An Analysis of Caste based Social Inequalities in Health of Tribal Population in Assam

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Abstract:

Caste is one of the traditional measures of social segregation in India and differs from other indicators as it is both endogamous and hereditary. Evidence suggests that belonging to lower caste exposes one to social inequalities and effects health adversely. Despite policies targeting scheduled castes (SC) and scheduled tribes (ST), there remain large disparities of living standards between SC/ST and non-SC/ST households in India. In a caste-ridden society like India, social hierarchy also can be a serious handicap for utilization of available services in the health and educational sector. This paper examines health inequalities between two broad caste/tribe groups in Assam . The National Family Health Survey, India which has provided data on a variety of health indicators by caste/ tribe, by education and by standard of living (which can be taken as a proxy for economic conditions) provides ample opportunity to examine the social inequalities in health. This paper attempts to assess the extent of in equalities in health status existing in Assam with focus on caste/tribe. It also examines how far these inequalities are the result of caste/tribe per se or whether they can be attributed to the differential economic conditions and educational status of individuals belonging to different caste/tribe categories.

Keywords: Caste, Social inequalities, Health care, Reproductive health.

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Introduction:

In December, 2004, Health Unlimited, a UK based non-governmental organisation, and the London School of Hygiene and Tropical Medicine hosted a meeting of experts in indigenous health to mark the end of the International Decade of the World's Indigenous Peoples. The main objectives of the Decade's are strengthening international cooperation for the solution of problems faced by indigenous people in such areas as human rights, the environment, development, education, and health. In their assessment of the Decade, the UN Commission on Human Rights observed that indigenous peoples internationally continue to be among the poorest and most marginalised and that "the adoption of a declaration on the rights of indigenous peoples, one of the main objectives of the Decade, has not been achieved".

Improving indigenous peoples' health is a critical but complex challenge. In some regions, indigenous peoples are unrecognised and uncounted. When data do exist, indigenous peoples have worse health and social indicators than others in the same society. Essential to understanding of the health problems of indigenous peoples. Indigenous people are also known as tribal, aboriginal, or minority peoples. But definition of who is indigenous is a dif?cult task. Maybury-Lewis argues that "indigenous peoples are de?ned as much by their relations with the state as by any intrinsic characteristics that they may possess. They are often considered to be tribal peoples in the sense that they belong to small-scale pre-industrial societies that live in comparative isolation and manage their own affairs without the centralized authority of a state". The lack of clear definitions of indigenous combines in some regions with a systematic marginalisation and isolation of such peoples. This isolation has a huge effect on availability of information about the demographic and health status of indigenous peoples, particularly in low-income countries. As a result, there are very different demographic estimates of indigenous peoples. The health of indigenous peoples is substantially poorer than the general population. For example, In India the infant mortality rate (IMR), child mortality rate and under 5 mortality rate (U5MR) of the scheduled tribe population was higher (i.e. 62.1, 35.8 and 95.7 as per 1000 live births) than the other people (i.e 57, 18.4 and 74.3 as per 1000 live births) (NFHS-3).

Marginalization of certain groups or classes occurs in most societies including developed countries and perhaps it is more pronounced in underdeveloped countries. In the Indian context, caste may be considered broadly as a proxy for socio-economic

status and poverty. In the identification of the poor, scheduled caste and scheduled tribes and in some cases the other backward castes are considered as socially disadvantaged groups and such groups have a higher probability of living under adverse conditions and poverty.

The health status and utilization patterns of such groups give an indication of their social exclusion as well as an idea of the linkages between poverty and health. Caste in Indian society is a particular form of social inequality that involves a hierarchy of groups ranked in terms of ritual purity where members who belong to a particular group or stratum share some awareness of common interest and a common identity. Structurally the lower castes were economically dependent on the higher castes for existence. The Scheduled Caste remained economically dependent, politically powerless and culturally subjugated to the upper caste. This kind dominance of higher castes on the lower castes effects their overall lifestyle and access to food, education and health. The scheduled tribes like the scheduled castes face structural discrimination within the Indian society.

