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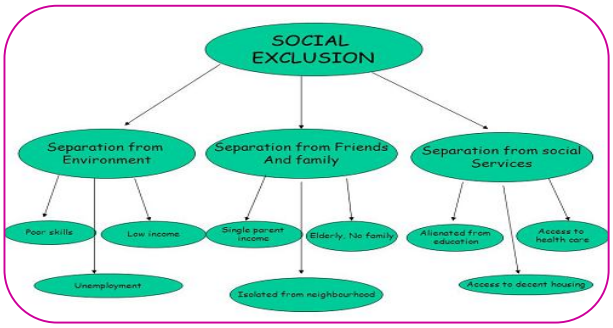

SOCIAL EXCLUSION AND ISSUES OF HEALTH: AN EMPIRICAL STUDY OF UP-BUNDELKHAND

Narendra Gupta
Assistant Professor, Department of Sociology, Bundelkhand Degree Collage, Jhansi .

ABSTRACT:

Social exclusion happens when someone is left out of mainstream society, deprived of opportunities for the participation in economic, social and civic processes. It is a process by which certain groups are systematically put into disadvantageous position and are discriminated against on the basis of their ethnicity, race, religion, sexual orientation, caste, gender, age, disability, migrant status or place of domicile. In a country like India which is highly caste based and where all kinds of differentiation is cropped with the birth of an individual into certain caste; caste becomes one of the basic yardstick for social exclusion and discrimination. This kind of caste based exclusion has led to adverse effect on the health status of socially excluded persons. Health is defined as social, physical and mental wellbeing of a person. In case of Dalits the social and mental aspect of health is certainly governed by the structural realties of Indian society, where they are treated as untouchables subject to harsh kind of discrimination and do not have rights to live a life with dignity. This has strong bearing on the physical health of this group. In this perspective the present paper is an attempt to collage the picture of sickness and other related aspect of health and nutrition of Dalits in the Badokhar Khurd Block of Banda District of UP-Bundelkhand. Based on empirical research on health, the paper takes recourse to the following broad objectives: (i) the level and magnitude of poverty among Dalits in the study area, (ii) The frequency of falling sick; its causes; and loss of working days due to sickness, (iii) the level of nutrition intake, (iv) It also ascertains the change brought by the health related programmes in the life of Dalits.

KEYWORDS : *race, religion, sexual orientation , social exclusion and discrimination.*

INTRODUCTION:

Social exclusion is an extreme form of vulnerability and deprivation. Problem of societal exclusion has originated due to ignorance, apathy, laziness of depressed and deprived due to section of society. It takes the form of discrimination based on several dimensions such as caste, gender, ethnicity, race, religion, sexual orientation etc. Discrimination occurs in public institutions, such as the legal system or education and health services, as well as social institutions like the household (DFID, 2005).In a country like India which is highly caste based and where all kinds of differentiation is cropped with the birth of an individual into certain caste; caste becomes one of the basic yardstick for social exclusion and discrimination. This kind of caste based exclusion has led to adverse effect on the health status of socially excluded persons. In case of Dalits, the social aspect of health is certainly governed by the structural realties of Indian society where they are treated as untouchables subject to harsh kind of discrimination and do not have rights to live a life with dignity.

The region is agriculture based and most of the locals are engaged in agriculture activities for subsistence. But since last one decade, regular droughts, crop failure, scanty rains, poor irrigation facilities, burden of agricultural and private loans have been sweeping the happiness of the region. Except it due to high prevalence of caste discrimination in the region the wellbeing of Dalits has been neglected by the dominating castes that have high influences in social, political and economic context. All these factors have trapped the persons especially Dalit communities in vicious circle of poverty and health predicaments. They are facing insurmountable hardships and health hazards and are not yet to know what kind of modern health care vis-à-vis facilities available for treatments. Many government and non-government (NGO) agencies are working in the area by implementing various programmes like Integrated Child Development Services(ICDS), National Rural Health Mission (NRHM), Pradhan Mantri Swasthya Suraksha Yojna (PMSSY), National Anti-Malaria Programme (NAMP), National Cancer Control Programme (NCCP), Janani Suraksha Yojna (JSY) etc. for ensuring better healthy life and have benefited them in some extent but are not proved much beneficial or accessible to the aggrieved people.

