Health Status of Marginalized Sections of the Society

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Abstract

Marginality is an experience affecting millions of people throughout the world. This problem is considered to some extent in most of the following chapters. Being poor, unemployed, discriminated against, or being disabled by a society that won't work around the problems of impairment; they all bring with them the risk of exclusion. Being excluded from economic, social and political means of promoting one's self-determination can have adverse effects for individuals and communities alike. This chapter focuses on social marginalization to see how community psychologists can understand it and challenge it at the same time. In this paper an attempt is made to assess the health status of marginalized sections of the society.

Key Words: Mortality, Natal, Low Birth weight, Anaemia, Social Group

Introduction

People who face marginalization in society—whose needs and experiences are overlooked and who have limited resources and power due to some facet of their identity can have unique privacy-related needs and behaviours that must be recognized by researchers and designers of technology. Marginalized groups can experience disproportionate harms when their privacy is violated. Marginality is an experience that affects millions of people throughout the world. People who are marginalized have relatively little control over their lives, and the resources available to them. This results in making them handicapped in delving contribution to society. A vicious circle is set up whereby their lack of positive and supportive relationships means that they are prevented from participating in local life, which in turn leads to further isolation. This has a tremendous impact on development of human beings, as well as on society at large. As the objective of development is to create an enabling environment for people to enjoy a productive, healthy, and creative life, it is important to address the issue of marginalization

The concept of marginality was first introduced by Robert Park (1928). Marginalization is a symbol that refers to processes by which individuals or groups are kept at or pushed beyond the edges of society. The term outsiders may be used to refer to those individuals or groups who are marginalized.

The Meaning and Nature of Marginalization

In general, the term 'marginalization' describes the overt actions or tendencies of human societies, where people who they perceive to undesirable, or without useful function are excluded, i.e., marginalized. The people who are marginalized - are outside the existing system of protection and integration. This limits their opportunities and means for survival. The term has been defined in 48 the following ways:

Peter Leonard defines mardity as, ". . .being outside the mainstream of productive activity andlor social reproductive activity".

The Encyclopedia of Public Health defines marginalization as, 'To be margmdized is to be placed in the margins, and thus excluded from the privilege and power found at the center".

Laitin observes that, "'Marginality' is so thoroughly demeaning, for economic well-being, for human dignity, as well as for physical security. Marginal peoples can always be identified by members of dominant society, and will face irrevocable discrimination."

Merriam-Webster's online dictionary definition of the ten, marginalize, is "to relegate to an unimportant, or powerless position within a society or group"

According to Sommers et. al., "Socio-economic marginality is a condition of socio-spatial structure and process in which components of society and space in a territorial unit are observed to lag behind an expected level of performance in economic, political and

These definitions are mentioned in different contexts, and show that marginalization is a slippery and multilayered concept. To further clarify the meaning and concept let us discuss certain features of marginalization:

- Sometimes, whole societies can be marginalized at national and global levels, while classes and communities can be marginalized from the dominant social order within the local level. In some other contexts, the same community can be marginalized in certain country (Jews in Germany or Russia) whereas they are not marginalized in another country (Jews in the U.S.A.).
- Marginalization also increases or decreases at certain stages of life cycle. For example, the marginalized status of children and youth may decrease as they get older; the marginalized status of adults may increase as they become older; the marginalized status of single mother may change as their children grow up
- Individuals or groups might enjoy high social status at some point of time, but as social change takes place, they may lose this status and become Marginalization .

Thus, marginalization is a complex as well as shifting phenomenon linked to social status.

Structural Discrimination

Structural Discrimination in India norms and cultural practices are rooted in a highly patriarchal social order where women are expected to adhere to strict gender roles and they are affected by more health problems as compared to men. The prevalence of poverty and economic dependence among women, their experience of violence, gender bias in the health system and society at large, discrimination on the grounds of race or other factors, the limited power and their lack of influence in decision-making are social realities have an adverse imp act o n their health of women’s. So women face particular health issues and particular forms of discrimination, with some groups, including internally displaced women, women in slums and sub-urban settings, indigenous and rural women, women with disabilities or women living with HIV/AIDS, facing multiple forms of discrimination, barriers and marginalization in addition to gender discrimination.

ST’s and SC’s

ST’s and SC’s 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 nequality 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 (lower castes) 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. Unlike the scheduled castes, the scheduled tribes are a product of marginalization based on ethnicity.

