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Access to Health Care and Patterns of Discrimination:
A Study of Dalit Children in Selected Villages of Gujarat and Rajasthan

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Foreword

Indian Institute of Dalit Studies (IIDS) has been amongst the first research organizations in India to focus exclusively on development concerns of the marginalized groups and socially excluded communities. Over the last six year, IIDS has carried out several studies on different aspects of social exclusion and discrimination of the historically marginalized social groups, such as the Scheduled Caste, Scheduled Tribes and Religious Minorities in India and other parts of the sub-continent. The Working Paper Series disseminates empirical findings of the ongoing research and conceptual development on issues pertaining to the forms and nature of social exclusion and discrimination. Some of our papers also critically examine inclusive policies for the marginalized social groups.

This working paper "Access to Health Care and Patterns of Discrimination: A Study of Dalit Children in Selected villages of Gujarat and Rajasthan" looks at the nature and forms of discrimination experienced by Dalit children in accessing health services provided by the primary health centres and private sector providers in the rural areas. Employing a blend of public health and social exclusion approaches, this field based study measured the degree of discrimination in health care for Dalit children in various spheres. The paper argues that the consequences of discriminatory practices severely limit Dalit children from accessing health services, and are attributable to the poor health and high level of mortality of Dalit children in the studied areas. The paper also reflects on discrimination differential between public and private sector health care. Highlighting inabilities of the present policy frameworks to deal with caste and untouchability based discrimination in health care services, the study calls for developing safeguards and codes to check discriminatory practices at all stages of service delivery.

This is part of a knowledge partnership between UNICEF and Indian Institute of Dalit Studies to unpack policy concerns of relevance to all children from the perspective of socially excluded communities. We hope this Working Paper will be resourceful and supportive to academia, students, activists, civil society organizations and policymaking bodies.

Surinder S. Jodhka
Director, IIDS

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1. Introduction

Social discrimination is a universal phenomenon which is reflected in various forms among different people across regions. Caste, however, is a unique determinant of social discrimination in the Indian Sub-continent. There are various forms of discrimination experienced by the Dalits in different spheres and by different personnel and health is also one such area where caste-based discrimination is experienced. While much of the literature has explored social discrimination, not much seems to reflect on the experience of discrimination in accessing health care among Dalits. Much less has interested the researchers to document Dalit children. Scanty literature which exists largely deals with the utilisation of care. Some of the earlier research on health care utilisation was done to explore the acceptance of western medicine among the Indian populations. Studies conducted in different villages in India during 1950s and 1960s suggest that it was ignorance and poverty more than the status on the social rung which enhanced or hindered the utilisation of care services (Castairs, 1955; Marriot, 1965). Such inferences could also be due to the sensitivity of the western researchers towards an issue like caste, which is so endemic to Indian sub-continent. In the linkages between poverty and health, latter is assumed to be largely dependent on health culture which comprises of perception of illness, worrying about it and taking an action for its remedy (Banerji, 1982). Poverty is an important determinant of access to health care services (Djurfeld and Lindberg, 1976; Zurbrigg, 1984); and most poor are Dalits as well as most Dalits are poor[1]. Poverty evolves a different health culture and

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affects perception of illness and utilisation of care. A rather national picture was generated regarding the utilisation of the health care services by the scheduled communities after the National Health and Family Surveys (IIPS, 1995, 2002, 2007) were conducted and spurt of research papers emerged. It was evident that the level of utilisation is much lower among the Dalits as compared to the non-Dalits. (Ram et al, 1998; Acharya, 2002; Kulkarni and Baraik, 2003).

1.1. Purpose of the Study

With this background, therefore, the present paper aims to understand the nature and patterns of caste based discrimination (henceforth referred as discrimination) in access to health care practiced in different forms; and the consequences of such practices. This is one of the initial studies to explore caste based discrimination in health sector. There are problems in defining the very concept of discrimination in health. Typology to understand it and empirical methodology to measure it are still evolving and yet to develop fully. The present paper, therefore, endeavors to develop a concept to define and evolve an empirical methodology to measure such discrimination. It proposes to identify nature of discrimination experienced by dalit children in accessing health care and examine the implications of discrimination in access to health care services among dalit children. Thus, the specific objectives are to:

1. Define the concept of discrimination in health care access and evolve a typology to understand it;
2. Develop a methodology to measure discrimination in health care access empirically;
3. Identify forms of social discrimination experienced in accessing health services;
4. Study the consequences of discrimination; and identify the best practices that improve access to health care.

1.2 Conceptual Framework

There are ample evidences of the practices of discrimination against the Dalits in different spheres and varied forms. Access to civic amenities and social facilities has always been a concern in the context of the Dalits. Although the constitutional provisions have been in place for penalising those practising

discrimination, yet it continues to thrive. Discrimination against Dalits has metamorphosed over time from overt, open and accepted norm to subtle, invisible, hidden and 'unaccepted' behaviour. In the present context the divide is between those who had the benefits in the past and were oppressing the Dalits in the worst possible way as their right; and those who have now been given certain privileges as part of the positive discrimination policy of the state. In the past, the former had internalised oppressing the oppressed as their right and the latter had internalised being oppressed as their normal lives. This continues even today, though with a difference. What used to be obvious and overt earlier has become subtle, covert and surreptitious. Resentment of non-Dalits towards the Dalits is present and gets reflected in various forms, in sporadic incidences across the country.

Through history, the practice has been to assume that Dalits are the serving class and therefore what they need at best is the skill to be able to serve the rest. Any reflection of their upward mobility on the social scale above the level of servitude has more often than not, raised unpleasant questions and derogatory comments from the non-Dalits. Children among them are in no way different. Children in their vulnerability experience additional discrimination due to their age and social identity as Dalits. Discrimination is likely to be present in the health care access in the forms of refusal to observe certain norms which are mandatory in care giving, but are often violated while rendering care to the *Dalit* care seekers. These may be manifested in the form of refusal to touch, enter into the house, and share the seating place, sharing the food and water, and transportation. The spheres in which discrimination is likely to be visible are care delivery 'spaces' which could be the care centre or the users' house.

What are these factors which continue to reign over and above constitutional provisions? What makes this religion which claims to be 'all embracing' and touted as 'a way of life', fail to accept some its own people? It becomes imperative, therefore, to understand the factors which still fuel the element of discrimination experienced by the Dalits at various levels and in different forms and spheres.

Theoretical perspective

The mechanisms which come into force to activate social discrimination in accessing care among Dalits, especially children; have been conceptualized through the perspectives of social capital and social identity.

The notion of social capital was strengthened in relation to social context of marginalized groups (Coleman, 1988). Social networks and norms of reciprocity and trustworthiness arising out of them became the reference point for social capital by the 1990s with the works of Putnam (1993, 2000). The central thesis of social capital emphasized on social networks as valuable assets which needed to be cultivated and preserved (Field, 2003). Often negative outcomes such as exclusion of outsiders from resources controlled by network members restrict individual freedom. Downward leveling of norms may block members of historically oppressed groups from participating in mainstream society (Portes, 1998; Baum, 1999, Kawachi, 2000). However, as part of the group or network, there are likelihoods of positive outcomes such as inclusion as group member and therefore access to resources and participation in activities of and by the group. Thus, in case of access to health care, social networking establishes and endorses some care services which are disseminated and promoted by care providers at different levels of care giving. Based on this, those who form the part of the social groups exercise their discretion for access and utilization.

Identity is important in understanding social interaction. It is socially located because it is through this concept that the personal and the social are connected. Identity provides links between the personal and the social, self and society and is relational. It is constructed through relations of difference, such as 'us' and 'them'. Identity also has to accommodate and manage differences. Formation and establishment of identity involves locating and transgressing boundaries. The Dalit identity places the individual in certain social realm which superseded other attributes acquired and innate. Recognition of self in relation to others often leads to two starkly opposite responses- docile, on one extreme and volatile on the other. Consequently, there are evidences of prevalent discriminatory behavior such as not placing medicine on hands of a Dalit; and the helpless acceptance of such care; not sitting on the designated places in fear of being rebuked and insulted. At the other end of the social identity scale, assertive recognition of self is likely to reflect anger and discontent and may also lead to lesser discrimination due to the fear of the notoriety of anger. There is also a possibility of genuine positive response from the others to the assertion of the Dalits.