In this background, the paper is divided into four parts. The first part discusses theoretical understanding related to the area. The second part focuses on the brief introduction of the study area. Third segment of the paper highlights health status of Dalits and reasons that are responsible for the problem of ill-health of respondents in the study area. Analysis of the implemented policies has been done in the last section of the paper.

Health: A Theoretical Understanding

Health is a generic word and it is defined as "a state of complete physical, mental and social well-being and not merely as absence of disease or infirmity" (WHO, 1946). Good health keeps human being and society happy. Without good health individual and society face difficulty to function. But good health, being dream of most people, each and every person in India does not maintain good health and avail the benefits of government policies. Hierarchy and social stratification abound with regional disparity keep health policies and programmes away from a large chunk of people even after six decades of independence. Accordingly people living in rural areas specifically Dalits face insurmountable hardships and health hazards. Dalits are yet to know what kind of modern health care vis-à-vis facility available for treatments. They still follow and practice the age old health care as their forefathers followed. Belief in superstition, traditional socio-cultural institutions and taboo also are responsible for their hazardous health.

Present political culture, impoverished condition and illiteracy further keep them away from modern health facility. As a matter of concern, (ethnography of health and medicine) many scholar tried to focus upon traditional healing practices in remote rural areas of India. Among them S.C Roy (1915), D.N. Mazumder (1926), N.K. Bora (1972), P.O. Bodding (1925), L.P. Vidyarthi (1969), B.K. Roy Barman (1946), V. Elwin (1943), P. Chandra (1957), M.N. Das (1960), D.K. Sarkar (1958) are the pioneering contributors. G. Morris Carstairs's (1955) *'Medicine and Faith in Rural Rajasthan'* points out difference between view of physician and village folk with regard to theories of etymology. He says sickness is much a moral as a physical crisis of rural India. The study '*Western Medicine in a Village of Northern India'* of Mckim Marriott (1955) highlights responsibility, charity, power and respect are important for interpersonal relation in medical sphere. He observes it is not much of technical skill which gives prestige to a healer but spiritual power gains through deity. K.A. Hasan's '*Medical Sociology of Rural India'* (1979) analyses effect of modern scientific medicine in a village as well as behavioural factor involved in failure or success of physician in the village. Mark Nichter's (1981) *'Toward a Culturally Responsive Rural Health Care Delivery System in India'* finds practice of medicine is culturally responsive and physician be trained to communicate with their patient within their conceptual frame work. In *'Folk medicine in large in North India'* R.S. Khare (1963) offers three interconnected cultural formulations which seem to characterize traditional Indian medical system and which help to introduce consideration of indigenous cultural construct and interpretation in medical anthropology. To him village therapeutic system continues to dominate on cultural markers as body and being- *dava* (medicine), *dua* (blessing), *dharma* (religion) and *daiva* (God). It exploits in practice ethical overlap and ethical difference between indigenous and modern western medical system. O. Edward Henry's '*An eclectic magic religious medical practitioner of eastern Uttar Pradesh in Northern India'* (1979) highlights symbolic explanation of setting in cure, role of curer, his public image and items action of curing ritual. It shows how

assemblage of symbol establishes expectations of help based on perceptions of healer and therapy becomes powerful. The study '*Recourses not the Constraints on Health: A Case Study of Kerala'* of K.M. Panikar (1992) reveals how factors contributes comparatively far better in Kerala. Analysis of data suggest reason for better health in Kerala as it lays much or equal importance to preventive and promotive measures like sanitation, hygiene, immunization programme, infant and antenatal care, health education etc. as curative medicine.

