POSITION PAPER

UNIVERSAL HEALTH COVERAGE FOR THE COMMUNITIES DISCRIMINATED ON WORK AND DESCENT (CDWD)

Executive Summary

According to the World Health Organization (WHO) “Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course”. The definition is undeniably compelling and seems to hit the mark, and nations all around the world are working towards achieving the same goals—especially those that haven't yet—as well. This is especially relevant in light of the terrible pandemic that the entire world has recently experienced. The pandemic also presented some nations with additional significant issues, since their health system is underperforming and their spending is extremely low, which puts everyone at risk, particularly those from disadvantaged social groups like the Dalits in South Asian nations.

Dalits are Communities discriminated on Work and Descent (CDWD) they are one of the most marginalized communities, with approximately 220 million people situated in Bangladesh, India, Malaysia, Nepal, Pakistan and Sri Lanka. These communities are traditionally excluded communities based on their standing in the social hierarchy and their inherent nature of work dictated through principles of purity and pollution. According to an alternative report submitted to OHCHR Dalit women's health is dire, with high maternal and infant mortality rates due to inadequate access to healthcare services, resulting in a life expectancy as low as 50 years and a sex ratio of 922/1000.

1https://www2.ohchr.org/english/bodies/cerd/docs/ngos/dalit-women-cerd.pdf
discriminated against by the systemic structures and dominant communities in various forms and have sustained this discrimination through atrocities and violence. The position paper highlights the state of Universal Health Coverage for the Communities Discriminated on Work and Descent (CDWD) including Dalits in the South Asian Countries namely India, Nepal and Bangladesh. Additionally, the paper also emphasises the significance of universal health coverage (UHC), the role of stakeholders, and the need to develop sustainable solutions for global health issues especially for the CWD community including Dalits. It offers strong recommendations that are directly supported by the opinions of the community.

I. Introduction:

The goal of universal health coverage is to ensure that everyone has access to high-quality medical treatment without ever having to worry about their finances. The notion of UHC is not a recently developed phenomenon. After Germany implemented public health care in 1883 to protect the health of its youthful population, this idea was first developed. It all started in 19th-century Europe with Bismarck's reforms in Germany and the UK's 1946 announcement of the National Health Service. The WHO constitution was established in 1948, two years later, and the importance of "Health for All" was emphasised in the Alma-Ata Declaration of 1978. Similarly, events like the World Health Report 2010 and the resolution at the 58th World Assembly in 2005 both underlined the need of pushing nations to include UHC and financing for health care systems.

On the other hand, there has been a global campaign for universal health care, or UHC. UHC is well known for improving "health, social cohesion and sustainable human and economic development and as a precursor to strengthening national health systems" in international conferences such as the Rio Summit 20+ on sustainable development.

One potential overarching objective for health is universal health coverage, which was established in the Post-2015 Development Agenda, which replaced the Millennium Development Goals. According to the 2010 WHO study, universal health coverage (UHC) aims to ensure that
everyone receives the necessary medical care without having to worry about facing financial hardship due to excessively high out-of-pocket expenses. It includes coverage for financial risk protection in addition to a full range of quality healthcare services, including prevention, treatment, palliation, and rehabilitation. Universal coverage is the third feature, and it ought to be accessible to everyone. All nations are allowed to move towards universal health insurance, even though a large portion of the globe still lacks it. Enhancing information access is one such measure.

A variety of health system elements are included in UHC, such as infrastructure, medication supply management, personnel, finance policy, information systems, and service delivery (Carrin, et al., 2008) (Fesiya. 2022). To move forward to universal health coverage (UHC), each country needs to improve their existing systems. However, each country needs to make progress in three areas to reach the goal of universal health care. The first area is how many people are covered by a group of funds, the second area is how many people can be covered, and the third area is how much money is shared among the countries². UHC means that we need to make sure that healthcare costs are not too high, that good healthcare is available everywhere, and that the cost of health care doesn't make people less able to use it or make their families poorer (ibid. 2022).

As the cornerstone of pledges to achieve the third set of health-related Sustainable Development Goals (SDGs), the governments of South Asian nations have adopted the objective of universal health coverage. Rapid urbanisation is one of the obstacles to getting universal health coverage. Urbanisation, a major force behind the region's social and economic development, but causes unequal development and impedes attempts to safeguard the health and provide the impoverished and urban poor in South Asian cities with access to healthcare. Importance of Universal Health Coverage (UHC) (Adams, et.al 2018).