Understanding the Universe of the Dalit Child

During childhood, Dalit children may not be exposed to the labels like caste or untouchability. However, parents and adults are anxious that the child should not be hurt by transgressing the existing caste boundaries in innocence, hence

the child is fed with many instructions of 'Do's and Don'ts'- don't go there, don't enter such house, don't enter the temple, don't play with so and so, don't play in a specific place, don't touch something/someone, don't sit around such a place, don't argue with so and so, don't back answer so and so, don't fight with so and so - a whole lot of protective and preventive instructions more specifically to the girls, like don't dress like this, don't sit like this, don't come in notice of dominant caste etc. There are certain do's like - bow before so and so, say *Namaste,* stand when so and so comes, do services when demanded, do physical labour when demanded, do menial work, agree when in conflict, say good things about so and so, praise so and so. There are thus clear instructions of physical distance and geographic boundaries a *Dalit* child is taught to maintain.

Measuring Discrimination

Discrimination in access and utilization of health care is mostly observed in the disparity in care provisioning at the health care centre by the providers-doctor and the supporting staff; and at home during the visit by the health worker. Discrimination in access and utilization of health at the health centre may be practiced during diagnosis, dispensing of the medicine, laboratory tests; while waiting in the health centre, and in paying the user fee. Discrimination during diagnosis may be measured in terms of time spend in asking about the problem and touching the user while diagnosis. Discrimination during dispensing the medicine can be measured in terms of the way medicine is given to the user- placed on the palm, kept on the window sill/floor, someone else is asked to give. Discrimination in the laboratory can be measured in terms of direct touching of the user for the tests and x-ray. Discrimination while waiting can be measured in terms of duration of waiting, space for waiting, waiting till the other dominant castes have been provided services, attitude of the paramedics towards them while they wait. Discrimination during payment of user fee can be measured in terms of actual amount being paid, time for waiting to pay and space for waiting (separate queue). Discrimination at home can be in direct and indirect forms. It can be measured in terms of entry into the house, touching the user, sitting in the house, eating or drinking in the house or the eating/drinking eatables given by the user and not touching while giving the medicine (direct). Dissemination of information regarding health camps and programmes can be the indirect form of discrimination. Untouchability related discrimination can be measured in terms of experiences at different unit of the health centre and during home visits by the health workers through qualitative questions. Exclusion of discriminated groups in accessing certain type of services where touch is involved (such as vaccination) will also reflect on the traditional notion of polluted and pure.

Some Indicators for measurement of discrimination in various spheres

- Home visit- not entering the house, entering only the main entrance, not in the living quarters, not sitting in the house if entered, not consuming any thing to eat when offered by the resident.
- Practice of Untouchability- giving the medicines in the hands without touching the hand or any other part of the body, keeping the medicine on floor or paper, on anything else but not directly on the hand.
- Information- no information, incomplete/incorrect information about health and immunization camps.
- Dispensing of medicine- in the hand, without delay; on the dispensing window sill, without delay; in the hand, after everyone else has been given; on the dispensing window sill, after everyone else has been given; not giving at all.
- Diagnosis- may be measured through the indicators such as time spend in asking about the problem; sympathetic tone of the providers; and use of derogatory words as identification markers, not touching the user while diagnosis.
- Laboratory test/x-ray- can be measured in terms of the time of the test/x-ray done, immediately as the turn comes or wait till everyone else's tests/x-rays are done.

1.3 Methodology

The methodology adopted in the present study has three parts. The first deals with defining discrimination and developing a concept and typology of discrimination with respect to health care. The second part of the methodology deals with database and sample design. The second part is based on methods of measurements which include selection of indicators; ranking of indicators; construction of a composite index; and content analysis of the narratives obtained from the Consultative Meetings and discussions held during the fieldwork.

Defining the Concept of Discrimination in Health care access

Social discrimination is related to lack of access to services and goods offered by societies. Social and religious groups appear to accentuate social discrimination by denying certain opportunities pertaining to social and religious practices and access to services to some and not to others. Caste-based

discrimination is permanent in nature and differs from exclusion that is created and recreated by the operations of social and economic forces. It focuses directly on the nature of the lives people live and disadvantages they experience (Thorat et al, 2006). It is a part of basic institutional framework and institutional arrangement within a nation and refers to institutions and rules that enable and constraint human interaction. Public goods and services which should be available to all are limited to a select few based on the caste hierarchy. They are isolated, lack social ties to local community, voluntary associations, trade unions or even nations. They are disadvantaged in their ability to use their legal rights and constitutional provisions effectively. They are unable to overcome both consumption and work related disadvantages. Forced inclusion or exclusion, partial or complete, amounts to discrimination (Thorat, 2002).

On the basis of the foregoing understanding, discrimination in accessing health care can be understood as complete exclusion of Dalits from accessing health care. There is denial of certain services and selective inclusion or partial denial of services to reflect access to some and not to the others. There can be unequal care access in terms of time spend with; tone and use of derogatory words for; dispensing of the medicine via a medium to; and not touching the discriminated groups by the provider. Unfavorable or forced inclusion in providing certain services such as health camps; and exclusion from certain service provisioning such as health camps, health education programmes, water supply, electricity and infrastructure too can be understood as caste based social exclusion. As an attribute of individuals, caste-based discrimination focuses directly on the health status of Dalits and disadvantages they experience. Discrimination in access to health care service can thus, be understood through three basic forms-

- Complete exclusion or complete denial of health care services
- Partial denial or selected exclusion of health care services
- Unfavorable inclusion or forced inclusion for certain services.

The state health care system entails to provide services to all without any discrimination. However, if a group of people are completely excluded from availing some services for whatever reasons, it may be termed as *complete exclusion*. Many a times some people have access to some services and not to others. Also they may be discriminated by the service providers and co-users at the place of service delivery in terms of priority and proximity. They may have access to some services and not to others. This is *partial denial or selected exclusion*. This can be visualized in two ways- differential treatment

by the health providers and differential treatment by the co-users of the care. There can be differential treatment by the health providers. There are different types of care provider; public sector, private sector, non-profit/NGO sector. The providers are from different streams of care – allopathic, homeopathic, indigenous/ traditional. The treatment can be differential in terms of providing no, less, or wrong information; providing discriminatory treatment at the place of delivery of care; involuntary inclusion or exclusion in some schemes; discriminatory treatment during emergency and home visits; and behavior and attitude of the provider.

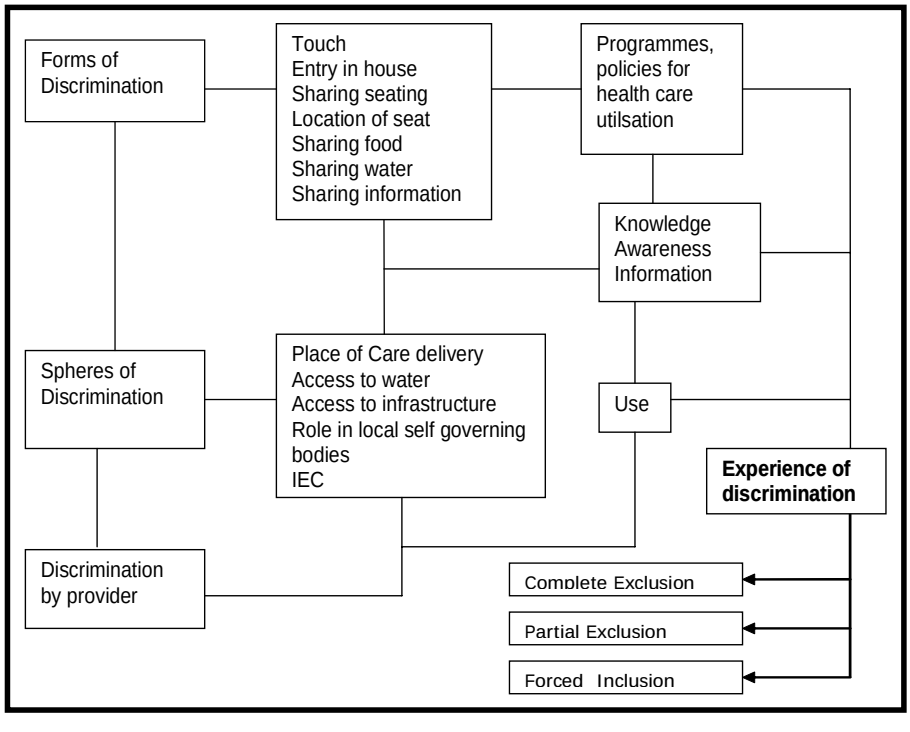
The co-users of the care can discriminate in the use of space for waiting. Their behavior and attitude can be derogatory, dominating and suppressing. They may be surpassing rules to use the services when it is actually due to the people from the discriminated groups (pushing them back in the queue). In access to water and electricity too, there are evidences of such discrimination. There can also be differential treatment for certain services. There can be forceful inclusion in certain services for some specific groups. There could be some forceful inclusion to participate in health camps; sanitation and cleaning of village; local self governing bodies like Panchayats, in case of mothers. There are also chances that some people are forced to avail some services in spite of their unwillingness. This may be considered as *unfavorable or forced inclusion*.