Moreover, spread of education, especially among women in rural Kerala is a crucial factor to high degree of awareness of health problems and fuller utilization of available health care facility. His case study gives policies and priorities and lack of resource may not be impediment in improvement of health status even in low income society. M.N. Srinivas (1979) in his monograph *'Management of Rural Health Care'* reviews efforts of government in delivery of health care service to rural people since beginning of planed era. He says people living in interior and remote rural areas do not have access to primary health care. Problem of health care service in rural areas has peculiar characteristics like their concept of health and disease is traditional, apathy towards allopathic medical practitioners, limited capacity to pay cost of treatment, transport and communication difficulties, unqualified medical practitioners and health centers are under staffed. Doctors and paramedical workers do not want to work in rural areas because of professional, personal and social reasons. Therefore, to remove such problem enhancing number of primary health centers and the sub-centers is not only solution, rather to develop philosophy of providing integrated health care system. For making health service more meaningful to people of the country, it is necessary to bring about fundamental change in focus and approach to entire health care delivery system in general and above rural health services in particular. In her study *'Rural Medical Care in a Changing Setting'* Indu Mathur (1987) observes functioning of mobile hospitals and health unit in Rajasthan. Close observations reveal certain specific features of social structure and organizations of camps, which are not present in other treatment situations of level as follows. The situation is temporary. All staff work as a team. Treatment process does not involve any financial consideration. Private practice is not allowed to staff. Humanistic value is central around which all activities are organized. A comparison of two treatment situations – a hospital and a camp – confirm observation that people accordingly on the basis of demand of the situation constrained their action of their co-participants. Madhu Nagla*'s Sociology of Medical Profession: A Study of Doctors at Medical College Hospital Rohtak'* (1980) reveals almost all doctors to a large extent satisfied with their service. While some face problem in unfair term of service, hard work, unsatisfactory financial rewards, loss of freedom to move etc. A.L. Srivastava's (1979) study explores nature of interaction in a hospital which exists among three interacting units of hospital organization viz. doctor, patients and paramedical staff. He finds doctor's behaviour towards patient is not much influenced by socio-economic status of patients.

Studies on different dimensions of health, conducted by cross-section scholars reveal multitude factors behind health problems in general and India in particular. In a nutshell we can say that health is viewed as a means of disease free body and mind. Concept of health is contextual. Multifarious terms and ideas are used to designate the term health. Health and disease in remote areas get regularly interwoven into cultural matrix keeping aside important factors such as economy and political culture. It is very essential to evaluate and assess the impact of government plan, policy and programme of health, because, till now most Dalits are caught by various diseases and face several health problems in their life. Further, the term health care system refers to country's system of delivering services for the prevention and treatment of disease and for the promotion of physical and mental well-being of particular interest to a health care system is how medical care is organized, financed, and delivered. The World Health Organization (WHO, 1995) defines 'health as a fundamental human right inclusive of physical, mental and social well-being and not merely absence of disease or infirmity'. Such a definition of WHO may not be appropriate to all societies. Achieving good health is still a dream of many people. Alma Ata declaration and South East Asian Health Charter along with WHO want government of all nations to achieve goal 'Health for All by 2000'. Government of India adopts various measures to improve health status of people. Though health policies of India are often viewed as urban biased but there are various plans and policies to improve health of rural people. After six decades of independence it becomes imperative to know achievement of successive governments towards health facility for people irrespective of religion, caste, gender and regional differences. With this theoretical background let us discuss the health situation of Dalits of the region.

