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Caste and Care: Is Indian Healthcare Delivery System Favourable for Dalits?

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CASTE AND CARE: IS INDIAN HEALTHCARE DELIVERY SYSTEM FAVOURABLE FOR DALITS?

Sobin George[1]

Abstract

The paper examines whether the dalit castes are adequately represented in the health service system in rural India in the context of the already established caste based discrimination in service delivery. Drawing from official data, the paper shows an overall domination of non-dalits in healthcare services. The paper presents two scenarios to understand it further. Fist is the similarities in health disparities between SCs and non-SC/STs of Bihar and Tamil Nadu, which have huge presence of non SC/STs in significant positions of healthcare delivery. Second is the case of Andhra Pradesh (undivided), which has less intergroup disparities and better distribution of health personnel from dalit castes at all levels of health services. These cases confirm the persistence of unfavourable environments for dalits with the domination of non-dalits in health services.

Introduction

The development literature in the recent past has brought out the stark differences in the social and economic status of Dalits[2] and Adivasis[3] as compared to other social groups in India. Most of these studies tended to focus on the correlates of group identity, material deprivation and poverty of these groups to their development deficit (Haan 1997, Thorat and Deshpande 2001, Shah 2002, Deshpande 2008). It indeed assumes significance in the context that their proportionate share in the category of 'poor' is much higher than other social groups .These scholarships are also grounded on the fact that they are the people who have been victims of discrimination and exclusion from the time immemorial notwithstanding the fact that its nature and forms have changed overtime. History illustrates that discrimination and exclusion of certain groups due to their identity based on social origin, ethnic and religious background, gender and nationality have been a reality in the Indian society. When it comes to questions of development and meaningful citizenship, discrimination still appears to have multiple ramifications related to exclusion from economic entitlements, basic services and opportunities on one hand and humiliation, subordination, exploitation and denial of rights on the other.

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[2] The term 'Dalit' implies 'oppressed' or 'broken'. It was first used by Jyotirao Phule in the context of the oppression faced by the untouchable castes. The word was also used by B. R. Ambedkar in his speeches. This paper uses the term 'Dalit' to refer to the ex-untouchable communities of India, who are constitutionally categorised as Scheduled Castes (SC). This paper uses the term 'SC' interchangeably as well, especially while referring to the official data.

[3] The term 'Adivasi' is derived from Sanskrit denoting 'original inhabitants' of peninsular India. It is generally used to refer to the constitutional category of Scheduled Tribes (ST) in India. The term 'tribe' however has colonial connotations of backwardness, primitiveness and pre-civilisational societies. Therefore identity assertion movements of these communities prefer Adivasi to Scheduled Tribes. It should also be mentioned that the term 'Adivasi' is not a consensual one among all groups in India; for instance groups especially from North East region of India prefer them to be called as indigenous people. This paper uses the term Adivasi; nonetheless it also uses Scheduled Tribe interchangeably, especially while referring to official data.

The dominant discussions in public health in India often tended to sideline the questions of discrimination while examining the gap in health status among social groups mainly due to the over influence of more visible issues such as unbalanced resource allocation and spending, poor coverage of services, infrastructure lacuna, human resource shortage, affordability and issues of governance. If not many, there are evidences that discrimination and resulting deprivation have an impact on health of the people in the Indian context. Borooah (2010) showed that people's health outcomes are significantly affected by their social group and there is a 'social gradient' to health outcomes in India. Some studies highlighted the lower level of utilisation of health services among the Dalits as compared to the non-Dalits (Ram *et al* 1998, Kulkarni and Baraik 2003, Baru *et al* 2010). Acharya (2007) drew attention to different levels of discrimination in Dalits accessing health services in the state of Gujarat and Rajasthan. Dasgupta and Thorat (2009) brought out the differentials in the rate of decline of IMR and maternal health between Scheduled Caste (SC)/Scheduled Tribe (ST) and other social groups. Saroha *et al* (2008) based on the study among rural Hindu women in Maitha in Uttar Pradesh highlighted that caste is a significant barrier to maternal healthcare service use among the rural women.