Discrimination in access to health care is mostly observed in the disparity in care provisioning at the health care centre by the providers- doctor and the supporting staff; and at home during the visit by the health worker. Discrimination in access and utilization of health at the health centre is likely to be practiced during diagnosis and counseling, dispensing of the medicine, laboratory tests; while waiting in the health centre, and in paying the user fee. Discrimination during diagnosis may be measured in terms of time spent in asking about the problem and touching the user during diagnosis. Discrimination during dispensing the medicine can be measured in terms of the way medicine is given to the user- placed on the palm, kept on the window sill/floor, someone else is asked to give. Discrimination in the laboratory can be measured in terms of direct touching of the user for the tests and x-ray. Discrimination while waiting and payment of user fee can be measured in terms of duration of waiting, space for waiting, waiting till the other dominant castes have been provided care, attitude of the paramedics towards them while they wait. Discrimination during payment of user fee, if any, can be measured in terms of actual amount being paid, time spent for waiting to pay and space for waiting and a separate queue for payment.

Discrimination at home during the visit by the health worker may occur while entering the house, touching the user, sitting, drinking/eating in the user's house and while giving medicine and information regarding health camps/ programmes to them. Selective dissemination of information regarding health camps and programmes; and exclusion of Dalits in accessing certain type of services where touch is involved (such as vaccination) also reflect on the traditional notion of polluted and pure and the consequent discrimination.

Thus, discrimination can be practiced by different providers across spheres and forms. Present policies and programmes for health care and against discrimination; awareness regarding these policies and programmes and their ability to use them culminate in the experience of discrimination, expressed as complete or partial exclusion; and forced inclusion in access to health care services (Figure 1).

Figure 1. Patterns of Discrimination in Health Care Access- Conceptual Framework



Typology of Discrimination in Health Care Access

These three forms of caste-based discrimination are visibly experienced in different spheres and can be identified along with consequences with a set of indicators. Typology of discrimination has been developed to identify the spheres in which different forms of discrimination occur and the probable consequences (Table 1). The spheres of discrimination broadly include visit to/ by provider for diagnosis and counseling, dispensing of medicine, conduct of pathological test and referrals. The forms include duration of interaction, touch, speaking gently, use of derogatory words or phrases, and long waiting time. The personnel include doctor, lab technician, pharmacist, and grassroots level health workers such as Auxiliary Nurse Midwife (ANM)/Village Health Worker (VHW)/Lady Health Visitor (LHV); and *Anganwadi* worker (AWW).

Table 1: Typology of Discrimination in Access to Health Care Services by Children

Form	Sphere	Indicators	Consequences
Complete exclusion Access is completely denied	Denial of information on health/ immunization programmes; and infrastructure on the basis of caste identity	No Information on health/ immunization programmes to be held and held in the past; Absence of infrastructure (water source, location of water source, absence of electricity, approach road)	Deprivation of required immunization; exposure to health risks such as poliomyelitis, chicken pox; measles etc; lack of safe drinking water; power supply; and physical access
Partial Exclusion Discriminatory access to services; and inclusion with differences; differential treatment to lower caste, from that of a higher/dominant caste user	Denial of Information on health/ immunization programmes; and development schemes; access to some service; and conditional access to some on the basis of caste	Incomplete or incorrect information on health/immunization programmes to be held; and held in the past; beneficiaries from among those discriminated; limited access to water sources; access to some source; approach road to dalit quarters; partial or no electrification; poor services/ facilities in dalit quarters	Miss some health care/ immunization programmes leading to illness; lack of safe water exposes to water borne diseases; partial power supply strains the eyes, incomplete roads linking the living quarters of the discriminated and the dominant groups make care access difficult/ not possible.
Unfavorable inclusion or forced inclusion	Forced participation in health camps, sanitation and cleaning of the village (roads and drains for instance)	Participation in health programmes to meet the target fixed for the programme; Cleaning the drains/ roads/ service centre premises forcefully or unwillingly	May not be needed; can be harmful; can be disgraceful to be force to do an unclean job.

On the basis of this typology the study was designed to collect information on some forms of discrimination in different spheres and practiced by different providers; and probable consequences of such practice.

Sample design and data base

The present paper is based on the study of 12 selected villages in two states of Gujarat and Rajasthan. Ahmedabad in Gujarat and Barmer in Rajasthan were the two districts selected for study. The villages were selected from Dholka Taluka in Ahmedabad District and Barmer Tehsil in Barmer District. Two PHC villages, two villages with sub-centers and two without a sub-centre were selected from each state (Table 2).

Table 2: Field sites in Gujarat and Rajasthan

State	**Total**	**Gujarat**		**Rajasthan**	
District		Ahmedabad		Barmer	
Taluka/Tehsil		Dholka Taluka		Barmer Tehsil	
PHC	04	Koth	Amaliyara	Ranigaon Khurd	Sanawada
PHC villages	04	Koth	Amaliyara	Ranigaon Khurd	Sanawada
Sub Centre villages	04	Gundi	Ranoda	Undkha	Lilsar
Non-sub-centre villages	04	Bhurki	Rampur	Ranigaon Kalan	Siyaagpura
Total villages	12	3	3	3	3

Two hundred dalit and 65 non-dalit children were interviewed from the 12 selected villages. In case of those aged below 12 years, their mothers were interviewed. About 6-10 In-depth interviews were held in each village. The respondents were mothers, children, Panchayat Raj Institution (PRI) members, non-government organization (NGO)/ government organization (GO)/ self help groups (SHG) workers; *Anganwadi* workers; auxiliary nurse midwife (ANM) and health worker (HW). At least 2 Group Discussions and 1-2 Consultative Meetings were also held in each of the village. Life course analysis and Case Study of selected individuals were also done (Table3).

Table 3: Respondents/participants for Selected Research Techniques

Individual interviews in each village		
Unit	**Dalit respondent**	**Non-dalit respondent**
PHC village	16	04
Sub-centre village	17	03
Non-sub centre village	17	03
All	**50**	**10**
In-depth interviews in each village		
Respondents	**No of Interviews**	
Mothers with <12 years	1-2	
Children 12>	1-2	
PRI/NGO/GO/SHG	2-3	
Angawadi/ PHC workers /ANM/ HW	2-3	
Total	**6-10 (includes 2-4 non-Dalits)**	
Group Discussions in each village		
Participants	**No of Interviews**	
Mothers with <12 years	2-3	
Children 12>	2-3	
Key Members of the village	1-2	
Grassroot level workers	1-2	
Total	**6-10 (includes 2-4 non-Dalits)**	
Consultative Meetings		
Participants		
Mothers with <12 years	1-2	
Children 12>		
Key Members of the village		
Grassroot level workers		
Total	**1-2 (includes non-Dalits participants)**	
Life Course Analysis Technique/ Case Study		
Participants	Boys	Girls
Aged <12	6	6
Aged12-15	6	6
Total	**12**	**12**

Methods of Measuring Discrimination

Methods of measuring discrimination include selection of the indicators from different spheres, forms and personnel who may practice discrimination. These indicators were used to derive the share of discrimination experienced in a given sphere and form by any provider. They were also ranked to understand the perception of dalit and non-Dalits regarding discrimination; and were used for construction of composite index. Narrative analysis of the consultative meetings was also done. The following section discusses this.

Selection of indicators

For the present study 15 variables of discrimination in different spheres, forms and providers were selected. The recall period was one year prior to the field work[2]. These included visits to the doctor (diagnostic), conduct of pathological test, counseling, dispensing of medicine, seeking referral (spheres); duration of interaction with the care provider, touch (without offending), speak gently, no use of demeaning words/phrase, not waiting to give chance to the dominant caste person(s) (forms); and different care providers such as doctor, lab technician, pharmacist, Auxiliary Nurse Midwife (ANM), Health Worker (Table 4).