II. Background of Communities Discriminated on Work and Descent:

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² World Health Organization (WHO). Making fair choices on the path to universal health coverage
Communities Discriminated on Work and Descent are some of the most marginalised and excluded groups in the world. These communities experience discrimination at work and based on their descent. These groups encounter marginalisation and segregation in many facets of their social, economic, political, and cultural systems, whether on a local, regional, or worldwide scale. Significant repercussions follow from this marginalisation, including unjust deprivation and systematic exclusion from essential life experiences like social interactions, education, healthcare, access to clean water and sanitation, work opportunities, voting rights, equitable access to land and housing, and involvement in public religious institutions.

Centuries-old societal institutions have sustained the systemic violence against these Discriminated on Work and Descent (DWD) populations, such the Dalits (previously known as 'untouchables') in South Asia. It is significant to highlight that the effects of DWD communities are not limited to South Asia; this is a worldwide problem that affects over 270 million people throughout Africa, Asia, Europe, and Latin America.

Despite constitutional and legal protections in many countries, Communities Discriminated on Work and Descent (CDWD) continue to experience systematic segregation, discrimination across generations, and exclusion from public resources and privileges. They are victims of both modern and even historical types of slavery in most nations. Severe and extreme kinds of violence are used in response to any attempts to question procedures. Within these groups, inequality and violence against women and children are compounded.

Caste is one of the main ways that inequality shows up in South Asia. Discrimination against the marginalised caste groups is both systemic and individual, and it stems from caste, a social structure with political and economic implications.

“One in four Indians faced discrimination while accessing health services due to their caste and religion,” Oxfam India said, citing findings of the survey. As per the NFHS-5 survey conducted between 2019-21, the data reveals that there is a significant disparity in neonatal mortality rates between Dalit infants, with 29% succumbing to death within the first month, and the upper castes, where the rate stands at 20%.
“The surveys show that the basic rights of patients’ in India are being routinely denied in healthcare facilities, for the poor and middle class alike. Skewed power dynamics with respect to class, caste, religion, and gender between the healthcare providers and patients deepen existing structural inequalities in the healthcare system,” Oxfam India. The resulting disparity in key health indicators includes a wide gap in the nutritional status of young children and their mothers, and overall access to healthcare.

In Nepal, there are around twenty-three distinct Dalit communities. The Civil Code, which became effective in 1854, legalised the Hindu caste system in the Kathmandu Valley and throughout the kingdom. This code officially oppressed Dalits since they were the lowest class of people. Even though caste-based discrimination, including untouchability, was outlawed in 1964 by the New Civil Code, individuals continued to practice it out of custom and culture. Following the 2006 people's revolution, caste discrimination has been given considerable consideration in the interim constitution (Sob, 2012).

III. Purpose of Status Paper: The purpose of the status paper is to highlight the state of Universal Health Coverage for the Communities Discriminated on Work and Descent (CDWD) including Dalits in the South Asian Countries namely India, Nepal and Bangladesh.

IV. Importance of UHC:

1. Advancing Universal Health Coverage (UHC)

Global Movements and Milestones- The UN General Assembly Adopts the political declaration of the high-level meeting on universal health coverage in the year 2023. The UHC Action Agenda aims to rally countries and stakeholders behind a set of concrete actions and milestones, and to strengthen coherence in political processes related to health in 2023, including the high-level meetings on tuberculosis and on pandemic prevention, preparedness and response, as well as the SDG Summit, the G7, the G20, and the Intergovernmental Negotiation Body (INB) on a pandemic accord.
The health system of the countries in South Asia need to strengthen all three dimensions of UHC i.e. maximizing the population covered, increasing the range of services offered, and reducing the cost-sharing.

A human rights and people-centered health systems approach to UHC: UHC is rooted in a wider, longer, and deeper journey toward the realization of human rights, using various legal, historical, institutional, and social arguments. UHC implicates a wide range of human rights, including the rights to life; health; security; equality and nondiscrimination; freedom of movement, association, and assembly; information; expression; privacy; participation; an adequate standard of living; food; water; adequate housing; education; social security; and access to the benefits of scientific progress. These and other rights are enshrined in international and regional treaties and in national constitutions, and they also form part of customary international law. Overall, they can be traced back to the Universal Declaration of Human Rights, which established the normative foundation for the international human rights movement.

