

Caste Exclusion and Health Discrimination in South Asia: A Systematic Review

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Abstract

The caste system is social stratification system that has been used over the last three millennia. This review aims to investigate caste-based inequity in healthcare utilisation in South Asia, particularly focusing those at the bottom of the caste hierarchy, commonly known as Dalit communities. A systematic methodology was followed; key databases (including CINAHL, Medline, SocINDEX, PubMed, Nepjol, JSTOR and ASSIA) were searched for relevant articles published before 2019 October, using comprehensive search strategy in accordance with the PRISMA guidance. In total 15,109 papers were found, and from these, nine selected papers were included in the review. The papers focused on studies in both India (n=7) and Nepal (n=2) and utilised a range of methods including qualitative (n=2), quantitative (n=3) and mixed methods (n=4) approaches. The review identified four main themes: stigma, poverty, cultures and beliefs and healthcare. Caste-based inequity impacts upon all aspects of an individual's well-being including violence and everyday life risks. Caste also impacts upon individuals' opportunities to access education, employment and healthcare. Dalits appear to experience this more significantly due to both poverty and their caste status which increases their vulnerability to health risks.

Keywords: Asia, caste, dalits, social exclusion, health equity, health access, health utilisation

What we already know:

- Health inequity is determined by broader social factors such as socioeconomic status, education, poverty, gender and caste.
- In Nepal and India Dalits are the most marginalised people at the bottom of social hierarchy who experience most barriers to accessing public services.
- Social stratification by caste is made worse by discrimination and a lack of education.

What this article adds:

- Understanding experiences and challenges associated to health service uptake of Dalit minorities due to caste discrimination.
- Identifying gaps between caste and health equity and highlights possible factors underlying discrimination.
- Aspects that limit access to health services among Dalit communities, including stigma, poverty, culture and beliefs and healthcare.

Introduction

Discrimination impacts upon wider determinants of health such as education, employment, income and housing.¹ Caste is a fundamental determinant of social exclusion and development, indeed international human rights organisations argue that worldwide over 260 million individuals experience this exclusion.² To understand caste discrimination, it is important to clarify the caste system and those groups most disadvantaged by it, generally called ‘lower caste’, and widely known as ‘Dalits’.³

The 3,000 year old caste system is one of the oldest social hierarchies and it forms the foundation of Hindu society.⁴ This system includes four divisions ‘*Brahmins*’ priests;

'*Kshetriyas*' warriors; 'Vaishyas' merchants; and '*Sudras*' servants. Underneath these castes lies '*Ati-Sudra*'; Dalits, also known as untouchables.⁵ Dalits rest at the bottom of the caste hierarchy and are often perceived as: water polluting, untouchables, impure, doom, pariganit, tallo jat.⁶ Dalits are an outcasted group, often referred to as "Broken men" in Hindu scriptures, Ambedkar noted that they are referred to as "Protestant Hindus" or "Harijans" or "untouchables and depressed class" or "scheduled caste".⁷ However, the word 'Dalit' is widely recognized, and the Dalit movement emphasizes the importance of accepting this term to note the continuous discrimination based on caste.⁵ Caste discrimination is a highly sensitive and politicized issue in Asia,^{3,6,8} especially India and Nepal where more than 80% of the population are Hindu.⁹ Criticizing the caste system is hindered by a fear of offending religious or cultural sensitivities among Hindus.⁸

Studies have reported that people from high castes experience freedom and high status whereas, people from lower caste are restricted in attending schools, temples and courthouses. Furthermore, they are restricted in trading goods, labour and were stigmatised through the practice of untouchability.¹⁰ Caste-based inequity also impacts upon employment limiting Dalits to low status occupations such as making brooms, baskets, ropes, sex workers and domestic labours.¹¹ Dalits are also linked to occupations such as scavengers, sweepers, ragpickers, coolies which are considered to be dirty, unimportant and unhygienic and hence associated with religious notions of purity-pollution.¹² Dalits have also been prevented from establishing equal relationships in social, educational, political and economic domains in comparison to those from higher-caste.¹³ The Dalits are especially vulnerable and isolated due to this notion of untouchability in the caste system.¹⁴

Hinduism is a very patriarchal religion, and in Hindu-dominated societies women's status is traditionally lower than that of men.¹⁵ Caste-based disparities interact with patriarchy

and together play a significant role in further isolating *Dalit women* who are also known as the ‘Dalit among Dalits’. As such, Dalit women experience double discrimination based upon their caste identity and their gender. They are largely ignored and experience discrimination leading to health inequity, especially with regards to maternal health services.¹⁶ Caste and gender often render Dalit women and girls particularly vulnerable to being excluded from schooling, generating literacy barriers.¹⁷ In Nepal, there is a paucity of studies on the health perspective of women, especially Dalit and disabled women accessing and using maternal health services.¹⁸ Due to social and religious practices, women from these communities are more vulnerable to sexual exploitation. Similarly, due to caste discrimination Dalit women experience difficulties accessing social, economic, civil rights and entitlement. The main challenges they face include; poor health, reduced education, economic deprivation due to limited employment opportunities, reduced public service and political participation, violence and atrocities, prostitution and gender inequality.¹⁹ In this review, we seek to also understand gender aspects of caste by presenting challenges Dalit women face.