Prevalence of discrimination in different spheres and forms by providers was measured by simple percentages calculated on the basis of total number of times that dalit children were exposed to an event, for instance, dispensing of medicine, and experienced any form of discrimination. Ranking of the selected variables was also used to understand the perception of dalit children about the discriminating health care providers and treatment which they desire from them.

Table 4: Selected Variables for Discrimination by Sphere, Form and Providers

Sphere	Form	Provider
Visit to/ by provider (diagnostic)	Duration of interaction with the care provider	Doctor
Counseling	Touch (without offending)	Lab technician
Dispensing of medicine	Speak gently	Pharmacist
Pathological test	Use of demeaning words/ phrase	ANM/ VHW/ LHV
Seeking referral	Wait to give chance to the dominant caste person(s)	*Anganwadi* worker

Construction of the Index of Discrimination

Respondent who reported having experienced some discrimination (in form, sphere and by provider) at least 5 times during one year prior to the survey were given a score of 5; those who reported having experienced at least 3-4 times were give a score of 2.5; and those who reported less than three times were given a score of 1. Scores for each respondent was computed using these weights assigned to them on the basis of number of experience of discrimination. The scores accrued by the respondents ranged from 5 to 25. The average score for each respondent was computed for 'sphere', 'form' and 'provider' separately. Sum of scores on all variables was divided by 5 (total number of variables used in 'sphere' to derive the average score). Similarly, scores were obtained for 'form' and 'provider'. Since an event of discrimination can occur only in a given sphere, in a particular form and by the act of a provider, making it essential for the three-sphere, form and the act of the provider to happen simultaneously. Therefore, an average of the 3 values for sphere, form and personnel was derived to get the index of discrimination.

Index was computed for sphere, form and provider separately. Then they were composed together to compute a composite index of discrimination. Thus,

Index of discrimination (ID) = {(Index of sphere discrimination) + (Index of form discrimination) + (Index of provider discrimination)}/3

Or $\sum(IDs + IDf + IDp)/3$

Index of sphere discrimination (IDs) = ([Ss1+ Ss2+ Ss3+ Ss4+ Ss5)]/5

Or $\sum Ss/5$

Index of form discrimination (IDf) = ([Fs1+ Fs2+ Fs3+ Fs4+ Fs5)]/5

Or $\sum Fs/5$

Index of provider discrimination (IDp) = ([Ps1+ Ps2+ Ps3+ Ps4+ Ps5)]/5

Or $\sum Ps/5$

Where,

Ss is the score of a respondent on each variable of sphere of discrimination;

Fs is the score of a respondent on each variable of form of discrimination;

Ps is the score of a respondent on each variable of discrimination by provider.

The weighted average for all the variables was the score for the respondent. These scores were used to access which form of discrimination was more prevalent in which sphere and practiced by which provider. (Table 5).

Table 5: Scores and Weightage for Degree of Discrimination

Scores categories	Degree of discrimination	Weights for scores
<2	Low	Less than 2 times-1
2-4	Medium	2-4 times- 2.5
4>	High	More than 4 times-5

Perception of the severity of discrimination experienced, however, was not taken into account for construction of the index. One time experience was considered 'low' even if perceived as 'more discriminating' than that experienced more than once. This has been dealt in the section on prevalence of caste-based discrimination.

Narrative analysis

Information gathered from the consultative meetings and discussions were used for narrative analyses largely to reflect on the causes of discrimination both from the viewpoint of the dominant community members as well as the Dalits' children and their mothers.

Discussion and Analysis of Empirical Results

Empirical results of the data from the field have been processed and analyzed using three methods- ranking, composite index and narrative analysis. In the following section prevalence of discrimination has been measured using simple percentages and ranking of experience of discrimination in different forms, sphere and by providers. Subsequently, discrimination differentials between public and private sector providers in different spheres; and perception of dalit children about the providers who discriminate, and desired treatment from them has been discussed. Level of discrimination indifferent study villages has been discussed in the next section using composite index. The third section deals with causes of discrimination as perceived by non-Dalits and Dalits. Possible consequences are also discussed.

2. Prevalence of Discrimination

In the present section nature of discrimination experienced by dalit children in different spheres, forms and by different providers is analyzed as follows:

2.1 Spheres of Discrimination

As regards the sphere of discrimination, visit to/ by provider; dispensing of medicine; counseling; conduct of pathological test; and seeking referral for further care were taken into account. Most children experienced caste-based discrimination in dispensing of medicine (91%) followed by the conduct of the pathological test (87%). Of 1298 times that the 200 dalit children were given any medicine, they experienced discrimination on 1181 occasions. Nearly 9 out of 10 times dalit children experienced discrimination while receiving or getting the medicine or a pathological test conducted. While seeking referral about 63% times dalit children were discriminated. Also, nearly 6 in every 10 times dalit children were discriminated during diagnosis and while seeking referral.

2.2 Forms of Discrimination

Forms of discrimination, complete or partial exclusion and forceful inclusion were examined through duration of interaction with the care providers; whether the user was being touched (sympathetically); and spoken gently or referred to by the provider without using demeaning words; and whether the dalit child was made to wait for longer duration than due while accessing care. It was observed that most of the discrimination was experienced by dalit children in the form of 'touch' 94% times, when they accessed health care. Duration of time spent between the provider and dalit children was the next most discriminating form. About 81% times dalit children were not given as much time by the providers as other children. The use of derogatory words and waiting at the place of care provisioning were the forms where less discrimination was experienced as compared to duration of interaction and touch. About 7 out of 10 times children were discriminated by doctors, lab technicians and RMPs *vis-à-vis* touch. This form was more vigorously practiced by pharmacists, ANMs and AWWs. They did not touch the dalit children for almost every time they interacted with them (Table 6).

As regards the place of discrimination, discrimination occurs while providing and receiving care at home. Providers do not enter, or only up to a certain

limit. Comparatively lesser discrimination is evident at care centre. There are no separate places for waiting, but dalit users feel inhibited to share the same space as the dominant caste. There is no evident difference in time spent. There are, although, some evidences of use of less respectful words -*"they are dirty so falling ill is natural".* Dispensing of medicine is done directly on hand through a piece of paper, and not in small packets conventionally used for putting the medicines (tablets); *"they can digest even stone so …"* Using the water pot is subtly discouraged; "*Do not touch it will break*"

2.3 Discrimination by Providers

As regards the discrimination by providers such as doctors, lab technicians, ANMs/ VHWs/LHVs, and AWWs, the grassroots level workers like ANMs and AWWs were the most discriminating than higher order providers such as doctors. More than 93% times dalit children have experienced discrimination at their hands while about 59% times they experienced any form of discrimination by doctors. Pharmacists discriminated the most while giving the medicine and least in making them wait for their turn. However, lab technicians seem to be most discriminating in terms of making them wait (91% times) and least in the conduct of the pathological test (71% times). While most other providers discriminate mostly when it comes to touching the dalit child, probably, due to the nature of the work which lab technicians do, 'touching' becomes inevitable. They need to position a dalit child's body part for an x-ray, or a blood test, for instance, as much as they do for the others. So this form of discrimination is 'less' practiced by them. As regards the ANMs, more than half of the total visits that they have made to the dalit households, it has been after they have visited the others. Almost every time they have visited dalit households, they have not entered the house and have taken great care not to touch their children and have spent lesser time than they usually would have spend with the non-dalit children. Almost always (98% times), the AWWs serve food to the dalit children at the end. The traditional Healers and RMPs appear to be less discriminating than other providers. (Table 6).

