Social Discrimination in Health

(*with Reference to Caste, Class, Gender and Religious Minorities*)

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1.0 Introduction

The 40th Annual Meet of medico friend circle (mfc) organised in Delhi (India) from February 13-15, 2014, takes place at a very critical juncture in the public health history of India from the point of view of the socially disadvantaged communities. Medico Friend Circle was initiated four decades ago (in 1974) by visionaries of an alternative society, in the backdrop of the social ferment and social movements of 70's within the JP Movement (Movement led by Jay Prakash Narayan). This history has had an overwhelming influence on the thinking of mfc members in terms of envisioning a society based on equality, democracy and social justice, and with the understanding of health in its broadest sense – encompassing its social determinants, and as an indicator of human dignity and individual as well as community well being. mfc has been a witness to the history of people's health in India through the last four decades (1974-2014) with uninterrupted Annual Meets, a bi-monthly bulletin, as well as in terms of taking principled position offering critical responses to challenging issues to the health of the marginalised communities in India. In spite of mfc being a completely voluntary group, with expenses being shared by members who work country-wide in health related organisations, it has been involved in campaigns, research, fact-finding and dissemination of crucial information to the public. At a time when the marketised, privatized, fragmented and reductionist understanding of health is promoted, the theme of 40th Annual Meet - *social discrimination in health with reference to caste, class, gender and religious minorities* – will focus on the issues of social exclusion and discrimination which continue to haunt the lives of subordinated groups through societal structures, policies which favour the status-quo of such structures, with serious consequences to health of the disadvantaged and the marginalised. The experiences of communities that have been and still are discriminated and stigmatized on the basis of caste, class, gender orientation and religion are further favoured through the combination of neo-liberal policies, practices of privatization, fermenting communal and ethnic conflicts and by perpetuating violence on the basis of gender or sexual orientation.

Social inequalities and unequal health outcomes:

There has been a growing literature endorsing the hitherto known common sense understanding that socio-economic inequalities lead to unequal and adverse health outcomes. The Black Report in England, research by Michael Marmott conducted in fairly well-off societies such as United Kingdom have substantiated this argument. (Marmott and Wilkinson 1999). That health is

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beyond clinical/medical/health care and that health care itself is influenced by various socio-political and cultural factors has been very well articulated by the report of the Commission on Social Determinants of Health (CSDH) of World Health Organisation (WHO – CSDH 2008). The various determining factors influencing the health status of individuals and groups summarizing it the present day coinage of 'social determinants of health'.

The impact of social discrimination on health is studied by various scholars especially using the eco-social theoretical framework. Most of these studies are done keeping race as the axis of discrimination especially in United States of America (USA) and Europe. According to this framework, racial discrimination, a form of social discrimination and societal injustice, becomes 'embodied inequality' manifests itself as health inequities. The eco-social theory is very pertinent to understand and conceptualise social discrimination in relation to health. This theory of disease distribution concerns who and what drive social inequalities in health. [A central focus of this framework is on how we literally and biologically embody exposures arising from our societal and ecological context. This can also be seen expressed in the distribution of health and illness among populations. The eco-social theoretical framework, inter alia, has relevance to the theme of social discrimination that MFC is discussing about where the axes of discrimination are caste, class, gender and religion.

The core constructs and core propositions of this theory are well enunciated (Krieger 2012). Some of the core propositions of this theory include**:** *People literally and biologically embody* their lived experience, in societal and ecologic context, thereby creating population patterns of health and disease ; s*ocieties' epidemiological profiles* are shaped by the ways of living afforded by their current and changing societal arrangements of power, property, and the production and reproduction of both social and biological life; i*n societies exhibiting social divisions based on property and power ,* the greater burden of disease is on with less power and fewer resources,

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Among the core constructs of this theory, two are of special significance to the theme of discrimination in health: (1) *embodiment* **(**we literally incorporate, biologically, in societal and ecological context, the material and social world in which we live); (2) diverse *pathways of embodiment include a range of phenomena:* (social and economic deprivation, exogenous hazards, hazardous conditions, social trauma - discrimination and other forms of mental, physical, and sexual trauma-, inadequate or degrading health care, and degradation of ecosystems, including as linked to alienation of Indigenous populations from their lands.

