the report which clearly demarcate the jurisdiction of the CEI Act. Looking at the sub-clauses I and II quoted above, it is clear that Clause (a) applies to all central educational institutions in every region other than the specified North Eastern region, and Clause (b) applies to central educational institutions in the North-East.

Further, paragraph 3.5 of the 234th report (quoted below) categorically says that SC and ST reservation is a compulsory component of the reservation policy.

> While […]. The Committee is also aware of the fact that reconciliation has to be made between 50 per cent cap on reservations and 27 per cent OBC quota. The committee is of the view that OBC percentage is to be decided by taking SC and ST reservation as a compulsory component. Since the extent of reservation is 50 per cent whatever remaining after fulfilling the SC/ST reservation may go to OBCs.[12] (GoI, 2011, pp 17–18)

It can also be inferred from Section 5 of the CEI Act, 2006 that "mandatory increase in number of seats" is only to facilitate reservation for OBC, and hence no central educational institution is authorized to reduce the allocation for SC and ST categories in order to allocate seats for the OBCs. This is also emphasized in the 234th report that OBC reservations have to be made after reserving seats for the SCs and STs.

Hence, as per the CEI Amendment Act, 2012 if a department calls for four seats, two seats are unreserved and one seat each for SC and ST categories is reserved. And this 15 per cent and 7.5 per cent for SCs and STs, respectively are not the maximum, as clauses (a) and (b) of Section 3 of the Amendment Act, 2012 discuss the modalities when the reservation for SCs and STs exceed their stipulated percentages. When this combined percentage exceeds 22.5 per cent, the act says that the seats have to be increased in order to accommodate the OBCs in such a way that the remaining percentage of reserved seats shall be allotted to the OBCs even if it is less than 27 per cent. In that case, four seats should be increased to six seats and one seat shall be allotted to the OBCs, and this brings the reservations for SCs and STs below 50 per cent in states other than North-East India. The Amendment Act, 2012 also states that when the seats reserved for SCs and STs exceeds 50 per cent in central educational institutions in North-East India, then there shall be no seats for OBCs. Overlooking

[12]Please see Clause 3: Section 3: "Reservations of seats in Central Educational Institutions under the title Recommendations/Observations at a Glance," (GoI, 2011).

the recent communications from UGC, instructing the universities to follow the Amendment Act, 2012, the Pondicherry University administration has reduced a social justice mechanism to a mere statistical tool and accommodated SC and ST Ph.D., aspirants only when the share of SCs or STs exceeded 0.5 seats taking the department wise annual intake into account.

Therefore, the allocation of seats in regions other than the North-East would be:

Table 1: Comparison of allocation of seats across categories

Total intake	Current method of allocation in Pondicherry University[13]				Method as per CEI Act and Amendment Act[14]			
	Unreserved	SC	ST	OBC	Unreserved	SC	ST	OBC
1	1				1			
2	1			1	1	1		
3	2			1	2	1		
4	2	1		1	2	1	1	
5	3	1		1	3	1	1	
6	3	1		2	3	1	1	1
7	4	1		2	4	1	1	1
8	4	1	1	2	4	1	1	2

Therefore, a central university in regions other than the North-East may provide representation to SCs, STs and OBCs when there are six seats in a department. However, if the percentage proportions have to be maintained then there need to be eight vacancies in a department in an academic year. While some universities adopt the strategy of accumulating eight seats in each department to ensure representation to all categories, some universities, such as the Pondicherry University, do not do so.[15] In this scenario, the university calls for PhD admissions without declaring seat allocation across categories, and invites applications openly. If there is more than one seat, the university allots the first reserved seat to an OBC candidate. This method of allocation could be justified only if the university adopts the roster system as other categories left out in one year shall be accommodated in subsequent admissions. By not adopting the roster in admissions, the university systematically denies reservations to the SC and ST categories. Also, this manner of allotting seats to the OBCs not only violates the

[13]This is evident from the details of PhD admissions uploaded by various departments in the university website. For details see Pondicherry University 2016b, 2016c, 2016d.