According to the report of National Family Health Survey (NFHS)- 3, in India tribal's are facing various health problems like malnutrition related diseases, parasitic diseases including malaria, diarrhoea, respiratory disorders etc, and genetic disorders including sickle cell disease, thalassemia, STD and HIV/ AIDS etc. They constitute a large proportion of agricultural labourers, casual labourers, plantation labourers, industrial labourers etc. This has resulted in poverty among them, low levels of education, poor health and reduced access to healthcare services. They belong to the poorest strata of the society and have severe health problems.

Table1 : Occupational structure of STs and Non-STs in India

Population	Primary Sector	Tertiary	Ratio
Non-Scheduled Tribe	43%	29%	3 : 2
Scheduled Tribe	66%	15%	9 : 2

Source: Census 2011

Above table clearly indicates large disparities in occupational structure between the two groups at the national as well as sub-national levels. Two-thirds of Scheduled

Tribes are still working in primary sector, whereas this proportion is lower for Non-Scheduled Tribes i.e. scheduled caste and other population (43 percent). The involvement of Scheduled Tribes is low in tertiary sector (15 percent), as compared to Non-Scheduled Tribes population (29 percent).

The rate of morbidity, mortality and other health indicators reveal that the health status of tribal population is very poor.

Table 2 : Health indicators of India and Assam

Indicators	India	Assam
Maternal Mortality Rate (Per 100000 live birth)	178	328
Infant Mortality Rate (Per 1000 live births)	47	58
Total Fertility Rate	2.5	2.4
Crude Death Rate	21.4	22.4
Neo Natal Mortality Rate	33	39
Post Natal Mortality Rate	32	20

Source: IIPS, SRS (2010-11) and NFHS-3

There are many studies which indicate that communicable diseases, genetic disorders and nutritional disorders are more prevalent among tribal population in India. On one hand the communicable diseases still show higher burden while on the other non-communicable diseases are on the increase despite the poor low nutritional status and higher physical activity in their communities, thus increasing the disease burden.

The health of adult indigenous people is similarly poor, particularly for communities whose original ways of life, environment, and livelihoods have been destroyed and often replaced with the worst of western lifestyle—i.e, unemployment, poor housing, alcoholism, and drug use. At the extreme, indigenous peoples suffer systematic repression and deprivation, to the extent that their demographic survival is threatened. Access to health care is also poor for
indigenous peoples, often partly due to their physical isolation, but also related to their weak position within national priority-setting.

As per 2011 census the scheduled tribe population i.e. 10,42,81,034 is living in

India, which constituted 8.6% of the total population of India. About 705 tribal groups and subgroups including 194 primitive tribes live in India. They have been designated as 'primitive' based on pre-agricultural level of technology, low level of literacy size, isolation from mainstream of population, economical and educational backwardness, extreme poverty, dwelling in remote inaccessible hilly terrains, maintenance of constant touch with natural environment and unaffected by the developmental process undergoing in India. The health status of tribal population is much poorer as compared to the non-tribal counterpart.

Objectives:

The main objectives of this paper are-

1. To analyse the health status of tribal people in Assam and
2. To study the factors affects the health condition of tribal people in Assam

Methodology:

The methodology of this paper is descriptive in nature. All the datas are secondary data which are collected from various govt. reports, research journals, NFHS 3 and 4, Annual Health Report, SRS bulletin etc.

Analysis:

Health Scenario of Assam

Prior to examine the health status of tribal people it is worthwhile to have a glance at the current health status in the state. This section reviews the current health status in Assam by looking at three indicators viz. crude birth rate (CBR), crude death rate (CDR) and infant mortality rate (IMR) from 2001- 2012.

