Caste-based healthcare inequality in Dalit communities in Makwanpur, Nepal: A mixed-methods study

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Abstract

Introduction

The caste system is a three-millennium-old social stratification system. Caste discrimination is common in Nepal despite being illegal since 1962. Dalits (known as untouchables) rank at the bottom of the caste hierarchy and often experience discrimination due to notions of untouchability resulting in poor health outcomes. Caste-based inequality has an impact on the wellbeing of individuals, experiences of violence, and opportunities to access education, employment, and healthcare. This research will help to understand discrimination by caste through exploring experiences and challenges that Dalit minorities face in accessing and utilising health services.

Methods

A cross-sectional mixed-methods study was conducted in Makwanpur district, Nepal in 2019. Qualitative study included six focus group discussions, six key stakeholders' interviews and five exit interviews. The quantitative survey included 202 health workers. Qualitative data were organised using NVivo 12 software and thematically analysed, and quantitative data were analysed using SPSS 26 descriptive analysis.

Findings

The qualitative findings identified, caste discrimination affects health (physical and psychological), impacts wider health determinates (gender, education, employment, and poverty) and positive attitudes of health workers towards Dalits. Research presented that Dalits do not prioritise medical healthcare thus, resulted poor health. Nearly all (98.5%) health workers stated that no discrimination in health services towards Dalits, however, 53% reported that no discrimination and promoting equal opportunity will contribute to better health outcomes within Dalit communities.

Conclusion

Caste-based discrimination is still prevalent in Nepali society and influence individual's health. The services that actively promote, and address health inequality experienced by Dalits are lacking. The outcomes of this thesis can help to identify gaps in Dalit healthcare, leading to better training and education and benefitting policy makers, health workers and researchers alike.

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Declaration

I hereby declare that I conducted all the work presented in this thesis, entitled, *Caste-based inequality in healthcare focusing on Dalit communities in Makwanpur district, Nepal*. It is in accordance with the requirements of Bournemouth University for a PhD degree. This work is presented to the best of my knowledge and has not been published except as acknowledged in the script. All quotations have been distinguished by quotation marks and their sources acknowledged. This thesis has not been submitted for any previous degree.

Raksha Thapa

15th July 2022

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
BIAS	Behaviours from Intergroup Affect and Stereotypes
BLM	Black Lives Matters
BU	Bournemouth University
CBS	Central Bureau of Statistics
CHAS-NORC	Center for Health Administration Studies and the National Opinion Research Center
CMA	Certified Medical Assistant
COVID-19	Coronavirus Disease
CRT	Critical Race Theory
DoHS	Department of Health Services
EI	Exit Interview
FGD	Focus Group Discussions
GAL	Global Alliance for Literacy
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HA	Health Assistant
MBA	Masters in Business Administration
MDG	Millennium Development Goals
MoHP	Ministry of Health & Population
MO	Medical Officer
MSH	Management Sciences for Health
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organisation
NHRC	Nepal Health Research Council
NHSS	Nepal Health Sector Strategy
NLSS	Nepal Living standard Survey
NMICS	Nepal Multiple Indicator Cluster Survey
NR	Nepali Rupees
NSAC	Nepal South Asia Centre
NSIS	Nepal Social Inclusion Survey
NSSO	National Sample Survey Office
PCS	Personal, Cultural and Structural
PEO	Population, Exposure and Outcomes
PhD	Doctor of Philosophy
PPE	Personal Protective Equipment
SDG	Sustainable Development Goals
SHS	Social Health Security
SPSS	Statistical Package for the Social Sciences

TB	Tuberculosis
UCDF	Underprivileged Community Development Forum
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPR	Universal Periodic Review Process (UPR)
UREC	University Research Ethics Committee
USA	United Sates of America
USD	United States Dollar
WHO	World Health Organization

Chapter 1 Introduction to the study

1.1 Overview

This chapter presents the background of the study. It introduces and explains the caste system within Hindu society and provides further explanation about the Dalit community and their place within the caste system in the South-Asian sub-continent. This chapter presents literature on existing practices of discrimination based on caste, (focusing on Dalits) highlighting the conditions and status of Dalits in Nepal. This chapter also includes information about Nepal, its healthcare system and legislation regarding caste, as well as the background of the researcher. This chapter concludes by providing an overview of the thesis.

1.2 Country background: Nepal

Nepal is a small landlocked country located in South Central Asia. It is situated between China in the north and India in the east, west and south. It is home to the highest mountains in the world including Mount Everest, known locally as *Sagarmatha*, and boasts many other natural and cultural sites including rivers, cities, and temples. Nepal has unique geographical diversity starting from 60 meters above sea level in the plains (Tarai) region in the south, all the way to the highest peak in the world, Mount Everest (8,850 metres), in the north (Government of Nepal and Secretariat 2013). Nepal is occupied by 29.1 million inhabitants (Office for National Statistics 2021b). Between 15 to 20% of the population are Dalits, reported in the census (2011). The most recent census (2021) has not reported the breakdown of population by caste so previous census data (2011) was used. The national census (2011) reported Hinduism as the main religion (81%). There are 126 different caste/ethnic groups including eight major caste groups and 25 sub-castes. Nepal has 122 languages, including Nepali, Maithili, Bhojpuri, and Tharu. The official language of the country is Nepali, with approximately half of the population (44.6%) speaking

the Nepali language (Central Intelligence Agency 2018). The capital of the country is Kathmandu. Major cities include Pokhara, Chitwan, Biratnagar and Hetauda.

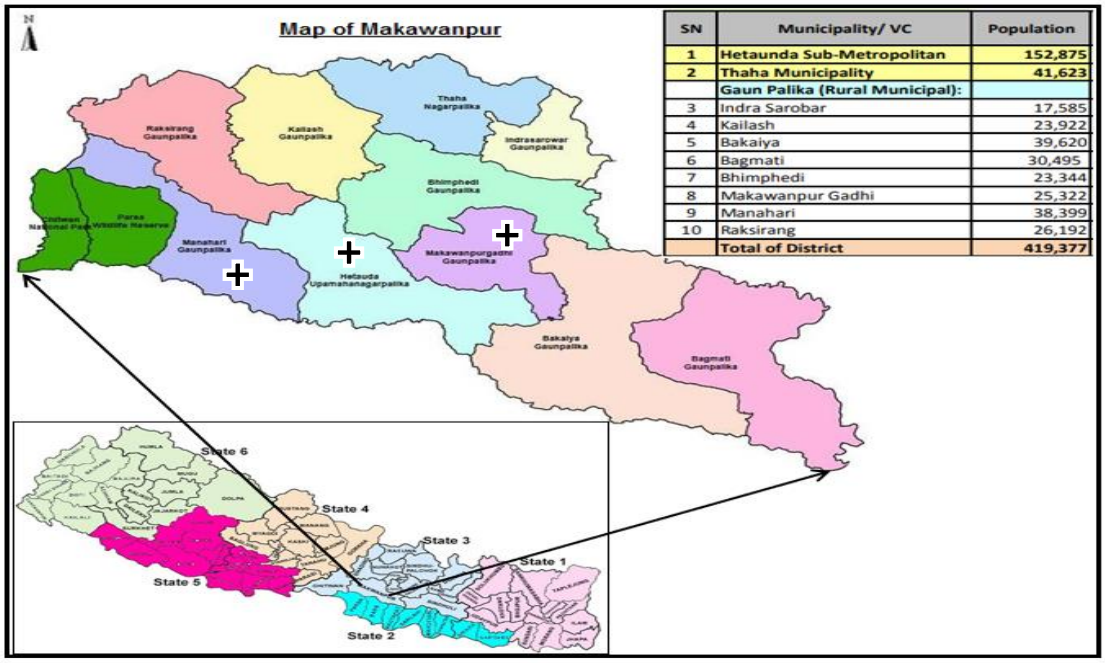
Nepal has witnessed many changes since becoming the Federal Democratic Republic of Nepal on 28th May 2008. Nepal's Maoist party started the transition with a decade long civil war (1996-2006) and ended a 240 year old monarchy by removing the last king Gyanendra Shah, (Hutt 2020). Evidence has emerged that this long civil war had a negative effect on the country's health and healthcare system. It led to over 13,000 fatalities, 1,200 disappearances, disablement, and internal displacement of thousands of people (Devkota and van Teijlingen 2010). Similarly, in rural areas, thousands of health services were destroyed with many health workers also mistreated and killed (Devkota and van Teijlingen 2010). In 2015, Nepal also suffered from a severe earthquake, which led to over 9,000 deaths, thousands of injuries and destroyed many villages and heritage sites (Regmi et al. 2015). Since then, Nepal has been struggling to maintain political and economic balance and has been identified as one of the poorest lower middle-income countries in the world, especially compared to neighbouring countries India and China (Central Intelligence Agency 2018). These continuous changes such as civil war, natural disaster and political imbalance has harmed Nepal's economic and health status, with the poorest suffering the most both economically and health wise.

The life expectancy for women is 72 years and for men is 69 years, basic literacy rates (self-reported ability to read and write) are for female 60% and 79% for males and male to female ratio is 84.5% (i.e., 84.5 males per 100 females). The total gross domestic product (GDP) is 31.04 billion (USD) in 2020/21 and the total health sector budget was 2.87% of total budget (Ministry of Health and Population 2020). Nepal is about half as poor per head of the population as its neighbouring India (Central Intelligence Agency 2018).

The research was conducted in the district of Makwanpur, one of the 77 districts of Nepal. Makwanpur is located in the central part of the country. A map of Nepal

showing the district of Makwanpur is presented in the Figure 1.1. The survey with healthcare workers was conducted throughout the district. Research areas have been marked with a '+ 'symbol where qualitative research was conducted.

Figure 1-1: A Map of Makwanpur District



SN	Municipality/ VC	Population
1	Hetaunda Sub-Metropolitan	152,875
2	Thaha Municipality	41,623
	Gaun Palika (Rural Municipal):	
3	Indra Sarobar	17,585
4	Kailash	23,922
5	Bakaiya	39,620
6	Bagmati	30,495
7	Bhimphedi	23,344
8	Makawanpur Gadhi	25,322
9	Manahari	38,399
10	Raksirang	26,192
	Total of District	419,377

Adopted from (The Kathmandu Post 2017)

The district falls under Bagmati province and the headquarter of the state is Hetauda, which is about 55 miles (driving distance) east from Kathmandu. The total population of the district is 420,477 (Office for National Statistics 2021b) and the representation of Dalits is low compared to other districts; only 3% have been officially identified as Dalits (District Coordination Committee Office Makwanpur 2020). The largest ethnic group in this area is Tamang caste of Tibeto–Burman origin, and 90% of them are Buddhist (Morrison et al. 2014). According to statistics presented by the Underprivileged Community Development Forum (UCDF), Dalits in Makwanpur lag behind in every sector including education, health, politics and government jobs

compared to places like the capital city, Kathmandu where the status of Dalits is notably better (The Himalayan 2007).

1.3 Discrimination

Both racism and discrimination are deeply rooted in economic, political and socio-cultural perspectives, limiting individuals' access to and use of healthcare services (Williams and Mohammed 2009). Discrimination has been identified as the limited opportunity provided to discriminated groups or individuals to actively engage economically, politically and socially in society (Desai 1976; Desai and Kulkarni 2008). It may be reflected in lower wages, employment levels, and/or education levels, resulting in a more limited access to basic human and societal needs such as food, shelter, clothing and health services. Similarly, discrimination causes poverty and acts as a barrier to reducing poverty. Political discrimination can be identified by limited access to voting, restricted participation in political processes, not being taken seriously or limited involvement in the decision-making process. Social discrimination occurs due to unfair treatment based on cultural values and norms or societal beliefs for certain groups through restrictions on social events and limiting access to public places (Salter et al. 2018).

Discrimination occurs due to the unfair and prejudicial behaviours towards individuals and groups based on their characteristics such as age, sex, gender, race or ethnicity. These groups are often classified as outsiders, low class or outcasts within a society or country (Tunga 2009). Various social determinants act as barriers to discriminated people, hindering them from fulfilling their potential in life (Laurencin 2014). Further information related to discrimination is presented in Chapter 2.

Better health and wellbeing is a basic human right around the world (United Nations 2015). However these primary rights have been eroded due to discrimination (Bailey et al. 2016). For example, discrimination leads to inequal access to quality education, income, food, housing, and other environmental and social determinants, including

health. Thus, it also leads to a significant decline in the health status of communities (Bailey et al. 2016).

Discrimination related to race and caste/ethnicity in healthcare is evidenced to be increasing worldwide, and therefore has been considered a key determinant of the quality received in healthcare services (Gold 2014). '*The Sprit Level: Why More Equal Societies Almost Always Do Better*', presents the interconnection of health and equity, and concludes that discrimination is dangerous to health (Wilkinson and Pickett 2009). Furthermore, people who are discriminated against are prone to poorer healthcare, with a positive correlation between higher levels of discrimination and lower standards of care, lower life expectancy, lower birth weight, higher infant mortality and depression rates (Laurencin 2014).

Discrimination pervades the healthcare system due to the lack of health information, access to resources, implementation and policing of legislation and policies to reduce discrimination (Human Rights Watch 2013). This has clear negative consequences for both health service users and health workers (Biggers 2020). However, practice of discrimination is not a unique issue to Nepal. Notable examples include exploitation of the African slaves by Europeans, blacks in former apartheid states of southern

Africa, and Russia's Jews who are confined to the Pale of Settlement. Even western history is littered with such unethical acts, with some still practiced in modern-day societies (Simon and Thorat 2020). Racism and discrimination are key contributing factors towards increasing disparities in both physical and mental health among discriminated groups (Okazaki 2009). Furthermore, 'The Black Lives Matter' campaign has highlighted structural and hidden racism and discrimination in the USA (Hardeman et al. 2016) and elsewhere including the UK. Racism against black communities has resulted in poor health outcomes as demonstrated by many health and wellbeing measures such as life expectancy, maternal mortality rates and disease prevalence (Leitch et al. 2021). A UK report identified that discrimination and social

inequality may have contributed to higher death rates among Black and Asian people due to COVID-19 (coronavirus disease) (Iacobucci 2020).

In recent years, Nepal has undergone several changes from a monarchy to federal government, earthquakes, and continued political instability (Hutt 2020). The latter refers to political parties changing over a fairly short period of time due to conflicts between various parties or an inability to govern. All this has worsened the situation in terms of disproportionately limited availability of health services to people who are marginalised, including Dalits (Upreti 2010). For example, the number of Ministry of Health & Population (MoHP) offices has decreased from 111 to 106, and Department of Health services (DoHS) offices have decreased from 196 to 121 without planning and implementation. This has resulted in reduced services, control and effectiveness of remaining services (Ministry of Health and Population 2019), therefore Nepal's healthcare system has struggled to meet health demands of the people (Adhikari et al. 2022). Research has identified that this reduced availability of healthcare and services is usually not effective enough to reach the local level, especially in terms of providing health services and management within rural areas (Görgen et al. 2004; Adhikari et al. 2022).

Research has identified that different caste/ethnic communities in Nepal such as Dalits as well as *Adivasis* (Indigenous people) experience increased levels of discrimination, poverty and lower-quality education (Ramaiah 1998; George 2015b; Devkota and Butler 2016; Subedi 2022). Similarly, a recent study in Nepal on caste-based discrimination identified 205 different kinds of existing practices such as untouchability, forced labour, and social boycotting within eight distinct research sites in Nepal (International Dalit Solidarity Network 2016). Researchers view caste as a key determinant of social exclusion and development which, they argue, affects more than 260 million individuals globally (Mosse 2018).

As stated above, sources of discrimination can be linked to various social determinants such as age, gender, ethnicity, economic conditions and education (Morone 2017).

However, in the context of Nepal, little is known about the experiences of caste inequality – especially within the healthcare sector - and how it may act as a barrier to better healthcare. The purpose of this research, therefore, is to investigate healthcare inequality due to caste-based discrimination, with a particular focus on those who lie at the bottom of caste hierarchy: the Dalits (see Chapter 3).

1.4 The caste system

In order to have a better understanding of Dalits and their health experiences, it is important to understand the caste system. The existence of the caste system is centuries old and functions by sorting members of the population into hierarchical factions from birth. It is a scaling system based on 'purity' (Aigner and Cain 1977). Purity is a moral judgement about people and families, such that some are perceived to be 'better' than others. Those who are perceived to be better (i.e. pure), cannot be physically touched by people of lower purity, resulting in the practice of untouchability (Michael 2007). The caste system operates by restricting social interaction, occupation, education, and health opportunities for lower caste groups. This results in a large gap between castes (Aigner and Cain 1977). The caste, known as the '*varna'* system, is the core foundation of Hinduism which controls the interaction of specific groups and individuals. Additionally, the caste system also labels the status of individuals in society based on their prosperity, land holdings, profession, and occupation (Bhattachan et al. 2009). Although the concept of the caste system is core to Hinduism it is also found in other religious groups. Caste discrepancies can be identified within Christianity, Islam and Sikhism in the South Asian diaspora, despite a lack of scriptural support for caste (Waughray 2008). There are number of key caste indicators including occupation, surname, village from which family comes from, religion, skin colour (darker compared to other castes) and nose structure (Sebring 1969).

The caste system is an integral aspect of Hinduism, which is common in South Asia and mostly dominant in Nepal and India. In Nepal, King Jayasthiti Malla introduced a caste system in the 13th century, whereas Jung Bahadur Rana, former prime minister

further formalised the system through the *Muluki Ain* (Civil Code) in 1884 (Pyakurel 2007). It is identified as one of the strictest social stratification systems, where there is no flexibility in terms of changing one's caste, or moving between castes.

The caste system includes both endogamy (preserving castes and preventing caste fusion such as inter-caste marriage) and commensality (social interaction associated with inter-dining between castes) practices. The system refers to the hierarchical separation of society based upon four categories in Hindu mythology known as *varnas,* which in turn are based on social purposes or occupation, and at the empirical level, the concept of *Jati* (subcaste) (Waughray 2008). In the Hindu caste system, there are divisions (see Editorial, Section 1.7) or *varna,* namely, 'Brahmin', (priests, created from God's head) 'Kshatriya', (warriors, from God's arm) 'Vaishya', (merchants, from God's thighs) and 'Sudra', (slaves, from God's feet). Those outside of this caste system are the outcasted groups, (*atisudra, avarnas*) the Dalits.

Dalits are identified as "Protestant Hindus" and "Broken men" in Hindu scriptures and are often referred as chandalas, avarnas, atishudras, panchamas, antyavasan and antayas. They were referred to "untouchables", in the sense of physical contact (see Section 1.7) and "depressed class" by the British, and "scheduled castes" in the constitution of India (Menon and Contractor 2017). Dalit is a Sanskrit word that means divided or separated. The label of Dalit is determined by birth, and one cannot move between castes. Hence inter-caste marriage is a major challenge, however it may elevate Dalit/lower caste women and their children to upper caste as children in Nepal/ India get their identity from their fathers instead of their mothers (Soutik 2019).

The term Dalit is accepted by most Dalits and their leaders and refers to both the individual and a collective community. In traditional rural areas Dalits are often not welcomed in the village of upper caste groups and are restricted from many occupations. As such, they are forced to depend on unskilled labour such as removing dead animals from the community, street sweeping, garbage and drainage cleaning for their daily earnings (Ramaiah 1998). In many rural areas of Nepal and India, Dalits

are often not allowed to use public wells, enter schools, or walk on common roads. In many cases, they are even prohibited from eating decent food, owning property/land, or collecting any kind of wealth (Menon and Contractor 2017).

Legislation in Nepal outlawed the caste system since 1962 and recently passed a bill on Caste-based Discrimination and Untouchability (Offence and Punishment) Act, 2011, in an effort to eliminate discriminatory practices (see Section 2.8). The legislation bans any discrimination and/or different treatment towards "untouchables" and offers harsher punishments for officials guilty of discrimination. Thus, caste-based discrimination is defined as a criminal activity and victims are offered compensation (United Nations 2011).

