DALITs AND HEALTH

by

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Historical context

The Dalits are those who were referred to as the *chandalas, atishudras, avarnas, panchamas, antayas and antyavasan*. In the Hindus religious scriptures they were " Broken men" and " Protestant Hindus" to Dr. Ambedkar and "Harijans" to Gandhi. To the British they were the "untouchables and the depressed classes". They are referred to as the "scheduled castes" in the constitution of India. " Dalit" is a decent term adopted by the Dalits themselves to indicate the fact that they are the most oppressed, exploited and dehumanized section of the Indian society. (A. Ramiah 1994).

Dalits are the descendants of the pre Aryan Indians who claim to have their autonomous and egalitarian culture. The varna system was the creation of the post aryan era, which aimed at institutionalizing a class differentiation and political domination of the ruling class and was sustained by caste ideology of purity and pollution. The Indian society was stratified into four varnas - The Brahmin (the priestly class) which evolved from the head of god, the Kshatriya (Warrior class) from his arms, the Vaishya (traders and artisians) from his thigh and the Shudra (slave) from his feet. The ones beyond the pale of caste were the *chandalas, atishudras, avarnas, panchamas, antayas and antyavasan* – The Dalits. They were the offspring of a Brahmin female and a Shudra male. Their touch, sight and even shadow polluted. The Hindu lawmakers treated them as the most despised people. They were condemned to live outside the villages and earn their livelihood by removing the dead animals, garbage, sweeping the streets and drains. They had to live in the company of donkeys, dogs and pigs. Even during the British Raj they were not allowed to draw water from the village well, enter schools, not allowed to eat decent wholesome food and not allowed to walk on common roads. Women had to keep their breasts uncovered, not wear gold and silver ornaments and had to wear clothes made of coarse cotton. They were not allowed to own property or accumulate wealth amongst other discriminations and exploitations.

Though the Civil rights movement evolved during the freedom movement, untouchability and other discrimination against Dalits were not given any attention by the Indian nationalist leaders and intellectuals, as this would open a pandora's box of caste inequality within the country and weaken their fight against the colonial rule. During this phase, Gandhi was very alive to social evils, especially untouchability. He toured the length and breadth of the country to uplift the Dalits whom he called the "Harijans – The People of God". Unfortunately he perceived this issue with a welfarist ethical perspective rather than a rights perspective. The Dalit issue was perceived with a rights perspective during the post independent era by the movements led by Dr. Ambedkar and Periyar. Many civil rights groups that emerged

during the post emergency period also focussed attention on exposing atrocities on Dalits as a human rights violation.

The constitution of India enshrines principles of equality, freedom, justice and human dignity and requires both the state and the central governments to provide special protection to Dalit members, to raise their standard of living and to ensure their equality with other citizens.

This forms the basis of the implementation of the provisions in The Protection of Civil Rights Act, 1976 (earlier called untouchability – offences act 1955) and Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989.

The Protection of Civil Rights Act, 1976 (earlier called untouchability – offences act 1955) provides penalties for preventing a person, on the ground of untouchability, from entering a place of public worship and offering prayers or taking water from a sacred tank, well or spring. Enforcing any kind of social disability such as denying the use of road, river, well, tank, water tap, bathing ghat, crematorium ground etc., attracts the provision of this Act.

Besides the Civil Rights Act the Parliament also enacted the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989, in order to prevent the commission of offence of atrocities against the members of the SC/ST to provide special courts for trial of such offences. The need for this Act was felt because " under the circumstances the existing laws like the protection of Civil Rights Act, 1955, and normal provisions of the Indian Penal Code have been found to be inadequate to provide safeguard against the crisis against SC/ST (P.K. Gupta 1991)".

There is enough and more evidence – both scientific (analysis of records) and experiences of individuals at the grass root level, that despite these legal provisions, the Dalits are even today a socially isolated and a socially ostracized group. Historically till date there has not been much change in their status. Even after 50 years independence, their civil, social and political rights are still being grossly violated. The following amply substantiates these facts.