[14]This table is presented so as a counter to the Pondicherry University's practice of calling for PhD admissions even when there is just a single seat available in a department. The CEI Amendment Act, 2012 treats SC and ST reservations as a compulsory component of the reservation policy and OBC reservations as reconciliatory. Hence, a central institution cannot choose to allot seats to OBC candidates before allotting seats to the SC and ST students. Strictly going by the provisions of the Amendment Act, 2012, the institutions in regions other that the North-East cannot call for admissions if the annual intake is less than six.

[15]It can be observed form the 2016-17 prospectus that Pondicherry University has called for PhD admissions even if there is one seat in a department. It should also be noted here that in 2017-18 admissions, the University has made minimum four seats to call for PhD admission and one seat has been allotted to SC, the allocation is not as per CEI Amendment Act 2012, as it continues to exclude STs in departments where the annual intake is less than eight.

CEI Act but is also against the spirit of social and distributive justice envisaged by the reservation policy.

The Pondicherry University authorities have argued that OBCs are allotted seats because a higher proportion of seats are reserved for them and not because they are given preference over SCs and STs. In a reply to a right to information (RTI) query on the role of the liaison officer of the Special Reservation Cell in the Pondicherry University in the process of admissions, the assistant registrar replied that the cell is not involved in the admission process and the entire process is executed by the academic section.[16] Excluding a few departments where the number of eligible supervisors are more, most departments with fewer eligible guides have called for admissions to less than eight seats for several years, and, therefore, have systematically denied reservations to SC and ST categories continuously.

Even in 2016, about 31 departments called for admissions to six or less PhD seats, amounting to a total of 115 seats in which not even a single seat was reserved for STs and no seat was reserved for SCs in 14 departments where the intake was less than four. It is to be noted that two departments had advertised even for a single PhD seat, and if they continue to do so, even the OBCs will be denied reservation. As per the provisions contained in the CEI Act, 2006, a department in a central educational institution cannot admit students unless six seats are available. However, even those departments where there are six seats, the university has chosen not to reserve seats for STs, but have allotted two seats to OBC candidates and one to the SC applicant.

Table 2: Total number of PhD seats (less than eight seats per department) in 2016–17

Method of allocating seats across categories	Total	Open	SC	ST	OBC
Currently allocated by the University	115	63	17	0	35
As per CEI (tentatively computed taking SC and ST reservation as compulsory)	115	63	28	17	7
Difference	0	0	-11	-17	28

Source: Computed by the Author based on information from Pondicherry University Prospectus 2016–17.

Therefore, a central university can ensure the representation of all categories of reservation only if it adopts the roster system. While a few central universities follow the roster system in PhD admissions, the Pondicherry University has declined this demand citing the UGC guidelines,[17] and have continued to systematically exclude SC

[16]"The admission matters have been dealt with by academic section. The reply may be sent to the applicant directly by the Academic Section," PU/SRC/AR/RTI/2016/ dated 07/10/2016.

[17]For details see Clause 9 (b) in the UGC "Guidelines for Strict implementation of Reservation Policy of the Government in Universities, Deemed, to be Universities, Colleges, and other grant-in-aid institutions and centers," p 3.

and ST students from being admitted to PhD programs by conducting admissions even when there are one or two seats.

However, the policymakers should take keen note of the argument made by the university about the roster system. In their reply to the NCSC, in addition to Clause 9 of the UGC guidelines, the university stated that:

> even if roster is adopted, only the 7th point will go to SC and the 14th point will go to ST; whereas the University is now providing seat to SC at 4th vacancy and ST at 8th Vacancy. Moreover, as per the Act 2006 reservation is to be provided on the annual strength and there is no provision for a running roster or carry forward. Moreover, nowhere in the CEI Act (2006) or in the Amendment Act (2012) the word "Roster" has been mentioned and the University has been strictly following all the guidelines issued in this regard.[18]

What has not been stated explicitly in the above quoted point is that if the roster is accepted for implementation, the categories that were excluded in a particular year will get their due in subsequent years. The details of PhD admissions declared by a few departments in the university website proves that the university authorities' claim that the university is implementing reservations according to the CEI Act is false as SC candidates have not been allotted seats when the intake is less than 4, and STs have not been allotted seats in many departments even when seven to eight candidates have been admitted (Pondicherry University (2016b, 2016c, 2016d).