A Brief Introduction of Study Area[1]

Banda is a district of Bundelkhand region of Uttar Pradesh, called UP-Bundelkhand[2] and is divided into four tehsils; Banda, Naraini, Baberu and Atarra and into eight blocks; Baberu, Badokhar Khurd, Bisenda, Jaspura, Kamasin, Mahuva, Naraini and Tindwari. Banda lies between Lat. 24º 53' and 25º 55' N and Long. 80º 07'and 81º 34' E. Distance covered by district from East to West is 75 Km. And North to South 50 to 60 Km. It is bounded in the north by district of Fatehpur in the east by the district of Chitrakoot in the west by the district of Hamirpur and Mahoba and in the south by Satna, Panna, and Chhatarapur the districts of adjoining Madhya Pradesh .The district is linked with roadways to all the adjoining districts of Kanpur, Allahabad, Chitrakoot, Fatehpur, Hamirpur, Mahoba and the adjoining districts of Madhya Pradesh.

According to the 2011 census, Banda district has an area of 4459 sq. km. with a population of 17, 99,541 of which male and female are 9, 66,123 and 8, 33,418 respectively. Rural population is 15, 23,378 and urban population is 2, 76,163 of which rural male and rural female are 8, 19,025 and 1, 47,098 and urban male and urban female are 7, 04,353 and 1,29,065 respectively. Its population growth rate over the decade 2001-2011 was 17.06%. The literacy rate is 68.11% of which male and female literacy is 79.38% and 54.95% respectively. The district has population density of 404 persons per sq. km. The sex ratio of the district is 863 females for every 1000 males. Here 60 families of scheduled caste have been chosen from Badokhar khurd block of Banda district to know about their health status. The total populations of Badokhar Khurd block 161,638. Males constitute 87,684 (54.25%) of the population and females 73,954(45.76%) respectively. Block has an average literacy rate of 67% with male literacy of 68.67% and female literacy of 35.67%.

Health Status of Dalits in Study Area[3]

Health and health care are highly valued in society and they are also scare resources. Interested groups compete with one another to gain what they feel is their fair share of resources, as they do with other scare resources (Abdelhak, 1996). For some one staying healthy depends on having access to adequate food, satisfactory employment condition, clean water and good health care. People with higher social and economic standing in society have greater access to these resources, and they are generally healthier than the less affluent. For example high infant mortality among poor is not surprising because poor are less able to afford nutritious food, sanitary living conditions, access to prenatal care and the other things that reduce infant mortality (Doshi, 1995). In addition to issue of wealthier groups receive service in problem of how much service will cost in monetary and non- monetary terms and who benefits from health care treatment. Health care is more than medical care. It embraces a multitude of services provided to individual or community by health personnel aiming at promotion, protection and restoration of the health services to its people through its primary health care network.

Health care practices vary from place to place and time to time. Further, health status in physical sense influencing factors like height and weight, nutrition, the agility and flexibility or ability to move, sanitation and our compliance with prescribed medications, treatment, diet and etc. (Sharma, 1997). Sometimes Body Mass Index (BMI)[4] is used to understand the health status of individuals. Some parameters of health status are sex ratio, density of population, life expectancy, mortality, morbidity, maternal mortality, child mortality, birth rate, longevity, nutritional level etc.

In this backdrop certain question were asked to ascertain the health status of Dalits. Table.1 depicts that about 87 per cent of population became ill during last six month. This statistics unravels the level of sufferings and ill health of Dalit populations in the study area. Moreover, it is not a healthy condition for development as the number of persons becoming sick during last six month is very high. This can also be related to the level of food sufficiency, nutritional intake and other basic factors related to keeping health issues in mind. These questions are further explored by asking the frequency, magnitude and periodicity of falling sick.

[1]For more details see the home site of Bundelkhand, www.Bundelkhand.in.

[2]UP-Bundelkhand region comprises the seven districts (Jhansi, Jalaun, Hamirpur, Lalitpur, Banda, Chitrakut and Mahoba) with total area of 29418 Sq. KM, which is 12.21% of the total geographical area of the Uttar Pradesh.

[3]www.bundelkhandinfo.in.

[4]www.wikipedia, the free encyclopedia.