Table 6: Nature of Discrimination Experienced by Dalit Children in Health Care Access by Sphere, Form and Provider

Nature of Discrimination	Total Response	Positive Response	% Children experiencing discrimination
Sphere			
During Diagnosis or visit to the doctor	1045	596	57
During Counseling	1167	864	74
During dispensing of medicine	1298	1181	91
During conduct of pathological tests	708	616	87
While seeking referral	652	411	63
Form by Providers (Doctors)			
Less time given by doctor	943	594	63
Doctors do not touch	1041	718	69
Doctors do not speak gently	904	253	28
Users have to wait	979	235	24
Form by Providers(Lab technicians (LT) and pharmacists)			
LTs do not touch during pathological test	1041	720	71
LTs do not speak gently	704	612	87
LTs make them wait Pharmacists do not touch while dispensing the medicine	519	473	91
Pharmacists do not speak gently	931	903	97
Pharmacists make them wait	530	08	77
	698	579	83
Form by Providers (grassroots level workers)			
ANMs do not enter the house	567	533	94
ANMs spend less time	531	488	92
ANMs do not speak gently	208	144	69
ANMs visit them last	142	78	55
ANMs do not touch them while dispensing medicine	339	780	93
AWWs do not touch them	1931	1680	87
AWWs make them sit separately	1703	1465	86
AWWs do not speak gently	839	604	72
AWWs serve them food last	1902	1864	98
Form by Providers (Traditional healers- THs)			
THs do not touch	593	332	56
THs do not speak gently	936	665	71
THs make them wait	431	220	51
THs make them sit separately	321	67	21
Form by Providers (Registered Medical practitioners -RMPs)			
RMPs spend less time during interaction	104	69	64
RMPs do not touch	987	679	71
RMPs do not speak gently	213	113	53
RMPs make them wait	297	86	29
Total Dalit Children	200	200	--

However, non- Dalit Providers often contend that they do not differentiate while offering the services, when they actually do. They talk to the dalit users in haste; and do not speak respectfully/ lovingly (with children). Dalit users always feel inhibited to ask anything related to their health. They feel they will be snubbed or ridiculed, or not attended to. They are often not told properly about which medicine to take and how. Often the medicines are dispensed through a piece of paper to avoid touch. They have to wait longer for their turn because the dominant caste persons 'have to go' first. However, sensitive providers irrespective of Dalit status, make efforts to reach out to Dalit children. They are more accepted even among the dominant castes. They often take on the political groups evident of creating the tension and do not discriminate on the basis of caste.

3. Degree of Prevalence of Caste-based Discrimination-

Discrimination is least prevalent in interaction with the doctors and waiting time for them. Traditional Healers make them sit separately and the Registered Medical Practitioners (RMPs) make them wait before they attend to them. But less than 30% of the time, children have faced discrimination during such interactions with the doctors, Traditional Healers (THs) and the RMPs. Discrimination is more prevalent in visit to or by the doctor; being touched by and waiting for the THs ; Auxiliary Nurse Midwife (ANMs) visiting them last and the way RMPs speak to them. Prevalence of discrimination in these spheres and forms, practiced by some providers ranges between 50-60 %. Most dalit children face discrimination 60-70% time while seeking referral, time given and being touched by the doctors, time given by the RMPs and verbal interactions with the ANMs. Counseling, Laboratory Technicians (LTs) not touching during conduct of Pathological test, verbal interaction with pharmacist, AWW and the traditional healer are the spheres and forms in which 70-80% discrimination prevails. Conduct of the pathological test and interaction with the LTs, waiting time before the pharmacists attend to them, *Anganwadi* workers' refrain from touching them and making them sit separately are spheres and forms where 80-90% discrimination is prevalent. Dispensing of medicine, not being touched by the pharmacists and the ANMs while dispensing the medicine; waiting for LTs, ANMs not entering the house and spending less time; and *Anganwadi* Workers (AWWs) serving the food to them toward the end are the spheres and forms of the highest prevalence of discrimination, that is, more than 90%. While doctors, THs and RMPs are the providers who practice least discrimination in some spheres and forms, 20-30%; LTs, Pharmacists ANMs and AWWs are the providers who practice the most 90% (Table 7).

Table 7: Caste-Based Discrimination Experienced by Dalit Children While Accessing Health Care by Degree of Prevalence

Per cent Children experiencing Discrimination in various Spheres, Forms and by Providers					
20-30%	**50-60%**	**60-70%**	**70-80%**	**80-90%**	**90%+**
Doctors do not speak gently	During Diagnosis or visit to the doctor	While seeking referral	During Counseling	During conduct of pathological tests	During dispensing of medicine
THs make them sit separately	ANMs visit them last	Less time given by doctor	LTs do not touch during pathological test	LTs do not speak gently	LTs make them wait
RMPs make them wait	THs do not touch	Doctors do not touch	Pharmacists do not speak gently	Pharmacists make them wait	Pharmacists do not touch while dispensing the medicine
Users have to wait for doctors	THs make them wait	ANMs do not speak gently	AWWs do not speak gently	AWWs do not touch them	ANMs do not enter the house
	RMPs do not speak gently	RMPs spend less time during interaction	THs do not speak gently	AWWs make them sit separately	ANMs spend less time
			RMPs do not touch		ANMs do not touch them while dispensing medicine
					AWWs serve them food last

Note- Based on Table-3.No spheres/form or provider discrimination was reported to be ranging in 30-40%.

LT- Laboratory technician; TH- traditional healer; RMP- Registered Medical practitioner; ANM- Auxiliary Nurse Midwife; AWW- *Anganwadi* Worker

Doctors during diagnosis are sometimes less probing regarding the health problem, have an unsympathetic attitude and rude behavior towards the dalit children. The *pharmacist while* dispensing of medicine, often keep on the window sill without explaining the doses properly. The Lab Technician **d**o not

touch during the conduct of a test, they use of demeaning words, tests are often not conducted properly. They are told that the time to conduct the test is over. *Nurses w*hile applying medicine or putting the bandage on to a dalit user, reflect lack of any concern or sympathy. They do not explain to the Dalits how to take care of the wound/dressing. The A*NM/ LHV/ VHW o*ften do no visit the dalit quarters for counseling or dispensing of medicine or dissemination of information regarding health programmes or camp, except in case of target based programmes like immunization particularly polio.

Having seen the nature and prevalence of discrimination in different spheres and forms, it is worthwhile to examine which providers in public and private sector health care are more discriminatory.

3.1 Discrimination Differentials in Public and Private Sector Providers

A comparison between the proportion of children who have experienced discrimination at the hands of public and private providers suggest that the latter are less discriminating (Table 8). In both the sectors grassroots level providers are more discriminating as compared to the higher order providers. Traditional healers in the private sector and the *Anganwadi* workers in the public sector have discriminated against 38 children each. Lab technicians and pharmacists in the private sector are less discriminating than their counterparts in the public sector. Probably the market forces seem to put the discriminatory element at the back of the mind. While in the public sector regular salaries may not be affected by the number of users who have been provided care; it makes the difference in the private sector in terms of the money earned. The most discriminating providers in the public sector are the ANMs who have discriminated against 54 children. In comparison, the most discriminating in private sector are the RMPs who have discriminated against 44 children. The most discriminating sphere in both the sectors is dispensing of the medicine. Public sector, however, is less discriminating (80) than the private (98). This could also be because most children have experienced discrimination in this sphere by the traditional healer. They are, most of the time, local people from within the village and thus prefer to adhere to the norms of the discriminatory practices against the dalit children.

Table 8: Discrimination by Public and Private Sector Providers in Different Spheres

Sphere	**Public Sector Providers who discriminate**					
	Doctor	LT	Pharmacist	ANM/HW	*Anganwadi*	Total
Diagnostic	10	--	--	10	10	30
Counseling	14	--	--	16	14	46
Dispensing of medicine	--	--	44	22	14	**80**
Pathological test	--	34	--	--	--	34
Seeking referral	6	--	--	4	--	10
Total	30	34	44	**54**	38	200
Sphere	**Private Sector Providers who discriminate**					
	Doctor	LT	Pharmacist	RMP	Traditional Healer	Total
Diagnostic	02	--	--	08	30	40
Counseling	02	02	04	06	14	28
Dispensing of medicine	10	--	32	20	36	**98**
Pathological test	00	20	--	06	--	26
Seeking referral	02	02	--	04	02	08
Total Dalit Children	04	24	36	**44**	80	200

Note- Actual number of respondents reporting at least one experience of discrimination (which they perceive as most discriminating).

Actual experience of discrimination is in synchrony with the perception of the children regarding the most and the least discriminating provider in the public and private sectors. They perceive the ANMs and the traditional healers as the most discriminating and the doctors as the least. (Table 9).

Thus the treatment they desire from the providers is reflective of the fact that they, even though, lower in hierarchy do have self esteem and can articulate the rightful wish to be treated with dignity.