Difference, inequality, inequity, exclusion and discrimination:

Differences, inequalities and some form of hierarchies seem to be part of the societal functioning. We also do uphold the value of being different and diversity and hence, sameness is not being advocated as a virtue for health, wellbeing and dignity. The key challenge is, however, to see when and how these differences, inequalities and hierarchies become institutionalized to

restrict access to resources which are essential to a dignified living and give rise to socio-politico-economic structures which exclude and discriminate communities without power and resources. Such structures give rise to social discrimination which is legitimized in the name of caste, race, religion, ethnicity, gender etc. and in turn becomes the media to perpetuate inequity. The caste, class, religion and gender identity based discrimination in the community is the outcome of a system that is infected with this structural malaise and play out in all spheres of life. The lower one is in the power hierarchy, the more adverse the impact of health, dignity and wellbeing.

Political Economy of Social Discrimination in Health: Discrimination is generally understood as – 'unfair treatment of a person or group on the basis of prejudice' (Webster's Dictionary). The prejudice is embedded in the social structures and institutions. Though social stratification is a given thing in the social processes, due to the unequal appropriation of resources and power, many individuals and communities are rendered vulnerable due to the lack of ownership over and access to resources. The injustice experienced by the poor this way ranges from exclusion from enjoying equal opportunities and resource to being targeted through express violence through stated or unstated societal sanctions. The data on anaemia, children dying of malnutrition and hunger, maternal mortality, infant and neo-natal mortality, low literacy and inadequately paid labour, migration in search of livelihood etc. point to the communities who experience systemic and continuous discrimination through the inbuilt institutions of caste, class, gender constructs and religion. The adverse health outcomes, in a sense are not only an indicator to the public health delivery system, but more so of the foundations of prejudice and discrimination within which the very public health system is located. Dalit women who are brutalized, Muslim communities who are the constant targets of right wing religious hegemonies, the manual scavengers who are unpaid and have no option but to do manual scavenging, the sexual minorities who are criminalized due to their sexual orientation, the tribal women and poor who become easy prey for clinical and medical experiments tell the stories of horror of indignity experienced due to the unjust social structures where privileges are reserved for a few.

Health and disease are socially defined and produced: For long, the western bio-medicine has concentrated on the individual as the locus of illness and has depended on medical technology and the chemicals as healing agents. The dominant western allopathic medicine still defines health problems as technical problems. The research in the last few decades has provided sufficient argument for the social dimensions of health and disease. To accept that health and disease are socially defined and determined is one step ahead of the technological definitions. Health, however, is not only a socially defined, but also a socially produced natural reality (Djurfeldt and Lindsberg 1975). Epidemiology alludes to this in certain way by mentioning the distal, intermediate and proximal causes of disease, however it fails to recognize the structural roots of health and disease. The definition and production of health is embedded in the social-political-economic and cultural structures of the society which pay out the prejudices and discriminations that have adverse bearing on the health outcomes.

The societal positioning and the status enjoyed in the intersecting class, caste, gender and ethnic identities (religion, language etc) have a great bearing on the health and wellbeing enjoyed by the persons. The Commission on Social Determinants of Health (2008) recognizes the social roots and causation of health and disease. The social discrimination in health refers to the factors and processes that deny access to resources that determine health is rooted in societal structures. This plays out different ways, especially in the context of India. Dalits due to their lower caste status, women and sexual minorities due to their gender status and sexual orientations, tribals due to their vulnerability, religious minorities due to their minority status often enjoy less power to determine their own control and ownership over the determinants of their health.

Link and Phelan (1995) described socioeconomic status, social networks, and stigmatization as "fundamental causes" of disease. Link and Phelan maintained that these factors shape access to significant salutary resources that ultimately influence health, such as money, knowledge, power, prestige, and social support. They suggested that fundamental causes can affect health through multiple mechanisms and are not disease-specific. Further, as root causes, these factors continue to influence health regardless of the effectiveness of individual treatment or therapy. Even as knowledge about healthy behaviour increases and as effective individual treatments improve, populations characterized by socioeconomic disadvantage will always lag behind in their adoption of these health-generating behaviours and resources, resulting in persistent socioeconomic disparities in health (Geronimus 2000).