Since 1990 the constitution of Nepal Right to Equality Act (1990) has forbidden any kind of caste-based discrimination, especially against Dalits:

> No discrimination shall be made against any citizen in the application of general laws on grounds of religion (dharma), race (varna), sex (Ilinga), caste (jat), tribe (jati) or ideological conviction (vaicarik) or any of these.
>
> No person shall, on the basis of caste, be discriminated against as untouchable, be denied access to any public place, or be deprived of the use of public utilities. Any contravention of this provision shall be punishable by law (Himalaya 1990).

The caste and gender-based systems are perhaps the world's longest surviving social stratification systems, older than, for example, the class-based system. The older the tradition, the more difficult it becomes for change to occur because the practice is so deeply ingrained into a culture that is passed down from one generation to another. Additionally, the system is hidden within society (Human Rights Watch 2013). Therefore, despite a well-established *official* end to the caste system, Dalits still face

extreme discrimination; they are deprived from better education, employment and health services (Baru et al. 2010). This PhD research is predominantly focused on caste aspects of discrimination as this is more specific to Asia. It is also a unique concept and therefore requires more attention. Moreover, gender aspects such as double discrimination towards Dalit women is also acknowledged.

1.4.1 Dalits among Dalits- Dalit Women

This section is presented in addition to the editorial (Thapa et al. 2018), included in Section 1.7. This editorial is in an Open Access academic journal and was published during the early stages of the PhD journey, therefore the current section is both an addition and an update.

Dalit women are situated at the very bottom of the community and suffer triple discrimination based on caste, class, and gender. The caste system declares Dalit women to be automatically impure and untouchable; one of the main reasons behind social discrimination and exploitation (Navsarjan Trust India et al. 2013). Caste discrimination provides no protection against Dalit violence and the majority of them are characterised by gendered untouchability practices in the name of discipline. Waughray (2008) argued earlier that, due to the dual-headed prong of gender and caste, Dalit women and girls are deliberately targeted; they are raped and subjected to sexual torture and violence.

The majority of Dalit women in India and Nepal are poorly educated compared to their non-Dalit counterparts and are paid less compared to men. This often results in them becoming landless labourers or scavengers, with many forced into prostitution (Human Rights Watch 1999; Navsarjan Trust India et al. 2013; Sharma Gautam and Hearn 2019). Dalit women are particularly vulnerable due to the nature of their livelihoods, such as exposure to the community in search of water, food, firewood or wages (Waughray 2008). Similarly, in India, Dalit women were not allowed to cover their breasts (covering breasts meant paying a breast tax). The wearing of gold or silver

is prohibited – Dalit women are obligated to wear coarse cotton clothes. Although the system of paying breast tax is now abolished, this culture still necessitates social reform (Menon and Contractor 2017).

In a predominantly Hindu country such as Nepal, Dalit women and children often experience higher economic, cultural, physical and psychological violence (Devkota et al. 2017). In January 2011 the Universal Periodic Review (UPR) reported on the conditions of Dalits in all parts of Nepal; they found Dalits to be vulnerable and concluded that Nepal did not adhere to international human rights, particularly those that concerned women and children (Sob 2012). Dalit women in Nepal often have no power over resources such as money, land or housing, and are disproportionally trafficked to India for sex work (International Dalit Solidarity Network 2020). The majority of Dalits (80%) live in rural areas, hence, many of Dalits are unable to send their children to school due to geographical and economic limitations. A report from UNICEF (the United Nations Children's Fund) in 2016 identified that the average school non-attendance rate in most lower caste communities exceeded 30%, compared to a 14.3% school non-attendance rate in upper caste communities (UNICEF 2016). Though primary education is free of charge in Nepal, there are costs to secondary state school education. More significantly however, children of Dalits may be kept out of school to work or look after siblings (Zmarzly 2019). Dalit women often marry young - around 52% marry before the age of 18, therefore discontinuing their education prematurely. The globally accepted minimum age for marriage is 18 (UNICEF 2020), however, Nepal's Criminal (Code) Act (2017) strongly prohibits marriage under the age of 20 (Government of Nepal 2016). Dalit women are at higher risk of child marriage. Compared to those of higher castes, Dalit women are 52% less likely to wait beyond the age of 20 to get married (Baral 2019). Higher counts of child marriage and related health consequences often leads to higher illiteracy rates and an inability to become independent/support one's family (Navsarjan Trust India et al. 2013). In addition, Dalit women who try to better their situation or disregard the caste system in any sense often bear the brunt when it comes to acts of vengeance against Dalit

communities (International Dalit Solidarity Network 2016). There are cases of Dalit women in India being sexually assaulted and mutilated before they are massacred. They are often arrested, beaten and tortured during raids, raped in custody in order to teach lessons to their relatives, forced into prostitution following devadasi culture and used as a tool to impose political power and control Dalit movements (Human Rights Watch 1999).

Generally recognised the life expectancy of Dalits is lower than that of the general population (Kumari and Mohanty 2020). Having searched extensively for life expectancy data in Nepal, it does not seem to be routinely collected nor are population data analysed by caste. However, a recent study in neighbouring India found lower life expectancy among Dalits (Gellner 2022), it is highly likely the same pattern exists in Nepal. Dalit women also lie at the very bottom of most social indicators in Nepal, scoring 45.4% on literacy (basic reading and writing) compared 57.5% for the average female; they have an average life expectancy of 50 (55 for non-Dalit women) and lower participation rates in both the health and political sectors (Ministry of Health & Population 2011). The current political revolution (see Section 1.2) has made changes and included Dalit inclusion policies, such as 'at least two out of the four members of each Ward Committee must be women and that one should be a female member from the Dalit community'. However, Dalits are still excluded (Bishwakarma 2017). As a result of discrimination, education and poverty, young Dalit girls are more vulnerable to poor health due to malnutrition, infant mortality and even diseases that are easily preventable. A Dalit woman's access to legal rights and justice is compromised due to purposeful neglect (e.g., police refusing to file a case). Thus, very few cases are registered officially, and if a case makes it into the legal system, the chances of getting justice are minimal. (Navsarjan Trust India et al. 2013).

1.5 Personal background

It is important for the reader to understand who I am and what motivated me to conduct this PhD study. I (the researcher) am a Nepali woman originally from the study area:

Makwanpur district. I can speak and understand the Nepali language spoken in the research area and am familiar with the locals and area itself – which was one of the reasons behind selecting Makwanpur to conduct the research. My familiarity with the place and people offered an advantage, as being an insider is considered helpful in gaining trust and access within the community of research (Ryan et al. 2011). Being a Nepali and a woman presented added benefits to being an insider such as better access to participants and their overall acceptance of me. It was easier to connect with female participants. However, I am from a different caste than the target study population. This will allow me to discover something new by exploring issues those are hidden to insider due to preconception. As an outsider, it is required to maintain respect and an open attitude towards the study and population. Similarly, being an outsider may delay the establishment of trust due to a lack of cultural understanding alongside the time-consuming aspect of getting to understand participants' experience and attitudes (Dwyer and Buckle 2009). Therefore, to establish trust, participants were informed that the researcher was from the local community. Furthermore, the importance of participant responses and experiences (i.e., the fact that the findings of the research were based upon them) was explained beforehand. It is important to explain the purpose of the research, its possible benefits to the participants, presenting oneself as an individual student researcher, and involving local individual(s) to collect participants, especially for FGDs (Ryan et al. 2011). Without such procedures, participants may not be as expressive or comfortable in sharing their experiences. The research and its purpose were clearly explained to participants. It was also highlighted that participation was voluntary, and that privacy and confidentiality would be maintained.

I always wanted to focus my career (both academically and professionally) towards issues related to vulnerable communities, particularly due to the hardship they have had to endure till date, and their endless battles for equality and human rights. Hence, after completing my MBA (Master's in Business Administration), I started working with organisations that supported groups of people living with disabilities in the UK.

A couple of years of experience in this sector helped me to better understand issues related to the health and wellbeing of vulnerable groups, and the challenges that many experiences in accessing health services. This boosted my confidence to conduct research related to health and prompted me to focus on one of the most vulnerable and marginalised groups of Nepal, the Dalits.

1.6 Overview of thesis

This PhD thesis consists of ten chapters plus references and appendices. The first chapter, 'Introduction', provides a background to the study including topics such as discrimination-related issues, the caste system (and discrimination related to it), as well as the health aspects of discrimination. Furthermore, it shares Nepal's demography and profile, an introduction to the author, her experiences, and the choice of research. The introduction chapter also offers an overview of the thesis.

The second chapter, 'Literature review', presents an overview of the current evidence of inequality in healthcare at a national and international level, focusing on caste discrimination. The literature provides evidence of Dalit health outcomes and severity in Nepal. Furthermore, the literature also highlights the need to conduct this research study in Nepal based on gaps in the evidence pertaining to research, policy and practices.

The third chapter, 'Aim and objectives', presents the rationale of the study that triggers the aims and objectives of this PhD study. The main aim of this research is to investigate caste-based inequality in the healthcare sector, particularly focusing on those at the bottom of the caste hierarchy, the Dalits. Specific research objectives and research questions are also presented.

The fourth chapter, 'Systematic review', reports findings of the systematic review published in May 2021. This review explores possible factors that underlie caste-based discrimination and trends in discrimination and inequity over time. This review

identifies the uptake of health services by Dalits and presents the gap between health service utilisation of Dalits and higher castes in South Asia. As this expose evidence not identified by previous research in this area, it highlights the need to undertake this study in this field.

Chapter five, 'Methodology and methods', discusses the theoretical underpinning of this study and the different methods used for the study, including experience of data translation, transcription and analysis of data. This chapter justifies the need for and application of mixed (qualitative and quantitative) research approaches by providing supporting examples of research conducted in health inequality related issues. Furthermore, the chapter describes the researcher's experiences and issues encountered during the research project and how these were addressed. This section also addresses the quality assurance for this study. Finally, the key ethical issues related to the study are discussed.

The sixth chapter, 'Qualitative findings', reports key findings from focus group discussions, key stakeholder interviews and exit interviews. This chapter discusses the Dalits' experience of health; the challenges accessing their health, health conditions, available health services, and policies to reduce health challenges. Findings are discussed under themes: untouchability and discrimination, other social determinants and healthcare including fourteen other subthemes from qualitative data analysis.

Chapter seven, 'Quantitative findings', includes demographic and socio-economic characteristics of the survey participants (healthcare professionals) as well as major findings from the survey; status of current health services, health discrimination, gap in health utilisation, attitudes and practices of health workers and views on how to improve Dalits' health. The outcome of this chapter is based on the responses of survey respondents.

Chapter eight, 'Discussions', discusses the findings from qualitative and quantitative data analysis, and its interpretations in light of existing literature. Four main key areas

are discussed in this chapter: (1) social discrimination and its health impacts, (2) roles of other social determinants alongside caste, (3) status of health and resources, and (4) public health programmes. Finally, this section also includes reflections from a researcher role followed by research limitations and strengths.

Chapter nine, 'Conclusion', draws the key conclusion of this thesis, 'Caste-based healthcare inequality in Dalit communities in Makwanpur, Nepal', based on the key findings and further discussion from Chapter eight. This chapter summarises the conclusion under four headings: (1) discrimination in society, (2) social determinants as a key barrier to better health, (3) poor health status, and (4) lack of public health programmes.

The final chapter, (Chapter Ten) 'Recommendations', offers key recommendations for further research, policy makers, training and education and health workers.

This study highlights the gap in Dalits' health usage and has increased our knowledge of the overall Dalit experience regarding communities, health status and the challenges they face. It is hoped that the analysis and findings from this research will prove helpful, especially for policy makers.

At the end of this thesis all the appendices included in the thesis are listed: participant agreement form for Qualitative Assessment, participant information sheet for FGDs, discussion guide for FGDs, participant information sheet for Key Stakeholders Interview, questions guide for Key Stakeholders Interview, information sheet for Exit Interview, questions guide for Exit Interview, questionnaire for Quantitative Survey, permission for research – Makwanpurgadhi, permission for research – Manahari, permission for research – Hetauda, participant information sheet for Survey, ethical approval letter from BU, ethical approval letter from NHRC and research permission in the Makwanpur district.

1.7 Editorial Paper

This section presents the second part of Chapter 1. This editorial ‘Uptake of Health Services by People from the Dalit Community’ (Thapa et al. 2018), was published in the *Journal of BP Koirala Institute of Health Sciences* on 20th December 2018.

Editorial

Uptake of Health Services by People from the Dalit Community

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Abstract

Studies and reports on uptake of health services in Nepal and other low-income countries often focus on limitations due to physical factors, such as travel distance to health facility, or lack of medical facilities or electricity at the health care centre or focus on resources, such as lack of service providers, or lack of appropriately trained staff.

In this editorial article, we highlight the importance of discrimination as a reason for people not seeking available health care. Discrimination is particularly a barrier to service usage among the most deprived people in society, such as the *Dalit* community in Nepal and South Asia more generally. We discuss the caste-based discrimination in Nepal and its effects on health outcomes of those groups who experience such discrimination.

Introduction

Discrimination and racism are deeply rooted in socio-cultural, political and economic perspectives affecting individuals' access to health services and their utilization.[1] Discrimination leads to imbalanced access to quality health services, education, food, income, housing and politics. This is not a problem unique to Nepal; in the USA (United States of America), 'The Black Lives Matter' campaign illustrates the need to address deep-rooted, structural and hidden racism and discrimination.[2]

The two terms health and equity are interconnected. *'The Spirit Level: Why More Equal Societies Almost Always Do Better'*, identifies that discrimination is exclusively unhealthy. Across the globe, higher rates of discrimination are linked with poor health outcomes such as lower life expectancy, lower birth weight, higher infant mortality rate and higher level of depression rates.[3]

Discrimination leads to a significant reduction of health status. Discrimination includes various factors such as education, work, income, poor housing, and other social and environmental determinants.[4]

The key objective of healthcare is to support individuals in accomplishing the best attainable health outcome while maintaining quality of life and allowing individuals to take their equitable position in community.[5] Even though equality is fundamental principle, i.e. a Human Rights Obligation, inequalities in health care sector are still extensive and take many forms. In accessing health facilities, disparity based on an individual's *age, gender, ethnicity* and *economic status* remains a huge barrier blocking individuals to achieve the highest achievable standard of health. This has thus, resulted in poor health standard and prevents the efforts to achieve healthy lives for all.[6]

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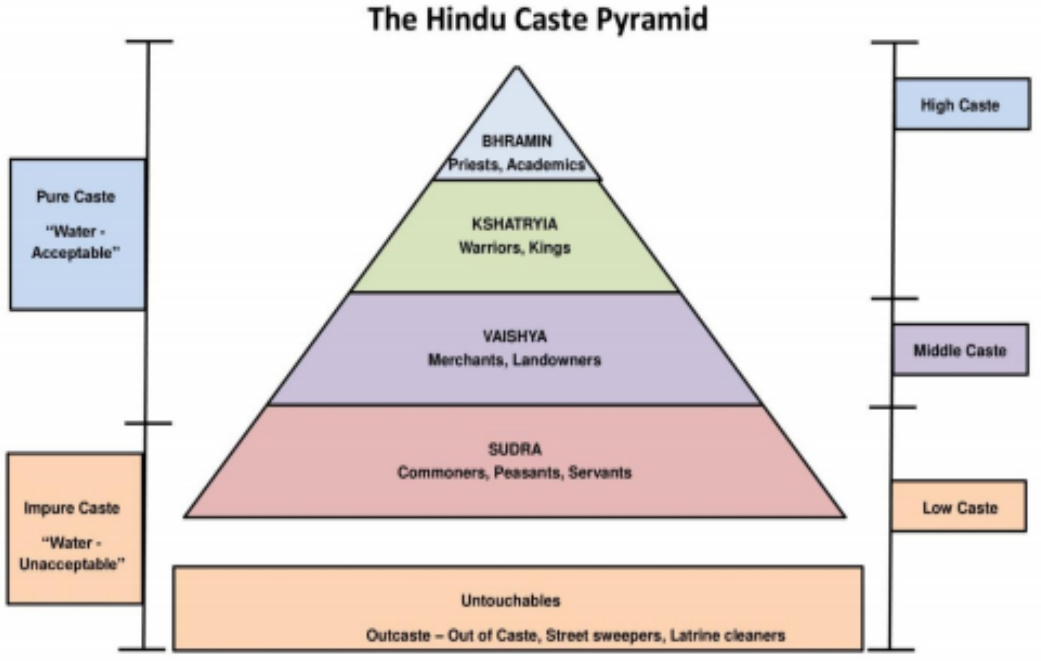
As mentioned above, sources of discrimination can be related to various social determinants, but the purpose of this paper is to focus particularly on health discrimination due to caste-based disparities. The paper examines the ongoing caste discrimination in Nepal and its effects on health outcomes of discriminated groups. In the current review, the consequences of caste disparities in the health sector will be assessed.

The Caste System and Discrimination

The caste system, one of the oldest ongoing social hierarchies in Nepal as well as in India, is almost over 3000 years old. In Hindu society, caste or 'Varna' system is its core foundation where each individual and group interact with each other in prescribed ways. In the Hindu caste system, there are four division of caste namely: 'Brahmins', priests; 'Kshetriyas', warriors; 'Vaishyas', merchants and 'Sudras' (untouchables) servants.[7]

Caste-based discrimination is a highly sensitive and politicized issue in Asia, especially in Hindu countries. Despite constitutional rights and regulations to safeguard minority groups, their primary rights have been continuously invaded.

"*Dalit*" is one of the highly discriminated outcaste minority group. These groups remains at the very bottom of caste hierarchy and are also referred as *water polluting, untouchable*, *doom*, *pariganit, tallo jat.*[8] The word '*Dalit*' is widely recognized term around the world. *Dalit* movement leaders have also emphasized the importance of accepting the term '*Dalit*'. The concept behind this is to represent the condition characterized by caste-based discrimination.[7]



(Adopted: https://detechter.com/9-myths-about-hinduism-that-most-people-in-the-west-still-believe)

Whilst a diverse group, the *Dalit* community is easily distinguishable through their name, origin, education, profession, father's profession, outfit and language. *Dalits* are segregated from the members of upper castes forbidden from touching upper caste members and their belongings. They are also prohibited to enter and/or use public properties, shops, hotels, restaurants and temples. They are even made to use separate utensils in public restaurants.[9] Discriminatory practices in schools and educational institutes are common. In any festivals and weddings social interactions of *Dalits* are very limited. They are only likely to perform ritual purposes such as washing, drum beating, skinning of dead animals and removing human excrement.[10] These professions directly effect on individuals' health due to direct exposure to disease.

Across South Asia, there are similar practices of discrimination. However, in some countries, regions and states where caste effects are high, the situation of *Dalits* are different for historical and political reasons.[11] *Dalit* groups are often still living in rural areas of countries in isolated habitations and are restricted to enter in upper caste areas. The study by Action Aid in Nepal on discrimination based on caste, identified 205 forms of caste discrimination in their eight sample sites. These 205 practices of discriminations (in Table 1) are related to different fields as follows.[12]

Table 1: Forms of caste discrimination in Nepal (n= 205)

Practices of Discrimination
Related to denial including: 14 to services, 10 to entry related, 10 to kinship and other relationships, 14 to participation and 6 related to access to public resources
Related to discriminatory and forced labour
Related to authority
Linked to attitudinal untouchability
Vicious behaviour
Social boycott
Related to various areas including: 11 to educational institutions, 18 to occupation, 14 government policy and program, 10 to political rights, 7 to NGO and government offices, 13 donors and development programs, 8 to cultural and other religious activities

Restrictions and exclusions on *Dalit* do not end here, it involves food, whether dining together or serving food cooked by a *Dalit*, ownership of land, prohibition on accessing certain kind of jobs and other different segregation practices resulting exclusion from society and economy. Due to barriers on accessing better jobs, the majority of *Dalit*s belongs to the poorest communities who also suffer from food deficiency. They fall into the bottom level of development statistics.[13] Most people in Nepal have access to basic health services, but they end up paying for many drugs, travel to health centres and using private facilities. Therefore, this impacts on *Dalits'* ability to pay for health services.