As per the dataset provided by NFHS-3(2005-06), the Infant Mortality Rate in the Scheduled Tribes population, was found to be about 62 per 1000 live births and U5MR was 96 per 1000 live births. Compared to rest of the population, IMR was higher by 27 percent and U5MR rate was higher by 61 percent. According to the report of NFHS-4 the IMR (48),U5MR (56), Maternal Mortality Rate (MMR) 300 per 1 lakh population. Assam has the highest Maternal Mortality Rate (MMR) in the country. In Assam Life expectancy at birth 63.6 for men and 64.8 for women, national average stands at 67.3 and 69.6 respectively. Full Vaccination Coverage Coverage 47%. Children's Nutritional status

(children age below 5 years who are underweight is 29.8%). Underweight women with BMI below normal 25.7%.

Looking at the improvement in the health status between 2001- 12 in following table it is observed that CBR has declined from 26.8 to 22.5 (4.3%) and CDR has declined from 9.5 to 7.9(1.6%) which is 1.5% in rural and 1.0% in urban areas. In case of IMR the condition has worsened in 2001 which was 76 in rural and 33 in urban areas. In 2012 it was decreased to 58 in rural and 33 in urban areas which is stagnant. Moreover, the health condition in the rural areas is pitiable compared to the urban areas in State. In view of this rural health care should be an area of utmost precedence of any government social sector policy, especially health policy.

Table3 : Estimated Birth Rate, Death Rate and Infant Mortality Rate of Assam

Year		Birth Rate			Death Rate			Infant Mortality Rate	
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
2001	26.8	27.8	18.5	9.5	9.8	6.6	73	76	33
2003	26.3	27.2	18.0	9.1	9.5	5.9	67	70	35
2005	25.0	26.6	15.3	8.7	9.2	5.6	68	71	39
2006	24.6	26.1	15.4	8.7	9.2	5.8	67	70	42
2007	24.3	25.7	15.5	8.6	9.1	5.7	66	68	41
2008	23.9	25.3	15.7	8.6	9.0	5.6	64	66	39
2010	23.2	24.4	15.8	8.2	8.6	5.8	58	60	36
2011	22.8	24.0	15.5	8.0	8.4	5.6	55	58	34
2012	22.5	23.7	15.6	7.9	8.3	5.6	55	58	33

Source: Compiled by the author from SRS Bulletins(2001,03,06.07,08,09,10,11,12,13) Sample Registration System, Office of Registrar General, India.

Health Status of Schedule Tribes in Assam:

The NER (8 states) covers an area of around 3.7% of the countries total geographical area. The region consists of 45.6 million population. Most of the region is

characterized by hilly terrain, leading to outreach constraints these are inhabited by tribal and people belonging to different ethnic and cultural groups. The region is home to over 200 tribal communities which constitute about one fourth of the region.

Assam is the nerve-centre of North-Eastern Region of India. It is paradisaical state of colourful tribal population like Karbi, Bodo, Dimasa, Chutia, Mishing, Tiwa, Rabha, Khamiyang, Phake etc.(Sen,2009). As per 2011 Census total population of Assam was 31,205,576. The total population of the state has increased from 26,655,528 to 31,205,576 in the last ten years with a growth rate of 16.9%. The scheduled tribe population of the state was 38,84,371 of which 19,57,005 are male and 19,27,360 are female in 2011 census.

Table4 : Health indicators of Scheduled Tribe of India and Assam

Name	Infant Mortality Rate		Total Fertility Rate		Under 5 Mortality Rate		Neo Natal Mortality Rate	
	ST	Others	ST	Others	ST	Others	ST	Others
India	62.1	48.9	3.12	2.35	95.7	59.2	39.9	34.5
Assam	59	74	2.5	2.7	83.2	100	43.9	48.1

Source:IIPS, NFHS-3 (2005-06)

The above table shows the various health indicators of Assam and national average of Scheduled Tribe population.

Reproductive health of Women in Assam:

The concept of reproductive health has been defined as "a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free from fear of pregnancy and contracting diseases" (Fathalla, WHO,1988).