The university administration has justified their act by arguing that the CEI Amendment Act, 2012 does not apply to the Pondicherry University. Their reluctance to follow UGC's recent guidelines proves their unwillingness to implement the reservation policy as per the CEI Amendment Act. 2012 as it clearly prioritizes reservation for SCs and STs over OBC reservation. It is the bitter truth that the university went ahead to complete the admission process in 2016 even after strong objections were raised by SC and ST students, faculty members, and Pondicherry University SC/ST employee welfare association. While the PhD admission was kept in abeyance owing to a mismatch between the policy and the method that university followed, in a meeting held on 10 August 2016, the registrar cited "oral instructions" from the UGC and subsequently ordered the departments to proceed with admissions. However, in his reply to an RTI query on the matter, the UGC joint secretary categorically denied this and stated that "there is no convention or relevance of anything called as 'oral instruction' nor was any occasion or reason for the same here in this matter."

Notwithstanding this, the deputy registrar (academic) in her reply to the Pondicherry University SC/ST Employees Welfare Association (PUSC-STEWA), stated that the "university is implementing 15 percent for SCs, 7.5 percent for STs, and 27 percent for OBCs" and it is worthwhile to note here that the CEI Act has not been referred to in this letter.[19] Moreover, the details of admission presented in the annual

[18]Para 3 of "Para wise remarks on the petition filed by (…) to National Commission for Scheduled Caste," letter PU/DR/Aca2/2016-17/295 dated 07/12/2016.

[19]PU/AS/Aca-2/Ph.D. Admission/2016-17/184 dated 25/08/2016.

report of the university proves that this claim made by the deputy registrar in her reply can hardly be substantiated with department wise data. It can be observed that in 2013–14 several departments did not admit SC/ST students even when the intake was more than ten students in PhD programmes.[20] A number of other departments where the intake was less than four did not have SC candidates and several departments with an intake of less than eight did not have ST candidates. Thus, the facts are contrary to the claim made by the deputy registrar (academic) and even the then vice-chancellor (i/c) is also reported to have given a similar statement to the press (Senthalir S. 2016b).

While the university has responded to the NCSC that the Amendment Act, 2012 does not apply to the Pondicherry University, in a response to the UGC and Ministry of Human Resource Development (MHRD) the deputy registrar (academic) stated that "the admission to the PhD programme in the university has been completed as per the Central Educational Institutions (Reservation in Admissions) Act 2006 and as amended in 2012."[21] Given these two responses, it will not be an exaggeration to call this a systematic exclusion of SC and STs from PhD programs by the university authorities as willful. It should also be noted that university administration has presented different facts to different bodies.

Need for an Effective Monitoring System

The way Pondicherry University has implemented reservations necessitates a serious introspection because a central educational institution which is governed by acts and statutes of the Parliament has avoided implementing the directions received from the UGC and MHRD. Why should an institution run by the government not implement schemes meant for the upliftment of the SCs and STs? Does the government take a serious note of institutions undermining the authority of the ministry and governing bodies such as the UGC?

The failure of these institutions to effectively implement the reservation policy points towards the fact that mere communication of these policies to universities alone is inadequate to ensure the deliverance of social justice, and it is high time that the policy makers realise this. In regard to the RTI query "whether the communications from UGC regarding implementation of reservation in admissions and appointments are displayed in the university website?," the Pondicherry University administration replied that "All communications on reservation policies on appointments received from UGC are not displayed in University website. Reservation is adopted and followed in appointments/promotions as per Government of India Policies."[22]

This reply demonstrates the unwillingness of the authorities to keep the public and the stakeholders informed about policy changes and did not provide a reason for this practice. It is also to be noted that this reply is silent about the reservation policy followed in admission. The very non-transparent state of affairs raises serious doubts

[20]See Table 8.2 Details of SC/ST Student Admitted to Various Courses, presented in *28th Annual Report of Pondicherry University for the year 2013-2014*, pp 227–28

[21]Reply written by the deputy registrar (academic) to the UGC and MHRD— No: PU/AS/Aca-2/Reser./2016-17/273 dated 21/11/ 2016.

[22]Pondicherry university circular number PU/ESTT/NT-I/II-5/540/2016/208 dated 27/8/2016.

whether the policies enacted by the government are seriously followed, and if so, why are these circulars not made available in public domain? The resultant ignorance about policy changes among the stakeholders reduces implementation of government policy in a public institution to a matter of administrative discretion and benevolence of individuals in positions of power.