Table 1 Family members fallen sick during last six months (Out of total respondents)

Family members have fallen sick		
Response	**Frequency**	**Percentage**
Yes	52	86.67
No	08	13.33
Total	60	100.00

Table 2 Magnitude of family members falling sick (out of total respondents)

Magnitude of members falling sick		
Response	**Frequency**	**Percentage**
Very Often	17	29.02
Occasionally	32	54.65
Rarely	08	13.38
Unable to answer	03	02.95
Total	60	100.00

Table 2 reflects that more than 29 per cent of the population falls sick very often, whereas about 55 per cent fall sick occasionally and 14 per cent rarely fall sick. The magnitude of becoming sick is not that problematic and rampant as only 29 per cent becomes very often sick. But it can be linked with the level of poverty persist among these 29 per cent of population. When we analyzed these 29 per cent of our respondents and linked with their caste identity, it reveals that 82 percent population belongs to Chamar category and remaining per cent belongs to other community. It reflects that the intensity and magnitude of becoming sick among Chamar are more in compared to other sub caste groups among Dalits. Further this results needs to be contextualized in the perspectives of the locus of the study area and in the socio-economic set up of the Dalits to ascertain the linkages between ill health and other factors. Pertaining to the kind of diseases they suffer it is further explored and analyzed and found that about 87 per cent population fallen sick during last six month in which there are about23 per cent suffered from various diseases. Among the sick persons, about 33 per cent suffered from cold, cough and seasonal fever and etc.; 22 per cent suffered from diseases like pneumonia and malaria; 10.56 per cent suffers from problems of jaundice, hepatitis B, gastroenteritis, typhoid and 16.22 per cent suffers from tuberculosis., asthma, chest congestion. Moreover the total numbers of people suffered from other various diseases.

A disease is an abnormal condition affecting the body of an organism. It is often construed to be a medical condition associated with specific symptoms and signs. It may be caused by external factors, such as infectious disease, or it may be caused by internal dysfunctions, such as auto-immune diseases. In humans, "disease" is often used more broadly to refer to any condition that causes pain, dysfunction, distress, social problems, and/or death to the person afflicted or similar problems for those in contact with the person. In this broader sense, it sometimes includes injuries, disabilities, disorders, syndromes, infections. Isolated symptoms, deviant behaviors, and typical variations of structure and function, while in other contexts and for other purposes these may be considered distinguishable categories. A diseased body is quite often not only because of some dysfunction of a particular organ but can also be because of a state of mind of the affected person who is not at ease with a particular state of its body. Death due to disease is called death by natural causes. There are four main types of disease: pathogenic disease, deficiency disease, hereditary disease, and physiological disease.

Table 3 Name of the Diseases the family members suffered in the last six month (Out of total family members of 60 households)

Diseases		
Name of the Diseases	**Frequency**	**Percentage**
Cough, Cold and Fever	19	33.04
Tuberculosis, Asthma and Chest congestion	07	16.22
Pneumonia and Malaria	12	22.19
Jaundice, Hepatitis. B. and Typhoid	06	10.56
Cancer	04	02.35
Gynecological and maternal related	02	01.93
Blood Pressure, Tension	02	01.39
Not Applicable	08	12.32
Total	60	100.00

{Note: Total 60 household surveyed out of which 52 families fallen sick during last six month}.

Table 4 Reasons of suffering from such diseases

Reasons	**Frequency**	**Percentage**
Anemic, weakness, food insufficiency	21	35.00
Depression, Tension	04	06.66
Water borne Diseases	03	05.00
Smoke allergy	06	11.00
Cold wave	08	13.33
Unable to treat due to poverty	11	18.01
Unable to answer	06	11.00
Total	60	100.00

The respondents also gave their reasons for falling ill, which is depicted in the table 4. As the data suggest that, about 35 per cent of populations are fallen sick due to food insufficiency. Excessive cold wave also causes illness for about 13.33 per cent of people and 11 per cent fall sick due to smoke allergy. All above reasons indicate the cause of illness such as food insufficiency, mosquito bites, water born disease and other unhygienic conditions in and around their vicinity. Cold waves also become one of the causes for falling sick as they did not have sufficient warm cloths to prevent from cold wave. Further, about 11 per cent which is more than 1\4th of the total respondent of even did not know the reasons for which they fall sick. That is because they never visited the doctor for treatment.