While there is evidence to support the linkages between social exclusion and the poor health status of Dalits and Adivasis, the exact pathways need to be examined further. The Indian health landscape thus is very complex due to the multiple deprivations that certain group of population face which eventually lead to poor nutrition, poor hygienic environment and ecological conditions conducive to ill health and diseases (Nayar 2007). This paper attempts to situate this problem in the analytical context that the inferior health outcomes of the marginalised are to be seen in the context of the existing intricacies of social exclusion that they experience and "graded discrimination" between and within various social groups. The following questions, subsequently, become important. Whether there are notable intergroup disparities in health outcomes and access to healthcare? If so, whether it could be understood by dalit's experience of discrimination in health service system? And finally if it is attributable to caste based discrimination, whether the present health service system has adequate personnel from discriminated groups to take care of this? This paper draws from two official data sources including National Family Health Survey (NFHS 2 & 3) rounds in order to understand some of the health outcomes across social groups and National Sample Survey organisation (NSSO) 68th round on employment and unemployment (2011-12) to present social group wise information of personnel in the healthcare delivery system. Apart from these data sets, the paper relies on published research on qualitative dimensions on healthcare access for marginalised social groups.

Marginalities and Inferior Health Outcomes

The linkages between group identity and health assume importance while we look at the level of deprivation of each group in comparison with other dominant communities and attempt to link with factors of discrimination and isolation. Some sets of studies have fairly attempted this task of bringing out the group specific differentials of health. Barik and Kulkarni (2014), for instance, highlighted the intergroup differentials in health status of SCs and STs. The study showed that children from Dalit and Adivasi populations faced higher risks of mortality as compared to the Non SC/STs. These disparities were noticeable in all states except a few including Assam, Haryana, Himachal Pradesh, and Jammu and

Kashmir. Similarly, the study revealed that the nutritional status of Dalit and Adivasi women and children in India is relatively poor. Thorat (2007) discussed the disparities in health status and healthcare access of Dalit and Adivasi children as compared to other groups in various states. The study further attempted to link the disparities with practices of untouchability and discrimination against Dalits. Dasgupta and Thorat (2009) reiterated the persisting trend of inequalities in health status and healthcare access of Dalit and Adivasi children that Barik and Kulkarni brought out. The study noted that indicators such as malnutrition and child mortality remained the highest for Adivasis followed by Dalits during 2005-06. Borooah *et al* (2012) brought out that morbidity and health care burden of dalit women are higher than others due to their lower access to healthcare services.

Available data from National Family Health Surveys (NFHS) also validated the inference that there are intergroup disparities in health outcomes such as infant mortality, maternal mortality, nutritional status and institutional delivery unfavourable to SCs and STs. NFHS data for three rounds showed that the pace of reduction in Infant Mortality Rate (IMR) was low for SCs and STs between 1992 and 2006 as compared to Non-SCs and STs. Similarly, under-five mortality remained the highest for Adivasis during 1992-93, 1998-99 and 2006-06. NFHS data also showed that dalit and adivasis children have the higher burden of malnutrition than others. States, where proportion of underweight Dalit children remained above the all India average of Dalits in 2006, were Bihar and Madhya Pradesh. Similarly, Bihar, Madhya Pradesh and Uttar Pradesh reported higher proportion of underweight Adivasi children in 2006 as compared to all India figures and other states (see table 1). Access to antenatal care was the lowest among Adivasi women as compared to Dalits and other social groups. Institutional delivery was the lowest among Adivasis followed by Dalits. States including Bihar, Uttar Pradesh, Assam, Orissa, Rajasthan, Himachal Pradesh and Madhya Pradesh had lower access to skilled attendants for Dalits and Adivasis (see table 2)

Dalit's Experiences of Discrimination in Health Services

The data presented from NFHS surveys and available published literature showed that though the health outcomes and access to health slightly improved for all social groups, marginal positions of certain group of people continue to be a factor that reproduces and widens disparities, especially in the context of Dalits. As a result, there is a substantial gap in terms of health status and access to health services existing for these social groups. The literature shows that much of this could also be attributed to the group specific indicators of social exclusion such as discrimination and isolation for Dalits and Adivasis. Identified forms of discrimination in the sphere of health services against Dalits included separate standing lines, being ignored and kept waiting for long, discrimination in health check-up and treatment, including the avoidance of physical touch, discrimination in the delivery of the medicine and avoidance of visit to houses by public and private doctors and medical practitioners (Acharya 2010). The study by Acharya (2010) revealed that 94 per cent of children experienced discrimination from grass root level workers in the form of 'ANMs not entering the house'; 92 per cent in the form of 'ANMs spend less time'; 69 per cent in the form of 'ANMs do not speak gently'; and 55 per cent in the form of 'ANMs do not touch while dispensing medicine' in the villages of Gujarat and Rajasthan (Ibid: 218). The study

brings out both subtle and active practices of discrimination against Dalits by healthcare providers, which was presented as follows:

