

HEALTH CONDITION OF DALITS IN INDIA

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Abstract - Human right applies universally to all. The process of identifying vulnerable groups within the health and human right generated from the pressing reality on the ground that stemmed from the fact that there are certain groups who are vulnerable and marginalized lacking full enjoyment of a wide range of human rights, including rights to political participation, health and education. Vulnerable groups are disadvantaged as compared to others mainly on account of their reduced access to medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing, sanitation etc. The present study was undertaken based on (NFHS-3) secondary data. Stunting, wasting, underweight and anemia in children and anemia in adults are higher among the lower castes. Similarly, neonatal, postnatal, infant, child and under five statistics clearly show a higher mortality among the Schedule Caste. The study calls for continued investment in education, with a special focus on Schedule Castes dominated areas for both men and women in order to reduce maternal, infant, and child mortality.

Key Words: Dalit, IMR, NMR and Under 5 Mortality

1. INTRODUCTION

Human right applies universally to all. The process of identifying vulnerable groups within the health and human right generated from the pressing reality on the ground that stemmed from the fact that there are certain groups who are vulnerable and marginalized lacking full enjoyment of a wide range of human rights, including rights to political participation, health and education. Vulnerable groups are disadvantaged as compared to others mainly on account of their reduced access to medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing, sanitation etc. The term Scheduled Caste (SC) has a long historical origin. Prior to the year 1935, when the Government of India (GoI) Act, 1935 was enacted, the communities suffering from the stigma of Untouchability were being referred to as untouchables or exterior castes or depressed classes or by various caste names most of which were derogatory.

As a part of the social and political changes to be introduced in the year 1935, the various castes, which suffered social disabilities, were listed in a schedule and from that time onward they came to be described as SC. After the constitution of India was enacted, the list of SC was notified by the President of India in accordance with the provisions of article 341 of the constitution. The SCs thus represent a constitutionally declared collection of castes, communities or groups, their defining characteristic being the suffering from the traditional practice of Untouchability. In terms of the provisions in Article 341, the SCs have been specified separately in relation to each other States and Union Territories [1]. In India, the amelioration of the lot of the underprivileged people in India, particular of the tribes and those castes and classes which are given an inferior status due to the accident of birth, has to be an important, aim of any Government to commit to democracy [2].

The delivery of health care in almost every country involves some form of Public Private Partnership (PPP) [3]. Rural people are frequently illiterate and have no experience or understanding of the city or the complexities of the hospital system. To assist patients attending secondary care Government Hospital (GHs), the Government of Tamil Nadu (GoT) approved the proposal of Tamil Nadu Health System Project (TNHSP) to create patient counselling centres. Healthcare systems need to allocate more time and resources for planning and forecasting [4]. Counselling of antenatal and postnatal is useful to inpatients and outpatients those are coming to the hospital. It saves the life of child and mothers and leads to safe motherhood during the pregnancy. Explanation of doctor's note and drug consumption by counsellors to the patients is more effective to save the time and healthy life. In the present exercise the National Family Health Survey (NFHS)-3 surveys in India examined with an objective to study the health condition of Dalits in India.

2. METHODS

This study uses secondary data from the NFHS-III (2005-06) clearly highlight the caste differentials in relation to health status. The NFHS of India is one of the largest surveys conducted worldwide in the field of population and health. NFHS surveys are conducted under the Ministry of Health and Family Welfare (MoHFW), GoI, with the International Institute for Population Science (IIPS), Mumbai as a nodal agency. The NFHS-3 covered a sample of 124,384 women aged 15-49. The survey was conducted in 29 states of India, where about 99 percent of country's total population live. The NFHS-3 gathered data on 39,677 children born in the five years preceding the survey. Information was collected on various aspects of maternal healthcare utilization for live births in the three years preceding the survey.

3. ANALYSIS AND DISCUSSION

It is widely recognized that the determinants of health are social and economic rather than purely medical. The poor health of people from the lower castes, their social exclusion and the steep social gradient are due to the unequal distribution of power, income, goods and services. The following table reveals the neonatal mortality rates by background characteristics.

Table 3.1 - Neonatal Mortality Rate (NMR) by Background Characteristics

(Per 1000 live births)

Areas	Background Characteristics	NMR
Urban	SC	35
	ST	29
	OBC	26.4
	Other	27.5
	Total	28.5
Rural	SC	49.6
	ST	40.9
	OBC	42.1
	Other	38.1
	Total	42.5
Total	SC	46.3
	ST	39.9
	OBC	38.3
	Other	34.5
	Total	39

Source: NFHS-3 2005-06, MoHFW, GoI.