Table 5 Treatment undertaken

Treatment undertaken		
Response	**Frequency**	**Percentage**
Govt. Hospital	16	25.61
Private Hospital	24	45.41
Asha	01	00.15
Quack	09	15.41
No Treatment	06	08.68
Unable to answer	04	04.74
Total	60	100.00

Table 6 No of times they fallen sick in a month

No. of times falling sick in a month		
No. of times falling sick	**Frequency**	**Percentage**
Once	25	41.66
Twice	16	26.67
Trice	06	10.63
Four times	03	05.00
Unable to answer	10	16.04
Total	60	100.00

Table 5 shows that about 50 per cent of respondents visited private hospitals for their treatment and about 9 per cent with the help of quacks and about 25 per cent are visited to government hospital. It can be said that more than 1/3 respondents are not going to govt. hospital. Now the question arises why? It is because of lack of information and they were misguided as a result 30 per cent people are getting the treatment from untrained doctor, who only earn money from them nothing else. This happens due to their poverty and they do not have any other alternative except visiting the untrained doctors. Table 6 reflects the frequency and level of falling sick. More than 40 per cent population fallen sick once in a month; 26 per cent are fallensick twice; about 10 per cent fallen sick thrice and about 5 per cent fallen sick 4 times in a month. Hence it shows that people are not getting proper nutritional diets and living in unhygienic places for which they are succumb to various diseases.

Table 7 Due to sickness absent from work

Due to sickness absent from work		
Response	**Frequency**	**Percentage**
Yes	34	57.14
No	18	29.48
Unable to answer	08	13.38
Total	60	100.00

Table 7 suggest that more than half of the families are absent from work due to sickness which results the loss of man days and brought monetary loss to them. Immunization forms one of the most important and cost effective strategies for the prevention of childhood sicknesses and disabilities and is thus a basic need for all children. The schedule has been recommended by the Ministry of Health, Govt. of India and is one of the most widely followed by the child health care practice.

Table 8 Situation of Daily Diet Pattern in Dalit Families

Are you and your family members in a position to take proper diet daily?		
Response	**Frequency**	**Percentage**
Yes	23	38.33
No	31	51.67
Unable to answer	06	10.00
Total	60	100.00

Table 8 reveals that about 52 per cent of families are not able to take proper diet daily and about 10 per cent are not able to answer whether they are taking proper diet or not. In other words, it can be said that in

every three persons only a single person is able to take proper food. This shows that less than 50per cent Dalits have the calorie intake which is less than the stipulate calorie norm fixed for rural areas i.e. 2400 per day by the government. It means if we take the nutrition intake[5] as the indictors of poverty then more than 50 per cent of the respondents live below the poverty line and suffer from calorie deficiency and are considered as poor by the planning commission norms.

ANALYSIS OF HEALTH PROGRAMMES IN THE STUDY REGION[6]

The implemented programmes by government related to health in India are working for providing better health to the people. The programmes such as Integrated Child Development Services (ICDS) is related to primary social welfare scheme to tackle malnutrition and health problems in children below 6 years of age and their mothers with aim to be the girl child up to her adolescence, all children below 6 years of age, pregnant women and lactating mothers. Pradhan Mantri Swasthya Suraksha Yojana with purpose to correct the imbalances in availability of affordable/reliable tertiary level healthcare in the country in general and augmenting facilities for quality medical education in the under-served States. Janani Suraksha Yojana targets to decrease the neo-natal and maternal deaths happening in the country by promoting institutional delivery of babies. In this scheme, one important role is of the ASHA activist whose role can be of an encouraging person in the field to encourage institutional deliveries among the poor women. National Malaria Control Programme with the following objectives: firstly, to bring down malaria transmission to a level at which it would cease to be a major public health problem; and secondly, thereafter an achievement was to be maintained by each state to hold down the malaria transmission at low level indefinitely.