> During diagnosis, doctors are sometimes less probing regarding the health problem, and adopt unsympathetic attitude and rude behaviour towards Dalits. The pharmacist, while dispensing of medicine, often keep it on the window still, without explaining the doses properly. The lab technician does not touch the Dalit children during the conduct of a test, and often tests are not conducted properly; the patient is told that the 'time for rest is over', and demeaning words are used as well. While applying medicine, or putting the bandage on to a Dalit user, nurses show lack of any concern or sympathy. They do not explain to the Dalits how to take care of the wound/dressing. The ANM/LHV/VHW often do not visit the Dalit quarters for counselling or dispensing medicine, or for dissemination of information regarding a health programme, a camp, except in the case of target based programmes like immunisation, particularly polio (Acharya 2010:221)

Shah *et al* (2006) in a study conducted in seventeen districts from Andhra Pradesh, Bihar, Tamil Nadu, and Uttar Pradesh revealed the discrimination faced by Dalit women in health services in government hospitals. Five hundred Dalit women who were interviewed described their experiences of discrimination in public sphere. This study brought out the discriminatory practices against Dalit women and children in various spheres by doctors, nurses and village health nurses when they entered government hospital or when they contacted medical staff inside and outside these institutions. This study also discussed the consequences of discriminatory treatment in access to health services on Dalit women and their families. It specifically showed that out of 375 villages surveyed, untouchability, which is prevented by law, was found to be practiced in the entry into primary health centres against Dalits in 68 villages (Ibid: 70). Similarly, discriminatory treatment in PHCs was reported from 37 villages. The most striking practice of discrimination in the health service against Dalits that the unwillingness of health workers to visit Dalit households. This was found to be prevailing in 142 villages out of 434, which the study covered for this purpose (Ibid: 72). It bears greater significance in the context that household visit by health workers is a vital part of health service system in ensuring childhood vaccination, nutrition and treatment for communicable diseases, above all health education in the rural areas. The following narrations given in Shah *et al* (2006) provide a vivid picture of discriminatory practices against Dalit children and women in anganwadis where most of the ICDS services are provided.

> Dalit women from Sanjhik, Bhabal and Randa villages in North Orissa say that upper caste anganvadi workers do not allow them to enter the anganadi centre. Their children are also discriminated against. In Simlapur village in central Orissa, women report that the health worker takes Rs.150 from them for every visit to the Dalit hamlet. Dalit women across Uttar Pradesh report that the ANMs practice untouchability; hardly any pregnant Dalit women approach health workers for their services. In Pandalam Thekkekara, Kerala, Dalit women report that the doctors at the local hospital spend more time examining and treating upper caste women. (Shah *et al* 2006: 127)

Irudayam *et al* (2006) highlighted the discriminatory practices against Dalit women and children while accessing health services in public and private centres in the villages of Andhra Pradesh, Tamil Nadu, Bihar and Uttar Pradesh. The study shows that discrimination predominantly is reflected in the form of medical negligence. The study quotes several instances of medical negligence from these states. The narrations given in the study provide a fair account on how taboos like untouchability can multiply casualties for a Dalit woman at the time of prenatal, delivery and antenatal care when 'touch' by care providers is very significant. The study reports fifteen such cases from these states. In some circumstances, negligence by the practitioners in the public hospital made them vulnerable to the

exploitations in the private hospital, which in turn put them in to debt trap. Major types of medical negligence from public health providers that the study revealed are ignoring the patients or kept waiting for long, indifferent verbal response, rude verbal response, refusal of medical treatment and substandard medical treatment (Ibid:363-366). Though Dalit women and children sought medical treatment in private clinics and hospitals out of desperation, they faced different sets of discriminatory treatments there as well. It included omission of professional expertise, commission of error in exercising professional expertise, and commission of error in exercising professional expertise alongside commercial motivation (Ibid: 367-368).