A large number of Dalit in rural areas in India are deprived from or are refused access to health services due to their social status.²⁰ The state of Nepal aimed to address the issues of caste discrimination by developing affirmative regulation and policies (health policies, nutrition health policy, federal structure policy).^{18,21} However, despite legislation outlawing the caste system in Nepal since 1962, discrimination in accessing health services still continues due to a lack of state-run services, as well as denial and discrimination in the provision healthcare to Dalit who seek health services.²² Typical discriminatory behaviours include refusing to: enter Dalit’s houses or allowing them into your house; share food and water; seating places; transport; and generally refusing to touch. Health discrimination is likely to be seen mainly in areas where care is provided, which can be health centres or a

patient's own home.²³ Research highlighted that Dalits are also more vulnerable to HIV (Human Immunodeficiency Virus) partly due to high migration to escape from caste-based discrimination.¹⁴

Whilst there are many papers written on caste, to date no systematic review has been conducted to explore the caste-based inequality in accessing healthcare services in South Asia. To bridge this gap, this review explores possible factors underlying discrimination and trends in discrimination and inequity over time. This review aims to address the research question 'What is the evidence that Dalits (i.e. lower castes) have different health service utilisation than higher castes in South Asia?' Our findings will be useful for policymakers and researchers alike.

Methods

A systematic review was conducted in accordance with the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) as this allows inclusion of published papers to examine health discrimination on the basis of individual's caste.²⁴ Population, exposure and outcome (PEO) framework²⁵ was used to develop the research question and form the search strategy. This included: population; dalits, untouchables, low caste, outcaste, minority group, socially excluded group, discriminated group, exposure; discrimination, inequality, inequity, racism, barrier, violence, judged, prejudice and outcomes; service uptake, motivation, hospital uses, health Standard, health promotion, health equity, equality, health access, health utilisation.

The following databases were searched: CINAHL, Medline, SocINDEX, PubMed, Nepjol, JSTOR, ASSIA and EBSCO Discovery Service (EDS) for relevant articles. Table 1 shows different but interrelated search terms which varied depending upon the database. Boolean

operator ‘OR’ was applied in combining different search keywords for study population, exposure and outcomes, whereas ‘AND’ was applied to merge population, exposure and outcomes. Proximity ‘N3’ was applied to ensure the searched studies were health related. The parameters which framed the review included studies written in English and published in peer-reviewed journals.

“INSERT TABLE 1 HERE”

Screening and Selection:

Papers were selected using four stage process suggested in PRISMA: - identification, screening, eligibility and included (Figure 1).

“INSERT FIGURE 1 HERE”

Records were identified through database searching (n=15,106) and from other sources (n=3), resulting in 15,109 records identified. After removing duplications, 9,721 articles were screened by reading the title and abstract against the inclusion/exclusion criteria. This included papers published between 2000-2019, primary research (qual/quant/mixed) secondary data analysis of routine data, focused on health, health access, health inequity or discrimination against Dalit community, studies focussed upon south Asia, papers written in English and peer reviewed. At this stage the majority of records (n=9,668) were excluded on the basis of main interest of paper not related to caste and health discrimination, language (not written in English), demographical location (research outside South-Asia), participants (population other than Dalits) and publications (not research paper). 10% of the rejected papers were also blind peer reviewed [EvT, VH and PR] to ensure quality control.

In the third stage, all remaining 53 records full text articles were reviewed by the first author against the inclusion/exclusion criteria and double checked by the rest of the research team [EvT, VH and PR] to reduce possible researcher bias. At this stage nine papers were selected and 44 papers were excluded largely due to study not being primary research, not focused on health or health access, focused on wider aspects of discrimination, not focused on South Asia, and published before 2000.

Data Extraction:

Data extraction was conducted by first author and reviewed by co-authors to ensure consistency. Any disagreement in the selection was resolved through discussion with other authors.

Results:

Nine papers that met inclusion criteria were included, Table 2 shows a summary of the appraised papers. Of the nine selected papers, two were qualitative studies, three quantitative and four were mixed method . The selected South Asian studies were carried out between 2000 and 2019, mainly in India (n=7) and Nepal (n=2). These studies assessed caste-based discrimination in the healthcare sector.