Atrocities

The break up of the atrocities for the latest year 1995 shows that this includes 513 murders, 4,000 grievously hurt, 439 arson and 787 cases of rapes. The data June 1981 onward shows that annually about 500 Scheduled Caste persons are murdered, 4,000 are hurt, 400 to 900 are subject to arson and 10,000 faced other offences giving an average of 15,000 cases of atrocities annually. (S.K.Thorat, Human Rights and Dalits)

Untouchability

Dr. Mumtaz Khan (1995) concludes from a study based on 52 villages drawn from 52 taluks with 941 samples, for Karnataka that: " Contrary to

expectations…the practices of untouchability in several areas of human social interaction are very much alive in the rural areas.

Areas of Practice of Untouchability

Area	Untouchability Practice per cent of respondent
Hotels	80.5
Temples	77.2
Religious Procession	77.2
Tank Water	68.4
Tap Water	77.2
Social Mixing	70.2
Economic Activities	56.0
Political Activities	29.8

Violation of Political Rights

A study on Karnataka observed that: " Tensions in the political spheres of village life occur quite often due to high caste preventing the Harijan from participating in political activities, from not voting for a particular candidate etc. Dr. Venkateswarlu has given enough statistical support in favour of violation of political rights". A number of studies point out the discrimination of Dalits in land and employment market and discrimination in wage earning as well. The Dalit labourer tends to get lower wages as compared to a non-Dalit worker.

Discrimination in Education

A number of studies observed discrimination of scheduled castes in schools and colleges. Dr. Geeta Nambissan observed that " within the school it appears that Dalit students continue to experience social discrimination and thus can be seen both in the official curriculum and the hidden curriculum of schooling. Scheduled Caste communities and the experience of untouchability rarely form part of the school knowledge. Though untouchability and maintenance of social distance from certain communities still persists in most parts of India, such practices are rarely mentioned in the school boos or discussed in the classrooms" (PUCL Bulletin, April 1995 edited by Dr. R.M. Pal and published by Peoples Union for Civil Liberties).

Dalits and Health

Any discourse on any dimension of the lives Dalits has to be placed in a historical context so also true in the case of health.

The World Health Organisation defines health as a " state of complete physical, mental, social and spiritual well-being and not just the absence of disease and infirmity". For the purpose of our discussion we would like to broaden this definition and define health also as a function of nutrition,

education, employment, housing, access to drinking water, sanitation and hygiene among others.

The World Health Organisation points out that the increasing gaps in maternal and infant mortality and under five mortality rates between countries is indicative of a health crisis and therefore it demands decisive action. The Black report in the UK marked differences in mortality rates between occupational classes, for both sexes and at all ages (Townsend and Davidson 1982). Hecklers report on black and minority health clearly shows that minority groups suffer excess morbidity and mortality related directly to social inequalities. This is true even for many European countries which shows inequalities in health across classes.

In the Indian context the facts mentioned in the introduction very clearly indicates that historically to date the Dalits have suffered discrimination at the cost of the Brahmanical obsession with "purity and pollution". Initially the form of discrimination was very visible and normative (which is still alive in rural India) and now urbanisation has made this discrimination more sophisticated especially in towns and cities.

There is no doubt that this has had a detrimental effect on all the dimensions of health highlighted earlier. Inequalities in health status is the most grave and inadmissible of all inequalities as it has a direct impact on an individual's right to life. Yet there is negligible data available on Dalit and health. The only available information, is the data that is available as a part of nation wide surveys, such as the National Health and Family Survey, the National Sample Survey, Human Development Report and the Census and passing references to differentials by caste in micro level studies of health status of a population are practically the only source of information on the health status of Dalits.

The following set of empirical data will give us some basic idea about the health status of Dalits in rural India and their human development profile. We are concentrating on rural India as most of the Dalit population is based in rural India. We would be looking at a few vital indicators of health of women and children as they are the most vulnerable sub group within this larger group and they are the most sensitive indicators of the health status of any population. We would like to make a preliminary inference to see if the two are related and suggest recommendations with regard this issue.

- **General population distribution**

Population Distribution of Schedule Castes

Social Group	**Population (%)**	**Rural (%)**	**Urban (%)**
Scheduled Castes	16.48	81.28	18.72
All India	100.0	100.0	100.0

Source: Census, 1991.