Deshpande (2007) in a study conducted in the villages of Manvi Block, Raichur District in Karnataka delineates how the status of Dalit women as an equal citizen is at stake while accessing public health services, which are supposedly universal and inclusive. Her study highlighted discriminations with regard to 'reluctance to touch', 'long waiting' and 'different treatments' for Dalits and non-Dalits in primary health centres. She quotes the questions that one of her dalit respondents asked to an upper caste doctor, which is worth quoting here as well:

> Why don't you touch us, why have you become a doctor if you are going to treat people like this? It was some of us women from the Dalit hamlet who raised the issue and fought with her. Why do you pick a fight? Others warned us. She will give you some poisonous injection they said. People here are afraid to ask questions to a doctor, they feel- Only when you have had enough of life, should you question a doctor. She was a Lingayat (upper caste). Why don't you touch us we had asked her. She had argued back-'Why if I touch you will I get extra insight about what is wrong with you?' Yes you will get a different diagnosis, we had replied, (Quoted from Deshpande 2007:16)

Differential treatment for Dalit and non-Dalits in PHCs is a very common phenomenon. As noted in the studies mentioned earlier, it is very much interwoven in the doctor-patient relationship and varies context specific, especially when doctor is upper caste and patient is upper caste and doctor is upper caste and patient is a Dalit or Adivasi. It varies from the tone of conversation, which is a vital part of diagnosis to prioritizing the non-Dalit over Dalits, irrespective of the casualty of the case. Deshpande (2007) again quotes in her study:

> If two child birth cases have come to the hospital- one of a Brahmin (upper caste) and one of a Madiga (Dalit), the treatment is different. For a richer person the tone is respectful-" yen ri?"- Or what happened to you is asked so lovingly? The suffix 'ri' is attached. For poorer patients it is- indifference. If the poor woman is about to deliver we have to go call the nurse. But for them, they don't have to be called. (Huligamma, 35, Pothnal), (Quoted from Deshpande 2007:18)

Some studies highlighted the discriminatory practices in associated sectors like Mid-day Meal Scheme. For instance, Thorat and Lee (2006) brought out the practices of caste and untouchability-based discrimination and exclusion in the Mid-day Meal Scheme and the Public Distribution System in selected states in India. This study, which covered 531 villages from 30 districts in Rajasthan, Uttar Pradesh, Bihar, Andhra Pradesh and Tamil Nadu, brought out various forms of discrimination and caste prejudices that operate in the functioning of these programmes and its negative implications on access to this scheme for Dalits and Adivasi children. They identified five types of discrimination against Dalit children including separate seating, separate meal, resistance of higher caste to eat the food prepared by Dalit cooks and inferior or insufficient food in the Mid-day Meal schemes in these states (Ibid:293). Similarly Drèze and Goyal (2003) highlighted the discrimination faced by Dalit children in accessing the service of mid day meal.

Whether caste based discrimination by the service providers plays a role in the health-seeking behaviour of an individual's? Navaneetham and Dharmalingam (2002) reveal that proportion of lower caste women who received maternal healthcare services such as antenatal care, iron folic acid supplements, having a trained attendant present at birth, contraceptive service, curative health services from qualified providers, and gynaecologic services are less when compared to upper-caste women. Saroha *et al* (2008) found that the use of maternal healthcare services, such as antenatal care, tetanus toxoid, iron folic acid supplement, trained birth attendants, and contraceptives among Hindu Dalit women in Uttar Pradesh was very low. In certain cases, discrimination in health services and financial un-affordability determined the decisions of treatment seeking of Dalit families. Dalip (2005) showed that the proportion of untreated patients among Dalits and Adivasis living in rural areas was higher as compared to other groups. He notes that while proportion of untreated patients among Dalits and Adivasis in rural India was 18.1 per cent and 21.5 per cent respectively, it was 16.8 per cent for 'others'. Irudayam *et al* (2006) details the changes in health seeking behaviour due to discrimination in public health institutions and it adverse outcomes for Dalit women, children and their families. The study showed that some women stopped treatment in Government hospitals and did not seek care from private hospitals or clinics, primarily due to higher cost of healthcare. In some cases, though women sought treatment in private hospitals, discontinued after a point of time due to financial constraints and huge opportunity costs such as loss of working days associated with treatment. During the instances of medical urgencies, some of them had to access loans to complete treatment in private hospitals, which put them in to huge debt (Ibid: 372-374).