Despite decades of the old system for "schedule castes" and "schedule tribes" in education, health, profession, political grounds to secure *Dalit* rights; it does not habitually lead to equal opportunity, access to healthcare and labour market. Therefore, only a very minimal percentage of the professional work force

consists of individuals from *Dalit* communities.[14]

There is a gender aspect to caste discrimination. Gender discrimination exists in societies especially in *Dalit* communities and has been ignored from a long time. However, the focus on gender discrimination is growing.[15] In many countries, women receive lower priority, less support and health care compared to males. One of the highly vulnerable groups among *Dalit* is *Dalit* women, also known as '*Dalit*s among *Dalit*'. In Nepal, women are the ones who perform a lot of day-to-day activities. *Dalit* women have to face discrimination in their daily life while fetching water, buying groceries, visiting temples and taking their children to school. Their position in the community makes them vulnerable to verbal and physical exploitation, slavery and forced labour, kidnapping, human trafficking, naked parading, rape, pulling out hair and nails and other sexual violence.[16] Evidence of extensive violence, exploitation and indecent, inhumane behaviour has been identified in many studies on *Dalit* women which has direct effect in their physical and mental health.[17]

This double discrimination in Nepal has also affected the education sector resulting in low literacy rates of *Dalit* women; literacy rates are 33.8% in *Dalit* women and 54% in all Nepali women. It also has a great impact on life expectancy, national female average is 59 years compared to *Dalit* women's' 50.8 years.[18] In Nepal, *Dalit* women have low levels of empowerment as highlighted in inclusion index of World Bank/ DFID. Education and health go hand to hand and can create better opportunity for sound health as educated people are more likely to understand their health needs, communicate with health providers and follow instruction.[19]

The Way Forward

Many researchers have identified wide-spread caste-based discrimination in the health sector; therefore, precise and disaggregated data on of *Dalit* men, women and children are in high demand. The Government of Nepal and other social planners have given distinctive attention in shortening the gap in education, health and income differences based on social status.

This issue is being addressed at an international level, for example: United Nations' Sustainable Development Goals (SDGs). The adoption of these goals would help to improve the lives of many in society, especially *Dalit*s. It would not be possible to achieve its goal 3 ensuring Healthy Lives and Promote Well-Being for All At All Ages without dealing with caste-based discrimination in health care. The gender aspects of caste-based discrimination would be another barrier in achieving another goal 5 achieving gender equality and empower all women and girls.[20] It will also endanger its primary goal of no poverty and hunger. Nepal is a signatory country of SDG declaration, ranking third in South Asia SDGs performance index.[21] As such, Nepal should focus more in converting its SDGs into reality to maintain as well as to improve its position of performance index.

Nepal has been changing rapidly, since the fall of the monarchy and becoming a new republic in 2008. Its revolutionary changes are a sign of new beginning for *Dalit* community. The present constitution facilitates new opportunities and possibilities for safeguarding *Dalit*s' rights, including reserving seats for backward castes in education, parliament, public sector and civil services. As a result, some practices of

discrimination seems to have diminished, specially in younger age groups of Nepal.[7]

This paper has identified the need of inclusive and innovative ways of identifying barriers of health supply aspects in delivering adequate, fair and non-discriminatory health service. Another way can be recruiting health professionals from the *Dalit* community in significant positions to reduce caste differences and control the shortfall in health infrastructure to inhibit unavoidable exclusions.

There are some comprehensive health policies in place in Nepal, for example: The National Health Policy 1991; the Second Long-Term Health Policy (1997-2017).[22] However, the gap still remains. Therefore, to empower *Dalits* in Nepal, both government and private agencies should work together in developing and improvising policies to improve the health, education, economic and social status of people from *Dalit* community and cutting out barriers that deprive *Dalits* in utilizing these facilities. Motivating *Dalits* to take social improvement opportunities and allowing them to participate in labour market and other income generating activities.

Conflict of Interest: The authors declare that they have no competing interests.

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1.8 Chapter Summary

This chapter briefly presents Nepal country profile and the research area, Makwanpur district. It introduces discrimination globally and in the context of Nepal and India. It also presents the Hindu caste system, its hold in Nepali communities and how it stimulates social stratification. Further, it describes Dalits' status and effects of caste division, and highlights the discrimination related to it. It also presents Dalit women and their vulnerability. This also provides the basis for the literature review (Chapter 2), which demonstrates evidence of discrimination and policies related to it. Finally, both the personal background of the PhD researcher and an overview of the entire thesis is provided.

Chapter 2 Literature review

2.1 Overview

This chapter presents existing literature on the theoretical evidence of discrimination, exploring why and how discrimination occurs, its implementation and issues related to it, focusing particularly on caste aspects of discrimination. This chapter further reflects the impact of discrimination on health. In terms of the international focus of the United Nations' Sustainable Development Goals (SDGs), this thesis links to several, especially SDGs 1,3,4,5 & 10 (further details see Section 2.7), alongside other government plans and policies. This process was undertaken at the start of the study to shape research aims, objectives and questions, and was refined throughout the study.

2.2 Literature search strategy

The literature review process commenced in 2018 (first year of PhD study) to identify research gaps on caste/ethnic discrimination and assess existing literature related to discrimination and health aspects to develop research aims, objectives and questions. To execute the literature search, the strategy used in the systematic review paper (Thapa et al. 2021) was considered, as most of the relevant papers are included in the systematic review. This chapter supplements the systematic review paper and adds a more theoretical perspective to the concept of discrimination, particularly caste discrimination. The topic of caste discrimination has been researched but is often published locally in reports and non-indexed journals. Some of these papers were found through so-called handsearching.

2.3 Theoretical evidence of discrimination

Discrimination refers to unfavourable behaviours towards an individual on the basis of race, colour, religion, national origin, age, sex, disabilities, gender and ethnicity (Özcan et al. 2011). Discrimination and issues related to it have been a topic of intense

discussion for years. It has been defined as an exclusion of some individuals and groups from obtaining equal education, income, power and treatment (Klasen 1999). The practice of discrimination affects millions of people around the world. It has been known as a tool of operation and exploitation that develops divisions in health, wealth and power (Ataöv 1988).

Although there exist many definitions of discrimination, it's rational acknowledgement is very difficult to understand as it is linked to unethical practices such as unfair and unequal treatment, and those who are involved refuse to accept that. (McGinley 2010). Discrimination is defined by Dinur (2021) based on two aspects: (1) intentional discrimination (discrimination against racial/ethnic minorities, group-based travel and immigration bans, diversity-based policies) and (2) unintentional discrimination (unconscious bias) known as disparate impacts (Dinur 2021). Intentional discrimination refers to differing behaviour based on individual characteristics whereas disparate impact refers to equal treatment based on a given set of rules, but the latter is constructed in a form that favours a member or group (Reskin 1998; Blank et al. 2004).

Intentional discrimination often starts with creating a verbal and non-verbal hostile environment and may lead to unfair treatment such as denial of education, employment opportunities or undermining performance (Talaska et al. 2008). Avoidance is another measure; this takes the form of choosing one's own comfortable group over another outgroup, or choosing not to associate/self-isolate from the outgroup (Pettigrew and Tropp 2013). Similarly, segregation occurs by excluding the outgroup from allocation and access to resources. Examples include the restriction of equal housing, education, employment, and healthcare (O'connor et al. 2001). Segregation can further extend to physical attacks and extermination. Hate crimes are usually linked to the manifestation of overt prejudice and result from perceived pressures to maintain ingroup standards and values (Glaser et al. 2002). Additionally, disparate impacts refer to the phenomena that impact upon and individual's attitude, and the behaviour of in-group members

towards out-groups based on belief and associations that are often unconscious. These forms of discrimination are automatic, indirect, ambivalent and ambiguous (Cuddy et al. 2007).

Dalits experience both types of discrimination; direct discrimination in the form of verbal abuse, non-verbal rejection, physical attacks and untouchability, and indirect discrimination where societies have specified a set of cultural rules and procedures that all must follow, but are still tailored to the benefit of the upper caste group(s) (Blank et al. 2004).

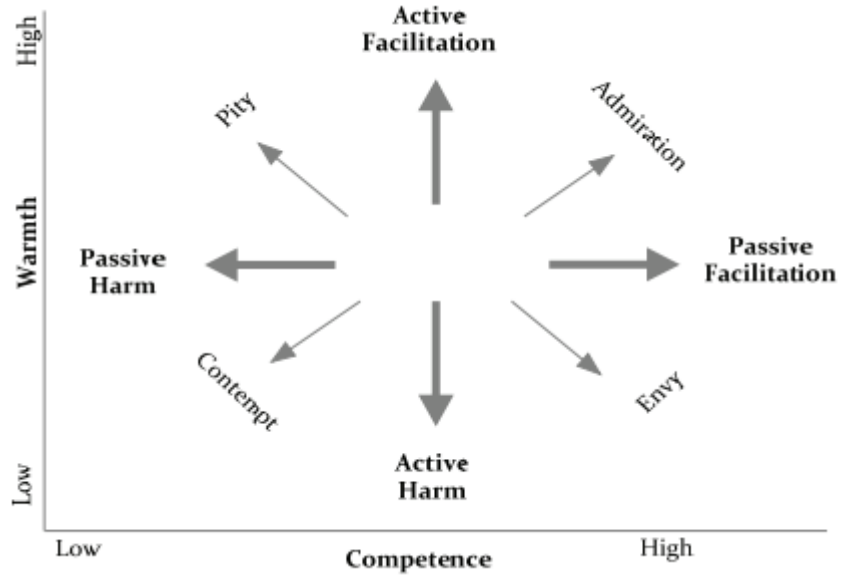
The differences based on one's race, ethnicity, gender or other characteristics persist in society and affect people's individual achievements as well as their health and wellbeing. Discrimination has become a fundamental issue that remains widespread and continues to exacerbate social division (United Nations 2018). In this kind of societal environment, discrimination can grow, thus promoting prejudice and negative stereotypes. Consequently, it may limit equal opportunities and policies, cause psychological health issues through internalised biases and stereotype threats, and encourage explicit and implicit inequality that reduce access to basic resources including healthcare (Williams and Mohammed 2013).

In addition to evident verbal and non-verbal hostility, untouchability, aggressive approach behaviours, limited opportunities and access to equal treatment (Al Ramiah et al. 2010). Across many historical periods, countries, and cultures, systematic inequality between dormant and non-dormant members or groups has been evident; e.g. poor health outcomes experienced by ethnic minorities (Underwood et al. 2004), receiving poor education (Cohen et al. 2006), and getting unequal treatment in the justice system (Steffensmeier and Demuth 2000).

This research focuses on four major theories of discrimination; the social identity perspective, the 'behaviours from intergroup affect and stereotypes' map, adverse racism theory and system justification theory (Al Ramiah et al. 2010). Social identity

perspectives identify that individuals/groups are possessive towards self-esteem to maintain positive and superior social identity which may result in a form of discrimination referred to as intergroup bias (Tajfel 1974). Social Identity Theory examines common processes leading to intergroup discrimination, the BIAS map (Behaviours from Intergroup Affect and Stereotypes) (See Figure 2.1) (Cuddy et al. 2007).

Figure 2-1: The BIAS Map: Behaviours from Intergroup Affect and Stereotypes



Adopted from Cuddy et al. (2007)

The BIAS Map outlines distinct emotions and behavioural tendencies expressed towards discriminated groups. The stereotype model also highlights that minority groups are more likely to experience overactive discrimination, resulting in active harm. This harm also include verbal abuse, bullying and harassing, as well as hate crimes (Cuddy et al. 2007). The theory of aversive racism extends social identity theory and the BIAS map by further recognising when discrimination will be produced or controlled. Examples disregarding someone's presence, avoiding eye contact, excluding opportunities, supporting racism or groups/parties that adopt unequal

agendas. Additionally, one will hesitate to discriminate when right or wrong is clearly understood, however there is a higher chance of discrimination when one can justify their actions, or the behaviour is not clearly understood (Dovidio and Gaertner 2004).

Discrimination on the basis of caste/ethnicity is illegal in Nepal but still flows as cultural capital from generation to generation (Saroha et al. 2008). For example, it can happen on a very personal level such as refusing to sit and eat next to Dalits. System justification theory compliments social identity perspectives by examining why discrimination is perpetuated and tolerated. System justification theory explains that the system based on the drive of the positive social identity perspective of feeling superior is a fair system. This leads to in-group bias and their low status can be deemed as deserving of punishment for their unworthiness (Jost and Burgess 2000).

2.4 Discrimination based on caste

There are many forms of discrimination such as race, sex, gender, ethnicity, age, or disability. However, discrimination based on one's race or ethnic background is a common global issue and has been present throughout history and even continues today. There are similarities between racism and caste-based discrimination in that one group is behaving prejudicially towards another group who are perceived as inferior, such as fair skin being favourable over brown/black skin (Pol 2020). However, caste is different from race. Race refers to the division of people based on physical characteristics, whereas caste is a social division of people based on occupation (Reddy 2005). Similarly, ethnicity categorises a population based on their ancestry, history, language, cultural and nation.

In the context of Nepal, the population is divided into three ethnic groups: Indo-Nepalese, Tibeto-Nepalese and indigenous Nepalese. Indo-Nepalese are considered Indian migrants and occupy Tarai plains, river valleys and fertile lower hills. Tibeto-Nepalese are migrants from Tibet and occupy the higher hills of Nepal. Further, the third group, indigenous Nepalese are a much smaller group that includes tribal and

indigenous communities of Nepal (Levine 1987). The caste system is a hereditary social construct of Hindu religion, endogamy and social hierarchy (see Section 1.4). Despite caste having no physical traits the system is practiced among the people of same ethnic origin, cultural background and nationality (CasteWatchUK 2017). Caste discrimination against Dalits have two major factors: untouchability and unequal treatment. Upper caste groups seek to defend their established status by denying Dalits development and Dalit rights (Saikia 2014).

In a global context, policies against discrimination are more than six decades old, however have been hidden from the International Human Rights Agenda and been acknowledged since 1990s by the former UN Sub-Commission for promotion and protection of Human Rights (Waughray 2008). The caste system (see Section 1.4) creates a social division which labels Dalits as the lowest. This division reinforces social exclusion of Dalits. Social exclusion is a multidimensional phenomenon including, but not limited to, material deprivation and the inability to fully participate in social, cultural, economic, and political life and processes. Poverty, education and health are all important aspects of this dimension (Thomas et al. 2000).

Social exclusion and poverty have a symbiotic relationship in that they strengthen one another. Poverty significantly affect Dalits in comparison to other castes due to a social structure that still obstructs access to job opportunities in the name of caste separated jobs and purity. This therefore affects income inequality and the main caste pay gap (Das 2008). Social status is commensurate with financial power. It has been evident that caste-based occupation plays a significant role in the low mobility of the labour market in India. Dalits' jobs are not respected nor paid equally which contributes to the high poverty rate they experience (Munshi and Rosenzweig 2006). Similarly, in Nepal, some Dalits still work as *Haliya Pratha* (bonded labour) or *Khala Pratha* (forced labour) and do not get any paid at all (Shrestha 2002). It is established that education provides a level of understanding that gives rise to opportunities such as employment and access to health (see Section 6.3.2). However, access of formal

education and interactions with other communities are minimised. For some Dalits (young men in particular), despite having received some level of education , they are unable to direct that education towards landing secure employment (Jeffrey et al. 2004). The harm in health comes not only from material deprivation, but social and psychological problems resulting from living in relative poverty and lack of education as well. In the case of Dalits, 60% of Dalit children in Nepal often suffer from chronic malnutrition (Devkota et al. 2017). Caste - on top of poverty and having less access to education - limits many opportunities in society for Dalits including health services, awareness and knowledge of healthcare and family care, or money towards receiving better health (Nepal National Dalit Social Welfare Organisation 2018).

Caste discrimination is a global issue affecting hundreds of millions of lives around the world (Shrestha 2002). Caste issues, specifically the social exclusion of Dalits, has been a sensitive topic of South Asia including India, Bangladesh, Sri Lanka and Nepal. Similarly, the Osu people of Nigeria, Buraku group of Japan, and certain groups in Mauritania and Senegal also experience caste-based discrimination (Human Rights Watch 2001). Despite being an international issue it is difficult to find caste issues treated alongside race, gender and age in global analyses, such as poverty and inequality (Mosse 2018).

In the context of Asia, illusions of supremacy are mainly related to religion and the caste system. It has been evident that caste/untouchability – and the discrimination related to it - is hugely prevalent in countries like India and Nepal who have a Hindu majority (Jodhka and Shah 2010). This social inequality presented by a birth-based caste system still hinders millions of lower-caste peoples' lives and has survived millennia, so is therefore a challenge to eradicate. (Simon and Thorat 2020). Caste division divides society into two categories, the touchable and untouchables, both of whom are forced to reside in separate colonies (International Dalit Solidarity Network 2009; Ninan 2012). The untouchability has declined on the surface level, at least in

public places. However, upper caste remains separated from lower caste residentially, occupationally and socially, and creates caste invisibility (Waughray 2008).

In the context of India, millions of the population are grouped under marginalised communities including Dalits and Adivasis, who comprise 25% of the total population. These groups are exposed to extreme discrimination, contributing towards higher death rates in comparison to upper caste groups - 61 of every 1000 died in the community compared to 19 of every 1000 for upper caste people in India (Sur 2020). Dalits are still subjected to ever more degrading and unhygienic work and live in constant fear of public humiliation and violence. Almost 90% of all poor populations and 95% of all illiterate populations in India are Dalits (Mayell 2003). According to a report of National Crime Statistics India, crimes against Dalits have increased by 19.4% between 2014 to 2015. Even for minor signs of Dalit resistance, harsh consequences are imposed. For example in India, two small Dalit children were burnt to death due to a dispute with an upper-caste child, a Dalit was killed for having the ringtone of a social reform song, and a Dalit's wrist was cut off for wearing a watch (International Dalit Solidarity Network 2016).

In Nepal, much research on social exclusion, poverty and human development has evidenced the extent of social exclusion of certain groups from household welfare, economic access and political participation (Nepal South Asia Centre and United Nations Development Programme 1998; United Nations 2018). These research studies examined deeply rooted caste, ethnicity, and gender-based discrimination and adverse consequences on education, employment, health and household welfare. Furthermore, these studies identified caste/ethnicity as a significant factor in social exclusion (Nepal South Asia Centre and United Nations Development Programme 1998; Acharya and Subba 2008; United Nations 2018). Similarly, a Nepal Social Inclusion Survey (NSIS 2012) highlighted caste and ethnicity as a major indicator of social exclusion (Gurung et al. 2014). Recent incidents of caste discrimination indicates that caste-based discrimination is still present in Nepal. A 12-year-old Dalit girl was found hanging

from a tree after being raped by different caste man. Similarly five men were killed for attempting to marry a girl from another caste (Human Rights Watch 2020).

Caste-based discrimination and associated poverty may result in difficulties accessing healthcare, and poor health can lead to economic failure, trapping individuals in a vicious cycle of poverty and poor health (Wagstaff 2001). Although studies around the caste system generally includes poverty and education, this research has focused on the health aspects of caste discrimination, the first of its kind in Nepal.

2.5 Impacts of discrimination on health

Discrimination limits individuals' opportunities, affecting their wellbeing, choices and independence. Continuous exposure may result in individuals internalising the stigma and prejudice directed towards them which is expressed in the form of shame, fear, low self-esteem and poor mental health (United Nations 2018). Discriminated groups and vulnerable people have limited access to health resources, poor health status and low life expectancy compared to non-discriminated groups (Scaria 2017). Therefore, despite unprecedent leaps in global wealth and technology, health equity gaps are still growing (World Health Organization 2018a).