The table 3.1 shows that the NMR of SC was 35. It is high compared with ST (29), Other Backward Class (OBC) (26.4) and other was 27.5 in urban. It is noted from the table that the NMR was high (46) among the SC. The NFHS-II (1998-99) documented a similar picture of lower accessibility and poorer health statistics among the lower castes. NMR was less among highly educated mothers compared to mothers with low education. The incidence of NMR was higher among working mothers compared to non-working mothers. Health seeking behaviour of the mother was significantly associated with neonatal mortality as also a proper medical check-up and immunization which showed positive relationship with neonatal mortality. The effective reduction in IMR will depend primarily on controlling neonatal deaths [5]. LBW, breastfeeding problems, practices, sepsis and hypothermia are frequently encountered among neonates in rural homes. There was a large unmet need for health care, and a huge burden of neonatal ill health [6]. 26 percent of the SC mothers in India received no antenatal check up during the preceding five years. Further, only 25 percent of ST mothers deliveries took place in healthcare facilities and 67 percent of deliveries were attended by untrained individuals [7].

Table 3.2 - Post-Neonatal Mortality Rate (PNMR) by Background Characteristics

Areas	Background Characteristics	PNMR
Urban	SC	15.7
	ST	14.8
	OBC	15.8
	Other	8.6
	Total	13
Rural	SC	21.4
	ST	23
	OBC	19.1
	Other	17.5
	Total	19.7
Total	SC	20.1
	ST	22.3
	OBC	18.3
	Other	14.5
	Total	18

Source: NFHS-3 2005-06, MoHFW, GoI.

The PNMR of SC was 15.7. It is high compared with ST (29) and other was 8.6 in urban in table-2. In rural PNMR were 21.4 among SC, 23 among SC. It is low among the other was 17.5. It is noted from the table that the PNMR was high (22) among the ST. Data shows that about 43 percent of tribal people and one third of the

SC people did not have single check up during the pregnancy among the SC women only one fourth reported having institutional deliveries [8].

Table 3.3 - Infant Mortality Rate (IMR) by Background Characteristics

Areas	Background Characteristics	IMR
Urban	SC	50.7
	ST	43.8
	OBC	42.2
	Other	36.1
	Total	41.5
Rural	SC	71
	ST	63.9
	OBC	61.1
	Other	55.7
	Total	62.2
Total	SC	66.4
	ST	62.1
	OBC	56.6
	Other	48.9
	Total	57

Source: NFHS-3 2005-06, MoHFW, GoI.

The IMR of SC was 50.7. It is high compared with ST (43) and other was 36.1 in urban. In rural the IMR was 71 among SC, 63.9 among ST. It is low among the other (55.7). It is noted from the table that the IMR was high (71) among the ST. The level of infant and child mortality is a useful indicator of development in any society. West Bengal has consistently had lower levels of infant and child mortality than the national average. Higher mortality rates among the SC and the ST segments of the population should engage the national commission. The problem is not acute in West Bengal, but in many other states this is not so. Urban areas certainly have better health facilities than total areas. It is likely, however, that the girl child has unequal access to this system. Higher mortality rate among Muslims and Christians in the state need deeper scrutiny. It is necessary to intensify efforts to reduce IMR through specific micro planning.

High rates of IMR and Under 5 mortality rate are in general, inversely associated with income. These inequities are also accompanied by wide gaps across gender and caste [9]. The risks of mortality before the age of five years are higher in girls than in boys among SC, ST, and OBC as compared to others; and in the rural areas of Uttar Pradesh (UP) one of the poorest states in India than urban Kerala. The nutritional status of children under five is commonly assessed using three indices: weight-for-height (wasting) which reflects acute growth disturbances, height-for-age (stunting) which reflects long-term growth faltering and weight-for-age (under weight) which is a composite indicator of both long and short term effects. Weights and heights of children are compared with the reference standards and the prevalence of anthropometric deficits is usually expressed as the percentage of children below a specific cut-off point such as minus 2 standard deviations (2SD) from the median value of the international reference data. Thus, children who are below the referred indices are termed as unhealthy children.