Review of Literature

Sanjiv Kumar and Prakash Bhadury (2014) in their research paper made an attempt on how Dattani has responded to the concept of marginality in Indian social construct in the 80s onward when Indian society has made its mark as the largest democracy in the world, yet reeling under several vexing issues, one of them being the problem of social inequality of which marginality forms part of it. According to authors Mahesh Dattani has taken up the taboo subjects like eunuchs, gay/lesbian relations, inter-caste marriages and, gender discriminations. A select drama has been taken up as to show the condition of sub-altarnity of the marginalised groups and how the dramatist has struck the conscience of the society by exposing the hypocrisy of the middle class urban Indian society. The deft use of English as a hybrid form of indigenous language has been a powerful tool in showing the conditions of marginality and class identity.

Joan G Mowat (2015) in his research article forwarded a new theoretical framework by which marginalisation, as it applies to a wide range of contexts, can be conceptualised and further interrogated. The author examines how marginalisation is experienced, with a specific focus upon children and schooling, and uses the concept of resilience as a lens through which marginalisation can be understood. The study recognises the importance of the wider societal and political context whilst also taking account of the interpretive framework of the individual and how risk and protective factors within the wider environment shape the experience and perceptions of the individual.

Dhavaleshwar C.U. and Swadi S.Y. (2016) in their research paper attempts to explore CSR practices in support of the development of Marginalised Sections in India. This Paper is designed with the use of secondary sources, academic articles, online journals, expert's expressions and self-observations to c analyse the new wave of improving the life style of the weaker sections, down-trodden, orphans and other Marginalised sections in India. The author concludes that except women empowerment activities, so far no serious effort has been done by the Indian corporate sector for the empowerment of marginalised sections.

The link between marginalisation, health and health inequalities

There is a broad consensus that health in general, and health inequalities in particular are strongly related with socio-economic determinants and that the possible level of marginalisation influences the well-being of

individuals and groups. Studies have demonstrated the link between social and material disadvantages and poor mental and physical health. Factors as employment, housing and education are identified as health determinants, which can reduce inequalities in health. Meanwhile, poverty – whether defined by income, socio-economic status, living conditions or educational level – is regarded as the largest single determinant of ill health.

"…Human poverty is deprivation in multiple dimensions, not just income. Industrial countries need to monitor poverty in all its dimensions - not just income and unemployment, but also lack of basic capabilities such as health and literacy, important factors in whether a person is included in or excluded from the life of a community."

(UNDP, 1998).

"Living in poverty is correlated with higher rates of substance use (tobacco, alcohol and illegal drugs), depression, suicide, antisocial behaviour and violence, an increased risk of food insecurity and a wide range of physical complaints. Large – and in fact increasing – numbers of people in European societies today are at risk of experiencing poverty sometime in their lives."(WHO, 1999)

"People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have, within their shorter lives, a higher prevalence of all kinds of health problems".

(Mackenbach, 2005) (7)

The WHO concludes in a report on social inequities in health that there are systematic differences in health status between different socio-economic groups. "These inequities are socially produced (and therefore modifiable) and unfair. In practice, all systematic differences in health between socio-economic groups in European countries could be regarded as unfair and avoidable, and therefore regarded as inequities. This judgement about unfairness is based on universal human rights principles". (Whitehead M. and Dahlgren G, 2006)

Despite progresses on social welfare in western societies, almost all European countries are faced with substantial inequalities in health within their populations, as well as within countries as between countries. In a project of Euro Health Net, which examined the situation in Europe, it is concluded that health inequalities cannot be tackled by the health system alone but only together with inter-sectoral cooperation and multidisciplinary approaches:

"Successful strategies that countries are adopting involve both upstream (wider determinants – the underlying causes) and downstream approaches (measures to reduce the consequences of unhealthy circumstances). Upstream approaches involve efforts to address the macro socio-economic environment (e.g. efforts to ensure that national policies promote human development and reduce social inequalities). They also entail improving access to education, healthy working conditions, reducing unemployment, social and community inclusion policies. Mid- and more downstream measures ensure that lifestyle related programmes (tobacco control, alcohol misuse, nutrition, physical activity and mental health) as well as health care services address the more vulnerable or disadvantaged groups of society." (Euro Health Net, 2007)

Live Births with Low Birth Weight by Social Groups

Table 1 furnishes the details of live births with low birth weight by social groups in India during 2015-16.