Goal 3.8 of the UN Sustainable Development Goals, the central global development agenda for 2015-30, adopted by the UN General Assembly in 2015, is a commitment by States to: “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” To generate the societal transformation required to ensure its successful implementation in countries, UHC still lacks sufficient clarity, both conceptually and operationally.

The extent to which the UHC target in the SDGs conforms with the requirements of the right to health enumerated in the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and other international human rights instruments and interpreted by international human rights bodies. Universality is a fundamental principle of human rights. Therefore, UHC implies that all persons in a country, including refugees, asylum seekers, and undocumented and documented migrants, should be provided with health entitlements for affordable and necessary health care. However, there is still a long way to go to
implement the need for an effective and integrated health system to incorporate the human rights principles of equality and non-discrimination, transparency, accountability, and participation.

2. Accessible and Inclusive Health Care services

Eliminating Financial Barriers to Healthcare: Amid the global drive for Universal Health Coverage (UHC), the focus is shifting to India's healthcare system. Without a constitutional requirement, a national policy, or public demand for UHC, there are significant risks in hastily adopting it in India. While the debate on UHC continues, India's healthcare delivery system stands at a critical juncture. From an economic perspective, an effective UHC implementation would aim to regulate unnecessary healthcare expenses to ensure future stability and growth. It is crucial to prioritize the protection of public health for the overall public good during the process of UHC implementation.

Health disparities persist in India, specifically among the Dalit and Adivasi communities, who experience shorter lifespans and poorer quality of life. The private health infrastructure in the country now comprises approximately 62% of the overall healthcare system, necessitating an examination of its responsiveness towards these marginalized groups. It is worth noting that only a small percentage, 4% of Adivasis and 15% of Dalits, seek healthcare services from private facilities. The 75th round of NSSO data reveals that the cost of inpatient care in private establishments is significantly higher, approximately 524%, compared to public facilities. This financial burden becomes even more concerning considering that 45.9% of Adivasis and 26.6% of Dalits belong to the lowest wealth quintile.

Owing to the influence of major global and local stakeholders, the evolution of Universal Health Coverage (UHC) in the privatized healthcare system of India seems to be taking a direction that involves the following crucial elements and current trends: (a) the establishment of large-scale tertiary care hospitals with public investments, (b) the procurement of drugs in bulk funded by the government and their distribution through the public health system, and (c) the implementation of diagnostic services for mass screening purposes through focused programs. (d) Hospitalization insurance coverage instead of coverage for health maintenance through
outpatient care. (e) Creation of a legal framework to extend the prescribing rights for allopathic drugs beyond licensed allopathic doctors. (f) Implementation of the public-private partnership model to establish primary care delivery units. (g) Sustained support for various public health initiatives, including population control, immunization, HIV, and tuberculosis.

The World Health Organization emphasized maximum population coverage, health service coverage, and financial protection, as three dimensions of UHC (Kabir, et al., 2018). The first dimension is relatively simpler to understand: what proportion of the people in the catchment of a health facility is covered for health services, and how many are left out. Reasons can be multiple and diverse, but ought to be minimized to ensure that the maximum population benefits from the essential health services available at the health facility. The second dimension is about the range of essential health services made available to the people e.g. immunization, family planning, antenatal care, delivery by skilled birth attendant, treatment of common ailments, and services for HIV/AIDS, tuberculosis, and malaria, etc. Third dimension is a bit complex and explains the expenditure incurred on health services. Besides the state financing or pooling of funds, the out-of-pocket expenditure determines the cost sharing by the patient, which is supposed to be minimal or zero at the point of service delivery. If the gap is large, the incidence of catastrophic expenditure and probability of impoverishment of the families is high due to purchasing of health. Hence, the third dimension of UHC calls for financial risk protection.

3. **Promoting culturally sensitive and inclusive health care practices**: The Indian National Health Policy, 2017, stipulates universal access to quality healthcare services across the country. “This indicates that wherever a person is in the social structure, they should be able to access adequate healthcare.”