Table 9: Perception of Dalit Children about Discriminating Health Care Providers in Public and Private Sectors

Discriminating Health Care Personnel- Public and Private Sector		
Provider	Rank	
Public sector	**Gujarat (100)**	**Rajasthan (100)**
Doctor/specialist	5 (96)	5 (98)
Lab Technician	3 (89)	3 (91)
Pharmacist	2 (73)	2 (83)
ANM	4 (64)	4 (71)
Anganwadi worker	1 (51)	1 (62)
Private Sector		
Traditional healer	1 (73)	1 (82)
RMP	3 (61)	3 (75)
ISM Practitioner	2 (52)	2 (65)
Allopathic Doctor	4 (40)	4 (51)

(Based on Individual interviews)

Note- Figures in parentheses denote the number of respondents who gave specific answers

3.2 Desired Treatment from Providers

All human beings are entitled to live with dignity. The Dalit children in both the states wished that the providers should speak to them gently without using derogatory and demeaning words. Time spent with the provider was ranked fifth in both the states as far as the desired behavior from the providers was concerned. Being touched gently, without being offended, appeared low in their ranking among the children in both the states largely because they may not be visualizing it as important element in care giving (Table-10)

Table 10: Desired Treatment from the Providers

Forms	**Rank**	
	Gujarat	**Rajasthan**
Time spend	5	5
Touch gently (without offending)	**4**	**6**
Speak gently	1	1
Use of respectful words	**2**	**2**
Consider equal	3	3
Prioritize severity of illness	6	4

Note- '1' denotes that highest number of respondents ranked a specific indicator as most desired.

Having examined the differential in experience of discrimination by sphere, form and providers, both in public and private sector among the dalit children, it is of interest to examine the levels at which the study villages get placed. Composite index has been used to examine this in the following section.

4. Level of Discrimination in the Study Villages

The villages were at different levels of discrimination in terms of sphere, form and provider. As regards sphere, Sanawada and Siyagpura in Rajasthan had most number of children who reported experience of discrimination. In contrast, Ranigaon Kalan had only 3 dalit children who reported to have experienced it. Ranigaon Kalan (Rajasthan) and Koth and Gundi (Gujarat) experienced the least. While Siyagpura is a remote village with sole dependence on the visit by grassroots level providers; Sanawada appears to have less considerate providers. On the other hand, the other villages have sensitive providers and have care provisioning centre within the villages Overall, there were more children in Rajasthan (39) who experienced discrimination in any sphere as compared to dalit children in Gujarat (33)

As regards the forms, Amaliyara in Gujarat had the least number of children who experienced any form of discrimination. Villages did not show much variation in form of discrimination. Consequently, while Gujarat had 32 dalit children who experienced discrimination of any form there were 31 in Rajasthan. Ranigaon Kalan (Rajasthan) had the highest number of children who experienced discrimination by providers as compared to Siyagpura which had only one child reporting discrimination by provider. This is largely because there were providers available in Ranigaon Kalan to interact with the children while in the other village very few visited. Rajasthan has fewer children (30) than Gujarat (35) who have experienced discrimination by providers (Table 11). Thus, while Gujarat practiced more discrimination in form and by providers, Rajasthan was higher on form of discrimination.

Table 11: Experience of Discrimination by Sphere, Form and Providers

Villages	Sphere	Form	Providers	Respondents
Gujarat	***33***	***32***	**35**	**100**
Koth	4	6	6	16
Gundi	4	6	6	16
Bhurkhi	7	5	4	16
Amaliyara	6	3	7	17
Ranoda	5	6	7	18
Rampur	7	6	4	17
Rajasthan	**39**	**31**	**30**	**100**
Ranigaon Khurd	7	6	5	18
Undkha	6	5	5	16
Ranigaon Kalan	3	6	8	17
Sanawada	9	6	2	17
Lilsar	6	4	2	16
Siyaagpura	8	4	1	16
Total Gujarat +Rajasthan	**72**	**63**	**75**	200

Note- Reporting of the event perceived as most discriminating in each category

The Composite index of Discrimination has been used to measure aggregate discrimination in sphere and form; and by provider in different villages (Table 12). Rampur in Gujarat, is a village with the least discrimination on all the three measures (sphere, form and provider) when composed together. Contrary to this, Ranigaon Kalan in Rajasthan is a village with the most children experiencing discrimination. This appears to be the reason for the village being ranked as the one where most of the children have experienced discrimination- highest among all the villages. Ranoda is a village with primary health care sub-centre where the functionaries are non Dalits. This village ranked second highest among all villages and the highest in Gujarat in degree of discrimination. This reflected if the providers are non-Dalits, access to care is difficult and often impossible.

Table 12: Level of Discrimination Experienced in the Study Villages

Villages (weights)	Res	<2E (1)	WS	2-4E (2.5)	WS	4>E (5)	WS	ΣWS	RV	RS	ID
Gujarat	**100**	***18***	***18***	***40***	***100***	***42***	***210***	328	NA		***3.3***
Koth	16	3	**3**	9	**22.5**	4	**20**	45.5	3	3	2.8
Gundi	16	1	**1**	5	**12.5**	10	**25**	38.5	2	2	2.4
Bhurkhi	16	3	**3**	5	**12.5**	8	**40**	55.5	7	4	3.5
Amaliyara	17	2	**2**	7	**17.5**	8	**40**	59.5	8	5	3.5
Ranoda	18	2	**2**	5	**12.5**	11	**55**	67.5	11	6	3.7
Rampur	17	7	**7**	9	**22.5**	1	**05**	**34.5**	**1**	1	2.0
Rajasthan	**100**	20	**20**	28	**70**	52	**260**	35.0	NA		3.5
Ranigaon Khurd	18	5	**5**	8	**20**	5	**25**	50.0	6	1	2.8
Undkha	16	4	**4**	6	**15**	6	**30**	49.0	5	3	3.1
Ranigaon Kalan	17	1	**1**	4	**10**	12	**60**	**71.0**	**12**	6	4.2
Sanawada	17	6	**6**	5	**12.5**	6	**30**	48.5	4	2	2.9
Lilsar	16	2	**2**	3	**7.5**	11	**55**	64.5	9	4	4.0
Siyaagpura	16	2	**2**	2	**5.0**	12	**60**	67.0	9	5	4.1
Total	**200**	**38**	**38**	**68**	**170**	**94**	**445**	651			**3.3**

Note- Figure in parentheses is the weight. Product of the value and weight gives the weighted score. 'E' denotes experience of discrimination in any sphere, form and or by provider; Res- Respondent; <2, 2-4, 4>- events experienced; WS- Weighted Scores; "WS- Sum of Weighted scores; RV- Rank among villages; RS- Rank within State; ID- Index of discrimination.

There are 3 villages- Ranigaon Kalan, Lilsar and Siyagpura in Rajasthan which have high level of discrimination. Undkha in Rajasthan and Bhurkhi, Amaliyara and Ranoda in Gujarat have medium level and Ranigaon Khurd and Sanawada in Rajasthan and Koth, Gundi and Rampur in Gujarat have low level of discrimination.

Gujarat has no village experiencing high level of discrimination, while Rajasthan has 3. There are more villages in Gujarat than in Rajasthan- 3 each, which experience medium and low level of discrimination (Table 13)

Table 13: Distribution of Villages by Level of Discrimination

Scores	High	Medium	Low
Value	4 and above	3-4	Less than 3
Villages in Rajasthan	Ranigaon Kalan Lilsar Siyagpura	Undkha	Ranigaon Khurd Sanawada
Villages in Gujarat	-- --	Bhurkhi Amaliyara Ranoda	Koth Gundi Rampur

In Ambaliyara, children from the Dalit community are seated separately from those belonging to upper castes in the *Anganwadi* Centre. In most villages there are separate *Aganwadis* for the Dalits and the non-Dalit children. In the *Aganwadis* where children from both communities come, separate vessels are provided for drinking water. One, Vinubhai and his wife, a nurse, worked to help the malaria affected persons during one of the outbreaks. They owned a vehicle which was used to take patients to care centers/ hospitals in other places at time of emergency, free of cost. The upper caste people initially tried to dissuade them from rendering their services to the Dalits. When they did not pay any heed to their intimidation, they were implicated in false charges of corruption. He is now suspended and the villagers do not have any mode of transportation incase of emergency. In Bhurkhi, most of the Dalits have to wait longer for their turn because the upper caste people are given priority. In some of the villages, the Dalits are given equal priority in terms of appointment with the doctors as the latter also belongs to the Dalit community. The Dalits drink water from separate vessels kept for them. The ANMs and other health workers rarely visit the dalit quarters of the village. In Siyagpura village, which is a non sub -centre village, Dalits do not sit on the benches available inside the care centre both public and private. In other provisions of public health like water and sanitation, there is rampant caste discrimination. The upper caste people warn the Dalits not to enter into water fetching premise and also ensure that the Dalits do not touch them. They do not accept water touched by the Dalits.