“INSERT TABLE 2 HERE”

Selected nine papers were critically appraised using the CASP ^{26,27} and McGill ²⁸ checklist, most scored average to moderate quality. From the nine studies four themes were identified including: stigma, poverty, culture and beliefs and healthcare.

Stigma

Stigma here is related to the stigma related to belonging to a particular group, in this case being a Dalit.²⁹ Almost all papers identified issues related to caste based stigma however four papers³⁰⁻³³ focused on the double discrimination of gender and caste experienced by Dalit women. Caste based health discrimination was dominant across low caste groups where basic health indicators for disadvantaged groups (including Dalits) were consistently poor in comparison to those in middle and upper castes³⁰. Caste is an important element in shaping individual's social identity and their wellbeing.^{34,35}

Dalits reported they were treated differently after people found out their caste status and those people then shared very little information about health services and programmes.³⁴ Dalits live in an oppressive society which impacts on every aspect of their life, they are not allowed to enter upper caste house, sit together or even sit in the presence of upper caste people. People from low caste are also forbidden to offer food or water to upper caste people.³⁵ Caste is one of the key factors of gender inequality which is associated with poorer education, nutrition and health as well as less access to human rights as illustrated by Dalit women being more vulnerable to diseases (malnutrition and anaemia) and maternal mortality.³¹ The caste system is further gendered in terms of employment, including daily wages and long working days which makes it difficult for women to look after themselves in pregnancy and care for their offspring after birth which, in turn increases their dependence on men.³²

Health outcomes of Dalit women are dependent on two major variables: caste and household wealth. Violence against women resulting from stress associated with unreliable work, low wage and men being unable to perform their role as "provider".³² Two studies identified domestic violence as a common issue with Dalit communities.^{32,36} Rao identifies

that both alcohol consumption and violence are signs of men failing to control their jobs and kids, and then blaming women for their inability to perform as housewife.³¹ Dalit women are not allowed to travel alone; their mobility is restricted after marriage and they have little involvement in important household decisions including decision related to seeking health care, which can be one reason why Dalit mothers have low levels of health service usage.³⁰

Dalit women often suffer harassment from men including their husbands or have abusive relationships.³⁶ When it comes to sexual intimacy, relationships between upper caste women and low caste men is strictly prohibited, it is believed that this will pollute upper caste women whereas sexual relations between upper caste men and low caste women is not prohibited.³⁵

Poverty

Four studies^{31,35-37} identified financial limitations as a major barrier in accessing healthcare and in health seeking behaviours. Dalits are generally poor and often not aware of free health services and government-provided health incentive schemes.³⁷ Dalits are minority communities who have significantly less landholdings, have a lower socioeconomic status and low literacy. They either work in upper caste people's fields or in low income jobs such as basket weaving.³⁵ In contrast, upper caste groups have a higher health knowledge, better health access as well as better employment and physical home environment compared to disadvantaged caste.³¹ Bhandari and Chan³⁰ found in their research that women from poor households are disadvantaged in terms of utilising health services and most of Dalits live under the poverty line.

The connection between caste and occupation is complex. Lower caste women, despite non-engagement in education (as most never attended school) are more likely to be

engaged in paid employment compared to women from other castes in society, as poorer women need to work to support their household.³³ Education changes social interaction and job opportunities, which negatively affects Dalits as nearly 70% are illiterate, much lower than other lower castes.³² Conversely, the same study also identified that improvement in level of education among Dalits fuelled violence due to refusal to work as submissive agricultural labourers.³¹

Kumar stated that private doctors who are usually unlicensed ‘quacks’ exploit women due to their lack of education, charging high fees which results in Dalit women taking loans for treatment, perpetuating their poverty.³⁰ He further added that without change in caste and class barrier, providing better health resources and improved health results are not possible, especially for women.³¹ Illness expenditures are mostly met by family members, loans from wider family or self-help groups or banks.³⁶ Two studies^{31,36} identified that taking out loans to cover health related cost is common within Dalits communities and this further constrains their financial ability. Polit explained the hopelessness, depressed environment of Dalit society where individuals cannot afford hospital treatment or time to heal shows the extreme level of poverty in Dalits communities.³⁵

Cultures and beliefs

Here any cultural factors or beliefs associated with health equity among Dalit communities are included. In South Asia, classifications based on caste and ethnicity are a main feature of social inequity which is closely connected with Hindu beliefs.³⁰ The cultural practices of discrimination effects ones mental and social wellbeing.³⁵ Despite regulations and laws prohibiting caste discrimination, continuous caste-based inequity creates hopeless and helpless situations for Dalits which contributed to the development of alcoholism and self-harming behaviours. In response to this some Dalits convert to Christianity to escape the

caste system altogether.³⁶ The caste system also influences marriages, as Dalits are less likely to be able to marry a partner from a higher caste as marriages are expensive as large dowries are expected by higher caste families.³²