Social discrimination as a driver to ill health: The social meaning of discrimination is explained in depth by Aaron Antonovsky (1960) and emphasizes on discrimination as a system of social relations and is an institution with its own processes and not merely an issue of psychological prejudice or individual behaviour. A whole range of social arrangements create and perpetuate social discrimination. One of the serious consequences of discrimination is a pervasive and systematic inequality of 'life-chances'. From the perspective of health, wellbeing and dignity, social discrimination can be construed as one of the prime drivers of ill-health. The embodiment of social discrimination can be exemplified by the life-experiences of Dalits, women, minorities who live in fear and the sexual minorities who are perpetually harassed. Not only that social discrimination creates barriers to a life of dignity, in itself it is a social barrier to enjoy good health and access health care. Embedded in the unjust social arrangements of the societal structures, it perpetuates the cycle of discrimination – marginalization and ill-health.

Inter-sectionality and axis of social discrimination: Discrimination and exclusion is faced by various individuals and communities with various sexual orientations, People Living With HIV/AIDS, people with disability, Women, Children, various occupational groups (e.g. sex workers, agricultural labourers), groups in subaltern or segregated geographical settings such as relief camps, slums etc. belong to various socially discriminated communities such as Dalits, Adivasis/tribals, Muslims and other persecuted or discriminated minorities. Along with this multiple marginalizations is a reality of the groups that face social discrimination. This has serious implications to health and illness; e.g. what happens to a Dalit woman who is disabled,

anaemic and is a HIV positive person? What is the health condition of aged men and women in vulnerable communities? How does a poor Muslim woman who might be with disability or distress in least developed pockets in the country cope with ill-health? What kinds of suffering they experience faced with droughts, food insecurity, floods, debt, recession, unemployment? In a malfunctioning public health system and a over-privatised and marketised/commercialized healthcare system, how much more impoverished and marginalized they become?

The intersectionality issues of focus:

Caste: United Nations refers Caste based discrimination as the Discrimination based on Work and Descent. The Draft Principles and Guidelines for the Effective Elimination of Discrimination based on work and descent identifies it as ' any distinction, exclusion, restriction, or preference based on inherited status such as caste, including present or ancestral occupation, family, community or social origin, name, birth place, place of residence, dialect and accent that has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life. This type of discrimination is typically associated with the notion of purity and pollution and practices of untouchability, and is deeply rooted in societies and cultures where this discrimination is practiced' (ISDN).

In South Asia, 'Dalits' (formerly known as untouchables) are traditionally people who fall outside Hindu caste system. However caste systems and related caste discrimination are also found in Christian, Buddhist, Muslim and Sikh communities. Caste systems and discrimination based on work and descent are also found outside South Asia in countries such as Japan, Yemen and African countries. The conditions of the life of Dalits in the caste-hegemonic society of India and social, economic, political and cultural systems are detrimental to dignity and wellbeing and hence is a major concern for health. The social discrimination is practiced in various and all spheres of life.

- extreme poverty
- degrading untouchability practices (e.g. denial of drinking water from upper caste water sources, denial of access to public and religious places)
- intergenerational bonded labour and child labour
- unemployment or dangerous/degrading employment (e.g. manual scavenging)
- restrictions on employment or forced occupations (e.g. trafficking and forced sex work)
- lack of access to justice, and discrimination and violence from the police and justice system
- lack of access to, control of, and benefit from resources - prohibition of ownership of land and property
- segregation in housing, school and burial/cremation grounds
- de facto prohibition of inter-caste marriage

- abuse or discrimination against Dalit children in schools - high dropout rate from school due to poverty and discrimination
- lack of political power or genuine/independent political representation at all levels
- caste discrimination in humanitarian response to disasters or conflicts
- discrimination or lack of access to health care - related high maternal mortality