It is evident from the preceding sections that some spheres (dispensing of medicine), forms (touch) and providers (ANMs) are more discriminating that the others and therefore some villages have lesser events of discrimination (Koth, Sanawada) as compared to the others. These differentials are likely to be due to the reasons which are assigned to the practice of discrimination in different villages, among different people in different spheres and forms.

5. Why Discrimination?

Most of the time, discriminatory practices are present because of their existence through history without being questioned. Stereotypical notions also accentuate this. Hence, directly asking the non-Dalits about the reasons for their practicing discrimination by and large suggests the causes of discrimination. However, perception of causes of discrimination differs from Dalits to non-Dalits.

5.1 How dominant caste persons perceive Dalit children

The non-Dalits have certain stereotypical notions about Dalits regarding their lifestyle, living conditions, personal hygiene and cleanliness. These notions are used not only as identifiers but also as reasons to discriminate against them. An attempt was made to understand how Dalits were perceived by the dominant castes. This was done on the basis of the responses from the 67 non-dalit respondents. A set of indicators reflecting the living conditions of dalit children and used as reasons to discriminate by the non-Dalits were ranked from the least to the most discriminating. Conventionally, improper drainage, flies and garbage, and consumption of stale food mark their understanding of the Dalits. However, during the group discussions, 'children with running nose, which they keep licking', ill-clad or naked children playing in the dirty streets also emerged as the markers.

Living conditions as perceived by the non-Dalits were reflective of some biases on the part of the non-Dalits as well as some inadequacies which the Dalits often suffer from. For instance, 'half clad children' could be more because of poverty than choice. Similarly, 'children with running nose' are more likely the outcome of inaccessible health care services than the deliberate health condition (Table 14). Nevertheless, in Gujarat, such children were considered to be a reason for discrimination, followed by the reason that *'they live with their animals in the same jhopa* [3]*.*

In Rajasthan, ill clad or naked children followed by those playing in the street often with dirty animals, along with the fact that most of them lived with their animals, was perceived as a factor for discrimination. Consumption of meat or stale or unclean food and 'dirty house' were also used as identifiers and reasons for discrimination though by fewer people in both the states. Physical cleanliness of the houses was not an important consideration probably because almost all houses of the study villages were neatly kept in both the sates. However, drainage was poor. Thus, those measures which are in the hands of

the Dalits are taken, to make their living better. Those measures which they cannot take result in negative impact.

Table 14: Perception of Dominant Castes of Dalit Children based on Living Conditions

Indicators[1]	Rank	
	Gujarat	Rajasthan
Dirty House	7	7
Presence of flies	6	5
Eat stale/ unclean food/ meat	5	6
Children have running nose (which they keep licking)	1	4
Children often half/ill clad or naked	4	1
Children play in dirty lanes	3	2
Domestic animals live with persons	2	3

Note-'1' denotes that highest number of respondents ranked a specific indicator

There are problems and issues pertaining to discrimination. Some 'solutions' were suggested by the children, mothers, providers (ANM and *Anganwadi* worker), PRI members, school teachers, and prominent villagers in group discussions and consultative meetings. Some meetings/discussions had a mix of Dalit and non Dalit participants while the others were conducted only with Dalits. The meetings and discussions focused on the issues such as causes and understanding discrimination through the perspective of children. The content analysis of the meetings and discussions resulted in identifying the problems, issues, solutions and expectations of the participants.

The Dalit children appear to be concerned with how others perceive them. They feel that changing the mindset of non-Dalits is extremely important to reduce the discrimination. They also consider it important to inculcate cleanliness among the dalit children which would help do away with the stereotypes. There are also reflections that much of the biases are due to reasons emanating from inadequate infrastructure rather than the dalit children themselves. (Chart 1).

Chart 1. Understanding How others Perceive Dalits

Issue	Experience	Expression	Solution/ Expected change
Sanitation and drainage	Mostly poor drainage in the Dalits quarters	Overflowing drains, clogged with filth, litter on the sides of the lanes and outside the house. Often the drains are not constructed or they are broken More evident in Gujarat as compared to Rajasthan	Local self governing bodies-should take the initiative. People should participate in keeping their surrounding clean. Non Dalits should not consider Dalit quarters as their trash dumping ground. Improve Environmental education among all children.
Personal hygiene	Depends on availability of water. Often clean. Sometimes some smell is present.	Dirty and smelling Children unclean and smelling *'Children often have running nose which they lick'*- a non-Dalit women, Undkha, Barmer	Inculcate cleanliness. Remove bias from the non Dalits against Dalits
Physical hygiene	Depends on the cleaners who clean the lanes. Domestic water collects in a ditch in front of the house, is channelised to the fields.	Houses are dirty, there are flies. Often the lanes are dirty too. Domestic water sometimes overflows from the ditch, lanes become dirty Smell, live with the animals Engage in rearing of pigs.	Proper outlet for the waste water into the fields to be put in place.
Children's Perspective	*'Mothers clean us.'* *'We oil our hair and comb.' 'We even tuck our shirts in the pants… how can we be dirty?'*	Disheveled hair, smell, wears dirty and crumpled clothes, often are half clad or naked especially smaller children. Often cry. Play in dirty lanes and with dirty animals	*'We should play together, eat together, study together… we.. sit together in the classroom….'*- school children in Ranoda, Gujarat

(Based on Consultative Meetings with Mothers and children)

5.2 How Dalit Children Perceive Discrimination

Children feel that the perception of others as their being unclean is actually because of the lack of sensitivity. Therefore, it is important to sensitize others. Most of the health related camps are held in the dominant caste areas. This restricts the use by the Dalits. So the providers have to be sensitive towards the need to locate the camp in other parts of the village which is accessible to Dalits more comfortably. (Chart 2).

Chart 2. Perception of Dalit Children about Discrimination

Problems	Causes	Solutions
Perceived as unclean, less informed/educated so need not be given same services	Lack of sensitivity; bias Poor socio-economic status often results in stereotyped image	Sensitization of the providers Alternate activities for income generation, specially in the view of dying traditional occupations such as weaving
Most camps are held in the dominant caste areas, so use is often restricted	Dominant castes wield power which providers often cannot overlook Dominant caste are more likely to provide the infrastructure for the service to be provided	Providers to be supported/ facilitated and encouraged for locating a service in non-dominant group locality
Most providers claim to be sensitive, yet evidence of discrimination	Understanding of 'sensitivity' depends on one's own biases	Mechanism for tacking historical biases - Leadership - Re-interpreting and questioning power relationships

(Based on Consultative Meetings with Mothers and children)

They have experienced caste-based discrimination and are convinced that they should be given the same space as the other children. Experiencing most discrimination at the hands of the grassroots level workers, they feel that non-dalit workers need to be sensitized and more dalit workers to be recruited, assumption being that they will be more considerate towards dalit children (Chart 3).

Chart 3. Understanding Discrimination- Children's Perception

Issue	Experience	Expression	Solution/ Expected change
Understanding of caste based discrimination.	Mostly experienced in social interaction with non Dalits on occasions like marriage ceremonies, festivals, and performance of rituals. **First experience-** Village shop keeper Temple visitors Temple priest.	Separate seating, separate utensils for foods, cannot perform some offering during the conduct of a festivity, restricted entry to some places of worship	IS THERE ANY?/ NO SOLUTION→ frequently posed question. Allow same space- both physical and social as others Improve educational levels and economic propensity
Understanding of caste based discrimination in accessing health care	Mostly experienced by the hands of grassroots level health workers and least by the doctors	Not touching while dispensing the medicine; Not entering the house; Not going to the Dalits quarters altogether	Workshops to sensitize the health workers, specially grassroots level Placement of more dalit workers.
Mechanism to reduce/ eliminate discrimination in health sector	Public sector providers discriminate more than private sector providers	Public sector providers do not touch, they spend less time, often talk callously/ rudely with the care user	More private sector providers. Even at the grassroots level
Children's perspective	Do not give chance to them/mothers to tell about the health problem Providers appear to be least interested in providing care to them	Often workers in the Health centre do not let them take water from the source (Tap, earthen pot, cooler) Providers do not often talk to them	Should be told that GOD MADE US ALL. This will help them treat us well. *'We are as much human as them. So why do they have to behave like this with us? Do they not know this?'*- a child Lilsar, Barmer, Rajasthan

(Based on Consultative Meetings with Mothers and children)

It is evident from the consultative meeting with the Panchayat members, teachers and other members of the village community that when there were elected members, officials, teachers and care providers from Dalit caste; and voluntary organisations sensitive to the issue of caste based discrimination in the area; more assertion among Dalits and less evidence of discrimination

were noted. Villages where such sensitivity lacked, hooliganism, often backed by local political outfits was conspicuous. For instance a Dalit Doctor (lady) was forced to 'go on leave' due to alleged misconduct of a Dominant caste youth with claims of 'political connections' (Undkha). There were apprehensions about dalit providers which often led to unpleasant encounters. A PHC doctor from Dalit caste (Ranigaon) 'satisfied' Dalits, though the non-Dalits felt he was there because 'the Sarpanch was also from Dalit caste'. His medicines were considered 'not effective', medicines are unavailable because 'they sell' them in the market. Acceptance of Dalit provider was also evident when the key villagers reflected sensitivity towards caste-based discrimination. Information about health camps were given adequately to dalit households. There were expectations that these important villagers would work towards bridging the gap between the Dalits and the non-Dalits. (Chart 4).