In this context, unless the personnel in administration respect the rights of vulnerable sections, the government institutions cannot achieve the goal of social and distributive justice. Nevertheless, the implementation of a significant social justice mechanism like reservations cannot be dependent on the whims of a benevolent administrator. Hence, it is better to create administrative mechanisms to prevent subversion of social justice mechanisms and to ensure that the system cannot be used for the vested interests of individuals in decision-making authority. While the CEI Act, 2006 and its 2012 amended version were communicated to the registrars of all central universities, we encountered a group of administrators who were ignorant about these rules even in June 2016. The only document they seemed to be aware of were the UGC guidelines put forth in the year 2006. It is once again a mockery of the system that the administrators cite guidelines as a counter to a central act enacted by the Parliament of the country.

Unless the personnel in decisive positions share the concern / ideals of the state with regard to social justice and empowerment, the policy initiatives by apex bodies governing higher education institutions in India would never be implemented in letter and spirit. The Pondicherry University example amply demonstrates that that administrations can follow policies of exclusion despite repeated representations made by the stakeholders. An institutional mechanism should be in place to ensure that the policies are implemented as intended by the government rather than being subverted by the vested interest of individuals in administrative capacity.

In this context, the intervention of the liaison officer of the special reservation cell of Pondicherry University and the response of the university administration to that is an example of how the members of dominant social groups use their position to further their vested interests. On 5 July 2016, the liaison officer of Pondicherry University has moved a file seeking details of students admitted across social categories to PhD courses since 2007. The section officer of the academic section in response to that noted,

> 4) Moreover, when the issue' regarding reservation in Ph.D. admission is under consideration of the University authorities, moving a file by the Special Reservation Cell unilaterally to the Academic Section without any approval of the higher authorities seeking details for a longer period of 10 years with an observation that reservation has not been followed in the University as per the norms of the Govt. rules *is not good office practice*. It may cause unnecessary embarrassment to the University. [23]

[23]Special Reservation Cell note file No PU/SRC/LO/2016/02 dated 05/07/2016 obtained through RTI. The liaison officer had sent two reminders and he had been subsequently transferred from that post and another person has been appointed as the assistant registrar of the Special Reservation Cell, and not as liaison officer. Though the transfer is claimed as

This remark has to be seen in the light of the responsibilities and privileges vested with the liaison officer as laid down by the office memorandum issued by the department of personnel and training of the Ministry of Personnel, Public Grievances and Pensions

> 3. Cases of negligence or lapse in the matter of following reservation and other orders relating to the Scheduled Castes, the Scheduled Tribes, the Persons with Disabilities, and the Other Backward Classes coming to the light through the inspections carried out by the Liaison Officer or otherwise, should be reported/ submitted by him to the Secretary/Additional Secretary to the Government of India in the respective Ministry/Department or to the Head of the Department in respect of offices under the Heads of Department, as the case may be. The concerned Secretary/ Additional Secretary/Head of the Department shall pass necessary order on such reports to ensure strict compliance of the reservation orders by the appointing authority concerned. (GoI, 2013).

Thus, the administration's reply not only hinders the liaison officer from discharging his responsibilities but also denies the independence vested upon the position as it condemns his initiative of seeking relevant information about PhD admissions across different reserved categories as "not good office practice."

The difficulties faced by the stakeholders belonging to SC and ST categories to ensure proper implementation of reservation as envisaged by the CEI Act and the recommendations of the Parliamentary Standing Committee talk volumes about the discriminatory tendencies prevalent among individuals holding administrative positions. Things could have been a little different if the apex bodies had also clarified the method in which the representativeness of SC, ST and OBC communities has to be ensured in educational institutions. The Pondicherry University example clearly demonstrates that any ambiguity in rules will be exploited in favour of the socially dominant, which automatically proves to be a systematic exclusion of SCs and STs.