Almost 16% of the population in India are SCs (dalits) within which 81% are in rural India and only 18% are in urban India. This indicates that "more than one sixth of India's population, some 160 million people, live a precarious existence, shunned by much of their society because of their rank as "untouchables " or "Dalits" - literally meaning broken people " (Broken People, Human Rights Watch, 1999)

- **Human development Report of Rural ,India,1994,Selected Indicators for schedule caste groups (See annexure 1)**

In terms of per capita income (Rs per year) the SCs (Rs 3,505) fall below the all India average (Rs 4,485). 31% of the SCs reported more than 50% of their total income as wages as compared to the national average of 27%. 55% of SCs contribute to the total adult wage earners as against other social groups contributing 38%. 51%of the SCs population lives below the poverty line as against the national average of 39%. According to the 37th round of the National Sample Survey (NSS) while schedule caste formed 20% of the house hold survey, they owned only 8% of the total land in rural areas in 1982.

According to the 37th round of the National Sample Survey (NSS) while schedule caste formed 20% of the house hold survey, they owned only 8% of the total land in rural areas in 1982. The 7+ years literacy rate and the ever enrollment rate (6-14years) is much lower than the average (39% and 60%) respectively against the national average of 54% and 71% respectively. There is not much of a difference between the proportion of total household income spent by SCs on education and the all India average (2.6% and 2.7% respectively). So also in the case of health, the expenditure by proportion of household income for SCs is 4.9% and 5.3% for all India. The Capability Poverty Measure (CPM) which is a simple average of percentage of births unattended by trained health personnel and percentage of stunted children and female illiteracy rates is higher than that of the all India population, 60% and 52% respectively.

In terms of households using facilities such as electricity and pipe water the SC households have a lower rate of usage than the all India average, 30% and 43% for electricity and 17% and 25% for piped water. SC households using Public Distribution System facilities is higher than that of the all India average (38% and 33% respectively). Only 21% of schedule caste population was literate in 1981 while the corresponding figure for the population as a whole was 36%.

Most of the SC population lives below the poverty line and most of them are wage earners i.e. agricultural labourers and are relegated to the most menial of tasks, as manual scavengers, removers of human waste and dead animals, leather workers, street sweepers, and cobblers (with an exception of those who have benefited from India's policy of quotas, in education and government jobs). Despite this fact the amount they spend on education and health is almost as equal to the all India average. They fall short of basic amenities like electricity and piped water. A high proportion of SCs depend on the PDS facilities for basic food requirements. Ironically there has been a move towards not only redefining the criteria for eligibility to the facilities where by a large proportion of the population would be deprived of this facility. There is a disparity between the literacy rate and the ever enrolment rate of the SC population which definitely points towards a high drop out

rate of Dalit children who end up being sold into bondage to upper class creditors or joining the work force. Even when there is reservation for them in education, they end up spending almost the same as the national average. The high CPM rate for the SC's is indicative of their low access to basic health care facilities.

- **Infant and Child Health Status**

Infant and Child Health Indicators in SCs and Others.

Indicator	SC	Others	Total
Mortality Rates			
Neonatal mortality	53.2	40.7	47.7
Post neonatal mortality	29.8	21.1	25.3
Infant Mortality	83.0	61.8	73.8
Child Mortality	39.5	22.2	30.6
Under five mortality	119.3	82.6	101.4
Immunization[2]			
All[1]	40.2	46.8	42.0
None	15.1	13.3	14.4

[1] BCG, Measles and 3 doses each of DPT and Polio vaccine excluding Polio 0.
[2] % of children aged 12-23mths who receive vaccinations anytime before the interview (according to the vaccination card or the mother), India 1998-1999
Source: National Family Health Survey 1998-99 (IIPS and ORC Macro 2000)

The above table very clearly indicates that mortality among all child groups is significantly high, especially for the below five mortality rates even though the rates of immunisation are comparable to those of others (ie excluding SCs). The rate of children not receiving any immunisation is much higher for SCs than others. The data shows that though the immunisation rates are comparable to those of the rest of the population, mortality rates for all groups are significantly higher than the rest of the population. This suggests that the health of this age group is not only a function of medical care but other socio economic factors also have a bearing on it. This can be further substantiated by the findings of a microlevel study conducted with rural SC population in Tamil Nadu , which showed an overwhelming health awareness among women though there were very high morbidity rates among the infant and under five age group. Nearly 48% of 209 death were of new born infants occurring within the first two or three weeks of birth a further 36%of deaths occurred among infants between one month and twelve months old. The study deduced that the high proportion of death in early infancy is a consequence of the high proportion (75%) of deliveries in the study population not being attended by a trained person. This coincides with the table given below

Delivery Characteristics

Percentage of Women by Place of Delivery, assistance during delivery and delivery complications by social group of women in India.