In Polit's study, people's health and wellbeing were strongly connected to several deities, demons and ghosts that live in their surroundings. Access to cures, ritual healing is restricted for Dalits due to the complex relationship between poverty and discrimination in society.³⁵ Inequity leads to frustration, anxiety and insecurities which resulted in incidents of spirit possession by both male and females to express resulting unexplained death while seeking exorcism treatment by the *ojha*.³⁶

According to two studies, it is believed that caste people are not highly educated and cannot understand health information provided to them.^{34,37} They are ill-mannered and do not communicate properly due to lack of understanding and knowledge.³⁴ Due to their limited access to care, Dalits lack knowledge about diseases and/or information about possible cures, which in turn leads to failing to identify symptoms or causes of illness.³⁷

Healthcare

All nine papers identified that caste affects health issues, four focussed³⁰⁻³³ on health issues related to women, one³⁶ focused on health issues related to HIV and the remainder focused on general health and wellbeing issues related to Dalits. Kumar's study asserts that disadvantaged women have high chance of severe illness and without any improvement in caste and class barrier, improved health resources and outcome is almost impossible.³¹ In Uttar Pradesh, India only 19% of people with long-term illness were treated due to poor availability of health services, high fees and untrained providers.³⁶ Poor health is connected with lower education level and having less land in low-caste women.³³ Dalit women usually do not visit hospital for treatment due to the travel distance to the hospital and they cannot

afford neither travel expenses, nor high treatment fees.³⁵

Kumar indicated that in Bihar, India's poorest state, local public medical services, often the only services affordable for Dalits, only addressed basic health needs.³¹ Despite developments in the Indian health structure including availability of sub-centres, public health centres and community health centres, poorer communities still experience a shortage of health institutions and skilled health workers.³⁸ Similarly, in Nepal, the healthcare structure is weak and access is limited for both Dalits and Non-Dalits. From skilled health workers to medicine, supplies and other equipment are in short supply therefore patients are referred to higher level of care adding high fees and transportation costs with no guaranteed satisfactory care. Due to literacy issues Dalits who travelled for better healthcare need support in filling in complex paperwork and they often struggle to get free access to services that are supposed to be free of charge.³⁷

As previously mentioned caste influences employment opportunities and few Dalits have gained healthcare positions such as general medical practitioners, specialists doctors, trained nurses, technicians and associated health staff. Their low representation compared to other groups of society promotes a favourable environment for caste inequality.³⁸ Dalit health workers including auxiliary nurse midwives suffered several difficulties; they were not treating well, patients and colleagues fail to follow their health advice and start taking them for granted due to their lower caste status.³⁴

Discussion

This review investigated caste- based inequity in healthcare utilisation in South Asia and included nine selected studies. These research studies were carried out in different cities, counties with different study participants however, most of them agreed a connection

between socio-economic differences and health disparities.³⁰⁻³⁸ It was found that low socio-economic status and holding less land is associated with poor health outcomes. Due to Dalits low status in Nepal and India, they have lower access to education and skilled well paid employment results in lower household incomes.³⁹ Dalits have lower occupational mobility, less land, poorer education and worse jobs. Discrimination in occupation, prolonged poverty and social stigma reduces their opportunity to access labour market in equal term with non-Dalits, they also fail to get into occupations that did not conform to their low social and political status.⁴⁰ Although law and policies have been introduced socio-economic hierarchies based on caste persist in South Asia.⁴¹

Dalit women are doubly disadvantaged due to their low caste status as well as the lower status of women in Hindu society. Lower caste women have increased burdens and risks on their everyday life, including domestic violence and more likely to experience severe sickness and limited treatment beyond locality. Self-help groups (SHG) have helped caste women reliance on moneylenders in the event of illness, to cover expensive private health services by providing limited credits.³¹ However, it is only available locally and not changing people's attitudes towards discrimination. Caste/ethnicity contributes to women's health, for example higher caste groups comparatively derive better benefits from an antenatal care (ANC) programme. Deprived caste/ethnicity group are disadvantages in terms of using ANC services compared to other caste groups. Similarly, mothers from wealthy household utilised ANC services more compared to poor households. However, when comparing caste intersecting household wealth results were slightly different. Disadvantaged women with lowest household wealth significantly used less ANC services compared to higher wealth with same household, similarly advantaged groups with lowest household wealth also significantly used ANC less whereas mothers from both groups with better wealth used were significantly more likely to use ANC services. This shows the

independent contribution of caste and wealth on health and contrary to the common beliefs that disadvantages groups are always disadvantaged.³⁰