Raksha in her work caste-based discrimination in health care reviewed caste-based inequity in health care utilization in South Asia, particularly focusing those at the bottom of the caste hierarchy, commonly known as Dalit communities. In Nepal and India, Dalits are the most marginalized people at the bottom of social hierarchy who experience most barriers to accessing public services (Thapa, 2021). The review identified four main themes: stigma, poverty, cultures
and beliefs, and health care. Dalits appear to experience this more significantly due to both poverty and their caste status, which increases their vulnerability to health risks. Many Dalits in rural areas in India are deprived from or are refused access to health services due to their social status. Therefore, training healthcare workers at all levels on the need for cultural awareness and inclusion can improve health equity. Additionally, inclusive policies can facilitate social mobility of marginalised groups (Jyotsana, 2020). Private hospitals often exhibit a bias towards urban areas, as approximately 67% of privately registered hospitals under PMJAY are situated in major cities (Prasad, 2023). Consequently, rural regions inhabited by Adivasi and Dalit communities continue to grapple with significant shortcomings in infrastructure. Within the private healthcare system, Dalits and Adivasis encounter discrimination, such as unequal treatment, being denied access to private clinics, and enduring prolonged waiting periods. The medical profession lacks adequate representation of Dalits and Adivasis in leadership positions. Additionally, there is a lack of social accountability for marginalized communities within the private sector. The regulatory mechanisms governing private healthcare are ineffective, with key provisions not being enforced (Kumar, 2016). To address these issues, the policy brief proposes recommendations to promote equity, accountability, and specifically address the concerns of SC and ST communities in the private healthcare sector.

The underrepresentation of Dalits and Adivasis in leadership positions within the medical profession is a pressing issue, as is the lack of social accountability for marginalized communities in the private sector. The existing regulatory mechanisms for private healthcare are ineffective, resulting in the non-implementation of crucial provisions. To address these concerns and promote equity and accountability in the private health sector, the policy brief offers recommendations that specifically cater to the needs of the SC and ST communities (Jadhav and Taneja, 2022). In a Qualitative study of sociocultural determinants of health inequities among Dalit population of Dhaka City, Bangladesh it was found that the health status of members of these Dalit groups is determined by an array of social, economic, and political factors (Kabir, 2018). Dalit’s experience of precarious access to healthcare or poor healthcare is an important manifestation of these inequalities and has implications for the economic and social life of Dalit
populations living together in geographically constrained spaces. The provision of clinical healthcare services alone is insufficient to mitigate the negative effects of discrimination and to improve the health status of Dalits (Kabir, et.al., 2018).

The study indicated that Healthcare issues of the Dalit population in Bangladesh remain largely neglected in the national government’s development agenda (IDSN, 2013), (Islam, F. (2007) despite its strong constitutional commitment. However, the general surveys such as Bangladesh Demographic and Health Survey, Bangladesh Urban Health Survey) does not present nationally representative demographic and survey data to demonstrate how extensively the healthcare access, and health and nutritional outcomes differ statistically between Dalit and other non-Dalit population in Dhaka city, some study reports indicate that Dalits have poor health outcome across the population in slum and other settings (Islam, et.al, 2018). For instance, Bangladesh's national and human development organisation stated that, “Health surveys and research programs conducted to assess the "public health situation" in the country tend to overlook the health conditions of children and mothers residing in Dalit communities' colonies and settlements. As a result, their unique health challenges, suffering, and the need for accessible and affordable healthcare that is free from discrimination go unnoticed and unaddressed” (IDSN, 2018). To achieve UHC, we need to address other barriers, like stigma and discrimination, that can make it hard for people to get the services they need. This can affect how people feel about their health (Rosenquist et. al 2013).

V. Collaboration among Stakeholders

1. Government roles and responsibilities: Government bears a primary duty of educating the CDWD population including Dalits about the UHC and associated health programmes. We discovered that the community has a strong desire for the government to establish an awareness camp in each of the villages during the survey. Communities reside in different geographic locations, but the same amount of work should be done to ensure that they have simple access to health treatments, information, and services. Along with bringing together representatives of state health agencies, government officials, and
healthcare professionals from across the country, the governments of these four South Asian nations should also work with local self-government, including Panchayat Members, various community organisations, civil society organisations, and social activists. It will not be effective to operate in silos and convene meetings with just the highest-ranking officials until and unless the community is included. Removing obstacles to guarantee that everyone has free access to high-quality healthcare at all levels of the health system should be the main goal, even within the public health system. The regulation and monitoring of the private sector is imperative, while the strengthening of the public health sector is imperative (Barai-Jaitly and Gosh, 2018).