In short, the macro data and other available empirical evidences indicate that there is a substantial social gap in health status and access to health services existing for Dalit and Adivasis. As it is already discussed, much of this can be also attributed to the group specific indicators of social exclusion such as discrimination and isolation for Dalits and Adivasis. This association, however, is complex and interwoven with structural as well as systemic components of exclusion, which often lead to poverty and material deprivation. In the case of Dalits and Adivasis, poverty and inferior conditions of living have an additional dimension of discrimination and isolation. Their historic deprivation of economic rights, such as rights to ownership of land, rights to buy and sell in the markets and problems associated with practices of cultivation as in the case of Adivasis to a greater extent determine their poor conditions of living. The data presented and literature reviewed clearly showed that though their situation changed over a period of time, strong undercurrents remain and 'Dalit' and 'Adivasi' continue to be an identity that reproduces and widens disparities in health outcomes.

Who are the Healthcare Providers in India?

Since the literature validates the discriminatory character of the present Indian healthcare service delivery system, it is important to understand the social profile of care givers. There is no direct data available on the social profile of personnel including doctors, technicians, nurses, assistants, Accredited Social Health Activists (ASHA) etc, across public and private sectors. However, we can get some indications from the NSSO employment and unemployment data, which provides information on health and related occupations as under the National Classification of Occupation (NCO). It should be

mentioned that the data does not give an absolute picture on the social group wise distribution of healthcare personnel; however is indicative of the social distribution.

As table 3 shows, except associate professionals of nursing, midwifery, ASHA etc., the share of Dalits in the occupations of healthcare sector is far below as compared to other social groups and is notably under-represented as a proportion to their total population in both rural and urban India. The health worker population ratio across social groups (table 3) shows that only the group 'others', which includes the middle and upper level castes has adequate/over representation among all health related professionals including general medical practitioners, specialists doctors, trained nurses, technician and associated health staff. While this group constitutes 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. Since the data does not give distribution across private and public sectors, one cannot argue that upper and middle level caste groups are dominant in the healthcare delivery system in the public sector. However, the overall pattern of their dominance in the sector is indicative of their strong presence in the public health delivery system as well. The overrepresentation of health professionals from upper and middle caste groups is starker in urban India except in the category of nursing professionals.

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 percents. In rural India, the underrepresentation of SCs is found to be the highest in nursing profession, the most crucial group of caregivers who need to closely interact with patients in a hospital setting. Urban India also followed the similar trend of underrepresentation of STs in all categories. For SCs it was pronounced most 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 5.5 per cent. In short, the data indicates that there is visible overrepresentation of middle and upper caste groups and underrepresentation of lower castes and scheduled tribes in the most important sections of care providers such as doctors and nurses. The dominance of upper and middle level caste groups in the key positions of health service system hence falls in line with the argument of discrimination in hospitals by personnel from these castes.

Whether such under and over representations have meanings for the inferior health outcomes of the discriminated groups? It is difficult to completely answer this question with the limitation of data and the methodology used in this paper. However, we could get some directions towards answering this question with the data on some of the health outcomes across social groups in various states. We would like to take data on births attended by skilled personnel as an example, which could directly explain the issue of accessibility to health services. Table 2 presents data on births attended by skilled personnel across social groups in some of the Indian states. The top ones among the better performing states are Kerala, Tamil Nadu and Andhra Pradesh (The National Rural Health Mission indeed has added more states to this group by 2015) and the bottom performers among the least performing states are Bihar and Uttar Pradesh. Kerala, being an exception, has only negligible intergroup disparity in access to

skilled personnel for child birth. Similarly, the difference between SCs and Non-SCs in Andhra Pradesh is low, but stark between STs and Non-STs. What is more important is the common pattern of higher level of intergroup disparity among the other top performing states (Tamil Nadu and Karnataka) and the least performing states (Bihar and Uttar Pradesh). While the differences in percentage point of access to skilled personnel at delivery between SCs and non SCs in Tamil Nadu, an overall better performing state, is 10.7 in 2005-06, it is 11.6 in Uttar Pradesh, one of the overall least performing states. This opens up the question of social profile of care givers beyond mere issues of physical and financial access.