The World Health Organization (WHO, 1948) defined health as, 'not only the absence of disease or infirmity but a state of complete physical, mental and social wellbeing'. However, in underdeveloped or marginalised communities, individuals' wellbeing is relentlessly compromised (World Health Organization 1948). For example, a study in the United States (US) identified several consequences of health discrimination including unbalanced prevalence of health lifestyle behaviours, socioeconomic status, education, reduced utilisation of resources and restricted access to health (Shavers et al. 2012).

The determinants of health (Dahlgren and Whitehead 2021) are social and economic rather than exclusively medical. It is globally identified that the poor health outcomes

of lower caste people are due to their social exclusion and extreme social restrictions in accessing income, goods, services, and power (Jacob 2016). Discrimination in terms of health in countries like India and Nepal is grounded in a system that denies certain communities access to health resources due to marginalisation, geographical remoteness, poor health literacy and negligence of service providers. Due to denial of health rights and the integration of better health, the health status of these communities is worsening (Jungari and Bomble 2013).

Evidence suggests strong links between discrimination and health - including mental and physical health (Baru et al. 2010). For example, a meta- analysis (Paradies et al. 2015) of 300 studies on racial discrimination and health identified discrimination as a significant predictor of an individual's mental health. This included higher depression, anxiety, psychological stress and negative mental health outcomes such as low self-esteem, wellbeing, life satisfaction and control (Paradies et al. 2015; Williams et al. 2019). Another meta-analysis of 51 studies in Europe supported growing international evidence of an inverse association between better health across diverse ethnic populations, and discrimination, higher emotional distress and poor wellbeing (de Freitas et al. 2018). Research has also identified that discrimination relates to adverse physical health, such as higher rates of cardiovascular disease and severe obstruction coronary artery disease among black veterans (Ayotte et al. 2012). Furthermore, a review of ten longitudinal studies highlighted a consistent association between discrimination and higher body mass index, and commonness of obesity (Bernardo et al. 2017).

Many incidents such as social exclusion, bullying, harassment and - in extreme cases – hate crimes have recorded evidence of caste discrimination that is affecting individuals' wellbeing, health services and the additional responsibilities of health practitioners. Research in India has acknowledged that one of the most important aspects of social exclusion is caste. An example would be the recent case of a female doctor from India who committed suicide due to caste discrimination and harassment

in her workplace in 2019 (Pol 2020). Similarly, patients being hesitant or refusing to receive health services from Dalit doctors was reported in India (Kishore 2016). As the majority of the lower caste population in Nepal live in rural areas (Ashworth et al. 2019; Sharma Gautam and Hearn 2019), accessing health services is more challenging due to travel distance, health expenses, or the need to earn a living each day such that there is no time to attend health services. Their unhygienic work makes them more prone to health issues. When Dalits do reach out for available healthcare they are often refused or provided limited services (Dyson 2001).

In the context of India, The National Family Health Survey -III (2005-06) described caste aspects in health status in the form of low contraceptive use (55% for schedule caste whereas 62% of non-schedule caste), limited access to maternal and child healthcare (vaccinated 31% of scheduled, compared to other caste coverage 40-54), low antenatal care, reduced institutional deliveries, and limited child immunisation among lower caste groups (Jacob 2016). Another study observed poorer self-reported health outcomes from women of lower caste in comparison to upper caste due to the inter-relation of caste and socio-economic position (Mohindra et al. 2006). Even children from lower caste families have negative health consequences due to caste discrimination. Examples of this include a higher malnutrition and child mortality rate (23.2%) compared of India's overall rate of 18.4% (Jungari and Bomble 2013). Similarly, another study reported high prevalence of preventable disease and death related to gastroenteritis, malaria, tuberculosis, filariasis, measles, whooping cough, tetanus and other skin diseases in lower-caste groups (Balgir 2004).

In Nepal, caste-related discrimination has been identified as a significant indicator of mental health issues. Nepal has been ranked as having the seventh highest global suicide rate in 2014 (World Health Organization 2014). Due to caste disparities and poverty, Dalit communities have considerably greater anxiety (Dalit 50.7%, high caste 20.3%) and depression rates (Dalit 50%, high caste 28.4%) compared to upper caste people (Kohrt et al. 2009). In addition, research in Nepal on several communicable

disease such as Tuberculosis (TB) (World Health Organization 2010b), Human Immunodeficiency Virus (HIV)/ Acquired Immuno-Deficiency Syndrome (AIDS) (Joint United Nations Programme on HIV/AIDS 2005) and leprosy (Heijnders 2004) has demonstrated that these diseases are more prevalent in Dalits. Violence against Dalits is still increasing in numbers and is a major cause behind the health issues. A report stated more than two dozen Dalits have lost their lives for not following caste-based norms since 2011, including many inter-caste marriages. Similarly, during the fiscal year ending in July 2020, 30 crimes related to caste based discrimination were registered with the police in Nepal (Maharjan 2021). Another report documented worse health accessibility and poorer health outcomes such as poor antenatal and maternal care, lower infant mortality, and higher malnutrition (Daniel et al. 2012) among lower caste population in Nepal (Ministry of Health & Population 2011).

It is widely recognised that the connection between health and human rights in the form of caste equality is inextricable, and that such violations can have serious consequences for an individual's health. However, many studies of discrimination have failed to examine the contribution that these social exclusions have towards disparities in health. This research has some aspects of the increasing empirical proof associating experiences of discrimination to health.

2.6 Nepal's Health System

Nepal is continuously working towards developing a comprehensive health system. This is promoted through a comprehensive framework of health plans, policies and strategies, including the National Health Policy (1991), the Ninth Five Year Health Plan (1997-2002), the Second Long-Term Health Plan (1997-2017), the strategic analysis to operationalise the second long-term health plan, the Medium-Term Expenditure Framework, Nepal Health Sector Programme - Implementation Plan 2003-2007, The Tenth Plan (Poverty Reduction Strategy Plan) 2002-2007, Health Sector Strategy- An Agenda for Reform 2004 and recent three-year health plan (World Health Organization 2007). Further, the National Health Policy 2017, has stated that

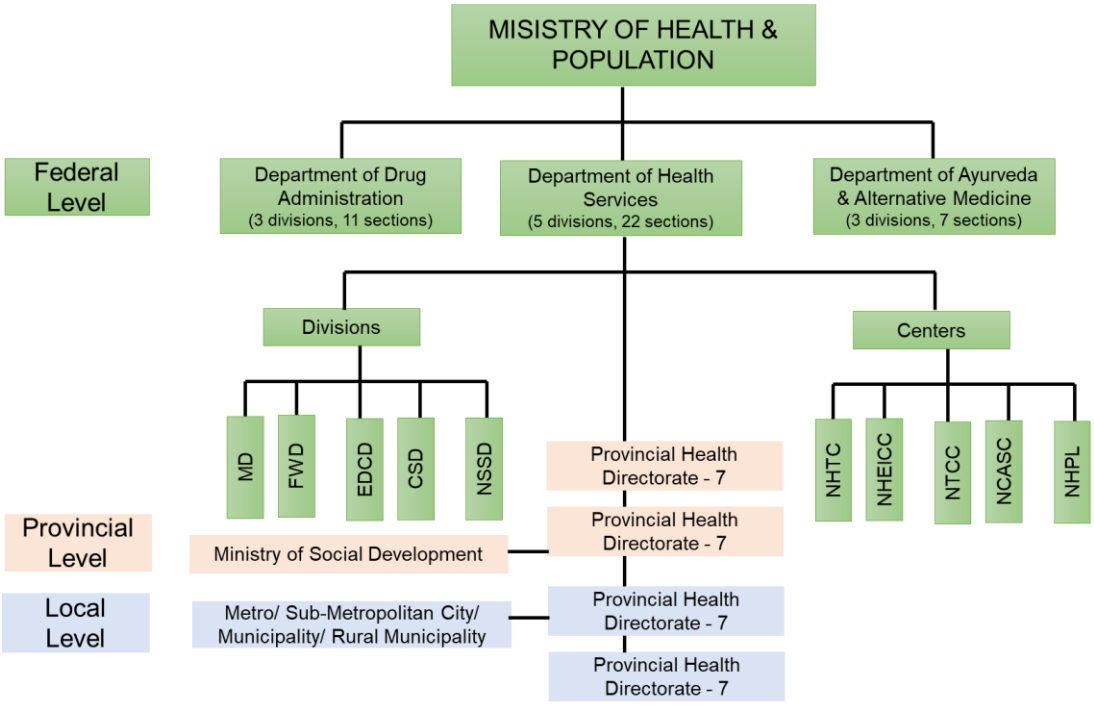
its goal is to provide equitable and accountable health services along with increased access for every individual to quality health-related services. This serves to ensure health becomes a fundamental human right to every citizen, regardless of any special characteristics. However, there remains no explicitly defined policy nor plan for the implementation of policies to improve the health status and access of Dalit communities (Ministry of Health and Population 2019). Despite equal access for every citizen, the health system of Nepal suffers ominous challenges in maintaining a quality health system due to poverty, illiteracy, weak infrastructure, unequal distribution of healthcare services, inadequate provisions of essential medical resources and medicines, health insurance policies, insufficient budget allocation for health, poorly regulated private health providers, a shortage of health professionals, poor retention of human resources in rural areas and geographical barriers (Mishra et al. 2015). The WHO recommended the availability of health workers - that includes physicians, nurses and midwives - should average 45 per 10,000 of the population. However, Nepal currently has only 34 health workers per 100,000 of the population, significantly lower than recommended ratio (World Health Organization 2018b). Nepal was already facing a shortage of medical staff prior to the COVID-19 pandemic. The onset of COVID-19 was further strain on a system already suffering from the shortage of health professionals and resources (alongside poor health status) (Neupane et al. 2021).

In 2007, Nepal's interim constitution addressed, for the first time, health as a fundamental right and stressed the public's right to access basic healthcare for free. However, the reality was far from ideal. Therefore, to ensure health rights were easily accessible, the Social Health Development Committee was formed in 2015. It introduced health insurance under the Social Health Security (SHS) scheme. The scheme planned to increase utilisation, access, and quality of the health system (Mishra et al. 2015).

Nepal has a mixed-healthcare system delivery, which includes public sector, private sector and non-governmental organisations (NGOs). The healthcare system is

managed by the MoHP (Ministry of Health & Population 2011). According to the new constitution of the Federal Democratic Republic of Nepal (2015), the health system is divided into three main organisational structures (see Figure 2.2): Federal level, Provincial Level and Local Level (Adhikari 2021).

Figure 2-2: Health system: Federal level, Provincial Level and Local Level



Adopted from Adhikari (2021)

A report published by the MoHP, (2019) has as its objective: providing equal access to health by establishing a network called 'Universal health coverage' with a motto called "Access of health to every individual", (Ministry of Health and Population 2019). However, it seems as if the report has not achieved its objective. Further analysis of the NDHS 2011 data revealed strong caste differences in health status, with Dalit, Adivasi, Chepang, and Janajati women using less critical healthcare services in comparison to other nationals. This is suggestive of significant intragroup disparities that must be taken into account (Deshpandey 2013). To ensure the best attainable

healthcare, factors affecting health must be reviewed, such as access to health and resources, availability of health professionals, health insurance, involving the private sector, and review budget planning.

2.7 Sustainable Development Goals (SDGs)

Nepal is continually developing its health system to meet the growing needs of its citizens as well as fulfilling international demands such as Sustainable Development Goals (SDGs). The Millennium Developments Goals (MDGs) were replaced by 17 SDGs, as they go beyond MDGs. The SDGs are part of a global agreement agreed by world leaders at the United Nations (UN) in 2015: The 2030 agenda for Sustainable Development (United Nations 2015). It was established to eliminate poverty, inequality and injustice, and to leave no one behind. The SDGs are globally applicable with signatories and are expected to deliver (Government Digital Service 2021).

The SDGs promote equality, elimination of discrimination, and socio-economic inclusion of everyone irrespective of their race, ethnicity, sex, age, religion, origin, or economic status (United Nations 2015), but there is no specific mention of caste Dalits.

Figure 2-3: Sustainable Development Goals 2030

Adopted from United Nations (2015)

The UN 2030 Agenda for SDGs has 17 goals (see Figure 2.3) that set clear targets for gender equity, education, health, decent work and inclusive growth, among others.

Goal 1, End poverty in all its forms everywhere
Goal 3, Ensure healthy lives and promote well-being for all at all ages
Goal 4, Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5, Achieve gender equality and empower all women and girls
Goal 10, Reduce inequality within and among countries

Above are the goals that explicitly influence the experience of caste-based discrimination for Dalits. Therefore, certain SDG goals will not be possible to achieve, especially 'goal 10, reduced inequality', without dealing with caste-based discrimination first.

2.8 Government plans and policies to address Dalit's issue

Caste-based discrimination is mostly experienced by Dalits in Nepal and India due to the practice of untouchability as a result of societal prejudices leading to, violence, abuse, ostracism of inter caste marriage, physical exploitation, slavery, lower paid jobs, lower literacy, lower life expectancy and limited participation in politics. Governments have prioritised this issue in their policies and strategies, however one of the reasons behind this continued inequality is the frequent failure of effective implementation of government policies to defend lower caste groups (Human Rights Watch 2001). For example, the government of Nepal passed the Muluki Ain (the civil code) in 1854 that suggests marriage between upper and lower caste is a crime. However, over the years, many amendments were made and today Offence and Punishment Act, 2011, Section 2 (f) has a provision of the right to marry from any caste. And to promote inter caste marriage NRs. 100,000 (around £690 (UK)) is

provided as an incentive (Poudel 2018). Similarly, policies related to reservation were introduced formally in 2007 to promote inclusion of women and marginalised members in employment and education. Furthermore, the concept of incentives encourages lower caste people to pursue education and inter caste marriage. However, these policies and concepts are not free from controversy and are believed to be affecting the merit-based system as well as preserving the discrimination and promoting casteism as the government itself appears to be labelling people based on their status/caste (Deshpandey 2013).

While Dalit oppression has been grounded in Nepalese culture for centuries. The Nepal government is working towards strong legal protection against Dalit discrimination from different dimensions including poverty, education, and health (Human Rights Watch 2004). Nepal plans to increase Universal Health Coverage (UHC) by improving its Health policy to improve access quality healthcare and free basic health services. The Nepal Health Sector Strategy (NHSS) 2015-2020, 2016-21 stands on four strategic principles: equitable access, improved quality, health system reform and a multi-sectoral approach; it carries the philosophy of constitutional provision to ensure universal access to basic health services (Governement of Nepal Ministry Of Health 2017).

After becoming a federal government, for the first time in the history of Nepal the new constitution introduced federal structure in 2015. The new constitution guaranteed health as a 'fundamental right', as stated in Article 35:

> 1) *every citizen shall have right to get basic healthcare free of cost from the state*; 2) *no one will be restricted from emergency healthcare;* 3) *everyone shall have right to get information about his/her healthcare;* 4) *every citizen shall have equal access to healthcare;* 5) *every citizen shall have right to access to pure drinking water and sanitation* (Constituent Assembly Secretariat 2015).

The Federal Government system has been restructured into 753 local governments to provide equal healthcare services to the citizens so that they have easy access to health services and can enjoy their wellbeing rights. The whole health system had to undergo this major change; many challenges were faced while implementing federal policies as roles and responsibilities were not clearly delegated or communicated between governments to ensure smooth transactions. This has resulted in rural areas where the majority of Dalits remain neglected and suffer more due to unequal provision of services (including health) due to geographical location (Vaidya et al. 2019).

Over the years Nepal has made remarkable progress in health including improved maternal health (skilled birth rate 1% in 1990 and 55.6% in 2014, increased use of contraception 24% in 1990 and 49.6% in 2014), a reduction in infant mortality rate (108 per 1,000 in 1990 and 33 in 2014), reducing under five (162 per 1,000 in 1990 and 38 in 2014), increasing immunisation against measles (92.6% in 2015), as well as improved combat against HIV/AIDS, malaria and other diseases (UNDP Nepal 2021). It has also succeeded in controlling tuberculosis, HIV, and malaria, whilst eliminating polio, maternal and neonatal leprosy, and tetanus (Thapa et al. 2019). The National Health Policy 2019 established efficient and equitable provisions of basic health services, including promotive and preventive care regarding maternal, reproductive, nutrition and child health (Ministry of Health and Population 2019). The Nepal Demographic and Health Survey (NDHS) 2016 also reported that health improvement is unequal with regards to province and wealth quintiles (Ministry of Health and Population 2019). Despite significant changes, there is still a gap in the health sector and need for continuous improvement to achieve the UHC and target of SDGs.

2.8.1 Challenges, opportunities, and way forward

Federalism has been an important aspect in developing health services, but also poses several challenges. Implementation of federalism has raised the key concern of prioritising needs when it comes to infrastructure planning, industries, employment,

and agriculture, over social sectors including health. Another issue has been the lack of delegation of authorities and responsibilities between 753 layers of local governments (Thapa et al. 2019). Research has identified that these kinds of challenges can be controlled by strong federal legislation (Schwefel 2011). It is clear that similar measures are needed in Nepal. Thus, the opportunity to produce strategies and policies provided in the National Health Policy 2019 to provincial and local governments (depending on their needs) may help to overcome these challenges.

There is no doubt that a country's government plays an important role in developing citizens and their health status. Therefore, the Nepalese government must uphold its constitutional framework and obligations to fight discrimination against Dalits and end the practice of untouchability (Human Rights Watch 2001). However, another major challenge is human resources management and boosting capacity at a local level to ensure that the smooth delivery of health services through the federalised layer to the local level is possible. This requires increased human resources based on increased population and burden of disease, the training and retention of skilled workers, and maintaining stock to deliver basic health services (World Health Organization 2018a).

Despite challenges, the change to federalism holds opportunities for the respective authorities. It also provides fertile ground, evidence-based planning, efficient legislation, and effective budgeting. The provincial and local government can prioritise and plan for community centred approaches and strategic planning. This may include concepts on restructuring and support on implementing policies for the smooth delivery of health services. Similarly, the government may focus on an effective transition plan that includes monitoring, evaluating, and managing health plans until they are fully in place

2.9 Chapter Summary

The literature review chapter critically reviews literature around social discrimination, caste aspects of discrimination, health impacts due to discrimination and issues not

identified in the previous systematic review included in Chapter 4. It describes theoretical aspects of discrimination in global phenomena including Nepal and India. Discrimination acts as an obstacle to accessing healthcare and has a major impact on Dalit life. This chapter details the plans and policies of the Government of Nepal in relation to caste-based health inequality, and a possible way forward. It also identifies several gaps in the health system and Dalit health, thus helping to develop rationale for this research.

Chapter 3 Rationale, aim and objectives

3.1 Overview

The literature review (see Chapter 2) and published systematic review (see Chapter 4) evidence a gap in health access and quality of health across ethnic, racial and socio-economic groups and stresses the need for more rigorous research that explores caste aspects of health inequality. As such, this chapter outlines the rationale of the study followed by its research aim, objectives and research questions.

3.2 Rationale of the study

Discrimination has a fundamental impact on the human rights of individuals (Block 1992). A number of studies have been conducted related to diversity and discrimination in different fields, including - but not limited to - textile and clothing, finance and insurance, manufacturing and education. the healthcare sector seems to have been overlooked in terms of exploring discrimination (Özcan et al. 2011). There is some research in health aspects, however, it mostly focuses on identifying clinical issues and diseases. This research study aims to study caste-based healthcare inequality to identify the key gaps in Dalit healthcare.