2. **Civil Society engagement and partnership:** According to the WHO action brief 2023, to get universal health coverage (UHC), civil society must enhance the health systems throughout society and assemble a workforce that is more capable, supportive, and efficient. Providing health services to communities and improving access, equality utilisation, financial protection, and care quality are all made possible by the crucial role that civil society plays in this process. CSOs also push for care that considers the socioeconomic determinants of health, placing them at the centre of service delivery. They coordinate multisectoral activity to address the underlying causes of care obstacles and oversee responsibility for investments made in health (Rosenquist et. al 2013). The involvement of civil society facilitates the health system’s ability to establish connections with marginalized populations and expand its coverage. They can enhance the capacity of frontline staff in the public systems through both formal and informal means. They possess the ability to suggest strategies for altering the mindsets and motivations of these individuals. The close connection between civil society organizations and the community can help fill in the gaps and provide data. Lastly, they can refer people to appropriate health facilities, minimizing out-of-pocket expenditure on health (Jayaraman and Fernandez, 2023). Through advocacy and accountability, civil society may play a critical role in ensuring that health finance policies, arrangements, and public budgets serve the needs of the most disadvantaged. To foster stronger cooperation between governments,
civil society, and communities, advocacy for health finance should be increased³. Different people and groups work together to tell people about their health. However, civil society is the most important part of this process. When we look at the past and present, we can see that civil society has helped a lot in telling people about health. Civil society helped by organizing, fighting for people's rights, and keeping an eye on health centers and programs in the community (Singh and Tomar, 2020).

VI. **Financing UHC for CDWD communities:**

1. **Mobilizing domestic resources:** The need for more complicated and advanced health care develops as nations increase access, populations age or grow, money increases, and improvements in medical technology. As acknowledged by the Addis Ababa Action Agenda (AAAA), domestic resources will be the main source of funding needed to achieve the SDGs. The AAAA specifically stressed that each nation is accountable for its own economic and social development and urged countries to use all available resources to support the SDG agenda. Nations came to a variety of agreements to boost public coffers, mostly through effective and fair taxes (WHO 2017).

2. **Exploring international aid and financial mechanisms:** Whether resources are accessible when needed depends on how they are collected, gathered, and used to the cost of health care. Thus, finance for health is essential to fulfilling UHC's goals. Nonetheless, a lot of nations find it difficult to advance towards UHC because of several shortcomings in revenue collection, fund-pooling, and health care procurement (Mathauer, et al 2020). To determine the "right next steps" for any country, it is important to consider its current health financing and system arrangements, as well as unique contextual factors like public administration structure and fiscal capacity. A customised policy response to these factors is necessary, so the search for a "best model" of health financing is not a relevant endeavor (Kutzin, et al 2016). Funding becomes crucial, particularly in the wake of a health disaster such as the pandemic, which affected everyone, including Dalit

communities. As a result, we require both robust health finance for medical crises like pandemics and general decent health financing for regular days.

The recognition of WHO has gone stronger over the past decade. Universal health coverage (UHC) has been identified as a priority for the global health agenda. However, when the CDWD communities are deprived of universal health coverage and neither do they have any awareness so that they can take advantage of it. Inadequate human resources such as health workers production, performance, and distribution challenges such as inadequate health facilities, inadequate medical facilities. Inequity in the allocation of public health resources, Lack of technology. Equipment, material of Supply side readiness. Among the plethora of challenges, financial hardships and inaccessibility to health institutions are the most prominent ones.

The average expenditure incurred for private hospital hospitalization is gruesome, multiple times the government hospital expenditure. Further, social exclusion prevents scheduled castes and scheduled tribes from accessing government health services and programmes and this worsens their health and nutritional status (Jadhav, 2022). The benefits are not yet reaped wholly by that section of the society, particularly CDWD who needs it the most. This is unaffordable for Dalits and Adivasis who are disproportionately likely to be poor. As per the National Family Health Survey 2015-16 (NFHS-4) data, 45.9% of the Adivasi population and 26.6% of the Dalit population are in the lowest wealth bracket (Yadavar, 2018).