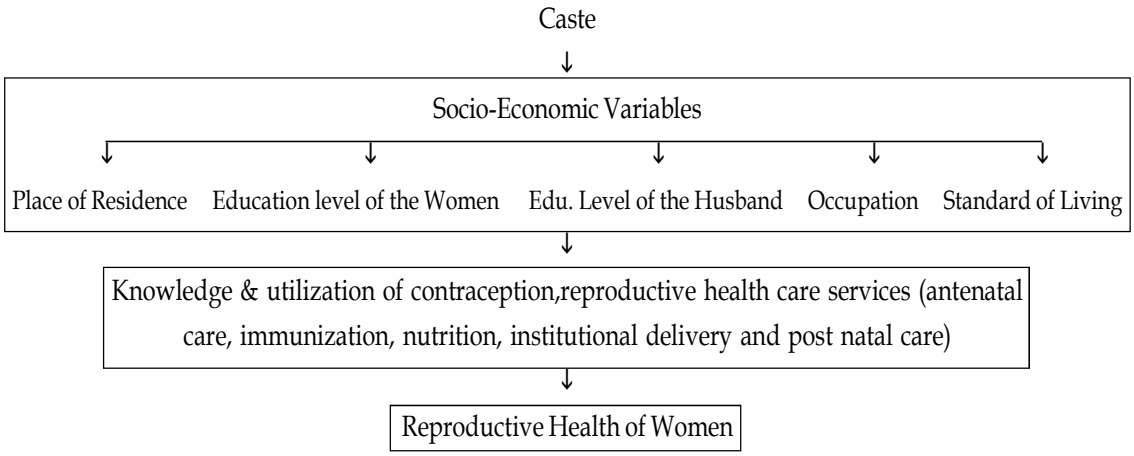
India's maternal mortality ratio (MMR) is highest in South Asia; 540 deaths per 100,000 live births or one woman dying roughly every five minutes. An estimated 1,

36,000 women die in India every year due to pregnancy related setbacks. Millennium Development Goal (MDG) 5 is focused on reducing maternal mortality and achieving universal access to reproductive health care. Under MDG 5, India has committed to reducing maternal mortality to 108 deaths per 100,000 live births by 2015. The latest estimates of maternal mortality rate (MMR) in India, from 2007 to 2009, show a national average of 212 deaths per 100,000 live births, a decline of 89 deaths per 100,000 live births since 2001–2003. However, the same estimates also demonstrate that wide geographical disparities persist. The highest MMR can be found in Assam, where it is 390, and the lowest in Kerala, where it is 81. India has made extensive efforts to reduce maternal mortality but many women still lack access to maternal and reproductive health care. As per NFHS-3 reveals that MMR in Assam is 328 which is higher than the national average i.e. 178. MMR of Scheduled Tribe is 342 in Assam (NFHS-3,2005-06).

Factors influencing Reproductive Health of Scheduled Tribe Population:

Health and illness have not only a clinical dimension but have also been influenced by the values, beliefs, customs, education, occupation, economic condition, etc. of people. Changes in socio-economic and cultural conditions of the rural people influence their health behaviour. Hence, changes in health behaviour are one of the indicators of rural transformation (Banerjee, 1989) like those of socioeconomic improvement, education, social awareness and exposure to the outside world, etc.

Table 5 : Framework of Influence of Caste on women reproductive health



The Reproductive health of women depends on various socio economic variables

such as place of residence, educational level of the women, educational level of the husband, Occupation and standard of living.

Education:

A strong relationship exists between a woman's literacy and her use of reproductive and maternal health services. A number of studies have examined empirical evidences concerning the influence of demographic and socio-economic factors of child survival (Gandotra et al. 1980; Clealand and Ginneken et al. 1988; Miller 1983; Das Gupta 1990; Caldwell 1979; Griffith et al. 2001). All these studies reinforce the existing argument for a greater emphasis on the schooling of girls to give women themselves and the next generation a greater chance of survival. Several authors have discussed the mechanism of literacy influence on infant survival (Caldwell 1979, 1986; Cohrane 1980; Hobecraft et al. 1984; United Nations 1985; Ware 1984; Gokhale et al. 2002; Govindasamy and Ramesh 1997). Ruzika and Kanitkar (1 972) found mother's literacy to be the most effective single factor determining the level of infant mortality in an urban setting. Literacy not only increases women's self- confidence but also makes them more exposed to information and thereby altering the way others respond to them.