Table 1

Percentage Distribution of Live Births with Low Birth Weight (Low) by Social Groups in India- 2015-16

Class	Percent distribution of births with a reported birth weight		Number of births
	Less than 2.5 kg	2.5 kg or more	Total
Scheduled Caste	19.1	80.9	41126
Scheduled Tribes	20.5	79.5	19454
Other Backward Class	17.7	82.3	84778
Other	17.2	82.8	47823
Don't know	25.0	75.0	1650
Total	**18.2**	**81.8**	**194832**

Source: National Family Health Survey (NFHS-4), 2015-16 (December 2017), Ministry of Health & Family Welfare.

Table 1 indicates that in 2015-16 194, 832 births were registered in India. Among various social categories low weight children born to Scheduled Tribes are higher than other social categories. In this regard they are followed by the Scheduled Castes with 19.1 per cent, who in turn is followed by Backward Classes with 1.7 per cent. With regard to children weighing 2.5 KGs and above general category candidates are at the top of ladder with 82.8 per cent and they are closely followed by backward classes with 82.3 per cent.

Early Childhood Mortality Rates

The details with regard to Early Childhood Mortality Rates (ECMR) per 1000 live births by social groups in India were given in table 2.

Table 2

Early Childhood Mortality Rates (ECMR) Per 1000 Live Births by Social Groups in India-2015-16

INDIA					
Social Groups	**Neonatal mortality**	**Post-Neonatal mortality**	**Infant mortality**	**Child mortality**	**Under-five mortality**
SCs	33.0	12.2	45.2	11.1	55.8
STs	31.3	13.1	44.4	13.4	57.2
OBCs	30.5	11.6	42.1	9.0	50.8
Others	23.2	8.9	32.1	6.6	38.5
Don't know	30.4	10.5	40.9	11.8	52.2
Total	**29.5**	**11.3**	**40.7**	**9.4**	**49.7**
RURAL					
Social Groups	**Neonatal Mortality**	**Post-Neonatal mortality**	**Infant mortality**	**Child mortality**	**Under-five mortality**
SCs	36.8	12.7	49.6	12.1	61.1
STs	33.4	13.9	47.3	14.7	61.3
OBCs	33.4	12.6	46.0	10.4	55.9

Others	27.7	10.5	38.2	7.4	45.4
Don't know	36.5	9.6	46.1	10.4	56.0
Total	**33.1**	**12.4**	**45.5**	**10.7**	**55.8**
URBAN					
Social Groups	**Neonatal mortality**	**Post-Neonatal mortality**	**Infant mortality**	**Child mortality**	**Under-five mortality**
SCs	20.7	10.4	31.1	8.0	38.9
STs	16.5	7.1	23.5	4.3	27.8
OBCs	23.1	9.0	32.1	5.8	37.7
Others	16.2	6.5	22.6	5.2	27.8
Don't know	(21.0)	(12.1)	(33.1)	(13.7)	(46.3)
Total	**20.1**	**8.4**	**28.5**	**6.0**	**34.4**

Source: National Family Health Survey (NFHS-4), 2015-16 (December 2017), Ministry of Health & Family Welfare.

It can be inferred from table 2 that at national level the neonatal mortality rate is high among the marginalized sections of the society. Among them the neonatal mortality rate is as high as 33 per cent among Scheduled Castes. The neonatal mortality rate of Scheduled Tribes, other backward classes is is 31.3 per cent and 30.5 per cent respectively. It is low i.e. 23.2 per cent among general category. With regard to Post-Neonatal mortality rate the Scheduled Tribes were at the top of ladder with 13.9 per cent. The Post-Neonatal Mortality rate of Scheduled Tribes (12.7 per cent) and Backward Classes (12.6 per cent) going hand in hand. Infant mortality rate of Scheduled Castes once again is high with 45.2 per cent and they are followed by Scheduled Tribes with 44.4 per cent. In case of Child Mortality rate The Scheduled Tribes were ahead with 134 per cent. Again with regard to under five mortality rate Scheduled Tribes top the list with 57.2 per cent and they are followed by Scheduled Castes with 55.8 per cent. More or less same trends were visible in case of rural and urban data.