Let us examine an assumption to understand this linkage of discrimination and inferior health outcomes of SCs. The assumption is that inadequate representation of personnel from discriminated groups in the healthcare delivery system can support the argument of existence of a favourable environment for discrimination in health services. The social profile of care givers in the states which have higher levels of intergroup disparities despite the achievements in health outcomes and the states which have negligible levels of disparities would be apt for examining this assumption. We take Bihar from the poor performer's group and Tamil Nadu from the better performing group. We also take Andhra Pradesh, which showed both better performance and lower disparities between SCs and non SCs.

Interestingly, the social profile of healthcare personnel in Bihar and Tamil Nadu shows some common features (see tables 4 and 5). Firstly, the share of health professionals including general doctors, specialists and associated health personnel from SC communities in rural Bihar and Tamil Nadu is far below their population share. While urban Tamil Nadu has relatively better representation of SCs in the category of general and specialist doctors, SCs in this category is notably underrepresented in rural areas. Secondly, there is a sweeping presence of health personnel from OBC community, which is the dominant social group (politically, educationally and economically) in rural Bihar and Tamil Nadu due to the changed caste equations with the relocation of middle and upper caste to urban areas. The urban healthcare landscape of these states is also dominated by non SC groups except the category of general and specialist doctors in Tamil Nadu.

What is more striking in these states is the very low representation of SCs as compared to the all India averages at the lower end of healthcare delivery system, which includes health workers and ASHAs. These health personnel play a critical role in the preventive and promotive health care such as vaccination, nutrition and pre and post natal care. They are also pillars of the ambitious national rural health mission, which has a special focus on direct contact with people and communities through house visits. The social profile of healthcare professionals in Bihar and Tamil Nadu shows that SCs are notably underrepresented in rural areas and hence validates the argument that there is a conducive environment for discrimination existing based on the lines of purity and pollution of caste system.

It is important to examine the social profile of health personnel in Andhra Pradesh, which showed both better health outcomes and less disparity between SCs and non SCs. Though Andhra Pradesh and Tamil Nadu are in the group of better performing states, the former has better distribution of personnel from SC community in all sections of healthcare personnel in the rural areas (see table 6), which could explain the low intergroup difference in health outcomes to an extent. Most importantly,

the state has a better representation from SC community in the category of nursing and midwifery associate personnel, which is an important part of preventive and promotive care. Similarly, SCs are adequately represented in the diagnostic and therapeutic services both rural and urban areas though representation of general and specialist doctors are not adequate for SCs in urban areas.

Concluding Remarks

The published studies presented in the paper highlighted the discrimination in the delivery of public health services at various levels. It is an important concern in the context that public health services are the only options available to resource poor Dalits for healthcare when it comes to the questions of financial affordability. The paper substantiates the argument of discrimination against dalits in hospitals. It indicates that dominance of caregivers from upper and middle level caste groups creates and sustains an environment that is favourable for discrimination. Similarities in the social profile of healthcare personnel, which is unfavourable to SCs, in Bihar a less performing state and Tamil Nadu, a better performing state is indicative of the favourable environment of discrimination against SCs in the rural areas. This is further verified by the example of Andhra Pradesh, which is a better performing state with less intergroup disparities and relatively better distribution of health personnel from dalit castes at all levels of healthcare delivery system in rural areas. Since discrimination has a strong dimension of personal experience, one cannot argue that such dominance is an absolute condition for discrimination. It is contextual and also varies from places to places and person to person. However, one cannot also discount the possibility of exclusion with this lopsided distribution unfavourable to dalits taking the pervasive nature of caste system its potential to recreate itself in any context. The Indian health service system at present is not equipped for addressing this issue. It opens up the need to further empirically test the assumption of the linkages between lower participation of dalits in healthcare services and their chances to be discriminated. It is also important to take sub castes as analytical categories here since discrimination has a graded nature even within a single social group based on the *jati*.

The deployment of healthcare personnel from dalit castes at all levels of the health delivery system in adequate numbers may be a policy option to solve issue for the time being. Whether such practices would further strengthen the existing caste relations is debatable; but urgent strategy should be to ensure adequate representation of healthcare personnel from excluded communities. Since prejudices based on caste are strong in the Indian society, there should also be adequate legal safeguards to check discrimination. Flagship programmes like National Rural Health Mission must have a special focus on social inclusion. This is to be reflected in resource allocation since localities where Dalits and Adivasis reside have severe shortage of health facilities, personnel and resources. Further, the inclusion agenda needs to be integrated in the written roles of duty-bearers such as ASHA, ANM, PRIs, NGOs, district administration and the state.