It is disappointing and depressing to realize that the SCs and STs have to take up a relentless fight even to implement a right that is already granted by the Parliament. These experiences indicate that the system that is currently in practice is insufficient to ensure proper implementation of both social justice mechanism and also welfare measures. Given the vulnerabilities of SCs and STs, the UGC and MHRD should place a system that compels the institutions to report with evidence that the policy changes/ welfare measures are implemented without any deviation within a specific time period. Rather than deputing an officer within the university as a liaison officer, the liaison officer should ideally be an autonomous authority appointed by the UGC / MHRD or the National Commission for SCs or National Commission for STs so that they are not controlled by the administrative hierarchies within an institute. Such a setup

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"*normal* administrative actions," replacing the liaison officer with assistant registrar need not be accepted as "*normal*."

would protect a proactive liaison officer being transferred at will by the university administration.

Further, there cannot be a worse atrocity than a government servant holding a responsible position failing to implement the welfare measures and social justice mechanism brought in by the government itself. Taking the number of students/ families who are adversely affected by non-implementation of policies, this is much worse than crimes/ violence that affect individuals as it produces irreversible outcomes and the loss is incurred by the most powerless and vulnerable sections in a casteist society. Given that these decisions are taken by public officials, it is high time that the government realizes that these are not unintentional lapses, rather these are systematic denials in the guise of ignorance. Hence, the UGC/MHRD should take serious note of how the CEI Act, 2006 and Amendment Act, 2012 are implemented and issue directives to universities to ensure the representation of all vulnerable sections in each and every program in every department. Given that they have not implemented roster in admission since 2006, the governing bodies of higher education should ensure that the university should declare backlog vacancies in PhD as it does in recruitment.

The regulatory bodies should contemplate punishment as per the provisions of Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Amendment Act, 2015 and other acts if any of the reserved categories are excluded systematically. Personnel who undermined the constitutional right to equality and other safeguards of the oppressed should be held guilty of discrimination and be punished stringently. Such administrators should be publicly blacklisted as discriminators and should be prevented from occupying any administrative post in the future. Only such stringent action would protect the sanctity of administrative positions in education which is undoubtedly the most significant pillar to facilitate an inclusive economic and social development.

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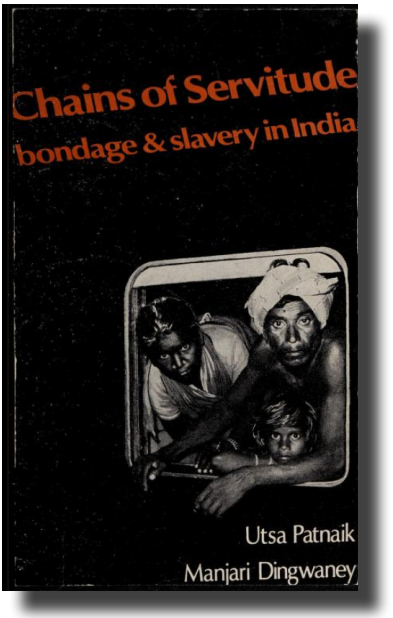
'Chains of Servitude: Bondage and Slavery in India'

Author: *Utsa Patnaik and Manjari Dingwaney*
Publisher: *Sangam Books*
Year: *1985*



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The genesis of slavery in India can be traced to at least late Vedic times with the emergence of the caste system in the Aryan's conquest. Unlike in the West, servitude in India did not exist in one particular form of bond labour ensured by extra-economic coercion, but the evolution and survival of the caste system and adaptations of the social norms complicated this issue further, where some castes remained in permanent subordination of other castes, hence providing different dimensions to forms of slavery in India. This volume, edited by Utsa Patnaik and Manjari Dingwaney, puts up nine essays to draw together different aspects of bondage along with the survival and evolution of these exploitative employer-labourer relations in the capitalist period. The essays are differentiated on the lines of the historical genesis of slavery, survival of past modes of production in contemporary readings, and depth analysis of the limit of law in the process of emancipation. The historical genesis is traced from the Vedas, Buddhist literature and the available religious literature hinting towards the presence of diverse forms of servitude under different reigns. Contemporary readings are based

on surveys and the case studies providing vivid representations of the conditions of bonded labour which continued even in the post-independence period. The third section focuses on limiting the laws introduced to abolish slavery but remains ineffective in its implication.