Dalit women, at the bottom of the caste, class and gender hierarchies, suffer multiple levels of caste discrimination. Violence and sexual assault are used to both maintain Dalit women's subordinate position and to humiliate the wider Dalit community. Vulnerability of Dalit women is reinforced by their lack of economic independence, low education, poor health and nutrition, early marriage, limited (or no) access to land and often deeply conservative and patriarchal societies. Forced and ritual prostitution linked to the Devadasi system, trafficking and domestic violence is widespread. With the intersectionality of age, divorced, deserted or widows, Dalit women with physical disability or mental illness the adverse impact on health attains disproportionate measures. While seeking healthcare, the negligence and denial experienced faced by Dalit men and women again becomes an additional space of experiencing discrimination.

- **Class:** According to the National Commission on Enterprises in the Unorganised Sector (NCEUS 2008) 90% of the workforce in India is in the informal sector. This is corroborated by the Economic Survey 2007-08 which estimates that 93% of India's workforce includes the self employed and employed in unorganized sector. The informal sector is facing the issues of social security which includes lack of health care. Due to the nature of their work and employment, the vulnerability to illness is very high.

  Ministry of Labour, Government of India, has categorized the unorganized labour force under four groups in terms of Occupation, nature of employment, especially distressed categories and service categories. In addition to these, there exists a large section of unorganized labour force such as cobblers, hamals (head load carriers), handicraft artisans, handloom weavers, lady tailors, physically handicapped self employed persons, rickshaw pullers, Auto drivers, Sericulture workers, Carpenters, Tannery workers, Power loom workers and Urban poor. The extent of unorganized workers is significantly high among agricultural workers, building and other construction workers and among home based workers. According to the Economic Survey 2007-08 agricultural workers constitute the largest segment of workers in the unorganized sector (i.e. 52% of the total workers).

  The work conditions and the very nature of the unorganized sector, they face adverse conditions of work and living which have adverse bearing on health. As per the National Sample Survey Organization (NSSO), 30 million workers in India are constantly on the move (migrant labour) and 25.94 million women workforce has been added in the labour market from the year 2000

onwards. The aged population among the unorganized labourers do not have any saving or social security. The existing social security legislations cover only 8% of the total work force of 459 million in India.

Besides, due to the privatization and neo-liberal policies adopted by the government of India, the labour market of India has been undergoing tremendous transformations, including growth of informal sector activities, deterioration in the quality of employment (in terms of job security, terms and conditions at work), weakening of worker organizations and collective bargaining institutions, marked decline in social security etc. The growing informalisation of labour market has been central to most of these transformations The inflation, recession, price rise and growth without employment creation has added to the swelling of informal sector and insecurities making them highly vulnerable to illness.

Dalits and women form a substantial part of the informal workforce and their health conditions in al already discriminated situation need to be cause of concern. Various occupations which are considered impure and hard labour becomes the only way of earning livelihood for them. Discrimination is experienced by people in life-events and processes. The accounts of people who are subjected to trafficking, forced into sex-work, bonded labour, trapped in the cycle and conditions of manual scavenging etc. would form another context of understanding discrimination. The substantial numbers of the work force of sanitation workers, manual scavengers, and sewerage workers come from Dalits.

- **Gender:**

  In a patriarchal society, unequal power relations between men and women precipitate ill-health for women. Gendered expectations in terms of roles and responsibilities, the relegation of women to the private domain (with expectations of being good daughters, mothers and wives) and hierarchal pecking-orders within the family affect health status as well as timely diagnosis and treatment. Disclosure of illness has different consequences for men and women, with the latter facing risk of violence and desertion, more so if the illness is debilitating, financially draining or stigmatising. This is especially true of reproductive, sexual or mental illnesses that may interfere with motherhood or sexual expectations from the husband. Added to the marginalisation within the family, women are further excluded through State policies related to population control. The artificial divide between the public and private domains results in families demanding sons from their daughters-in-law, and the State imposing the two-child norm. Social distortions such as pre-natal sex-selection are now evident as a consequence. The intersection of gender with caste and class further aggravates discrimination against women who have more than two children, resulting in reduced political access for poor and Dalit women, or shaming by health and development workers on a routine basis. In India, patriarchy is inseparable from caste. From ritual and food purity to endogamous arranged marriages, women suffer the brunt of the caste system more than men

do. Since they embody family and caste tradition and honour, silence around violence keeps women away from health services at crucial times in their lives.