None of the previous large studies in Nepal such as the Nepal Demographic and Health Survey (NDHS, 2016), Nepal Living Standard Survey (NLSS, 2011) and the Nepal Multiple Indicator Cluster Survey (NMICS, 2019) have explored underlying reasons for health discrimination and health uptake of people from Dalit communities (Gurung et al. 2020). Similarly, emerging findings have highlighted huge differences in the social, economic and health status of most deprived groups such as Dalits and Adivasis (indigenous people) in comparison to other caste groups of society. However, this research is focused on correlations between group identity, material deprivation, and poverty of these people, and their development deficit (De Haan 1997; Shah et al. 2006).

3.3 Aim and objectives of the study

The aim of this research is to investigate caste-based healthcare inequality in Dalit communities in Makwanpur, Nepal. Specific objectives are to:

- explore health discrimination in Dalit communities of Nepal.
- understand challenges that Dalit minorities face accessing health services.
- analyse the perception of health workers towards Dalit minorities.
- assess the range of health services provided in Dalit communities.

The study also intends to undertake a systematic review to bridge the gap between caste inequality and health as, despite many papers on caste, no systematic review has been carried out exploring caste inequality in health.

3.4 Research questions

This study addresses four research questions in order to achieve its objectives:

- What are the underlying reasons behind health discrimination in the Dalit community of Nepal?
- What challenges/experiences do Dalit minorities face while utilizing health services?
- How do health workers approach service users from Dalit communities?
- What are the available existing health services?

3.5 Chapter Summary

This chapter presents that discrimination and health are interrelated. However, caste aspects of discrimination and health is yet to be explored. This chapter highlights that gap and intends to fulfil it. Further, this chapter presents the research aim, objectives, and research questions.

Chapter 4 Systematic review

This chapter presents the systematic review paper titled 'Caste exclusion and health discrimination in South Asia'. The paper was published in *Asia Pacific Journal of Public Health* on 24th May 2021. For the purpose of this systematic review, the researcher searched the following health-related databases: CINAHL, Medline, SocINDEX, PubMed, Nepjol, JSTOR, ASSIA and EBSCO Discovery Service (EDS). The PEO (Population, Exposure and Outcomes) framework (Bettany-Saltikov 2012) was adopted to identify search terms (Table 4.1).

Table 4-1: PEO Framework

P	**Population**	Dalits, Untouchables, Low Caste, Outcaste, Minority Group, Socially Excluded Group, Discriminated group
E	**Exposure**	Discrimination, Inequality, Inequity, Racism, Barrier, Violence, Judged, Prejudice
O	**Outcomes**	Service uptake, Motivation, Hospital uses, Health Standard, Health promotion, Health Equity, Equality, Health access, Health utilisation

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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 3 millennia. This review aims to investigate caste-based inequity in health care utilization in South Asia, particularly focusing those at the bottom of the caste hierarchy, commonly known as Dalit communities. A systematic methodology was followed; key databases (including CINAHL, Medline, SocINDEX, PubMed, Nepjol, JSTOR, and ASSIA) were searched for relevant articles published before October 2019, using comprehensive search strategy in accordance with the PRISMA guidelines. In total 15,109 papers were found, and from these, 9 selected papers were included in the review. The papers focused on studies in both India (n = 7) and Nepal (n = 2) and utilized a range of methods including qualitative (n = 2), quantitative (n = 3), and mixed methods (n = 4) approaches. The review identified 4 main themes: stigma, poverty, cultures and beliefs, and health care. 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 health care. 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 utilization

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 marginalized 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 health care.

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 organizations argue that worldwide more than 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]

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The 3000-year-old caste system is one of the oldest social hierarchies and it forms the foundation of Hindu society.[4] This system includes 4 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, and 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 from attending schools, temples, and courthouses. Furthermore, they are restricted in trading goods, labor, and were stigmatized 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 labors.[11] Dalits are also linked to occupations such as scavengers, sweepers, rag pickers, and 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 regard 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 the following: 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 Dalits 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 of health care to Dalits who seek health services.[22] Typical discriminatory behaviors include refusing to enter Dalits' 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 centers 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]

While there are many papers written on caste, to date no systematic review has been conducted to explore the caste-based inequality in accessing health care 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 addresses the research question, "What is the evidence that Dalits (ie, lower castes) have different health service utilization 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 an individual's caste.[24] Population, exposure, and outcome framework[25] was used to develop the research question and form the search strategy. This included the following: population—Dalits, untouchables, low caste, outcaste, minority group, socially excluded group, discriminated group, and 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, and health utilization.

The following databases were searched: CINAHL, Medline, SocINDEX, PubMed, Nepjol, JSTOR, ASSIA, and

Table 1. Search Strategy.

Database	Filter	Search terms	Results
My Search—Peer Reviewed	Language: English Date:19672019	(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 utilization" or "health utilization"	6444
CINAHL Complete—CINAHL Headings	Language: English Date:1981-2019	*(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 ("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")	2107
Medline Complete—MeSH Headings	Language: English Date:1950- 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 ("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")	6269
SocINDEX with Full Text—Subject Terms	Language: English Date:1987-2019	*(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 ("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

EBSCO Discovery Service for relevant articles. Table 1 shows different but interrelated search terms that 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 that framed the review included studies written in English and published in peer-reviewed journals.

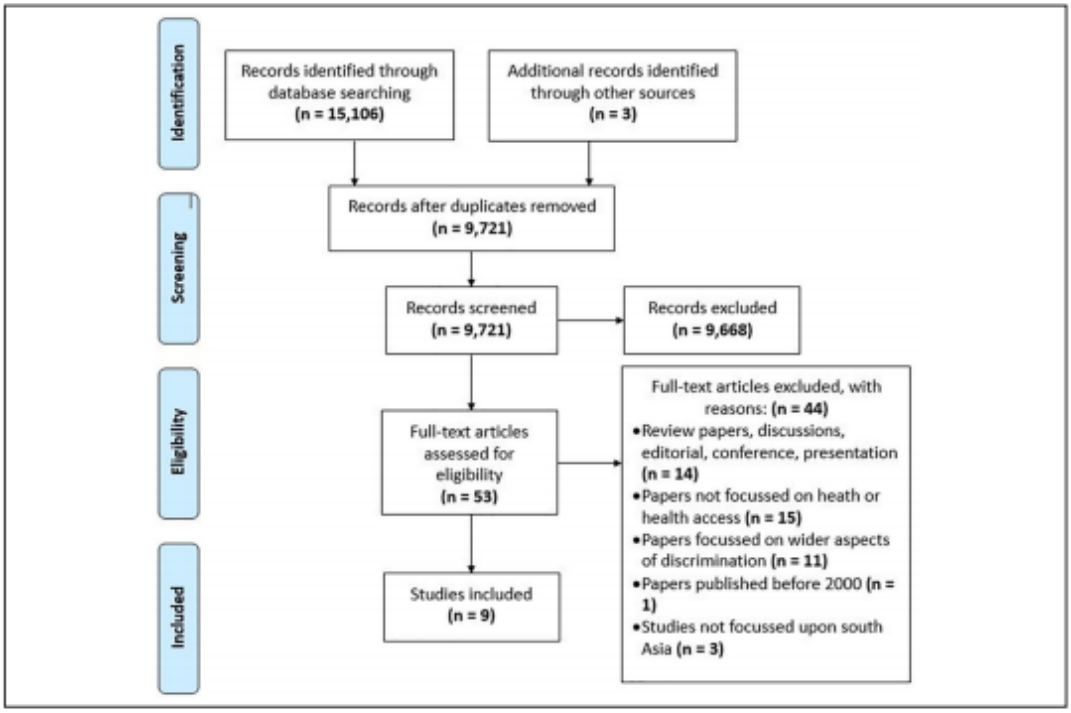

Figure 1. PRISMA flow diagram.[45]

Screening and Selection

Papers were selected using the 4-stage process suggested in PRISMA: identification, screening, eligibility, and included (Figure 1).

Records were identified through database searching (n = 15 106) and from other sources (n = 3), resulting in 15 109 records identified. After removing duplicates, 9721 articles were screened by reading the title and abstract against the inclusion/exclusion criteria. This included papers published between 2000 and 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 focused on south Asia, papers written in English and peer reviewed. At this stage, the majority of records (n = 9668) 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). Ten percent 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, 9 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 coauthors 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 9 selected papers, 2 were qualitative studies, 3 quantitative, and 4 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 health care sector.

The selected 9 papers were critically apprised using the CASP[26,27] and McGill[28] checklist, most scored average to

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 and Chan[30] (2016), Nepal	Investigate caste/ethnicity-based inequity in women's health service utilization, focusing on ANC in Nepal	Secondary cross sectional: Nepal Demographic Health Survey Data 2011, bivariate and multivariate analysis	4018 mothers aged 15 to 49 years 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 the wealthiest quintile.	Disadvantaged mothers using less ANC independently based on their caste/ethnicity and their household wealth. Advantaged mothers are also disadvantaged of utilizing 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 and wealth.
Kumar[31] (2007), India	Explore the link between 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 utilization, spending on food, basic needs compared with OBC. Participations' health impact was reportedly greater for OBC women than SC.	Caste and 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 marginalized.	Small sample, number of participants other than SHGs women is not made clear. Appraisal: McGill, 2018 (85%, medium).	Women are discriminated on gender, caste, and class, information on double discrimination would be helpful.
Polit[33] (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	First village: Dalits = poor, literate, high discrimination, and dependency. Second had 2 areas, occasional clashes, moderate dependency, employed, and educated people. Third village: only Dalits, less land, education, and jobs; no discrimination and dependency.	People's affects well-being more than translocation. 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 information 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 and Sathyamala[34] (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	1171 household Uttar Pradesh (UP) + 900 Tamil Nadu (TN) 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[35] (2006), India	Examine social patterning of women's self-reported health status: Kerala; 2 hypotheses: (1) low caste and 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 laborers, OBC are slightly more likely to work as wage laborers and forward caste engage in nonwage activities. Odd rations poor perceived health and ADL.	Caste and socioeconomic interrelated; lower caste magnifies health inequity. Being both lower caste and poor can trap people into poor health than either inequality on its own. Implementing interventions that deal with caste and 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 and attitudes and perceptions. Appraisal: CASP, 2018 (85%, medium).	Information on effects of gender inequality of women's self-reported health status would be helpful.

(continued)

Table 2. (continued)

Authors, year, and country	Main aims	Method and data collection/analysis	Participants	Results	Stated conclusion	Limitation, critical appraisal	Reviewer's conclusion
George[18] (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 (2011-2012)	National survey	Dalits are underrepresented in health professionals. Despite only 24% of rural population, other castes shares 40% in health professional. Shortages subcenters, PHCs, and CHCs.	Underrepresentation of Dalits in rural health care 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[17] (2012), Nepal	Examine health care access to Dalits through experiences of stakeholders throughout health system	Ethnography, participatory approach: KI interviews and 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 education, health education, advocacy, public inclusion, and dialogue.	Dalits and 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 information: 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 and Acharya[14] (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	20 ANMs, 20 ASHAs + 80 care seekers who delivered babies in last 6 months	5 Themes: Caste, perception and social identity, profession and social identity, maintaining identity, conflict and dilemmas, control and autonomy. Variation across caste of providers and seekers in shaping perception of each other.	Dalit providers lacked skills and health seekers are suspicious of their knowledge. Other staff limited interaction with Dalit care seekers and staff. Women faced gender and caste. Provider and seekers' caste more weight than profession and need.	Small number, no justification how themes were identified, no written consent. Appraisal: CASP, 2018 (90%, high).	Clarification on how FGDs were conducted and further information on double discrimination would be helpful.
Rao[13] (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—arranged 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.

Abbreviations: ANC, antenatal care; CASP, Critical Appraisal Skills Program; SHG, self-help groups; SC, scheduled castes; OBC, other backward classes; HIV, human immunodeficiency virus; ADL, activities in daily living; PHC, primary health center; CHC, community health center; FDG, focus group discussion; KI, key informant; ANM, auxiliary nurse-midwife; ASHA, accredited social health activist.

moderate quality. From the 9 studies, 4 themes were identified: stigma, poverty, culture and beliefs, and health care.

Stigma

Stigma here refers 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, 4 papers[30-33] 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 with those in middle and upper castes.[30] Caste is an important element in shaping individual's social identity and their well-being.[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 anemia) and maternal mortality.[31] The caste system is further gendered in terms of employment, including daily wages and long working days that 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 2 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[31] 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. 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 top-seeking health care, which can be one reasons 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 health care and in health-seeking behaviors. 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 with disadvantages caste.[31] Bhandari and Chan[30] found in their research that women from poor households are disadvantaged in terms of utilizing health services and most of Dalits live under the poverty line.

The connection between caste and occupation is complex. Lower caste women, despite nonengagement in education (as most never attended school), are more likely to be engaged in paid employment compared with 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 fueled violence due to refusal to work as submissive agricultural laborers.[31]

Kumar[30] stated that private doctors who are usually unlicensed "quacks" exploit women due to their lack of education, charging high fees that 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[35] 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 affects one's mental and social well-being.[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 behaviors. 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 marriage 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 well-being 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 sprit possession by both male and females to express resulting unexplained death, while seeking exorcism treatment by the *ojha*.[36]

According to 2 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]

Health Care

All 9 papers identified that caste affects health issues, 4 focused[30-33] on health issues related to women, one[36] focused on health issues related to HIV, and the remainder focused on general health and well-being issues related to Dalits. Kumar's[31] study asserts that disadvantaged women have a higher chance of severe illness and without any improvement in caste and class barriers, improved health resources and outcomes are 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 travel expenses or 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 subcenters, public health centers, and community health centers, poorer communities still experience a shortage of health institutions and skilled health workers.[38] Similarly, in Nepal, the health care 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 health care 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 health care positions such as general medical practitioners, specialist doctors, trained nurses, technicians, and associated health staff. Their low representation compared with other groups of society promotes a favorable 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 health care utilization in South Asia and included 9 selected studies. These research studies were carried out in different cities, counties with different study participants; however, most of them agreed there exists a connection between socioeconomic differences and health disparities.[30-38] It was found that low socioeconomic 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 labor market in equal terms 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, socioeconomic 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 are more likely to experience severe sickness and limited treatment beyond locality. Self-help groups have helped caste women reduce 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 toward discrimination. Caste/ethnicity contributes to women's health, for example, higher caste groups comparatively derive better benefits from an antenatal care (ANC) program. Deprived caste /ethnicity group are disadvantages in terms of using ANC services compared with other caste groups. Similarly, mothers from wealthy household utilized ANC services more compared with 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 with 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 also 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 affected 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] Programs like SGH or ANC may not be enough to overcome caste and health attitudes and such programs 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 well-being, 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 with caste discrimination.[2] Polit described how well-being in the 3 groups of Dalit villagers was affected by the circumstances of relative marginality as well as by general socioeconomic indicators. Dalits living together with a high-caste majority compared with 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 behaviors.[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 nonacceptance 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 reports domestic violence, risk presence in everyday life, poor education, employment, 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 health care. 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 behavior is limited as they survive on daily wages 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 has an impact on education and health knowledge (ie, health literacy).

This review also shows the interrelation of caste and socioeconomic standard as a source of inequality, that is, 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 decentralization 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 program 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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Chapter 5 Methodology & Methods

5.1 Overview

This chapter focuses on the methodology and methods used for the primary research in this PhD. It explains the rationale for using a concurrent mixed-methods approach and details the different data collection approaches applied in this study. The study area, population, recruitment, sample size, data collection tools, quality assurance, ethical considerations, and research challenges for this study are also discussed.

5.2 Mixed methods: A theoretical perspective

Research methodology is the procedure which researchers follow to explain, report and predict phenomena of their study (Rajasekar et al. 2013). Different research philosophies see the world differently - from different paradigms - hence different underlying philosophies address and ask different research questions and suggest different processes to answering these questions. Different research paradigms are based on different underlying assumptions of '*what is reality'* (ontology) and '*what is knowledge'* (epistemology) (McMillan 2015). These paradigms examine different hypotheses and assumptions based on the aim and purpose of research (Almeida 2018). These debates are generally focused on whether to apply a qualitative or quantitative research approach. Qualitative research is linked with interpretative approaches, whereas quantitative research method are linked with positivism (O'Cathain and Thomas 2006).

The quantitative research method is founded upon a positivist paradigm that is based on the belief that social reality is quantifiable and tangible. It is known as a method to find truth and understand society such that it can be predicted and controlled (Varpio et al. 2015). This paradigm is based on rationale, objectives, and a scientific hypothesis that views nature as a controlled and intricate phenomenon that is easy to understand, by breaking it down to quantifiable data (Tashakkori and Teddlie 2010). The

quantitative approach has been revised to post-positivism which does not reject the elementary view of observation and measurement but allows for the addressing of various criticisms of the quantitative research method, for example when considering social reality (Teddlie and Tashakkori 2003).

Quantitative research is based on a deductive model designed to test a hypothetical relation and to establish whether the hypothetical relations hold or not (Aaker et al. 2008) by collecting quantifiable data which are subsequently analysed using statistical techniques (Creswell and Clark 2017). In general, this research method allows researchers to scientifically seek numerical answers to research questions in an objective way and quantify these by carrying out statistical analysis (Rosner 2015). However, this method has limitations; it is objective and therefore may not be appropriate for subjective research or data where statistical experiments are not essential for detailed analysis of the phenomena (Beedles 2002). Additionally, this approach may not be suitable to compose an expression of historiographical changes (Morgan and Smircich 1980).

Conversely, qualitative research methods are concerned with the understanding, interpretation, and experience of the social world, which cannot be quantified. Reality is perceived through socially constructed and subjective understanding, which varies from person to person (Gill and Griffin 2009). In general, qualitative research aims to explore complex issues that may not always be readily expressed in numbers. This approach is very subjective in collecting an answer to the research question (Beedles 2002). The qualitative research method emphasises real situations and is important in addressing the ‘how’ and ‘why’ questions. Due to these benefits, the qualitative approach is popular in academic and clinical settings. (Mays and Pope 2020).

In a qualitative research approach, interrogating and inquiring reveals the understanding of phenomena (Hodges et al. 2008). This requires considering in advance both ‘what is required’ and ‘what is affecting research’ during each step of the project (Haddara and Lingard 2013). However, qualitative methods are not free

from limitations. For example, this method can lack a formal approach to quantify data and struggles to create possible explanations of theory and hypothetical speciation, therefore generalising outcomes is almost impossible (Affleck et al. 2013).

As a reaction to the separate quantitative and qualitative approaches, the pragmatic paradigm suggests realities can be single or multiple and are open to pragmatic investigation rather than involving the argumentative hypothetical perceptions of truth and reality (Creswell and Clark 2017). Despite many researchers' preference for one approach over another (often based on their individual philosophy), many may prefer to follow the pragmatic paradigm to research, combining both methods in the same research project, depending on the research question (Lodico et al. 2010). The pragmatic paradigm is the best fit for a mixed-methods design, merging both qualitative and quantitative perspectives within different stages of research such as data collection and analysis, data triangulation and conclusion (Tashakkori and Creswell 2007).

While most researchers follow some conventional methodology, combining both qualitative and quantitative methods and approaches in one research project is deemed compatible and widely accepted (Johnson et al. 2007). For several decades, researchers have been using mixed methods, for example they are very popular in the field of education and health. Mixed methods combines both quantitative and qualitative data inclusion and analysis in a single research study (Teddlie and Tashakkori 2003). Researchers emphasise that the key to effectiveness of mixed methods is to combine both methods to a point where the merge is not limited to advance or extend theories and test their application but to achieve data triangulation which produces greater understanding than a single method alone. Additionally, it overcomes or negates the limitations of an individual data collection method (Creswell and Clark 2017).

