Towards Equality in Healthcare
Trends over Two Decades

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The Rapid Survey on Children (rsoc 2013–14) indicates a new trend in the access of Dalits and Adivasis to healthcare. Since the previous National Family Health Survey (NFHS 2005–06) there has been a distinctly egalitarian trend of progressive increase in their access to healthcare and concomitant development indicators. Nevertheless, marginalised communities continue to remain consistently the most disadvantaged in terms of access to essential services, especially in the realm of nutrition and sanitation.

1 Healthcare

Two facets of the delivery of healthcare services illustrate this trend reversal—institutional deliveries and immunisation of children.

Institutional Deliveries

Historically, India has had a low rate of institutional deliveries. The NFHS in 2005–06 reported that only 38.7% of births were delivered in a health facility. But by 2013, the number of institutional deliveries had increased substantially to 78.7%. Equally significant is the fact that the rate of increase among lower castes and tribes in this period was higher (Figure 1). After languishing for more than a decade, the percentage of new births delivered in a health facility among Scheduled Tribe (ST) families, for example, increased from 17.7% in 2005–06 to 70.1% in 2013—a 300% increase—albeit from a low base. On the other hand, the comparable increase for “other” caste Hindus was a relatively more modest: from 51% to 84% in the same period. This indicates a distinct egalitarian trend and narrowing of the gap between various communities in the access to health services.

One of the most important contributors to this increase has been the Janani Suraksha Yojana (JSY), a conditional cash transfer launched in 2005. It offers new mothers a modest cash grant of Rs 600 to Rs 1,400. It has been considered to be a success even in the most backward districts (Dongre and Kapur 2013). The RSOC also confirms the socially progressive distribution of the JSY in terms of the greater proportion of eligible women from the marginalised castes and tribes availing its benefits (Table 1).

Another important contributor in recent years has been the outreach of the community health and nutrition workers directly to the homes of marginalised families. The RSOC 2013–14, for example, shows that the anganwadi workers (AWW) employed under the Integrated Child Development Services Scheme (icdss) since 1975 have been particularly effective in reaching out to pregnant and lactating mothers.

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women (Figure 1, p 24) and 42.5% of the st women were visited by an AWW at least once during their pregnancy compared to 32.5% of the “others.” The Supreme Court in its interim order of 28 November 2001, reiterated on 29 April 2004 and 7 October 2004, had insisted on the universalisation of anganwadis in every hamlet with outreach for every child less than six years of age. Over the last decade, this order has played an important role to expand the network of 13.3 lakh AWWs for integrated delivery of healthcare, education and nutrition services.

The accredited social health activists (ASHAs), specifically employed since 2005 as community doorstep health workers have also increased their outreach, though surprisingly to a lesser extent than the AWWs (Figure 1). The auxiliary nurse midwives (ANMs) who operate from health centres are expectedly less likely to undertake home visits. But surprisingly, the Rsoc 2013–14 indicates that community workers as a whole tend to pay more home visits after the birth of the child rather than during pregnancy.

Child Immunisation

In the realm of healthcare, universal immunisation of children against major vaccine-preventable diseases is considered to be one of the most cost-effective means to reduce child mortality. In 2005–06, less than half the children (44%) were fully immunised but there was an appreciable increase to almost two-thirds (65.3%) in 2013–14.

The immunisation coverage also reflects an egalitarian trend. For example, the percentage of fully immunised children rose for Scheduled Castes (SCs) by 55% from 2005–06 to 2013–14 as compared to 33% for the “other” caste Hindus (Figure 2).

Nevertheless, the stratified hierarchy of graded inequality has persisted for the last two decades. Only about half the children from the st families (55%) are immunised, followed by the SC (61.6%) and Other Backward Classes (OBCs) (65.4%). Children from the “other” caste Hindus, on the other hand, have the highest levels of immunisation (71.6%).

Again, the Rsoc indicates that anganwadis have been most effective since 63.1% of the st, 55.1% of the sc, and 52.4% of the obc compared to only 36.2% of “others” vaccinated their children at anganwadi centres (Figure 2). Government and private healthcare facilities, in stark contrast, had an almost reverse trend with greater utilisation by the upper castes.

2 Nutrition and Sanitation

However the progressive and egalitarian increase in healthcare does not imply that access to all essential services has been equally augmented. The situation of graded inequality remains unchanged over the last two decades on the nutrition and sanitation front.

In 2005–06, the NFHS reported a regressive trend—55% of the st, 48% of the SC, 43% of the OBC children and 33% of the rest of Indian children are underweight (Figure 3). This sequence remains unchanged in the Rsoc 2013, albeit at a lower rate. Adivasi children continue to be the most underweight—36.7% in 2013–14.

However one nutritional indicator where the strs have consistently and substantially outperformed all other social categories is in breastfeeding. Infants depend entirely on adult caregivers for their nutrition. The World Health Organization (WHO) recommends that all infants should be breastfed within one hour of birth with colostrum. In 2013–14, 54.7% of newborns in the st families were breastfed within the first hour of birth with colostrum. In 2013–14, 54.7% of newborns in the st families were breastfed within the first hour of birth with colostrum.
practice is also closely related to childhood stunting and undernutrition (Spears 2013; Chambers and Medeazza 2013).

But on the sanitation front, too, there seems to have been little progress with 50% of India’s population defecating in the open. But data shows that consistently over the last two decades the SCs and STs have had the least access to toilet facilities (Figure 4). In 1992–93, 88% of ST families did not have a toilet. Two decades later in 2013–14, this proportion had declined to only 69%. In contrast only 28% of the “other” caste Hindus had to defecate in the open for want of a toilet.

3 Conclusions

The Rapid Survey on Children indicates a new trend of the increased access to healthcare by marginalised communities. The sc, sr and obc families have made substantial gains in the last decade. Policy measures such as the universalisation of anganwadi centres in every hamlet, appointment of ASHAs as doorstep community health workers and the Janani Suraksha Yojana cash incentive to promote institutional deliveries have borne fruit leading to egalitarian outcomes.

However similar strides need to be achieved in the realm of nutrition and sanitation, where marginalised communities remain acutely deprived. However one area where other communities would benefit from emulating Adivasi families and their traditional wisdom is the initiation of breastfeeding within the first golden hour of birth.

REFERENCES


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