The introduction by Utsa Patnaik has outlined the timeline of the modern wage class from its historical origin to its continuation in the post-independence period. Appropriation of surplus by the Mughal Empire through the channelised process is regarded as the Indian version of feudalism which survived the precapitalist employer labourer relations (p. 3). However, the extent of these relations differed in regions and periods but existed throughout medieval India, framing the basis for hereditary servitude. Her discussion on the capitalist development of agriculture in the post-independence period outlines the inflationary pressure and redistribution of income, increasing profit/wage ratio, and significant difference in interest rate to landlord-turned-capitalists (approx. 8-9 per cent) as compared to poor peasants (approx. 18-44 per cent, informal loan).

The deteriorating effect of the Green Revolution on agricultural labourers is highlighted as benefits were not percolated down to rural power. The period witnessed a fall in real wages of agricultural labour, and they could not fetch the minimum amount required for reproducing labour-power. Bondage was not a static phenomenon as indebtedness was an in-built characteristic of contract by the landlords, enslaving the generations of labour-power.

In the essay on servile labour in ancient India, Uma Chakravarti describes servitude types between chattel slavery and free citizens. Her description of the word 'dasa' from the diverse ancient literature is a good source to interpret slavery in their respective (or masters') reigns. Among the various categories of dasas mentioned, it was propounded that the ones captured in the war have been significant in the origin of the institution of slavery. The forms of servitude, which involves the slaves captured in war or the enslaved people born in masters' houses, or those reduced to slaves due to their caste, are some of the dominant forms of slavery that existed in the ancient time instead of bondage labour. A historical timeline of the origins of the slaves and the words associated with them are provided with the analysis of their evolution over different periods. The above statement can be supported by analysing the term 'visti' (forced labour) provided in the essay (p. 54). Her investigation of the women in bondage, their servile conditions, and their reference in terms to the wealth of the master are detailed and mentioned. Exploitation suffered by the bondswomen was unique as they were not only faced with physical violence but also vulnerable to sexual abuse. Though there seems to be a lack of consistency in the essay, the detailed analysis of the above is quite interesting. Generalisations made by the author, such as bondage became the dominant form of slavery in the Mauryan period, need further investigation because it was extracted from Brahmin writings, which are acceptable for a particular area but not suitable for generalisation at the country level.

Salim Kidwai, in his essay 'Sultans, Eunuchs, and Domestics', emphasised more on chattel slavery than bonded labour. In medieval India, domestic slavery turns out

to be the dominant form. Although domestic slavery was present in the ancient era, it remained under-reported. In this essay, many new dimensions have been touched upon such as Muslim religious texts on slavery, the dependence of Sultans on slaves, bonded labour and its role in production (which is not so significant), tremendous growth in the incidence of domestic slavery, etc., which helped shape the notion of slavery and bondage in this period. Though the Muslim religious text calls for the emancipation of slaves, the opposite has been found in reality, as Caliph raised an army of 70,000 slaves as their exclusive basis of strength. The poor economic conditions and the repeatedly occurring famines have presented slavery as an alternative to ensure their survival. Hence, slavery and bondage become a passport for their entry to service in the military, which is desired to have a successful career. To ensure the reserve army of slaves, voluntary and involuntary surrender was carried out across regions (p. 86). Craftsmen were enslaved and sent to work in state factories and workshops. Though the import of slaves also occurred, the local supply ensured the major volume through the above means. It is interesting to note that despite this scratched period of different reigns, primitive forms of caste-based bondage survived in this period. Although the essay is limited to his Persian sources, it provides a detailed overview of different issues.

Tanika Sarkar deals with the bondage in the colonial period. Due to the shades of the caste and economic conditions on each other, delineating slave labour categorically is not an easy task. Different reigns and periods have led to the existence of all forms of labour. It is even difficult to distinguish between slavery and bondage for most of our period. Several categories exist among the slaves, each attracting different treatments from their masters based on their caste. Higher caste slaves were restricted to the more privileged domestic labour, while those of the low caste were employed in the menial outwork work. In this essay, the author has discussed several issues such as urban chattel slavery, the framework of caste within the slaves, the hereditary nature of bonded labour, the emergence of another form of slavery (other than chattel slavery and bondage), i.e., agrestic slavery, domestic slavery, indentured labour, the religious shade of slavery and bondsman and even the system for manumission. Though it is not easy to cover all of the above areas in one essay, given the varied literature on all the topics, fitting all of the above topics in a short essay has confused the standard timeline of events. Given the heterogeneity in different regions and policies during colonial rule, generalisations made by the author are broader than their scope. It was mentioned that slaves were sold for their defaults in revenue, but no further comment was made to state that this was done based on the earlier policy, which was soon abolished. The much-needed latitudinal description of various topics was missing, such as the framework of manumission or the inhumane conditions of forced labourers in plantations.