Table 3

Peri-natal Mortality Rate (PMR) For the Five-Year Period Preceding NFH Survey by Social Groups in India 2015-16

Social Groups	**Number of Stillbirths**	**Number of early neonatal Deaths**	**Peri-natal mortality**	**Number of pregnancies of 7 or more months**
SCs	751	1451	40.4	54544
STs	296	665	36.1	26581
OBCs	1361	2757	36.9	111622
Others	664	1075	30.1	57769
Don't know	32	48	36.0	2211
INDIA	**3104**	**5995**	**36.0**	**252,728**

1. Stillbirths are foetal deaths in pregnancies lasting seven or more months

2. Early neonatal deaths are deaths at age 0-6 days among live-born children

3. The sum of the number of stillbirths and early neonatal deaths divided by the number of pregnancies of seven or more months' duration, expressed per 1,000

4. Categories correspond to birth intervals of <24 months, 24-35 months, 36-47 months, and 48+ months

Source: National Family Health Survey (NFHS-4), 2015-16 (December 2017), Ministry of Health & Family Welfare.

It can be found from table 3 that the number of still births as well as early neonatal deaths and number of pregnancies of 7 or more months duration the other backward classes were stood at the top of ladder. With regard to peri-natal mortality rate the Scheduled Castes were ahead with 40.4 per cent and they are followed by other backward classes with 36.9 per cent.

Prevalence of Anemia in Women by Social Groups in India-2015-16

Table 4 presents the percentage of prevalence of anemia in women by social groups in India during 2015-16.

Table 4

Percentage Prevalence of Anemia in Women by Social Groups in India-2015-16

Social Groups	Anemia status by hemoglobin level				
	Mild (10.0 - 11.9 g/dl)	Moderate (7.0-9.9 g/dl)	Severe (< 7.0 g/dl)	Any anemia (<12.0 g/dl)	Number of Women
SCs	40.8	13.9	1.2	55.9	139148
STs	43.7	14.9	1.3	59.9	62695
OBCs	38.9	12.2	1.1	52.2	296292
Others	38.3	10.6	0.7	49.8	177127
Don't	38.4	15.6	1.0	55.0	4184
Total	**39.6**	**12.4**	**1.0**	**53.1**	**679445**

Note: Table is based on women who stayed in the household the night before the interview. Prevalence is adjusted for altitude and for smoking status, if known, using the CDC formulas (Centers for Disease Control (CDC). 1998. Recommendations to prevent and control iron deficiency in the United States. Morbidity and Mortality Weekly Report 47 (RR-3): 1-29). Haemoglobin levels are shown in grams per decilitre (g/dl).

1.For pregnant women, the value is 10.0-10.9 g/dl

2.For pregnant women, the value is <11.0 g/dl

Table 4 reveals that with regard to mild, moderate, severe and other kind of anemia the Scheduled Tribes top the list with 43.7 per cent, 14.9 per cent, 1.3 per cent, 59.9 per cent respectively. In this regard they are followed by the Scheduled Castes, other backward classes in different kinds of anemia.

Conclusion

Thus it can be concluded that vulnerable groups are defined as those who are subject to unfair treatment or are, relative to other age groups or sections of society, more dependent on others and therefore find it difficult to maintain their subsistence on their own and protect their rights. Besides this, certain groups in society are also subject to discriminatory treatment and feel marginalized. They need special attention to avoid exploitation. In India the women, children, scheduled castes and scheduled tribes, persons with disabilities, migrants and aged are regarded as marginalised or vulnerable groups. These people are socially, economically, politically and legally ignored and excluded in Indian society. It has been seen from the data that in Indian patriarchal society the women's especially the rural and tribal face domestic violence, physical and sexual abuse, nutritional and psychological problems which has a profound effect upon their health status. The health status and utilisation patterns of ST's and SC's give an indication of their social exclusion as well as an idea of their linkages between poverty and health. The economically dependence, politically powerless and culturally subjugated of ST's and SC's to upper castes affects their overall lifestyle and access to food and health etc. It is indeed

unfortunate that a welfare state, founded on the principles of equality, social justice and democracy should display such inequities in health and access to health care. It is the 'usual suspects'- rural India, the women's, children's, the lower castes (especially the scheduled castes), the scheduled tribes, the less developed states and regions of India, that show poor health status and restricted access to healthcare. Women's health needs are numerous- nutrition, general morbidity, reproductive health, disability, mental health, occupational health-and are interrelated.

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