VII. Conclusion:

From the personal anecdotes at the grassroots level survey and the interview it can be concluded that there is a need for the massive awareness amongst the CDWD including Dalits. Apart from this the role of the civil society is very important however the respective governments of the countries should not leave this job solely in the hands of the CSO’s. It has been recorded that people belonging to the Dalit community face double discrimination at the hands of the medical professionals who mistreat them rudely. It was also seen that the private healthcare is expensive and many people have actually paid out of their pockets, some also took loans, therefore it is pertinent for the government facilities to come to the scenario and provide the health benefits
particularly to the people from the CDWD communities especially Dalits. When enquired about awareness regarding. Utilising cutting-edge digital technology and making regular adjustments to dynamic health trends, national governments must strive towards sustainable health finance schemes.

SURVEY AND ANALYSIS:

Survey was conducted in three South Asian countries to assess the status of UHC related information among Communities Discriminated on Work and Descent. 450 CDWD respondents, including 150 each were surveyed from Nepal, India, and Bangladesh respectively. The schemes that have been considered for the survey are as follows India: Ayushman Bharat health Insurance scheme, Nepal: Health insurance enrolment, Bangladesh: Maternity Allowance.

Surveys were conducted in India- Bihar (Nawada, Jamui and Gaya), Nepal-Rautahat Madhesh Province, Bangladesh- Narayanganj, Dhaka, Maulvibazar, Satkhira.

A total of 450 respondents have been surveyed, out of which 91 were female participants in India and 104 female participants in Nepal and all 150 female respondents in Bangladesh.
About 52% of the respondents in India have reported having no familiarity with the detailed concept of the respective schemes in the country, the same has been reported in Nepal with 88% and Bangladesh with 21%.

Although the respondents are not familiar with the concept of the scheme, most of them have heard about it through various means like in Nepal through Radio FM, Doctor/Health Care providers, flyers and posters in their area. In India, through flyers and posters in their area, newspaper and television and government websites. In Bangladesh, through NGO workers, flyers and posters in their area, locals, neighbors and relatives, government websites, mobile van announcements, community meetings etc.

It is known through the survey that there is very low awareness about the respective scheme in the country which is only 37% in India, 8% in Nepal and 53.3% in Bangladesh.
Majority of the respondents have reported that the scheme is not accessible at all, which is 40% in India, 73% in Nepal and 23% in Bangladesh.
The major barriers for not being able to access the health services have been reported to be lack of awareness about available services, Geographical distance from healthcare facilities, Financial constraints, Poor quality of healthcare services, majority have also reported one or two reasons of the above as a major barrier. Majority of the respondents have also reported that the quality of the health care services for Dalits are poor and they also strongly agree that there is a need for targeted initiatives for Dalits in terms of health care services and facilities.

**Key findings**

1. Lack of awareness about the respective schemes amongst the CDWD communities especially Dalits in these four South Asian countries although most of them have heard about the scheme through various means but they do not know the concept of the scheme and its benefits.

2. The health care needs of the CDWD communities are varied across the geographical area therefore the same kind of intervention is needed in terms of accessibility and availability of the health care services.

3. The dispersion of information about the scheme in a language that the various Dalit communities speak or comprehend is also necessary; otherwise, awareness of the issue may be lacking.

4. A startling observation is that, individuals continue to express gratitude to the government when discussing the recommendations in case of India. Whereas not a single respondent was found who had knowledge of having seen successful examples of anyone getting treatment under the Ayushman Bharat scheme while it is said that this scheme is a very praiseworthy but they have no successful examples of the use of the same.

5. Huge lack of awareness among Dalits on the scheme (Ayushman Bharat) and their expectations that if minor diseases and accidental cases will be included under this scheme, then those who are far away from government hospitals or are unable to go to them, would have sought that facility in private hospitals.
6. There are states like Delhi, Odisha, and West Bengal in India where the ayushman bharat health scheme is not applicable, indicating that the coverage is not entirely universal.

7. The massive demands for the awareness of the scheme through camps in the villages have come through the community itself. In India the community members have requested the awareness camps be provided to all the villages by the government.

8. The Bangladesh Survey has highlighted the challenges of the Dalit mothers of not having free medicine, irregular checkups, inadequate iron tablets, no blood test, need for healthy food, appropriate behavior from the health care providers, distance of the clinics from their area, increase the amount of the maternity allowance etc.

9. Although in India some individuals are expressing their opinion that the scheme is highly commendable, albeit lacking any tangible success stories to substantiate their claims. There is a complete lack of awareness and understanding about the scheme.

   In Bangladesh the government does not really do a lot of awareness programmes, therefore most of the respondents got to hear about the allowance mostly through NGO workers. So, the government left the job of making people aware of NGOs. The government is ready to provide the allowance and take the credit but not ready to educate people about it. The lack of information or not knowing about this scheme appears a lot in the survey.