Table 3.4: Under-five Mortality Rate by Background Characteristics

Areas	Background Characteristics	Under-five Mortality
Urban	SC	65.4
	ST	53.8
	OBC	54.5
	Other	42.1
	Total	51.7
Rural	SC	94.7
	ST	99.8
	OBC	78.7
	Other	68.2
	Total	82
Total	SC	88.1
	ST	95.7
	OBC	72.8
	Other	59.2
	Total	74.3

Source: NFHS-3 2005-06, MoHFW, GoI.

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The under-five mortality rate of SC was 65.4 in table 4. It high compared with ST (53.8), OBC (54.5) and other was 42.1 in urban. In rural the under five mortality was 94.7 among SC, 99.8 among ST. It is low among the other (68.2). It is noted from the table that the total under-five mortality rate was high (95) among the ST, than followed by SC (88.1), OBC (72.8) and other (59.2).For children 1-5 years of age, the prevalence of underweight ranged from 13 percent in the state Meghalaya to 77 percent in Gujarat. The prevalence of stunting ranged from 20 percent in Goa to 83 percent in Gujarat. The risk of mortality before the age of five years are higher in girls than in boys; among SCs, STs, OBCs as compared to others; and in the rural areas of UP, one of the poorest states in India, than urban Kerala. Evidence from urban areas in Kerala and from educated mothers has shown that low mortality in children younger than five year is, indeed, possible in India. Under 5 mortality rate for the richest income quintile earners is three times lower than that for the poorest quintile. According to the WHO, a prevalence of underweight above 30 percent is considered serious public health problem.Total malnutrition is higher among women from SC and ST than for women in the OBC group and women from other castes, but the differences are small. In all caste/tribe groups, most malnutrition is due to under nutrition. The proportion of total malnutrition that is due to overweight or obesity varies from only seven percent for ST women to 38 percent for women who do not belong to ST, SC, or OBC. There are other underlying factors that likely to influence health status of a baby. One of the prime factors is the diet of an expectant mother. It has been revealed that the tribal people have lots of taboos and restrictions during pregnancy, especially in terms of diet.

CONCLUSION

Reduced access to maternal and child health care is evident with reduced levels of antenatal care, institutional deliveries and complete vaccination coverage among the lower castes. Stunting, wasting, underweight and anemia in children and anemia in adults are higher among the lower castes. Similarly, neonatal, postnatal, infant, child and under five statistics clearly show a higher mortality among the SCs and the STs in this study. Problems in accessing health care were higher among the lower castes. Female literacy and subsequent awareness to several health and nutritional aspects of life is one of the key factors for healthy life-ways for all human societies. Systemic injustice requires much more than a change of heart; it requires changes in social structures. Social injustice is killing people and mandates the ethical imperative of improving the social determinants of health. This study calls for continued investment in education, with a special focus on SCs dominated areas for both men and women in order to reduce maternal, infant, and child mortality.

REFERENCES

- [1] Sankaran S. R, "Welfare of Scheduled Castes and Scheduled Tribes in Independent India: An Overview of State Policies and programmes", Journal of Rural Development, vol. 9, no. 4, p1, 2000.
- [2] Radadhyaksha Ranjit, Encyclopaedia of Social Problems and Social Change, p.199, 2004.
- [3] Rajendran S and R. Ramachandran, "An Economic Study of Janani Suraksha Yojana in Salem Region", Peninsular Economist, vol. XXV, no. 2, pp. 227-229, 2012.
- [4] Uswa Ali Zia and Naeem Khan, "An Analysis of Big Data Approaches in Healthcare Sector", International Journal of Technical Research & Science, vol. 2, no. 4, pp. 254-264, 2017.
- [5] James and Subramanian (2004), "Neonatal Mortality in India: The Role of Maternal Factors", Demography India, vol. 33, no. 2, pp. 157-71, 2004.
- [6] Abhay et al., "Burden of Morbidities and the Unmet Need for Health Care in Rural Neonatal: A Prospective Observational Study in Godchiroli", Indian Pediatrics, vol. 37, no. (9), pp. 952-65, 2001.
- [7] IIPS, "National Family Health Survey-3", National Survey Report 2005-06, Mumbai: IIPS, 2006.
- [8] Kulkarni S, "Taking RCH programme to weaker sections- a challenge for India", Journal of Family Welfare, p.50, 2004.
- [9] Baru et al., "Inequities in Access to Health Services in India: Caste and Region", Economics and Political Weekly, vol. XCL, no 38, pp. 49-58, 2010.