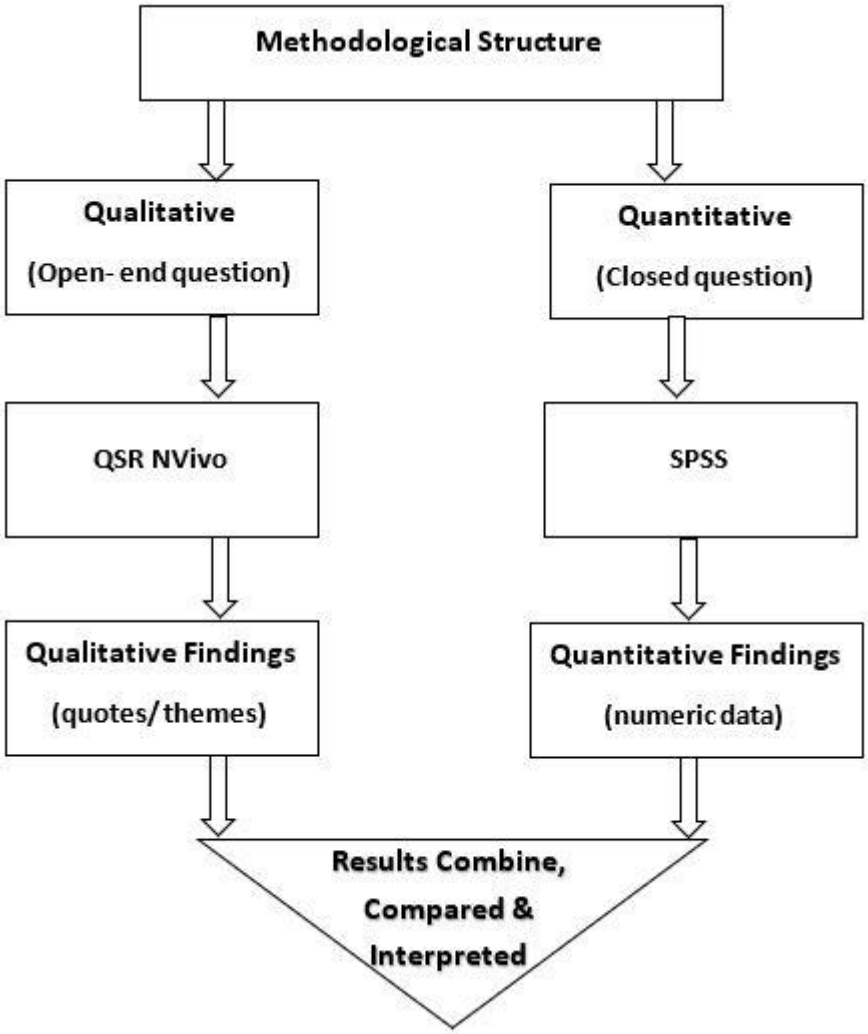
Mixed-method research is portrayed as a third paradigm that helps close the gap between qualitative and quantitative research, allowing practicing researchers to learn

methodologies and develop techniques that are more useful in real life (Onwuegbuzie and Leech 2005). Mixed-methods research has become a dominant methodology by creating a bridge between qualitative and quantitative research (Palinkas et al. 2011).

A mixed-methods design allows researchers to validate one set of data to another one, providing a platform to compare data or to answer various types of question (Creswell and Clark 2017). Additionally, this design is particularly useful when there is time limit. However, the outcome is received via the separate execution of each data, thus may offer less flexibility and level of understanding (Koskey and Stewart 2014). This approach is often described as a collaborative method as it combines two different methods such that synergistic evaluation of research is possible - one method allows the other to be more efficient and together both methods would deliver complete understanding of the phenomena (Greene and Caracelli 1997). However, the main issue in the use of mixed methods is a key to achieve maximum benefit to its capacity in order to enhance research credibility.

This PhD research adopts a concurrent triangulation design (Driscoll et al. 2007) (Figure 5.1) where qualitative and quantitative approaches are used concurrently, either throughout or at some step of the research process. This process aims to triangulate both sets of data to complete or validate results, answering the same research question (Rauscher and Greenfield 2009).

Figure 5-1: Concurrent triangulation



Adapted from Driscoll et al. (2007)

Qualitative data were thematically analysed, and themes and meaningful quotes were identified with the help of qualitative data organisation software NVivo 12 (QSR International). Similarly, quantitative data from the survey with healthcare professionals was presented and interpreted in numerical form through running statistical analysis using Statistical Package for the Social Sciences (SPSS ver. 26). Later both qualitative and quantitative findings were combined, compared, and interpreted in the Discussion (see Chapter 8).

5.3 Rationale for using mixed methods

Mixed methods give a voice to research participants and ensures that research results are constructed from the experience of participants. A practical strategy behind the use of mixed-methods research is that it allows concurrent triangulation of data, where both qualitative and quantitative data are collected and used to more precisely describe relationships between interesting response variables (Wisdom and Creswell 2013).

Research questions cannot always be addressed by just one approach, be it qualitative or quantitative, therefore can mixed methods help to tackle intricate interdisciplinary problems (Tobi and Kampen 2018). Methodology provides a guideline to focus on research and identify the research approach which is helpful in developing research methods to address particular research questions (Crotty 1998). It is the research questions that help determine what research method should be chosen among qualitative and quantitative methods (Silverman 2006). The qualitative study framework seeks to understand the certain behaviours, and shared views/expectations of each individual in a population. This will enable an exploration of possible discrimination against Dalits, and help researchers understand the perception of health workers towards Dalits as well as the challenges in assessing health services. A quantitative study, on the other hand, aims to evaluate and measure the behaviour of individuals of certain groups, allowing an assessment of the range of health services in Dalit communities.

The rationale of adopting a mixed-method approach in this Ph.D. research was to investigate caste-based discrimination in the healthcare sector, particularly focusing those at the bottom of the caste hierarchy, the so-called Dalit communities. The proposed topic is related to caste based inequality which is a very complex issue in the context of Nepal, as it is a sensitive, highly politicised phenomenon (Thapa et al. 2018) and criticizing the system may also raise religious or cultural sensitivities (Ninan 2012). Therefore, different methods are required to best understand these complexities.

A qualitative approach is characterized by its aims, which helps to understand lifestyle, status, and experiences of Dalit communities - all of which is not possible to express in numerical data. A quantitative approach explores the underlying reason of health discrimination in Dalit communities. The reason for mixed methods is to provide a better understanding of research issues than can be achieved by either qualitative or quantitative approaches alone. Indeed, some have stated that using mixed-methods research is the preferred approach in implementation research (Palinkas et al. 2011). Adopting both methods in this research enables the gathering of insights into the problem from various perspectives, thus allowing for a broader understanding of complex health issues (MacKenzie Bryers et al. 2014). Additionally, the triangulation of data allows researcher to derive convergence and corroboration outcome of research using a separate research approach (Greene et al. 1989). Further, this research adopts ideas of pragmatism as outlined in Section 5, and the researcher uses all suitable methods that help to investigate the particular research problem. Indeed, the emphasis is on the research question and its significance which should always drive the selection of research methods.

5.4 Mixed methods in this PhD research

This mixed-methods study investigates caste-based discrimination in the healthcare sector, focusing on Dalit communities in Makwanpur district. Table 5.1 shows the research questions corresponding to the research objectives and the methods and data collection approach used to answer each of the research questions. For the purpose of this Ph.D. research, qualitative and quantitative data were collected simultaneously and concurrently. Four different data collection tools as stated in Table 5-1 were used in this thesis.

Table 5-1: Research questions, objectives, and methods

Questions	Objectives	Data Collection tools/ Methods
What are the underlying reasons of health discrimination in Dalit community of Nepal?	To explore health discrimination in Dalit communities of Nepal	Focus Group Discussion (Qualitative)
		Self-Administered Questionnaires (Quantitative)
What challenges/experiences do Dalit minorities face while utilizing health services?	To understand challenges that Dalit minorities face accessing health services.	Focus Group Discussion (Qualitative)
How do health workers approach service users from Dalit communities?	To analyse the perception of health workers towards Dalit minorities.	Exit Interview (recently used health services and was not part of FGD) (Qualitative)
What are the available existing health services?	To assess the range of health services provided in Dalit communities.	Key Informant Interviews (Qualitative)

The study was conducted in Makwanpur District, one of the 77 districts in Nepal, which is part of the Bagmati province. According to the 2021 Census, the total population of this district is 4.2 million and 3% of the population are identified as Dalits (Office for National Statistics 2021b). The district covers an area of 2,426 km^2 about 55 miles (driving distance) east from Kathmandu, a capital city of Nepal.

This research comprises data from Makwanpurgadhi rural municipality, Manahari rural municipality and Hetauda sub-metropolitan city in Makwanpur district. Selecting different areas have allowed for a broader sample area as well as the capture of diverse participants. The rationale for selecting this study area is that the PhD researcher is familiar with the area and is familiar with the locals. Similarly, existing networks in the study areas were very helpful in identifying relevant key stakeholders and coordinating with them for research purposes.

5.4.1 Focus group discussions (FGDs)

A focus group discussion is an informal meeting of a group of people, arranged by the researcher. Generally six to twelve people are involved in focus group to discuss a particular research topic, therefore the quality of interaction is highly influenced by the size (see Page 67) of the group (Krueger 2014). Health conditions are influenced by the social environment and created within a social context (Carter and Henderson 2005) therefore FGDs are suitable for assessing experiences of public persons and understanding illness (Kitzinger 1993). Focus group discussions have now become a popular data collection method in health research (Rabiee 2004). It is a nondirective discussion which allows participants to explore research topics and interact within a group. However, the facilitator controls the topic of discussion to ensure research remains on topic (Wong 2008). Focus group discussions have been identified as a better way to understand and individual's feelings and their thoughts on products and services as well as subjective issues. This approach is suitable for research that deals with sensitive issues (van Teijlingen and Pitchforth 2006b) and there is no doubt that caste issues in Nepal are complex and sensitive (Thapa et al. 2018). It is also believed that data collected from focus groups are rich and often three to four groups are acceptable to meet data saturation (Krueger 2014). This kind of discussion is expected to be more detailed and comprehensive compared to the outcome of a one to one interview (David and Sutton 2004).

In this study a total of six (male= 3, female= 3) focus group discussions with a total of 41 Dalit participants (male = 20, female= 21) were carried out separately. Participants who were Dalits, lived in the area and were aged between 18 to 65 years were eligible for participation. The groups were arranged in circle in a comfortable setting, as relaxed and comfortable environments result in more successful focus groups (Van Teijlingen and Pitchforth 2006a). Groups were separated into males and females in each area as individuals often feel more comfortable and open discussing critical issues with someone of the same gender (Krueger 2014). Similarly, research identified that the gender of the interviewer influences the responses especially on sensitive

topics – females interviewers appeared to gather better responses as compared to male ones (Axinn 1991). Furthermore, Hindu society is very patriarchal and women's status is traditionally lower than men by almost every measure (Saroha et al. 2008). It follows that mixing groups may have inhibited participants from sharing their experiences. The rationale of categorising groups was to observe for any underlying gender aspects of double discrimination (see Section 1.4.1), to provide participants with a comfortable environment, and an opportunity to speak freely about their experiences and challenges.

In FGDs it is important to ensure enough targeted participants are recruited to capture rich and diverse views and boost the strength of research (Keith 2001). Recruiting and sampling begins with identifying, targeting and enlisting study participants and developing their interest in the research study (Rabiee 2004). Recruiting pre-existing groups are used based on the nature of discussion and group participation that fits research aims and provides answers to research questions. It also enables the capture of participants' own internal pre-existing dynamics (Barbour 2010). Pre-existing groups for focus groups are organised based on sampling criteria such as age, gender and caste groups. However, research also included some homogeneity, relatively do not know each other, while forming focus groups as to reduce power or status as well as to avoid discussion being overshadowed by one group member (Krueger 2014). For each focus groups a minimum of six to a maximum of eight participants were recruited. Characteristics of participants are explained in Section 6.2.1 (particularly Table 6.1). Recruiting less participants risks the discussion being led by one and having more participants can result in the FGD being crowded and risking individuals not having the opportunity to express their thoughts (Saunders et al. 2018). Small size focus group participants are easy to recruit and host, as well as it being more comfortable for participants. Even though less participants may generate less information, having smaller groups allows direct interactions and more time for participants that will help to capture in-depth opinions of each participant, including their reactions. It also saves time and results in more engaged participants. Large

groups, on the other hand, are hard to control; the process is time consuming and restricts opportunities for participants to share their views and experiences (Krueger 2014).

It was challenging to recruit for FGDs as individuals were very busy in their day-to-day lives (men driving for work and women doing household chores). Therefore, with the help of an existing relationship with stakeholders, a health volunteer from each area was identified to visit the research area, targeted based on selection criteria and approached random participants. Having a familiar face (a health volunteer) with the researcher helped participants to understand about the research and participate in the study.

For the FGDs participants were selected through a purposive sampling method which allows for an easy and active recruitment of participants and interest participant to contribute in research in accordance to power the need of the research (Bowling 2002). Before recruitment, all participants were provided with a participant agreement form (see Appendix 1) to read, understand and consent to participate in the study by signaturing or using the 'X' sign for those who were not able to sign. For illiterate participants, the agreement sheet was read aloud, and their verbal consent was sought. This form listed all actions and activities that would be performed throughout. Further, participants are handed a participant information sheet (see Appendix 2). Both forms were developed in Nepali and the opportunity to ask any questions was given. For ethical considerations see Data Analysis chapter (see Section 5.11). A prepared discussion guide in question form was used (see Appendix 3), to help researcher to reflect and conclude the quality and suitability of data collected through discussions. Questioning route promotes an interactive discussion and is also helpful in achieving data saturation and ending data collection as well as receiving comparable results (Hennink 2014). The discussions were started by the researcher who also acted as the facilitator, by going through the participant information sheet which included the research aim, objectives, contribution from participants, and taking informed consent.

Discussions were audio recorded with the permission of participants and the discussions lasted between 1 to 1.5 hours. It is recommended to use the language spoken by participants for the purpose of research, to understand participant's experience and perceptions (Twinn 2008). Therefore, all discussions and interviews were conducted in Nepali, the local language, by the student researcher who is a native speaker.

The purpose of these FGDs was to collect information that enabled the researcher to explore Dalit's overall life experience, their position in society, challenges they face while utilising healthcare service and its impact in their health whilst allowing participants to freely discuss their thoughts and experiences. Due to some circumstances, such as depending on daily wage for survival, most Dalit men were drivers, which meant they left very early in the morning for work and returned late at night. Upon return, the majority of them are drunk, which is regarded as normal within Dalit communities. Dalit women take full responsibility in running the household, including child rearing. This made it difficult to arrange time for FGDs. Therefore, women were encouraged to bring their children. As noted previously, the majority of Dalits depends upon daily wage for food, and it was recognised that attending FGDs may result in them not having enough money to feed their family for the day. Providing compensation motivates participants to participate in research (Krueger 2014). Therefore, non-monetary compensation (food and drink) was arranged to encourage people to participate.

5.4.2 Interviews

Interviews are a commonly used data collection approach to understand social phenomena as they focus on experience, knowledge, feeling, behaviour and beliefs of the individual (Britten 1995); it is a powerful yet flexible research tool that can expose many new areas of research (Aaker et al. 2008). Interviews are interactive with participants, allowing them to raise further concerns even after the interview, therefore discovering highly valuable findings. However, it is not free from limitations as

interviewer bias can affect the outcome (van Teijlingen and Forrest 2004). Such bias can be reduced by explaining research objectives including its social values, legitimacy and the importance of accurate and complete information to participants before the interview (Gregson et al. 2002). A semi-structured interview method was adopted and an interview guide with a list of questions was prepared in advance based on literature as well as consultation with an expert in the field. However, openness to both the interviewer and interviewees were in place to ensure further clarification and gather valuable information (Cohen and Crabtree 2006). Interview questions were initially developed in English and later translated into Nepali by the PhD researcher. All interviews were audio-recorded with the permission of the participants. Two sets of in-depth interviews were conducted, one was key informant interviews, and another was exit interviews. Exit interviews were conducted with service users who had used healthcare services in the past six months.

A total of six key informant interviews were conducted with relevant stakeholders (representative of Dalit organisations, women's group, public health officer and service providers) whether Dalits or non-Dalits. The key informant interviews explored risk and challenges in healthcare and policies related to it by exploring health accessibility, range, conditions of local health services and health policies. Whereas exit interviews sought the health users' experiences, health workerss approaches and their behaviour towards service users.

Key informant participants were identified through existing network with stakeholders in the study areas. Informal meetings with them were organised to brief the purpose of this study and to help recruit other key stakeholders. Characteristics of interview participants are presented in the Quantitative findings chapter (see Table 6.2). Interview participants were handed information sheets (see Appendix 4) and informed about research objectives, their contributions, voluntary participation, and their freedom to walk away during any state of the interview. Interviews started by taking informed consent followed by a semi-structured question guide (see Appendix 5).

A total of six exit interviews (Dalits=3, non-Dalits=3) were planned initially. However, due to a Dengue epidemic in the area only five interviews (Dalits= 2, non-Dalits=3) were conducted. Exit interviews consisted of both Dalits and non-Dalits participants who have recently used health services. None of these participants were FGD participants. Participants for the exit interview who met inclusion criteria were randomly selected by accessing admissions record book of hospital. Telephone contacts were collected to discuss further. From this admissions book patients who had recently used health services were identified and surnames were considered for their ethnicity. Those who met eligibility criteria such as recent use of health services, age (18-65), area (Makwanpurgadhi, Manahari and Hetauda) and ethnicity (Dalits or middle caste) were invited to participate in the study. Some are interviewed in their workplace, in their own homes but in a private room, and the rest were interviewed in a private hall in the community. Characteristics of participants are presented in Table 6.3. Participants were explained and handed information sheets (see Appendix 6) and informed consent was taken before participating in research. Exit interviews adopted a semi structured approach using interview guidelines in question form (Appendix 7).

5.4.3 Survey

Surveys are one of the most popular quantitative data collection methods. A survey is data collection through a set of prepared questionnaires focused on the statistical analysis of data (Saris and Gallhofer 2014). The strengths of this method are that it ensures participants anonymity, maintains confidentiality, honest responses and free expression as well as helps to reduce inadequate collection of data and create uniform data from different participants (Davis and Cosenza 2005). Considering all these, the most commonly used self-administrative questionnaires were adopted for this PhD research.

For the quantitative study, current health professionals in Makwanpur District were targeted to respond survey questionnaires (see Appendix 8). Approval from the study areas: Makwanpurgadhi rural municipality (see Appendix 9), Manahari rural

municipality (see Appendix 10) and Hetauda sub-metropolitan city (see Appendix 11) were sought prior to data collection. All health workers/professionals in Makwanpur district who were 18 years old and above were directly approached in their workplace. Participants who participated in the survey questionnaire were given a pen to motivate them to participate. The survey was based on the number and availability of health workers, using a so-called total sample. To support the PhD researcher during data collection and data entry, a local enumerator was recruited. The enumerator was provided a one-day recruitment training, helping them to understand the survey purpose, recruitment process and each question in the survey. Health workers have the most direct contact with service users. Hence their experience proves useful in exploring underlying reasons for health discrimination, attitude towards caste inequity and challenges to access health services.

The survey package included a participant information sheet (see Appendix 12) that explained research objectives, expected contribution of participant and their voluntary participation. Similarly, a participants agreement form was enclosed for their consent to participate (see Appendix 1). This stressed that research was conducted only for academic purposes and anonymity and confidentially would be maintained. As all health workers in the study district were targeted, a total of 400 survey packages were printed and distributed, and two weeks provided for them to complete their responses. However, after two weeks only 134 completed responses were collected. Therefore, another week extension was needed and a further 77 completed questionnaires were collected. Characteristics of participants are presented in 'Quantitative Findings' Chapter 7 (see Table 7.1). The initial plan was to get all health workers of the district to participate. However, due to the Dengue pandemic at the time, many hospitals and health posts were very crowded. In total 211 responses were received, 202 responses that met the quality requirements such as response level meeting 90% were included for further analysis (Chapter 7).