Insistence upon gender binaries also precipitate discrimination and violence upon people who don't fit into the strict categories of 'man' and 'woman'. Anyone who challenges heteronormativity is also vulnerable to marginalisation and exclusion, whether at home, in the clinic setting or in society at large. Unacceptable behaviour or choices ranging from inter-caste / religious marriage, same-sex preference, singlehood, transgender orientation or being in sex-work 'normalises' violence and discrimination against the individual or group.

Multiple axes of disadvantage create a complex web of discrimination – unless all these are taken into account while planning for inclusive health care delivery, the most subordinated are most likely to be left out. An intersectional approach that takes into account multiple discriminations is imperative if discrimination in health and health care delivery has to be addressed and eliminated.

- **Religious Minorities:** The Sachar Committee report of 2006, for the first time in India brought out the truth about the living conditions of the Muslim community. It revealed the extreme deprivation of Muslims in India and the low status the community has been relegated to, coupled with other exclusionary situations of violence, insecurity, identity crisis, discrimination in the public sphere, suspicion from other communities, and being branded 'unpatriotic'. The social discrimination factors that affect the health of the Muslims is exclusion from various development schemes, deep rooted prejudice, ineffective minorities' commission and the ministry of minorities' affaris. The repeated communal violence and conflicts that are engineered poses a constant threat to the physical and mental health of the Muslim community. The recent communal carnage in Muzaffarnagar (UP, India) which displaced thousands of people leading to deaths during the riots and later infant deaths in the camps is a sad reminder of the living conditions of Muslims in India.

The Sachar Committee unfortunately found SC/STs as the nearest comparable demographic entity for Muslims. According to the Committee report, Muslims record the second highest incidence of poverty, with 31% of people below the poverty line, following SC/STs who are the most poor with a Head Count Ratio (HCR) of 35%. Not only was the literacy rate for Muslims far below the national average in 2001 but the rate of decline in illiteracy has also been much lower than among SC/STs. According to the Sachar Committee's findings, 25% of Muslim children in the 6-14 age-groups either never went to school or else dropped out at some stage. In no state of the country is the level of Muslim employment proportionate to their percentage in the population. Not only do Muslims have a considerably lower representation in government jobs, including in public sector undertakings, compared to other excluded groups, Muslim participation in professional and management cadres in the private sector is also low. Their

participation in security-related activities (for example in the police) is considerably lower than their population share at 4% overall. Other figures on Muslim representation in civil services, state public service commissions, railways, department of education, etc, are equally appalling.

Health Services System as the expression of Socio-economic inequalities (Qadeer 2011): The health services system in India is plural in terms of knowledge system and practice. It is dominated by the allopathic (modern system of) medicine. However, one thing stands out is that barring a few indigenous or local health traditions which are practiced by people, in most of the systems of medicine the axis of discrimination that the MFC discusses is prevalent. It is marked by hegemony of caste, class and patriarchy and the prevalence of the discrimination of Dalits, women, unorganized labourers and not infrequently even the discrimination of religious minorities. The low paid and most stressful work, now is falling on the Accredited Social Health Activist (ASHA), e.g. who is a volunteer and a woman from the lower caste-class communities and is burdened with the public health activities while the medical officers are not available in the public health system and are generally engaged with private practice even while serving as medical officers. The discrimination faced by Dalits, women and minorities working within the system is known only anecdotal events and needs more in-depth research.