Place of delivery	Scheduled Castes	Others	Total
Percentage of women who had institutional deliveries	25.0	37.3	35.0
Percentage of women who had home deliveries	75.0	62.7	65.0

Source: Reproductive and Child Health Project, Rapid Household Survey-Phase I, India, 1998.

The study showed a clear indication that curative services were sort. So neither ignorance nor cultural beliefs prevent people from accessing health care. In the Under five category for 56%of all children ill medical help was sought.

- **Women's Health Status**

Ante natal Care

Percentage women who received any ante natal care (ANC) during pregnancy, by source of ante natal care and social group, India, 1998.

Social Group	Percentage distribution of women with:			Number of women
	Any ANC	No ANC	Total	
Scheduled castes / tribes	63.2	36.8	100.0	26895
Others	67.7	33.3	100.0	62582

Source: Reproductive and Child Health Project, Rapid Household Survey-Phase I, India, 1998.

The above table illustrates that a lesser percentage of SC women received ANC care as compared to others and a greater number of them did not receive any ANC care. This co-relates to the fact that the under-five mortality is very high for SCs.

Post Natal Care

Percentage of women by post delivery complications and type of treatment sought by selected background characteristics, India.

Complications/ type of treatment	Scheduled Castes	Others	Total
Percentage of women who had post delivery follow-up visit (within 2 weeks)	16.2	13.2	14.2
Percentage of women who had post delivery complications	45.2	41.1	42.0
Percentage of women who sought treatment post delivery complications	39.7	47.5	45.6

Source: Reproductive and Child Health Project, Rapid Household Survey-Phase I, India, 1998

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The percentage of women who had post delivery complications and who had at least two follow-ups is higher for SC's than it is for the others. The higher follow up rate could be due to the fact that they are based in communities that are regularly covered by government community health workers whose prime responsibility is identifying and referring cases of complication and follow up. Although percentage of women who sought treatment for post delivery complications is lower than that for the others. There could be various reasons cited for low treatment follow-up. Based on our field experience this could be due to lack of economic resources, urgency of getting back to work to sustain the family could have on their health among others. This needs to be explored further.

Assistance during Delivery

Percentage Distribution of births during the 3 years preceding the survey by attendant during delivery, according to social group, India, 1998- 1999.

	Assistance during delivery				
Social group	Doctor	ANM/nurse/midwife/LHV	Other health professional	*Dai* (TBA)	Other
Scheduled castes	23.5	12.1	1.2	37.7	25.1
Others	37.3	11.3	0.3	31.4	19.5

Source: National Family Health Survey (NFHS-2) 1998-99.

The table above shows that most of the SC women are being assisted by dais or traditional birth assistants (37.7%) as compared to 31.4% for others. Doctors assist only 23.5% of SC women in contrast to 37.3% for others. Assistance during delivery by Auxillary Nurse/Midwives or Local Health Volunteers is not very different for both the groups--- 12.1% for SC and 11.3% for others. There is a significant difference in the "other" category for

SCs vis-à-vis others. The reasons for this need to be explored. Though field level experience shows that the reasons could be no one being present during the delivery, delivery assisted by a family member, lack of economic resources, social isolation among others.

Place of Delivery

Percentage Distribution of births during the 3 years preceding the survey by place of delivery, according to social group, India, 1998- 1999.

	Health facility/institution			Home		
Social group	Public	NGO/trust	Private	Own home	Parents' home	Other
Scheduled castes	16.0	0.5	10.3	60.1	12.0	1.1
Others	17.9	0.9	21.3	47.1	11.9	0.9

Source: National Family Health Survey (NFHS-2) 1998-99.

Births taking place within their own homes forms the largest proportion of all deliveries taking place (60.1%) and significantly high as compared to others (47.1%). Followed by public services, for SCs 16.0% and for others 17.9%.

Nutritional Status

Percentage of iron-deficiency anaemia among ever married women and children under three years (6-35 months) by social group and degree of anaemia, India, 1998-99.