5.5 Data collection tools development

Data collection tools were developed in accordance with the objectives of qualitative and quantitative methods. Qualitative tools (FGDs, Interviews) and quantitative tools (questionnaires) were first drafted based on the literature and finalised through discussions with supervisors and experts on related fields to ensure that the tools were comprehensive and culturally accepted. Final tools were also reviewed by BU and Nepal Health Research Council (ethics committee) to ensure reliability and relevance.

The tools were initially created in English and later translated into Nepali as it is recommended to use the local language for quality data (Krueger 2014). Similarly, for the purpose of this research, the main reason of having all tools in Nepali is that it is easily understandable for the participants, due to their poor English skills. Further, differences in language may have various consequences, e.g., the individual may interpret questions and comments in an entirely different way than the researcher intended. This issue is significant in qualitative research as it works with words, therefore language is a core element in everything from data collection to interpretation and analysis (Van Nes et al. 2010). It is common to use narrative and metaphors to express experience in words with the exact meaning, therefore using the native language also allows for the capture of richness of experience. The narrower the gap between the meanings of a participant's experience and interpreted meanings of outcome, the more qualitative research is considered valid (Polkinghorne 2007).

Questionnaires were self-administered so that more truthful responses may be collected as it included questions participants may not feel comfortable to answer face-to-face to a remunerator (Tsang et al. 2017). Questionnaires (see Appendix 8) were divided into six sections: (1) demographic characteristics; (2) information on current health services; (3) discrimination related issues; (4) health service utilisation; (5) attitude and practices; and (6) responses towards Dalits. Questionnaires included a combination of open-end, close-end and Likert scale, depending on the nature of questions. Close-end and Likert scales are universally used for surveys as participants

are given options, so more responses can be collected, are easier to understand, and can be analysed statistically (Creswell and Creswell 2017). Despite its advantages, close-end questions have some limitations; they may lack desired options, may not capture accurate true responses, and could limit possible responses/information (de Leeuw et al. 2012). Therefore, some open-ended free text questions were added in survey questionnaires.

For the focus groups, a discussion guide was used to facilitate the discussions. Two different topic guides were used (Krueger 2014): first a list of pre-prepared discussions topics and some open-end questions were used to facilitate the discussions (see Appendix 3). A guide (see Section 5.4.1) is important in running a successful discussion as it maintains flow structure, creates an environment to have natural conversation, and engages participants (Krueger 2014). FGDs consisted of three main topics: life experience, social status, health utilisation and health impacts. Selected socio-demographics characteristics were also collected. Secondly, interview guides were developed for the purpose of semi-structured interviews to discover hidden issues or attitudes towards sensitive issues (Malhotra 2002). Key interviews (see Appendix 5) included 11 questions, whereas exit interviews (see Appendix 7) included 13 questions and some demographic characteristics of participants.

5.6 Pilot study

In research, the pilot study is considered to be a significant phase that will allow the researcher to get a better outcome from the research (Simkhada et al. 2006). The pilot study was conducted in two steps; first was reviewing by supervisors, by an expert in the field, and colleagues also doing their PhDs. All the feedback was considered when finalising the study tools. The second step was to carry out a pilot study before going live with a main study. This pilot study was an important step to determine the appropriateness of study tools.

For the pilot, a total of 14 potential participants completed the questionnaire from Hetauda. However, both outcomes as well as participants included in pilot study were not included in the main research. Similarly, two focus group discussions (one with men and one with female), three key-informant interviews and two exit interviews were conducted to text the qualitative tools. This pilot study was very helpful to understand suitability and comprehensiveness of study tools, to make sure that they were easily understandable for data collectors as well as respondents who participated, as well as to estimate the time taken for collection of data using each study tool. The outcome of the pilot study helped to improve wording, structure, and content of developed study tools. Furthermore, any disagreements that were raised throughout the pilot study were discussed and resolved. Similarly, continuous assessment and improvement was done throughout the research, especially for qualitative tools in accordance with the research need. For example, some wordings were changed in local language/terms, and options to multiple choice were added based on local availability.

5.7 Outcome of pilot study

During the pilot study we observed that due to a Dengue pandemic in Nepal, the hospital was very crowded, and it was very difficult to get hold of health workers and for health workers to spare some time to complete the survey. Hence only 14 staff out of 20 that were invited to participate completed the questionnaire. This indicated time constraints for the collection of survey data. Secondly, the questionnaires in the pilot study suggested the need to add “service user counselling” as a means to communicate health information. In the context of Nepal, the most common and effective method for communicating health information is identified as direct counselling to service users by health professionals, especially when they come to access health services. Therefore, with other modes of health communication such as radio/posterboards, service user counselling was also added. It was observed that participants easily accepted the term ‘Dalits’ and had no issues using it.

Participants were excited to be a part of the discussion, however arranging a focus group was challenging as most Dalits were dependent on their daily earning for survival. Hence help for arranging participants for focus groups was requested. It was identified that the offer of snacks can affect the discussion if they arrived in the middle of discussions therefore, the provision was made to offer at the end of discussions. Furthermore, it was observed that participants received many mobile phone calls including some emergencies during the pilot interview. This situation was not in the researcher's control therefore it was accepted that the full interviews may take longer than expected so a longer gap between subsequent interviews was planned.

Finally, participants in pilot exit interviews tended to talk more about the situation and cleanliness of hospital and show their frustration towards hospital management. Sometimes the interviewees went off track. Therefore, it was identified that an intervention may be needed to ensure research is on topic and quality data is collected. Further, it was observed that, in most cases, visitors of service users hold more information than the service user themselves. As a visitor was the one who observed the surrounding environment, communicated with other parties, stayed with service users throughout and catered to their every need. Therefore, it was decided to include service users and visitor (where need) to capture quality information.

5.8 Data management

All collected questionnaires were handed directly to researcher and stored safely in a locker and later transferred into a password protected computer. The PhD researcher manually entered all data into SPSS 26. Once data was entered then a data cleaning process began. This included changing format, categorising, and cross checking. After data entry, a random 10% of cases were double entered to ensure a high degree of certainty. This is to ensure data verification, completeness, quality of data and to identify any discrepancies in the data. Nine responses were removed as numerous questions were unanswered. A copy of final SPSS data was sent to supervisors for the purpose of cross-checking the reliability and validity of data. Final data from 202

participants were included in the main data analysis and dummy results tables were created to identify the data to be presented in this study.

All qualitative data, focus groups and interviews were carried out by a PhD researcher and were audio recorded, as it is agreed that recording and transcription more accurately represent the responses of participants (Tong et al. 2007) rather than contemporaneous researcher's notes during an interview session which may interfere with the process (Britten 2006). However, information that was not captured in the recording (i.e., expression, gestures) or received after interview was noted in the researcher's notes. The audio recordings were transcribed in Nepali and later translated to English by the researcher (see Section 5.9.1).

5.9 Data analysis

5.9.1 Transcription and translation

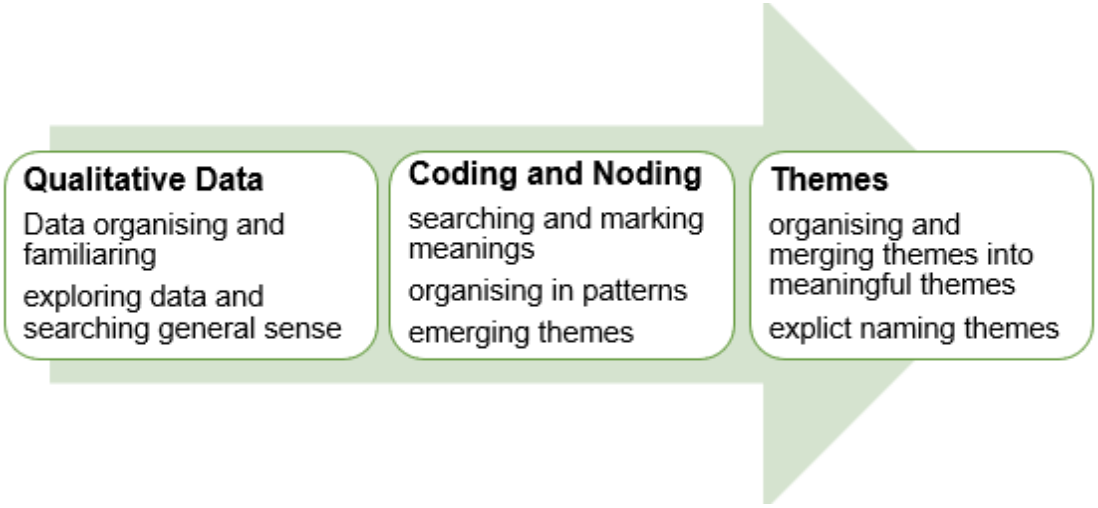
Focus groups discussions and interviews were translated from the original audio recordings of data (McLellan et al. 2003) (Nepali language) into English. Transcript-based analysis is a rigorous qualitative data analysis model which is useful for academic settings and complex research (Krueger 2014).

Focus group discussions, stakeholder's interviews, and exit interviews were conducted in the Nepali language and transcribed by researcher. The complete transcription includes setting description, development of interviews, any incident such as medical co-ordinate taking break for an emergency case or situation of health services and patients due to Dengue pandemic, any interesting data, further comments, and issues identified and records from the researchers notes. During the analysis, repeat listening of audio recordings whilst comparing with transcription was undertaken to cross-check reliability and to familiarise oneself with the data. Final transcriptions were sent to one of the supervisors, who is a native Nepali speaker to check quality and reliability of data. Any disagreements were discussed and resolved between the researcher and the supervisors.

5.9.2 Data coding and analysis

Coding can be seen as a process of organising data by bracketing chunks and writing words that represents a category in the margins (Creswell and Creswell 2017). For qualitative data, coding was conducted using NVivo 12, this helped to manage the vast amounts of data (Krueger 2014).

Figure 5-2: Coding steps for thematic data analysis



Adopted from Creswell and Creswell (2017)

All final transcripts of FGDs, stakeholders' interview and exit interviews were exported to NVivo 12. These transcripts were organised and read several times for the researcher to familiarise themselves with the recorded data. Knowing data from the early stage enables the researcher to have a general sense and understand common ideas, as well as get an opportunity to reflect on the data (Creswell and Clark 2017). From each transcript, finding and marking general ideas of data and grouping similar kinds of data, initial codes were generated. Similar codes were stored in a single folder called node in NVivo. These nodes are used based on frequently used words and phrases and output a meaningful concept based on what to look for to answer research questions. Each node may have more than one theme that holds meaningful information. Generated nodes were organised and processed to identify initial themes.

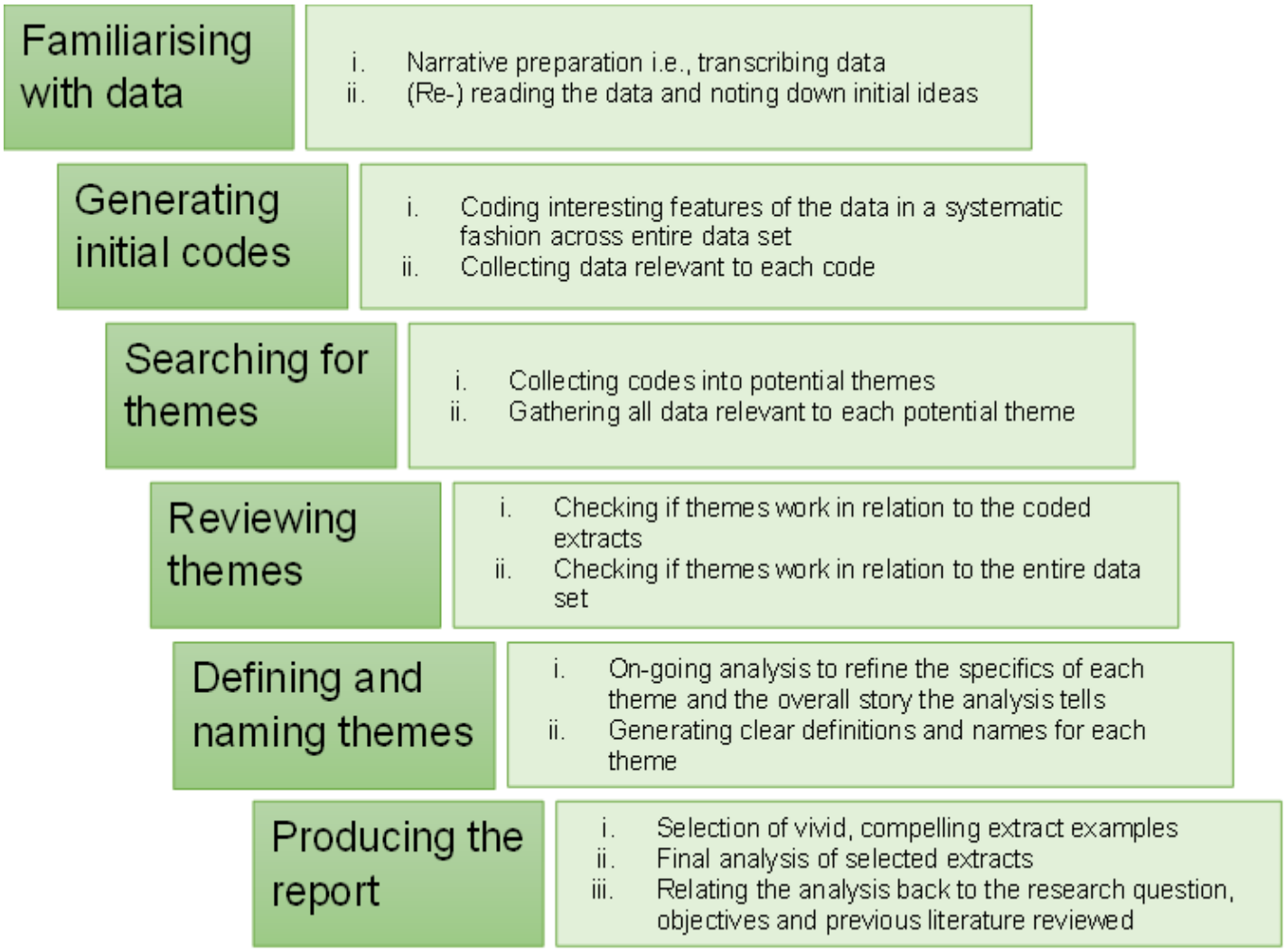
These initial themes were again reviewed and verified several times to form final themes. Different themes were merged into main themes to produce one core meaningful theme. Once data consolidation and reduction was done then themes were defined and named, and final themes were generated. Finally, thematic analysis and interpretation was conducted based on these final themes.

5.9.3 Thematic analysis

The method of data analysis should logically follow the method of data collection. Qualitative data analysis is a method to reduce and make sense from a huge amount of data from different sources, which may be helpful in answering research questions (Kairuz et al. 2007). Qualitative interpretations are constructed, and various methods of data analysis can be used in qualitative research, including grounded theory, thematic analysis and framework analysis (Yardley 2000; Braun and Clarke 2006; Mays and Pope 2020). This research followed one of the most popular methods used in the health sector, thematic analysis (Mays and Pope 2020). For this research, transcripts of focus groups, stakeholders' interviews and exit interviews were available for the thematic analysis of data.

Thematic analysis is a way of systematically spotting, organising and understanding data into patterns of meaning that allows researcher to discover the collective meaning of data in relation to a particular research topic and question (Guest et al. 2012). Thematic analysis is a flexible and a widely used data analysis method for identifying, analysing, and reporting patterns/themes from a huge data. Thematic analysis can be conducted in an inductive or deductive way. However, this research adopts inductive analysis, therefore it is data driven and processed without trying to match with a pre-existing coding framework (Braun and Clarke 2006). This research follows six phases of thematic analysis as proposed by Braun and Clarke (2006):

Figure 5-3: Phases of thematic analysis



Adopted from Braun and Clarke (2006)

Phase 1 – Familiarising with data: This phase includes immersing oneself in data by transcribing the literal meaning, inserting data into NVivo, reading the overall transcript, and listening to the audio again and again. During reading, making notes to highlight data that may be of interest and possible similarities to create patterns (Nikbakht-Nasrabadi et al. 2012). This was done using NVivo and preliminary

patterns were stored as nodes in NVivo. For this research this involved asking questions like what their core experiences were and making sense of the experience revealed outcome from their experiences.

Phase 2 – Generating initial codes: In systematic thematic analysis, coding is an initial step (see Section 5.9.2). The list of preliminary patterns is organised in a group and initial codes are generated from the data. Codes were created at the explicit or implicit level and evaluated in a meaningful summary of participants' experience and phenomena (Saldaña 2021). Using NVivo, similar patterns/cases were grouped together and given a different colour code - the codes with a high number of patterns were considered as possible themes.

Phase 3 – Searching for themes: In this phase, long lists of codes (63) are reviewed and brought together based on their similarities. Each set of codes stored were given a separate name. These codes are organised to give meaningful themes and subthemes and establish the relationships between them (Nikbakht-Nasrabadi et al. 2012). The map tab on NVivo has been useful to see relations between different codes, themes, and subthemes.

Phase 4 – Reviewing themes: In this phase, identified themes and sub-themes are reviewed. For example, themes that do not have supported data are reviewed, some themes are combined together, and some themes are merged to create new themes so that each theme provides a separate meaning, and gives the story of the data in relation to the research questions (Braun and Clarke 2006).

Phase 5 – Defining and naming themes: In this phase, final themes are refined during analysis. Here, selecting extracts to show and analyse as well as producing the meaning of each theme with regards to the research data is performed. Each theme must be unique and specific, and the name must be clear and accurate to provide the actual meaning to the reader (Guest et al. 2012).

Phase 6 – Producing the report: By this phase, a good set of themes are already generated, thus thesis writing, and reporting are done in this phase. During the reporting process, the arguments are presented in order to address the research questions.

In summary, the software package NVivo 12 was used to store data, highlight meaningful nodes, create and organise separate codes, and manage data. Stored transcripts and recordings were used for thematic analysis which were read several times carefully, considering different theme identifying techniques such as reoccurrence, categories, metaphors and analogy similarities (Ryan and Bernard 2003) to identify particular themes, patterns, responses and concerns(Bender and Ewbank 1994). Major themes regarding Dalits' health equity were identified and included in this research. Final themes and relevant quotations are presented in the qualitative findings chapter (see Chapter 6).

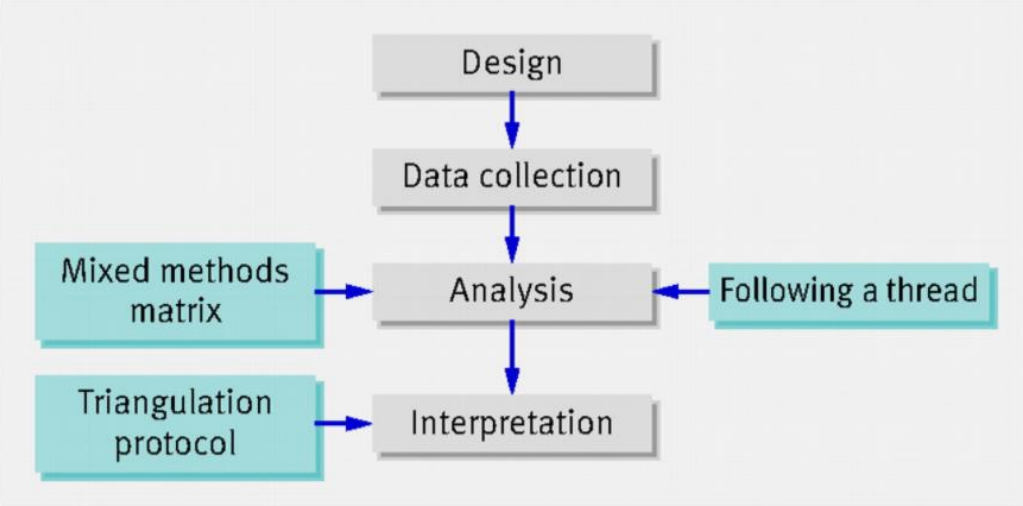
5.9.4 Quantitative statistical analysis

The management of quantitative data took place in SPSS (see Section 5.8). The data underwent descriptive statistical analysis, also referred as descriptive statistics or descriptive analytics. This descriptive analysis offers a simple way to present quantitative data representing a small sample in a manageable form. It is the process of using statistical methods to describe basic features of the set of data in a study (Trochim and Donnelly 2001). Descriptive analysis allows to simplify data on a relatively small group of people and is a sensible way of presenting and reporting basic information in the form of table, bars, charts, percentages, and frequency (Duquia et al. 2014). In this study, the researcher included 19 tables, which presents percentages, frequency and the probability value (*P value*) as relevant. Descriptive findings were further detailed in the quantitative chapter below (see Chapter 7).