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Annexure

Table 1: Percentage of Underweight Children (<3 years): Selected States

	NFHS 2 (1998-99)				NFHS 3 (2005-06)			
States	**Non SC/ST**	**SC**	**ST**	**Total**	**Non SC/ST**	**SC**	**ST**	**Total**
Andhra Pradesh	36.3	43.5	46.4	38.4	30.3	37.7	41.3	32.6
Assam	41.8	32	20.5	36.2	31.8	42.6	20.8	32.1
Bihar	53.2	58.8	60.7	54.8	53.3	66.7	62.9	56.6
Gujarat	41.9	46	57.4	45.7	42.5	43.6	63	44.7
Haryana	53.2	40	NA	34.8	37	47.4	NA	40
Himachal Pradesh	42.3	52.6	42.9	44.5	33.3	43.1	34.1	35.9
Jammu	31.5	55.1	40	34.9	25.3	47.1	34.8	31.6
Karnataka	40.5	52.7	57.1	43.9	35.8	42	46.7	37.6
Kerala	25.6	42.9	57.1	27.2	20.6	34	56.5	23.4
Madhya Pradesh	51.4	57.5	64.6	55.4	51.0	58.5	64.2	55.8
Maharashtra	47.6	51.4	65.3	50.1	31.1	41.3	55.7	36
Orissa	51	59.9	59.9	54.9	32.5	44.9	54	40.5
Punjab	23.4	39.1	NA	29.2	17.3	34.7	NA	24.2
Rajasthan	47.5	56.5	59.4	51	37.3	46.2	45.6	40.4
Tamil Nadu	32.8	49.2	55.6	37.1	25.4	40.1	35.7	29.5
West Bengal	45.8	56.6	57.7	49.4	34.4	41.5	57.7	38.1
Uttar Pradesh	49.2	60.2	59.3	51.9	39.6	46.7	61.2	41.7
New Delhi	32.7	40.9	50	34.6	26.5	29	33.3	27.1
All India	44.1	53.3	56.3	47.1	39.4	47.8	54.4	42.6

Source: NFHS 2 and NFHS 3, estimated

Table 2: Births Attended by Skilled Personnel: Selected States

	NFHS 2 (1998-99)				NFHS 3 (2005-06)			
STATE	**Non SC/ST**	**SC**	**ST**	**Total**	**Non SC/ST**	**SC**	**ST**	**Total**
Andhra Pradesh	69.8	60.3	28.4	65.3	77.6	79.5	44.7	75.2
Assam	21.6	24.6	20	21.6	36.8	30.3	33.5	35.1
Bihar	27.1	18	6.7	23.6	33.6	17.6	16.3	28.8
Gujarat	60.8	50.7	33.9	53.5	68.1	62.9	31	63.2
Haryana	45.8	31	N.A	42	50.7	44.4	NA	49
Himachal Pradesh	41.3	36.5	33.3	40.2	51.8	38.3	40.8	47.8
Jammu and Kashmir	45.8	27.1	24.3	42.8	51.8	45.3	35.3	47.1
Karnataka	64.1	47.6	38.3	59.2	74.9	55.9	53.7	69.7
Kerala	95.3	96.4	57.1	95	100	99	88.5	99.5
Madhya Pradesh	37.5	25.9	14	29.8	44.9	37.0	15.1	35.6
Maharashtra	62.3	65.3	36.7	59.6	76	68.6	31.6	69.1
Orissa	43.3	28.1	14.8	33.5	59	40.8	17.6	44.1
Punjab	69.8	50.5	N.A	62.6	77.5	55.4	N.A	69
Rajasthan	40.9	26.9	23.7	35.7	45.6	35.2	30.2	41
Tamil Nadu	87.1	74.8	44.4	83.8	93.9	82.6	92.9	90.7
West Bengal	45.7	46.5	25.3	44.5	54.4	53.3	25.6	52
Uttar Pradesh	24.8	17.1	13.3	22.8	32.1	20.5	12.8	28.8
New Delhi	71.2	51.7	50	66.6	69.2	47.3	44.4	64.1
All India	47.2	37	23	42.8	51.8	40.5	25.6	46.8