10. It is crucial for policy makers to recognize that a combination of social, cultural, economic, and political factors interact and significantly influence the health condition of the Dalit community.

The current health scenario of the socio economically marginalized communities requires exploration of the political, social, economic, and cultural determinants of health inequalities experienced by most of the Dalit population. We examine how caste-based positions generate and reinforce social stratification in society, and determine health inequities within Dalit population in these countries. We argue that health inequalities need to be viewed from a holistic perspective, keeping in mind the intersecting social, political, and structural factors.
Suggestions/ recommendations to Governments, civil society, and international organization:

1. We strongly recommend that the GDP for health care be at least 3% target set at the Alma Ata conference. The current GDP is not going to cover the people from the marginalized communities like Dalits.

2. To ensure that members of CDWD communities, such as Dalits, may easily create a card and get benefits, we urge that the relevant government appropriately adapt the scheme across the nation and streamline the procedure.

3. We demand the respective government to ensure that the CDWD community organisations including Dalits and civil society are part of the National Policy dialogue. Making policies for them without including their opinion is not going to work for them.

4. Universal Health Coverage (UHC) can only be universal if it is available and affordable universally across the country irrespective of Caste, Gender, Ethnicity and Location.

5. There must be data on the determinants of cost of care within the health schemes in South Asian countries so that the Health Benefit Package especially for the Dalit communities is based on the scientific evidence.

6. Community clinics suffer from the adequate infrastructure and resources therefore these clinics should be fully equipped with the same so that the people from CDWD communities have access to the health care facilities without any compromise.

7. Awareness about the benefits of health protection schemes amongst the CDWD communities is crucial as some of them do not know about those schemes and its benefits.

8. We urge the governments to provide funding support to identified Dalit families below the poverty line for one-time enrollment to help them experience the benefits of insurance schemes and develop a habit for it.
9. It is strongly urged to establish medical tribunals to adjudicate cases of medical offenses committed by the medical practitioners or registered care givers against offenses of caste-based discrimination and related matters. The medical tribunal should be established in districts of each state across the country for convenient accessibility of the patients.

10. Establishment of a complaint center for aggrieved patients availing treatment at the public hospitals like the National consumer helpline is strongly suggested for protection of patient rights in clinical establishments. The complaint center would serve as an avenue to lodge complaints on matters of negligence and unfair practices by the medical practitioner or the medical institution.

11. Setting up monitoring cells at the state level to monitor the public health institutions and the insurance agents at the state level across the country would assist in regulating complaints and surveillance of caste-based discrimination in the state health institutions in a systematic manner.

12. Improve monitoring and ensure accountability of health insurance agents and the insurance enrollment system, with local governments; health departments taking the lead in effective monitoring.

13. We urge the respective governments to enhance the quality of healthcare services at government hospitals so that the facility can be available by the CDWD communities.

14. In addition, there should be adequate representation of people belonging to CDWD communities including Dalits for representing the interests and issues emanating from different caste groups to ensure equality and speedy redressal of grievances.

15. The increasing trend of privatization in State and Central hospitals regarding laboratories and imaging centers has led to an affordability issue for the CDWD communities including Dalits. It is imperative to address and monitor this situation for addressing accessibility and affordability issues emanating from mismanagement of such public health institutions.
16. Improve the referral system and increase the number of health insurance-connected hospitals, making lab test facilities available at local health posts to reduce travel costs and enhance access for insurance policyholders.

17. Proper sensitization of healthcare personnel practicing at health care institutions is strongly proposed for overcoming entrenched caste-based discrimination with patients from Dalit and CDWD Communities especially during check-ups and treatment.

18. It is highly advisable to identify regions with a significant concentration of Dalits and CDWD communities. Furthermore, it is crucial to establish and equip public health facilities in these areas, adhering to the Public Health Standards. Unfortunately, the implementation of these standards remains incomplete.

19. Additionally, it is recommended to adopt population-specific sub-plans, such as the Scheduled Caste Sub-Plan, to effectively address the unique health concerns faced by marginalized communities, specifically those belonging to the CDWD populations.

20. Ensuring that union budgetary allocation in health for SCs and STs is proportionate to their population. The government must monitor the spending under these heads via a special monitoring cell.

References


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