MFC's response so far and present challenges: MFC has contributed significantly through writings and articulation the broadest understanding of health as wellbeing and dignity, beyond mere health and medical care. Firmly believing that such understanding of health is determined by the social structures has time again responded to the determinants and socio-political factors in their historical contexts. MFC has always believed people's movements and struggle for health. A few selected illustrations of MFC's active engagement and responses, among others, include the following:

- Theme based annual meets on : From 1974 – 2014 range from the relevance of present health services, role of doctors in society (1977), privatization of health care, alternative medical education, ethics, universal access to health care to the present – Social Discrimination in Health (2014)
- Range of critical publications include: In Search of Diagnosis (Analysis of the Present System of Health Care 1977) Under the Lens – Health and Medicine (1986), Medical Education Re-examined etc.
- The Bhopal Disaster Aftermath – An Epidemiological and Socio-medical Survey (1988) is one of the few scientifically investigated and publicly made available reports on the impact of the Bhopal Gas Tragedy. (The significance of the MFC report could be better gauged in the backdrop of the Indian Council for Medical Research –ICMR - study and the report which was never made available to the public). MFCs response to Gujarat Carnage 2002 was very engaging and critical.
- MFC's critical thought has always been ahead of times and is illustrated by the fact that in 2010 and 2011 MFC had already started the thought on Universal Access to Health

Care much before Government of India constituted the High Level Expert Group (HLEG). MFC discussed the theme in two successive annual meets and made substantial contribution to the HLEG too. Besides, MFC members have provided critical inputs to National Rural Health Mission (NRHM, especially to the component of foregrounding community's stake in policy space through communitisation and community monitoring.

Conclusion: A rigorous understanding and study on discrimination and health require conceptual clarity about the exploitative and oppressive realities of caste, class, gender and other multiple forms of adverse discrimination. It also requires careful attention to domains, pathways, level, and spatiotemporal scale, in politico-historical context. Besides, structural-level and individual-level measures to gauge without relying solely on self-reported data or the bureaucratic reports. An embodied or grounded analytic approach would help better understand and analyse realities of discrimination.

References:

Antonovkshy, Aaron (1960). *The Social Meaning of Discrimination*. Phylon, Vol. 21, No.1 (1st Qtr., 1960), pp. 81-95.

Cobley Bethan (2012). *Good practices and strategies to eliminate caste discrimination by governments, civil society, national & international institutions and agencies. International Consultation on Caste-Based Discrimination,29 November - 1 December 2011* · Kathmandu · Nepal. International Dalit Solidarity Network.

WHO - CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization.

Djurfeld & Lindsberg (1975). *Pills against poverty- a study of the introduction of western medicines in a Tamil village*, New Delhi: Oxford & IBH Publishing Co.

Geronimus AT. (2000). *To mitigate, resist or undo: addressing structural influences on health*. American Journal Public Health. 90(6):867-871.

Government of India (2006). *Social, Economic and Educational Status of the Muslim Community of India, A Report*.Chairperson: Rajendra Sachar (Sachar Committee Report). New Delhi.

Government of India, National Commission for Enterprises Among Unorganised Sectors (2007). *Report on the Conditions of Work and Promotion of Livelihoods in the Unorganised Sector*. New Delhi.

Krieger, Nancy (2012). *Methods for the Scientific Study of Discrimination and Health: An Ecosocial Approach.* American Journal of Public Health. Vol. 102, no. 5, 936-44

Link BG, Phelan J. (1995). *Social conditions as fundamental causes of disease*. Health and Social Behaviour. Extra Issue: 80-94.

Marmot, M. and Wilkinson, R.G. (1999). *Social Determinants of Health*. Oxford: Oxford University Press;

Prime Minister's High Level Committee, Government of India (2006). *Social, Economic and Educational Status of Muslim Community in India – A Report* (Sachar Committee Report). November, 2006. Available at http://www.minorityaffairs.gov.in/sites/upload_files/moma/files/pdfs/sachar_comm.pdf (Accessed: 8 January, 2013)

Qadeer, Imrana (2011). *Public Health in India: Critical Reflections*. Delhi: Daanish Books.

International Dalit Solidarity Network (n.d.). *UN Principles and Guidelines (Online version).* available at http://idsn.org/international-advocacy/un/un-principles-guidelines/un-pg-online-version/ (accessed: 8th January, 2014)

Webster's Dictionary (online). www.webster-dictionery.org (accessed 20th July 2013).