Source: NFHS 2 and NFHS 3, estimated

Table 3: Distribution of Various Healthcare and Related Occupations Across Social Groups, All India, (2011-12)

Personnel		Rural					Urban				
		ST	SC	OBC	OTH	Total	ST	SC	OBC	OTH	Total
Health professionals except nursing	Number (%)	15104 (1.3)	194008 (16.5)	493319 (41.9)	473561 (40.3)	1175992 (100)	26861 (1.5)	97344 (5.50)	548002 (30.8)	1108548 (62.3)	1780755 (100)
	Ratio to population	0.02	0.12	0.14	0.26	0.15	0.25	0.22	0.42	0.86	0.57
Nursing professional	Number (%)	2270 (1.9)	12433 (10.7)	19775 (17)	81948 (70)	116426 (100)	15169 (12.1)	34667 (27.8)	38498 (30.8)	36524 (29.3)	124858 (100)
	Ratio to population	0.00	0.01	0.01	0.05	0.02	0.14	0.08	0.03	0.03	0.04
Health Associate professional except nursing	Number (%)	63507 (8.7)	137331 (18.8)	279724 (38.3)	249457 (34.2)	730019 (100)	26646 (2.7)	240321 (24.0)	357508 (35.7)	377779 (37.7)	1002254 (100)
	Ratio to population	0.08	0.09	0.08	0.14	0.09	0.25	0.53	0.27	0.29	0.32
Nursing and midwifery associate professionals	Number (%)	23255 (4.0)	98168 (16.8)	309857 (52.9)	154378 (26.4)	585658 (100)	48101 (7.7)	118357 (19.0)	189694 (30.5)	266307 (42.8)	622459 (100)
	Ratio to population	0.03	0.06	0.09	0.09	0.08	0.45	0.26	0.15	0.21	0.20

Source: NSSO 68th round, employment and unemployment (2011-12), unit level data

Table 4: Distribution of Various Healthcare and Related Occupations Across Social Groups, Bihar (2011-12)

Personnel	Rural				Urban				
	SC	OBC	OTH	Total	ST	SC	OBC	OTH	Total
Health professionals except nursing	2088	105035	11176	118299	1019	831	11060	3971	16881
%	1.77	88.79	9.45	100	6.04	4.92	65.52	23.52	10
Health Associate professional except nursing	-	11870	68679	80549	-	27406	26573	15120	69099
%	-	14.74	85.26	100	-	39.66	38.46	21.88	100
Nursing and midwifery associate professionals	602	7989	-	8591	-	--	12287	4605	16892
%	7.01	92.99	-	100	-	-	72.74	27.26	100

Source: NSSO 68th round, employment and unemployment (2011-12), unit level data

Table 5: Distribution of Various Healthcare and Related Occupations Across Social Groups, Tamil Nadu, (2011-12)

Personnel	Rural			Urban				
	SC	OBC	Total	ST	SC	OBC	OTH	Total
Health professionals except nursing	-	36096	36096	-	47871	57458	23576	128905
%	-	100	100	-	37.14	44.57	18.29	100
Health Associate professional except nursing	874	44027	44901	2169	-	84197	-	86366
%	1.95	98.05	100	2.51	-	97.49	-	100
Nursing and midwifery associate professionals	-	42436	42436	-	10632	63399	4362	78393
%	-	100	100	-	13.56	80.87	5.56	100

Source: NSSO 68th round, employment and unemployment (2011-12), unit level data

Table 6: Distribution of Various Healthcare and Related Occupations Across Social Groups, Andhra Pradesh (Undivided), (2011-12)

Personnel	Rural					Urban			
	ST	SC	OBC	OTH	Total	SC	OBC	OTH	Total
Health professionals except nursing	-	4861	38725	31866	75452	-	24146	28367	52513
%	-	6.44	51.32	42.23	100	-	45.98	54.02	100
Health Associate professional except nursing	2743	46876	55294	46459	151372	19400	28705	12963	61068
%	1.81	30.97	36.53	30.69	100	31.77	47.00	21.23	100
Nursing and midwifery associate professionals	258	1764	10081	-	12103	18814	77682	-	96496
%	2.13	14.57	83.29	-	100	19.50	80.50	-	100

Source: NSSO 68th round, employment and unemployment (2011-12), unit level data

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