Dalit communities are not only affected by clinical issues but a variety of sociocultural determinants therefore to improve their health and well-being better policies are needed as well as a willingness to tackle sociocultural determinants of health inequality with the government playing a central role.⁴⁰ Caste influences are not limited to locational periphery and travels from village to the cities to all markets where “cultural and social relations play out”⁴² and effected the process of developments and educations. This review identified that the cultural practices of discrimination create psychological tensions disturbing mental health. Among Dalits mental health issues is often mistaken as being possessed by ghost. This kind of belief limits their access and understanding to better health services.³⁵ Programmes like SGH or ANC may not be enough to overcome caste and health attitudes and such programmes may leave disadvantaged people behind in terms of health improvements. Therefore, the global policy agenda and national health system improvements need to focus on improving health inequalities across disadvantaged populations.

Caste and discrimination is largely invisible in discussions of Sustainable Developments Goals (SDGs).⁴³ The SDGs of: no poverty, good health and wellbeing, quality education, gender equality and specially goal 10, reduced inequality for all, irrespective of age, sex, disability, race, ethnicity, origin, religion, economic or other status will not be able to achieve without dealing caste discrimination.² Polit described how well-being in the three groups of Dalit villagers was affected by the circumstances of relative marginality as well as by general socio-economic indicators. Dalits living together with a high-caste majority compared to Dalits living exclusively in a Dalit village are more marginal and have lower

state of well-being.³⁵ There is close interrelation between poor health, socioeconomic position and education. Education is an exclusive measure of socioeconomic and socioeconomic position controls health behaviours.³³

Health equity is also influenced by social status and perceptions of care providers and seekers, limiting their interaction with each other.³⁴ Throughout history, Dalits have been classified as serving class and their only skill required is being able to serve.⁴⁴ Non-Dalit health workers hold good understanding and respected in their community whereas Dalits had limited mobility and non-acceptance within societies.³⁴

Conclusion

This review presents caste discrimination and health exclusion in South Asia and highlights the promotion of health and well-being of disadvantages castes as well as for the need for further study in other cultural contexts within South Asia. Research on Dalits often evidence domestic violence, risk presence in everyday life, poor education, employment, d health hierarchies and inequities caused due to interconnection of caste, class and gender. Class and caste inequities have become more severe in affective and determining opportunities to access to healthcare. Inequity in health can be visible on both sides in terms of care provider as well as seekers. This review highlights that due to poverty Dalits health seeking behaviour is limited as they survive on daily wage and could not afford to lose their daily earnings. Similarly, deprived from accessing better health due to not being able to pay for expensive health services. Poverty also impacts on education and health knowledge (i.e. health literacy).

This review also shows the inter-relation of caste and socioeconomic standard as a source of inequality, i.e. the combination of being from lower caste and having low socioeconomic

position results in poor health rather than just being poor. Dalit women face double discrimination due to their identity as women as well as low caste. Women's interactions with education, income and standard of living is limited which leads them and their health very much dependent on existing gender relations. It will not be possible to boost the health of poor and Dalit women without decentralisation and increasing local accessibility of health services. Dalits women's problems are in addition to general weaknesses in health systems making accessing health care difficult for many people, not only for Dalits.

The evidence in this review indicates to the need for policy innovation and systematic and regular orientation programme to address caste exclusion, remove barriers and to provide support to Dalits development as well as pointing to the need of inequity discussions in global policy debate like Sustainable Development Goals.