At the level of primary health sub centres (PSHCs), the situation is terrible in UP-Bundelkhand. While the region should have had over 1000 such centres by norms of the National Rural Health Mission for the region (10 PSHCs per PHC) but it has only around 250. The situation is worst in Banda districts where there is only around one PSHC per PHC. In the region, the gap between required and available primary health sub centres would be staggering. Infrastructure is only aspect of health service; the more important aspect is availability of trained staff and adequate stock of medicines. The situation in the study area is dismal and has been reflected in extremely poor usage of government health facilities. A large `poverty and social monitoring' survey (PSMS-II) conducted jointly by the state's Planning Department and the World Bank found that only 10% of people in rural areas who consulted any medical practitioner went to a government health facility; the rest went to a private sector doctor (35%) or a quack or traditional healer (55%)(Guru, 2013).

One basic problem is very low percentage of births in hospitals (`institutional deliveries') or at home with assistance of skilled professionals. Another related problem is low presence of anganwadis, which are supposed to provide `integrated' care and supplementary nutrition to young children and expectant mothers. Congested living conditions also aggravate TB among adults, and its high prevalence in the area has not received any special attention. Another problem that has emerged due to high seasonal and annual migration is HIV-AIDS. High prevalence of HIV/AIDS cases has been detected in Lalitpur, Banda, Chitrakoot by the National Aids Control Organization (NACO) and the Uttar Pradesh State Aids Control Society. Besides, the most common illness in the area, diarrhea can only be tackled by adopting good hygiene practices and simple home treatment methods but is not undertaken well.

FINDINGS AND CONCLUSION

As discussed above, health is a generic term and needs to be understood from multi-dimensional perspectives. The issues raised in the paper substantiate that the frequency of falling sick among Dalits is much higher because they lack proper balance-diet due to lack of productive economic assets. The interesting fact is that, due to ill health, Dalit lose their man days and earnings which show that they don't have any alternative source of living except doing daily labour activities. Further, lack of any productive economic resources at their disposal is the main culprit and it has a direct link with historicity—since ages they are considered as service providing castes and need not to have economic assets. The second aspect is the

[5] Level of nutrition has been measured by prescribed in proper daily diet chart.
[6] www.bundelkhandinfo.org.

immunization of the kids and wards which reflects that Dalits lack awareness and lack of access to certain immunization programmes and mostly they undertake the immunization activities in the local health facilities avail with Asha in their area, however for treatment of their sickness large number of respondents prefer the private clinic followed by government hospitals. The third important question rose pertaining to the nutrition and calorie intake which reflects that 52 per cent Dalits take less than 2400 calorie per day. It unravels that the more than 50 per cent Dalits are poor by taking the calorie norm fixed for rural areas by the government.

Hence, the magnitude, level and intensity of poverty among Dalits in the study area are very much rampant and extensive which has a bearing with their caste identity and the exclusion. As discussed by K.R. Nayar the "poverty and social exclusion are important socioeconomic indicators which are often used while considering ill-health effects… In the 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 (Nayar, 2007). Likewise Thorat also concluded that socially weaker sections also tend to be economically weak, which is why the public health services are supposed to help them to access essential health services. However, the results clearly show that SCs remain relatively more deprived even in the utilization of basic health services. Efforts to improve the health delivery system and the economic conditions of SCs need to be strengthened for their all-round betterment.

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Narendra Gupta
Assistant Professor, Department of Sociology, Bundelkhand Degree Collage, Jhansi
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