The second section of the book contains five studies of prevailing conditions of slavery and bondage. Surveys and case studies presented in each chapter capture the

vivid description of different forms of slavery and the extent of these exploitative employer labour relationships. These studies have also presented a brief historical overview of the existence of slavery in the areas taken up for observation. All the five studies in the second section, i.e., agricultural labourers and handloom weavers in South Arcot (R. Vidyasagar), brick kiln workers in Muzaffarnagar (Sumeet Chopra), bondage in the Santal Parganas (S.P. Tiwary), migrant labour in Ludhiana and Hoshiarpur (Manjit Singh and K. Gopal Iyer), and female bondage in the Himalayan region of Jaunsar Bawar (Jayoti Gupta) points towards the evolution and survival of well-entrenched forms of debt bondage.

The case study of agricultural labourers and handloom weavers by R Vidyasagar points out that the heavy revenue extractions and pauperized peasantry are responsible for swelling up the rank of agricultural labourers. As a result of the industrial revolution in Britain, artisans, especially spinners and weavers, also added up to the rank of agricultural labour. Weavers were settled in the areas near the port to facilitate trade for European merchants and feed the industrial revolution in Britain. Merchants slowly gained control over the weavers by paying them advances. Contracts were drawn on such conditions in both the agricultural labour and weavers, facilitating their bondage to the respective moneylenders. The study of brick kiln workers in Muzaffarnagar district by Suneet Chopra shows inhumane working conditions of forced labour in brick kilns and how their wages were not even enough to ensure the minimum consumption. The Green Revolution and the capitalist approach to agriculture have mainly concentrated the profit from it at the top level. This capital approach's slow and spillover effects can be seen among poor peasants and cultivators. Although the failure of capitalism to overthrow the semi-feudal relations of the agrarian sector has been analysed, existing land relations seem to facilitate the survival of the past mode of production. The question of women in bondage is directly addressed in Jayoti Gupta's essay on the system of polyandry in a Himalayan region: because they are the common property of males within patriarchal families, women in this area have been driven to prostitution as pawns in relations of debt bondage and hence face compounded oppression as compared to their male counterparts.

All these studies center on the one main point that calls for more capitalism and redefining land relations to overthrow the exploitative employer labourer relations. Despite the introduction of various acts in colonial and post-independence times for the abolition of slavery, these were intentionally designed to remain ineffective as the colonial government did not want to disturb the revenue sources which were these landlords feeding on the profits generated by this bonded labour. These fieldworks and surveys confine the survival of past modes of production in even the capitalist mode.

The ineffectiveness of the law is emphasised by Manjari Dingwaney, who surveys the provisions of the various Acts dealing with slavery, indentured labour, and bonded labour. It was pointed out that the act's objective was tactical instead of based on principle. Though the proper treatment was given for explaining the ineffectiveness of

the acts, a detailed historical analysis behind the introduction of acts does not find any mention. The needs for industrial capital in England are not sufficient to explain why specific laws and not others were passed nor why some were effective. This important field still awaits historians to understand better the problems of analysing the making and consequences of policies.

There is no easy line of continuity among the three historical chapters and the contemporary regional studies brought together in the Patnaik-Dingwaney volume. The field surveys of small samples put the derived results under observation. In many instances, generalisations made from derived data go out of scope. The reason for selecting these particular articles other than the availability is not made clear.

The series of articles in this book describe the history admirably and the research quoted, though small scale, is often heart-rending in its description of the cruelties inflicted on untouchables and tribals, whether they are working on the land or in such associated professions as making bricks. The coverage of diverse forms of servitude and their evolution over time explained with the case studies and fieldwork makes it more interesting. This volume opens up future research on land and labour relations and research on a larger scale.