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Table 1 Search Strategy

Database	Filter	Search Terms	Results
My Search – Peer Reviewed	Language: English Date:1967 – 2019	(dalit* or untouchab* or “low caste*” or outcast* or minorit* or “social* exclu*” or “discriminated group*”) AND (discriminat* or inequal* or inequit* or racis* or barrier* or violen* or judg* or prejudice*) AND (((uptake* or motivat* or use* or adher* or promotion* or inequity or inequality) N3 health)) or "health access" or "health utilisation" or "health utilization"	6,444
CINAHL Complete – CINAHL Headings	Language: English Date:1981- 2019	(<i>Dalit* or Untouchab* or “Low Caste*” or Outcast* or Minorit* or “Social* Exclu*” or “Discriminated Group*”</i>) AND Discriminat*or Inequal* or Inequit* or Racis* or Barrier* or Violen* or Judg* Or prejudice* AND ("Health Services Accessibility" or "Quality of Health Care" or "Attitude to Health" or "Attitude to Health Personnel" or "Patient Satisfaction" or "Health Knowledge" or "Health Status Disparities" or "Healthcare Disparities")	2,107
Medline Complete – MeSH Headings	Language: English Date:1950- 2019	(<i>Dalit* or Untouchab* or “Low Caste*” or Outcast* or Minorit* or “Social* Exclu*” or “Discriminated Group*”</i>) AND Discriminat*or Inequal* or Inequit* or Racis* or Barrier* or Violen* or Judg* Or prejudice* AND (“Health Knowledge, Attitudes, Practice” or “Quality of Health Care” or “Quality Assurance, Health Care” or “Health Care Quality, Access, and Evaluation” or “Health Services Accessibility” or “Attitude of Health Personnel” or "Attitude to Health” or “Patient Satisfaction” or “Patient Acceptance of Health Care” or "Health Status Disparities” or "Healthcare Disparities")	6,269
SocINDEX with Full Text – Subject Terms	Language: English Date:1987- 2019	(<i>Dalit* or Untouchab* or “Low Caste*” or Outcast* or Minorit* or “Social* Exclu*” or “Discriminated Group*”</i>) AND Discriminat*or Inequal* or Inequit* or Racis* or Barrier* or Violen* or Judg* Or prejudice* AND ("Health of Minorities" or “Health Behavior – Research” or “Patient Satisfaction” or "Utilization of Health Facilities" or "Health Facilities" or “Health & Social Status”)	60
PubMed	Language: English Date: till 2019	((Dalit* OR Untouchab* OR "Low Caste*" OR Outcast* OR Minorit* OR "Social* Exclu*" OR discriminated Group*)) AND health discrimination) AND (nepal OR india)	48
Nepjol	Language: English Date: till 2019	Dalit and health	30
JSTOR	Language: English Date: till 2019	((dalits) AND (health)) AND (discrimination))	128
ASSIA:	Language: English Date: till 2019	(Dalit* or Untouchab* or “Low Caste*” or Outcast* or Minorit* or “Social* Exclu*” or “Discriminated Group*”) AND (Discriminat*or Inequal* or Inequit* or Racis* or Barrier* or Violen* or Judg* Or prejudice*) AND (uptake* or motivat* or uptake* and use* or Adher* or promotion*or inequity or inequality) N3 health)	20
Hand searches	Language: English Date: till 2019	Additional records through other sources	3
		Total	15,109

Table 2 Summary Table

Authors, Year and Country	Main Aims	Method and data collection/ analysis	Participants	Results	Stated Conclusion	Limitation, Critical appraisal	Reviewer's Conclusion
Bhandari & Chan, (2016), Nepal	Investigate caste/ethnicity-based inequity in women's health service utilisation, focusing on ANC in Nepal	Secondary cross sectional– Nepal Demographic Health Survey (NDHS) Data 2011, Bivariate & Multivariate analysis	4,018 mothers aged 15-49 who gave birth past 5 years	53% mother had ANC visit 4+ (mean 3.63, median 4.0), Hill Dalits and Terai Dalits were only 4%. Only 6% of disadvantages caste/ethnicity belongs to wealthiest quintile.	Disadvantaged mothers using less ANC independently based on their caste/ethnicity and their household wealth. Advantages mothers are also disadvantaged of utilising ANC depending on wealth.	Secondary data, Cross-sectional nature, not focus on quality visit. Appraisal: CASP, 2018 (75%, Medium)	In-depth study association double discrimination: caste & wealth.
Kumar, (2007), India	Explore the link between Self Help Groups (SHGs) + women's access to health services.	Mixed method: survey, interviews, case studies and focus group discussions	SHGs women (n=200), Family members, Community leaders	84% SC used unlicensed 'private doctors', paid high charges. No change reported in health, health knowledge, health utilisation, spending on food, basic needs compared to OBC. Participations' health impact was reportedly greater for OBC women than SC.	Caste & class powerful in determining women's access to health. Dependent on gender relations, income, education and general standards of living. SHGs, fail to overcome structural contexts hence failed to produce equitable health services to marginalised.	Small sample, No. participants other than SHGs women is not made clear. Appraisal: McGill, 2018 (85%, Medium)	Women are discriminated on gender, caste & class, information on double discrimination would be helpful.
Polit, (2005), India	To show how the relative marginality of Dalits affects the well-being of Dalit women.	Mixed method: Survey and Ethnographic research	Garhwali (state) women central Himalayas of north India	1 st village: Dalits = poor, literate, high discrimination & dependency. 2 nd had 2 areas, occasional clashes, moderate dependency, employed and educated people. 3 rd village- only Dalits, less land, education & jobs; no discrimination & dependency.	People's affects well-being more than trans location. Dalit living exclusively Dalit village not consider themselves marginal and well-being = greater. Dalit in village with a high-caste majority will feel more marginal therefore, well-being likely to be less.	Small sample, limited info on methods and data collection. Appraisal: McGill, 2018 (80%, Medium)	No clear identified result. Dalits not marginal in all villages and level of discrimination, access to health and well-being are very different.