Social Group	Percentage of women with any anaemia	Percentage of women with:			Number of women
		Mild Anaemia	Moderate Anaemia	Severe Anaemia	
Scheduled Castes	56.0	35.7	16.5	2.3	14,657
Others	47.6	33.3	12.9	1.5	31,112

Source: National Family Health Survey (NFHS-2) 1998-99

Anemic status is based on hemoglobin content in the blood.
The SC women have an overall higher rate of anaemia as compared to the overall i.e 56.0%and 47.6% respectively. Even across the 3 categories of anaemia the SC have a higher rate. This directly co-relates to their food consumption and other social economic factors.

Dalit women face the triple burden of caste, class and gender. Dalit girls are forced to become prostitutes for upper caste patrons and village priests. Landlords and the police to inflict political “lessons” and crush dissent within the community use sexual abuse and other forms of violence against women. World wide there is enough and more evidence to prove that violence has a detrimental impact on a women’s psychological and mental health.

Overall, both the high infant mortality rate and the high probability of dying before the age of five as compared to the overall general population in the rural areas clearly indicates that social and economic deprivation is a major contributing factor. Social and physical factors play a dominant role in child health after the period of infancy, when a child is exposed to infections caused due to a change in food consumption i.e. when he or she is being weaned or there is greater physical mobility. A study done by TK Sundari Ravindran in the Chengalpattu district of rural Tamil Nadu, also substantiates this fact. A study done by Trakroo and Kapoor in 1990 finds that there is no striking difference in perceptions of illness and in health behaviour between SC's and non SC's, and therefore the higher infant and under 5 mortality cannot be attributed solely cultural factors. The Chengalpattu study also supports this as over whelming majority of mothers were aware of the advantages of immunisation and co-operated with the health authorities in immunising their child. There is also a clear indication to the effect that curative health services are actively sought, within the constraints imposed by the socio economic situation. Neither ignorance nor cultural beliefs prevent people from seeking health care.

Disparity in access to resources leads to disparity in exposure to the risk of disease, leading to disparity in disease burdens. There is a very clear indication from the above data sets that the health status of children and women is very closely related to their social and economic status. More attention needs to be focussed on the health of women, which would also help improve not only the health of the child but the whole population.

Beef and the BJP

The Bharatiya Janta Partys (BJP),(a political party comprising of majority Hindus)decision to ban beef hits at not only Muslims and Christians but also SCs . This would mean depriving them of their food habits and forcing them to give up their culture to get Brahmanised (Illaiah, 1996). In rural India 50% of the SCs fall below the poverty line and the prevalence of tuberculosis recorded among SCs is high. It shows a co-relation with low levels of living and consequent malnutrition. The prevelance of tuberculosis decreases as poverty decreases, suggesting its close relation to poverty. For millions of SCs beef is the only most protein rich food that they can afford and a high protein diet is what is required to check chronic diseases like tuberculosis. Veena Shatrugna of the National Institute of Nutrition says, "beef contains 21 per cent proteins whereas rice contains only 6-8 per cent proteins". In most vegetables the protein content does not go beyond 10 per cent. This has been one of the reasons why the poorest of the poor have continued to eat beef despite the fact that Hindu ritualistic society condemns it. This is but one example of how discrimination against one group due to the dominance of the other effects their life-style, which could have far reaching consequences on their health.

Recommendations

- Information on health status of this vulnerable population and on factors significantly influencing it is vital for appropriate formulation of policies and targeting of services. Therefore, it is extremely important to scientifically probe into the status of health of Dalit in states and regions.
- The issue of inequality of health should be part and parcel of any discourse on inequality in social, economic, political and civil spheres of Dalit oppression.
- Create mechanisms within the whole health care system where they get a space to voice their health needs and be partners in setting their health care priorities and participating in developing creative health programmes to deal with their inequalities.
- There should be allocation of resources in the spheres of health and related sectors in favour of disadvantaged groups so that the gaps in their health status are narrowed.
- Dalits being the poorest in society, approaching the private system for care is a clear indicator of the failure of the public health system that needs to be looked at closely.
- Dalit women have been most ignored and special attention should be give to them.
- One should move from the welfarist mode to the rights perspective in addressing the issue.

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