Knowledge and perception:

Socio-cultural factors plays a key role in influencing men and women knowledge and practices related to maternal health. Since men hold the primary decision-making power in the society, the decision to go to a health facility in an emergency must wait until the husband (or in-laws) give consent. And also, the low value placed on girl's education leads to a low rates of girl's primary school enrolment. Even though knowledge about maternal health is not taught in school, the very fact of having attended school seems to increase overall awareness and ability to obtain new knowledge.

Decision making Power and women autonomy:

Apart from the socioeconomic aspects, there is also a growing number of study emphasising the role of women's decision-making autonomy on maternal health service utilisation and pregnancy outcomes. The causes of maternal mortality are unsafe abortion,

haemorrhage, eclampsia and obstructed labour as they together account for nearly two-thirds of total maternal mortality globally. Growing consensus suggests that a vast majority of these deaths are actually preventable simply by adopting the necessary precautions provisioned through basic MHS. Many studies have revealed that wife's autonomy on making decisions and some proposing that joint decision-making by husbands/partners and wives can produce better reproductive health outcomes than when one partner is left behind from decision-making tasks.

The unequal access to the health services has also expressed the ever-existing social inequalities. The programmes of socio-economic development, education, environmental sanitation, water supply, nutrition and health services have been adopted in an integrated scheme to improve social, economic and health conditions of the people in general and the weaker sections in particular. With the goal of "health for all by 2000 AD" and the Primary Health Care as a way to achieve it (WHO, 1988), India has launched several health care programmes of curative, promotive and preventive health. There is an enormous infrastructure of medical education, research and training centres, hospitals and dispensaries, Community Health Centres (CHCs), Primary Health Centres (PHCs) and sub-centres which serve the people. These infrastructural facilities in India are also aimed at serving especially the poor, weaker and under-privileged masses of which the tribals form a major chunk.

Despite govt. programmes and intervention, the reproductive health of women in India is very poor. Caste is one social institution in India whose impact on the life of the people cannotbe exaggerated. The influence of caste on reproductive health of women depends on Knowledge & utilization of contraception, reproductive health care services.

Conclusion:

With great efforts by the government and international and local non-governmental organisations, there have been some improvements in the health conditions of people in general and of the weaker sections in particular. However, the achievements and performances have been far from satisfactory. The tribal peoples particularly those living in backward areas have not had necessary access to health and other development services. Some of the schemes have been implemented among them either defectively or ineffectively. Besides, that they have their own reasons as to why they reluctancly receive or even do not receive benefits of the modern health'care schemes and stick to their

traditional or indigenous curative care systems. Even those who are provided with the health care facilities have not been able to utilize such facilities properly due to various reasons. One such reason is that they have found themselves in a dilemma as it has been hard for them to strike a balance between traditional and modern systems of medicine. Thus, the reasons like hostile environment, poverty, ignorance and illiteracy the tribal people have led to a sad scene regarding their health. This has also been supplemented by their superstitions, dogmatic and spirit oriented conception of health, illness, disease and death besides the lack of adequate health services among them. There have also been both general and special component plans and programmes to protect and develop their health. For instance, during the Fifth Five Year Plan, several schemes had been planned and implemented all over India under the Tribal sub-plan (TSP). One of these schemes is the provision for special nutrition and health care facilities to the tribals. Under the special nutrition scheme, Balwadis have been established to supply nutritional food to the pregnant and nursing tribal mothers and their children. On the health front, the Community Health Centres (CHCs), Primary Health Centres (PHCs) and sub-centres have been set up in the tribal areas. There is a strong association between education and use of reproductive health services such as family planning and ANC. The NFHS 3 indicated that the fertility rate among women with no education was 3.55, compared to 1.8 among women with 12 years or more education. Further, 29% of women with no education received at least one ANC visit as opposed to 88% among women with 12 years or more of complete education. Poor socio-economic status of women may directly or indirectly contribute to low use of reproductive and sexual health care services.

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