Priya, & Sathyamala, (2007), India	To explore level of ill health of people from low castes, capacities to respond to adult illness and support needed	Cross-sectional. Mixed methods: Survey and Interviews	1,171 household Utter Pradesh + 900 Tamil Nadu from SC, Interviews = 62 in UP + 52 in TN	Two regions had distinctive health vulnerabilities and support systems. Death rates UP (9.4) and TN (11.4) not as expected. UP 19%/94% had treatment and in TN 97% with long-term illness had some treatment. Sources of treatment were loans. Stigma long-term illness not problem.	People who are poor and lower castes are not equally susceptible to HIV. Social cohesion provided security from impact of poor living and working conditions. Traditional forms of social cohesion are under stress and new forms are inadequate. No social norms protect women.	Methods and selection of participant not clearly explained. Appraisal: McGill, 2018 (85%, Medium)	Discrimination on long-term illness is not a major issue however, fear of stigma led to preventable death.
Mohindra et al., (2006), India	Examine social patterning of women's self-reported health status Kerala; two hypotheses: (1) low caste & socioeconomic position is associated with worse health status, (2) associations between socioeconomic position and health vary across castes.	Secondary Cross-sectional data-household survey implemented by the Centre for Development Studies in 2003. Multilevel multinomial logistic regression model.	4196 non-elderly women of marital age (18-59 years)	Lower caste women, more likely never attended school and are predominantly wage labourers, OBC are slightly more likely to work as wage labourers and forward caste engage in non-wage activities. Odd ratios poor perceived health and ADL.	Caste and socioeconomic inter-related; lower caste magnifies health inequity. Being both lower caste & poor can trap people into poor health than either inequality on its own. Implementing interventions that deal with caste & socioeconomic disparities to produce more equitable results than targeting either inequality in isolation.	Cross-sectional study, multilevel multinomial modes in ADL, Self-perceived health, regular contact with professionals & attitudes and perceptions. Appraisal: CASP, 2018 (85%, Medium)	Information on effects of gender inequality of women's self-reported health status would be helpful.
George (2015), India	Examine Dalits in significant positions of rural health + improvement provisioning of health services in tribal India.	Secondary analysis - National Sample Survey Office (un)employment (2011-12)	National survey	Dalits are underrepresented in health professionals. Despite only 24% of rural population, other castes shares 40% in health professional. Shortages sub centres, PHCs and CHCs.	Underrepresentation of Dalits in rural healthcare delivery due to untouchability. Indian health system is not equipped to address exclusion, which for urgent policy attention.	Secondary analysis of health work force. Appraisal: CASP, 2018 (80%, Medium)	Further study on why in rural India significant jobs are likely to be taken by higher castes.

Daniel et al. (2012), Nepal	Examine health care access Dalits through experiences of stakeholders throughout health system.	Ethnography, participatory approach: Key informant interviews & FGD, stakeholder and institutional analysis.	19 FGD and 19 KI totals (n=209)	Dimension: info access, physical access, financial access, discrimination, and social capital restricting access to health services identified 5 themes: Human rights educ; health educ; advocacy; public inclusion; & dialogue.	Dalits & non-Dalits less access to health services due to lack of resources, absence of monitoring health care and problems decentralization also main causes of weak Nepali health system.	Less info: district due to language and geography - social relations for field visits. Appraisal: CASP, 2018 (70%, Medium)	A table reflecting KI and FGD would be helpful in better understanding of results.
Verma & Acharya (2018) India	Explore health interaction of Dalit health staffs with non-Dalit care seekers and vice versa.	Qualitative - In – depth interviews and 4 FGD, systematic random sampling. Thematic analysis.	20ANMs, 20ASHAs + 80 care seekers who delivered babies in last six months	5 Themes: Caste, perception & social identity, Profession & social identity, Maintaining identity, Conflict & dilemmas, Control & autonomy. Variation across caste of providers & seekers in shaping perception of each other.	Dalit providers lacked skills, & health seekers are suspicious of their knowledge. Other staff limited interaction with Dalit care seekers & staff. Women: faced: gender & caste. Provider & seekers' caste more weight than profession & need.	Small number, no justification how themes were identified, no written consent Appraisal: CASP, 2018 (90%, high)	Clarification on how FGDs were conduction and further information on double discrimination would be helpful.
Rao (2015) India	Discuss key conceptual ideas of agency, voice and interjectionally in relation to the role of marriage and sexuality in reinforcing caste and gender boundaries.	Mixed method: Survey, In-depth interview, FGDs and KI, Narrative	rural couples: 400 surveys, 40 in-depth interviews	Choice of marriage partner- arrange marriage among OBC, contestations among Dalits degree of control. Facing violence, resisting it, narrative by all women. Jobs are not easy for women, enhances dependence on their men.	More understanding needed on Dalit women's "acceptance" of violence. Inseparability / lack of agency, of action / patience, as strategies to challenge hierarchy and strengthen their bargaining position.	Narrative research, Appraisal: McGill, 2018 (80%, Medium)	More clear results, details related to data analysis, dowry related violence/ marriage.