Chart 4. Experience of and Expectation from the Dalit PRI Members

Issues	Experience	Expression	Expectation
Same caste Panchayat members	Mixed	Feeling of affinity, sense of dignity	Work towards bringing the Dalits and non-Dalit closer 'in reality'
Inform about available health services	Yes	Visits the house to inform	Ensure that the HWs are bias free or equip the Dalits to counter the bias
Health camps Immunisation camps	Most of the time	Uses posters, meeting and *anganwadis* for informing	Ensure that the camps are also held in the Dalits quarters too
Accessing the services	Often. They also try to rope in the health workers to do the job for them	Ensure that the health workers also take interest in this process	Ensure that there is no fear while passing through the non-Dalit quarters to access the services Improved roads Availability of the care providers Conducive behaviour of the paramedics and the ancillary staff. like watchman and gardener

5.3 Understanding Discrimination: Some Voices from the Field

Case Study 1- PHC Village Koth, Dholka, Ahmedabad, Gujarat Female aged 20. Married.

Recently married, is aware of the discrimination inflicted by high caste Hindu of the native as well as marital village. She finds the assertion levels different between the two villages. She feels that here she has more courage to react something discriminatory as compared to her native village. She feels that the *Dalit* community in her native village is more 'soft and docile'. She does not

want to get into any argument with the high caste Hindus and take the indignant behaviour without retorting. However, here in this village she has seen the assertion of the people is very high and not many of them react when a high caste Hindu tries to humiliate them in any way. Also, she feels that because the community is conscious, there is lesser instance of such humiliation as compared to her native village. Here in this village she has often taken small children of the family to school and to the health Centre on different occasions. Although she said that the teacher who takes the school fee, did not take the money from her hand, instead insisted that she keeps it on the table when she went there to pay the fees of the school-going children of the family. Similarly, in the PHC too, she was once refused by the doctor as she had come alone for her check-up when suffering from fever. She had seen there, separate earthen pots to drink from for the Dalits and the non-Dalit. She was later accompanied with her sister-in-law and was examined by the ANM.

Case Study 2 : PHC Village Koth, Dholka, Ahmedabad, Gujarat

Male aged 26 years. Trained as a carpenter, belongs to *Koli* caste. Works as a class IV employee at the PHC, but claims to earn more money as a painter. Has painted many Hindu gods and goddesses but worships Bhagwan Buddha because his grand father attended the meeting addressed by Dr B. R. Ambedkar when he visited the village. Since then his family has had one more deity alongside various many on their prayer altar. Educated up to class XII from the local school, he has many instances to quote regarding social discrimination experienced at various stages of his life. Like all other children of his ilk, he would be made to sit on a separate *'tatpatti'* with them. Most teachers did not encourage him and the others sitting on the same 'tatpatti' to participate in the classroom activities. He played and shared meals with these boys only. All through his schooling he remembers only one teacher who encouraged him to answer and even ask questions in the class. He was the Hindi teacher in class VII and happened to be a Dalit. He would always encourage the students to study well and become 'good human beings'. Although he feels sad for not having been able to complete graduation which he joined in the Dholka College, but is happy working in the PHC. He feels that his job gives him tremendous opportunity to interact with people regarding their health. He takes initiatives in ensuring that information reaches the Dalit quarters of the village. The elders in the community have worked towards cultivating and maintaining cordial relations between the Dalits of the village. Activities like collective prayers and meetings have been regularly organized to build upon the relationship among family members, neighbours, friends and peers. Youngsters like him are encouraged to be part of such activities.

6. Conclusion

The purpose of the present paper was to empirically understand whether discrimination exists or not in health care access for dalit children. If it does exist, then, in which spheres, and in what forms; and who practices it the most? For this purpose, conceptual definition and empirical method to capture nature and form of discrimination were evolved.

The most discriminating form was 'touch' in the sphere of dispensing of medicine. The most discriminating provider was the one at grassroots levels- the ANM in the public sector and the traditional healer in the private sector care. Thus the grassroots level workers were most discriminating in both the public and the private sector; and the higher order providers were least. The results of the study highlight that the villages which were more discriminating by form and the provider were less discriminating by sphere and vice versa. The paper also reflects on discrimination differential between public and private sector health care. Dispensing of medicine was the most discriminating sphere followed by pathological tests and visit to the doctors. Touch, time spent and way of speaking to the users were the most discriminating forms. On an aggregate level, while Siyagpura was most discriminating, Rampur was least. As compared to Gujarat, Rajasthan seemed to be more discriminating. Although, Gujarat was more discriminating in form and by providers; Rajasthan was more in spheres as compared to the other state. Rajasthan was most discriminating in sphere while Gujarat was slightly more discriminating than Rajasthan in form.

Such a pattern of discrimination is indicative of the poor health. If the medicine is not being dispensed properly, if the interaction with the provider is restricted due to use of derogatory words and refrain from touch (or offending touch) during diagnosis, counseling, pathological test or while seeking referral, there is a likelihood that the required health care will not reach the user. Apprehensions about being treated with dignity further restrict them from coming to seek and use care. This denies them the access to services and affects their health status.

The causes for discrimination are many. Some evidences from the field suggest that non-Dalits are governed by age old beliefs and stereotypes to continue practicing discrimination. Consultative meetings and discussions have reflected that the providers do not visit the Dalit quarters by giving reasons such as preference for central location to enable everyone's access; and that Dalit quarters are further inwards into the village, thus inaccessible to locate them

for rendering the services. Dalit providers, on the other hand, cannot enter the house of the non-dalit users; if they can, then up to the outer courtyard. They have separate cup/glass etc for consuming offered eatables; and have to wash the vessels after consuming which are 'cleaned' once again by the owners. Their 'efficiency' is almost always doubted.

Dalit children experience social hindrances toward health care access and often have to travel longer than others for accessing service. Discrimination in the delivery of the services is often visible. Children are not given the chance to express explicitly to the care provider in the health care centre. Burden of health care utilization is often not possible for Dalit children to bear. Benefits of the various development programmes which accrue to Dalit children are few. Different forms of discriminations are manifested at the interface of various factors and hence experienced differently by Dalit children. Discrimination in access and utilization of health care is mostly observed in the disparity in care provisioning at the health care centre by the providers-doctor and the supporting staff; and at home during the visit by the health worker. The forms and spheres of discrimination experienced by Dalit children in access to health services are many and have been reflected in the present paper. It is imperative to acknowledge the existing discrimination, recognize it and address it for elimination. For this, there is an urgent need for a policy which takes care of the prevention of discriminatory practices. There is also a need to sensitize people on the lines of gender sensitivity and penalize the guilty.

End Notes

1 More than one fourth (27% among rural and 24% among urban population), are Dalits in the population below poverty line. Among Dalits, 36% are below poverty line as compared to dominant castes. (NSSO, 55th Round, 1999-2000, as quoted in Shah et al (eds.) Untouchability in Rural India, Sage Publications, New Delhi.

2 The questions pertaining to discrimination in different spheres, in different forms and by different providers were chosen to compute this index. Responses of the mothers for children below 12 and of the children above 12 were included. There were 50 respondents from the four PHC circles (that is, PHC village, a sub centre village in the same PHC circle and a non sub-centre village from the same PHC circle) - Koth and Amaliyara in Gujarat, and Ranigaon Khurd and Sanawada in Rajasthan. Therefore, there were 200 respondents in all.

3 Based on discussions. *Jhopa* is a local term for thatched hut.

4 Evolved on the basis of groups discussion with the non-dalit respondents

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