Abbreviation: Activity in daily living (ADL), Other Backward Classes (OBC), Scheduled Castes (SC), Scheduled Tribes (ST), Auxiliary Nurse-Midwife (ANMs), Accredited Social health Activist (ASHAs)

Figures

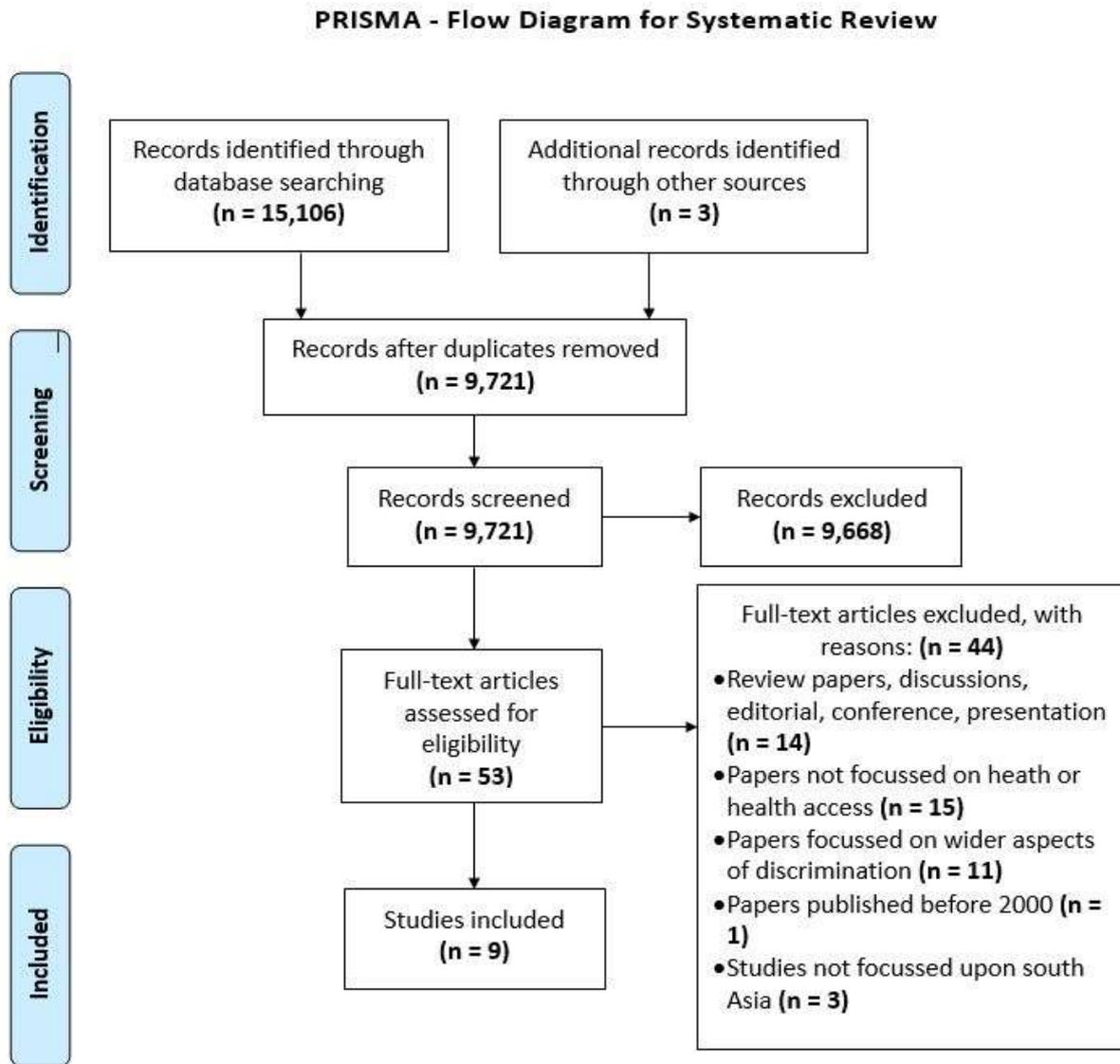


Figure 1 PRISMA Flow Diagram