5.9.5 Integration of data

The popularity of Mixed methods research is increasing among health and social science researchers (Lingard et al. 2008). One of the most important and often essential aspects of this method is integration - the interaction or conversation between qualitative and quantitative components of the study (Wisdom and Creswell 2013). Qualitative and quantitative approaches are often used to explore different aspects of the same research question. However, integration of data enables a greater outcome of the study. Integration can be conducted using three basic techniques (see Figure 5.4) (O'Cathain et al. 2010).

Figure 5-4: Data integrating techniques



Adopted from O'Cathain et al. (2010)

This study adopted a concurrent triangulation design, meaning data from each approach were collected and analysed separately in a similar timeframe to produce findings, and merged at later stage. Data integration was performed at the discussion phase, exploring both qualitative and quantitative data (Fetters et al. 2013).

5.9.6 Presentation of data

Data presentation includes pictorial representation of data using tables, figures, charts and maps. These methods add aspects of data visualisation which allows research to be comfortable and comprehensible. To give meaningful outcomes, the content of data presentation must meet the needs of research objectives and questions. Data with numbers and figures are presented in tables and graphics, while the qualitative interpretation is presented in the text, with relevant quotes also included to support themes (Fah and Aziz 2006).

5.10 Quality assurance

Quality assurance of academic research is based on the reliability and validity of research progress. Reliability and validity are the ways of presenting and supporting the rigour of research process and the trustworthiness of research findings. Reliability asks - when everything remains constant - how similar would the results be using a particular tool, test, or procedure such as questionnaires in different occasions. Validity describes a subtle concept of what we believe we are measuring compared to what we intended to measure (Roberts and Priest 2006).

In qualitative research, rigour is the trustiness of the research process and data produced (Stiles 1993). It is concerned with the extent to which results of the study or an outcome are repeatable in order to get same results at different occasions (Bryman 2016). In qualitative research, researcher bias may affect the research. Therefore, understanding research bias is important that allows the researcher to review critically and independently as well as performing independent checks. A blind study may also help to overcome researcher bias (Weber 1990; Pannucci and Wilkins 2010). The reliability of qualitative tools, data analysis and findings were independently validated by three academics. Similarly, data collection tools for each method were piloted through a local stakeholder - an officer from the health office to ensure data reliability and suitability in the local community. Any disagreements that rose from the few

transcriptions and coding of data and from the pilot study were discussed to form inter-rater reliability. Further, interview and focus group guides were continuously assessed and improved throughout data collection to ensure they were coherent and comprehensible. Throughout the process detailed notes were taken. This adds to the research auditability, therefore adds reliability. Further, specific codes and themes were generated to describe data, which were later revisited and validated by supervisors. Additionally, using a computerised data analysis package also enhances the reliability of research process (Roberts and Priest 2006). For this study, software NVivo12 was used. Recording and transcribing also enhances reliability (Sanjari et al. 2014). Thus, all interviews were audio recorded and recordings were transcribed by the native speaker PhD researcher and verified by a native speaker supervisor. With regards to the reliability of quantitative data, questionnaires were achieved by providing training to the data enumerators for survey data collection. Any confusion and issues were resolved so that the data collected from any other trained data enumerators would have the same results. Furthermore, as outlined in Section 5.8, a ten precent sample of the quantitative data was double entered for the purpose of quality control.

Validity in qualitative research is maintained in terms of how well the research tools assessed the research phenomena (Priest et al. 2002). In qualitative research, researcher bias is a potential issue in achieving qualitative rigor that may arise due to selective data collection and recording or data interpretation based on personal perspectives (Johnson et al. 2007). Thus, it is important to conduct qualitative research in a systematic way to ensure validity of research. Participants for the qualitative study were chosen purposively and chosen due to qualities they possessed/they met selection criteria (see Section 5.4). This study also includes data triangulation, combining two or more methods, data, theories is another way of achieving validity of research (Roberts and Priest 2006). The validity in quantitative research is achieved by maintaining the result accurately that represents the concept it claims to measure (Priest et al. 2002). Most of the survey items (questions) used for this study were

adopted and justified by comparing various other questionnaires, such as the Nepal Demographic and Health Survey (2016), the Nepal Social Inclusion Survey (2014), the Nepal Household Risk and Vulnerability Survey (2016) and the Nepal Living Standard Survey (2010/11).

5.11 Ethical considerations

Ethics is an essential part of research due to its moral and professional constraints to limit researcher's subjective perceptions (Eysenbach and Till 2001). It is evident that when conducting research three ethical issues related to maintaining confidentiality, anonymity and taking informed consent are particularly important (Goodwin 2006).

This research collected data on perceptions, views, and experiences of individuals. Some topics related to Dalits' experiences, their health and violence are considered more sensitive in nature. Therefore, this research followed a standard research protocol in order to protect and respect participants, privacy, dignity and rights. van Teijlingen and Simkhada (2012) suggested while conducting research in low-income countries, it is obligatory to seek ethical approval from the research ethics committee from the research country alongside the university-based ethics committee. This research sought ethical approval in the UK and in Nepal. Ethical approval was awarded by the Research Ethics Committee (REC) (see Appendix 13) at Bournemouth University and Nepal Health Research Council (NHRC) (see Appendix 14) as field work was conducted in Nepal. In addition to ethical consideration, permission to conduct health-related research in Makwanpur district was sought from the health office in Makwanpur (see Appendix 15). An online ethics checklist application was submitted to seek BU ethical approval (Ethics ID 22373). This application was approved in July 2019. Similarly, a proposal for ethical approval was submitted to the NHRC (Reg. no. 332/2019) online in May 2019. After resolving some comments made by the NHRC's reviewers such as adding a clear and specific study site in the research title, making the study objective more specific to research, separating

dependent and independent variables, and clarifying study population and selection criteria, ethical approval was granted by the NHRC ethical board in July 2019.

The researcher was physically involved in qualitative data collection. Direct interaction and communication raises some ethical issues on maintaining confidentiality, anonymity, taking informed consent and the researcher's impact (Sanjari et al. 2014). However, participants were informed and explained before participation that their participation would remain anonymous, and the information provided would be kept confidential to ensure privacy and confidentiality. Qualitative data collection was conducted in a closed room to ensure privacy and confidentiality. These were audio recorded and permission was sought in advance. Participants were informed that recording for academic purposes only. Audio recordings were destroyed after the transcription and analysis was completed. All transcripts were made anonymised and unique codes were given.

Informed consent (see Appendix 1) was taken in the participant agreement form, written from those who are literate and verbal for those who could not write. Obtaining informed consent is essential in research as they inform individual's role, rights and risk before participating, especially in low-and-middle income countries where limited work complies with ethical principles (Regmi et al. 2017). Informed consent allows participants to understand the research objectives, how the research will be conducted and any costs or benefits to participants before participating in the research. It also makes explicit the voluntary nature of the research and that participants can withdraw anytime without giving a reason (Van Teijlingen and Simkhada 2012). Further, literacy and language are important factors in achieving informed consent. It is unethical to receive written consent from those who cannot read and understand risk and benefit related to it. In this situation the informed consent sheet can be read out and verbal consent can be taken when risk related to research is low and potential harm is unlikely (Marshall 2006). When people agreed to participate, they were asked to sign or put 'X' (for those who cannot sign) on the agreement sheet.

5.12 Chapter summary

This chapter presented the methodological aspects of the research starting with philosophies underpinning mixed methods. Qualitative and quantitative studies were carried out in three different localities of Makwanpur district where the Dalit population is relatively higher. Finally, this chapter also outlined elements of research ethics in this study.

Chapter 6 Qualitative findings

6.1 Overview

This chapter presents the data collected from Dalits, key stakeholders, and recent health service users. In total six focus group discussions, six key stakeholders' interviews and five exit interviews were conducted in Makwanpur district (see Chapter 5.4). Qualitative aspects of this research aim to understand Dalit's experience, any risks and challenges they experience in assessing health, their health conditions, and their awareness of available health services and policies to reduce health challenges. This chapter first provides the characteristics of participants and is followed by qualitative themes identified for the research and the chapter's summary.

6.2 Characteristics of participants

6.2.1 Characteristics of FGD participants

The participants of the FGD were divided into male and female groups. In total six FGDs were carried out (comprising a total of 20 females and 21 males). The majority of participants had left school before fifth grade (in Nepal these are called school dropouts) (n=19) followed by no education at all (n=17) and few had attended college (n=5) (see Table 6.1). Similarly, most females were involved in household work whereas the males tended to drive for work.

Table 6-1: Characteristics of focus group participants

FGD	Number people	Gender / Age	Highest education	Place
1	6	Female (19-65) years	School Dropout (3) No education (3	Makwanpurgadhi
2	8	Male (19-65) years	School Dropout (3) No education (5)	Makwanpurgadhi
3	7	Female (26-53) years	School Dropout (5) College (1) No education (1)	Manahari
4	6	Male (28-46) years	School Dropout (5) College (1)	Manahari
5	7	Female (28-54) years	School Dropout (2) College (2) No education (3)	Hetauda
6	7	Male (32-65) years	School Dropout (1) College (1) No education (5)	Hetauda

6.2.2 Characteristics of key informant interview participants

Key informant interviews took place with six stakeholders. Four were government workers (including one medical coordinator from each area) and two worked for non-government organisations (NGOs). Regarding education, three had a master's degree, two bachelor's degree and one had completed secondary education (see Table 6.2).

Table 6-2: Characteristics of key informant interview participants

Participants	Gender	Education	Position	Organisation
KII1	Female	College	Director	NGOs
KII2	Male	University	Health Coordinator	Government organisation
KII3	Male	University	Medical Superintendent	Government Hospital
KII4	Female	Secondary	Operator	NGOs
KII5	Male	University	Health Coordinator	Government organisation
KII6	Male	College	Health Coordinator	Government organisation

6.2.3 Characteristics of exit interview (EI) participants

The exit interview participants were from different castes. Nine participants (four females and five males) were mainly school dropouts, four participants were Dalits and five were from non-Dalit castes (see Table 6.3). Three interviews were carried out in their own homes as they had just been discharged from hospital and stated that they would be comfortable conducting the interview in their own house, one was carried out in their workplace in a separate room and the remaining one in a local hired hall. In three interviews, there was more than one participant. This was due to a family member/carer being with the interviewee; these people provided additional information and commented on the experiences of the actual service user.

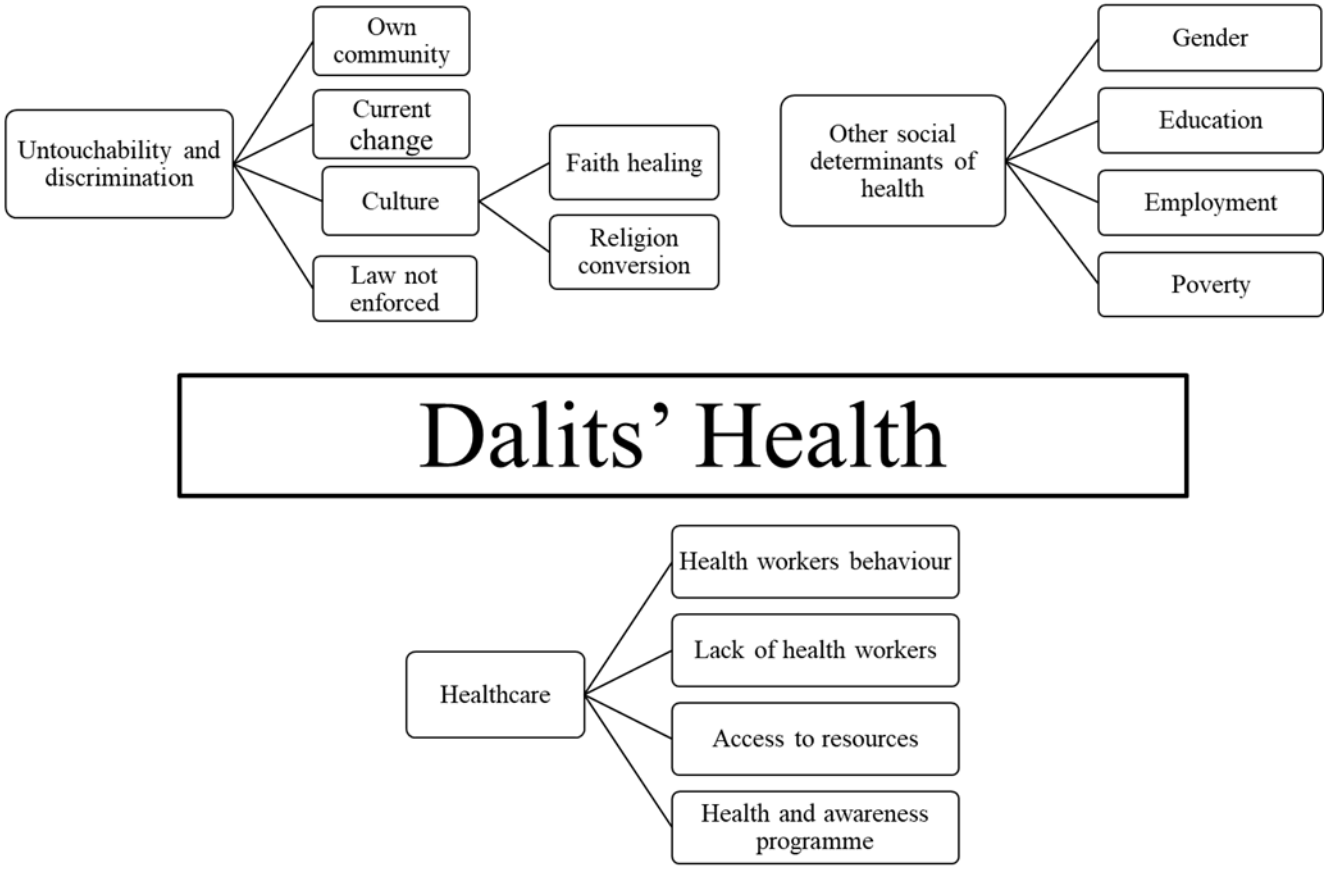
Table 6-3: Characteristics of exit interview participants

ID	Number people	Gender	Education	Caste/Ethnicity
EI1	3	Male (1) /Female (2)	School dropout	Dalit
EI2	1	Male	School dropout	Dalit
EI3	2	Male (1) /Female (1)	College	Brahmin
EI4	1	Female	College	Janajati
EI5	2	Male (2)	School dropout No education	Janajati

6.3 Qualitative results

Qualitative data were analysed to identify research themes. Three main themes untouchability and discrimination, other social determinants of health and healthcare were identified with several sub-themes (see Figure 6.1). Interestingly enough the research also highlighted that Dalits mentioned about discrimination, however they themselves do not link it to discrimination. Although many studies have established links between discrimination and health, in this PhD study Dalits themselves do not identify discrimination as a main reason of health inequity (see Chapter 8).

Figure 6-1: Themes and sub-themes



6.3.1 Untouchability and discrimination

Discrimination based on untouchability against Dalits, takes various verbal, physical and psychological forms. All participants agreed that some sort of discrimination due to untouchability occurred in society and most Dalits had experienced direct discrimination and challenges in their everyday life.

When asked about their everyday experience they explained social restrictions and their psychological effects. One Dalit illustrated that they were treated as less than a dog:

> *"We are restricted from entering temples, schools and other public places. Yes, there are many differences. For example, if I go to an upper caste person's house along with a dog, that dog enter inside the house waging its tail, but we must sit outside. I am treated lower than a dog and it is very humiliating and hurtful". (FGDs6)*

Along with the struggle to get food, water and shelter, Dalits live in constant fear of discrimination. Merely walking on public roads and crossing the path of upper caste people can be a life threating offense. Such constant fear and anxiety my lead to mental distress.

> *"In our generation and before that we could not even pass on the way of upper caste people as our shadow also could not touch them and seeing our face may bring bad luck. This considered as a very big offence". (FGDs6)*

Many shared their experience of physical abuse if they attempted to disobey or challenge the social hierarchy.

> *"One day, a dentist bought goat meat and she, a so-called doctor, told my child to not touch her. However, mistakenly my kid touched her. She got so angry, she pushed my daughter to ground, went to her room and slammed her door". (EI1)*

Participants shared another experience of abuse in a public place due to accidently touching a non-Dalit, not only from a high caste but other lower caste groups.

> *"In my village there was a governmental tap. My skirt touched one of the Tamang girls' jars while I was drinking water. She hit me with the jar, and I had a bruise". (FGDs1)*

Participants agreed that discrimination had become part of their life resulting attempts to address the reasons identified for the discrimination and to better and fit in the society.

"They said we were dirty, so we became cleaner, they said we were illiterate, so we went to get education. However, they still discriminate us". (KII1)

6.3.1.1 Own community

During this research, it has been identified that Dalits usually live in their own community rather than in mixed communities with upper caste members. This makes them feel safer and secured as they are less likely to experience discrimination from their neighbours that results in psychological relief

"It's like this, here we all are Pariyaar [a Dalit surname] community so around here we go to everyone, help everyone due to that they think there is no discrimination. We live in our own community, here we all are Dalits so have not suffered any kind of discrimination". (FGDs3)

However, a downside to living in an isolated area is the lack of access to health and other resources, which is detrimental to their wellbeing.

"Dalit habitation is further from health services, due to their financial condition, poverty, in places where economic movements and transactions are high, they could not afford to live there so live in isolated areas. Health posts are there where economic movements takes place or have markets. But they live quite far, usually in isolated places. Due to long travel distance and lack of travel facilities they do not come to health services and have not been able to interact with health providers". (KII2)

6.3.1.2 Current change

The harsh and unequal behaviour towards Dalits has improved compared to previous generations, although still continues in today's society. Some expressed that now there is less feeling of less discrimination and a better fitting in the wider society:

"Even in our generation, there was the fear. But now in our children's generation it has decreased, people are less discriminated. It was in our generation". (FGDs4)

So, there was a sense that discrimination towards caste is reducing. However, the change is not enough to overcome the fear of inequality that lies in society.

> *"No matter how much we preach against discrimination it still exists in various forms. When we go to rural places or talk about marriage, or social ceremonies, also attending funerals then discrimination prevails". (KII5)*

Several participants expressed that the government has tended to blame the Dalits for their experiences rather than systematically implementing programmes to address inequities that Dalit's face. Feelings of being blamed and not good enough, were mentioned:

> *"The government had an easy target while pointing out that we were discriminated due to us being illiterate but when we were aware about it and got education, they feared we would slowly rise to the top and they need to respect us. The government itself has become like that, the quota (Dalit seat reservation) system for Dalit people was cancelled. The government, its people and society should understand without it, discrimination is not going to stop". (KII1)*

Reducing discrimination against Dalits is not only a Dalit issue and will only be addressed if examined at national level addressing health, education and employment.

> *"They should understand that this is not only Dalit's problem but the whole state's problem and intervene in religious, political, or cultural level. If we attack such person from every level, then he/she gets compelled to accept us". (FGDs4)*

6.3.1.3 Culture

One of the main reason Dalits miss out on opportunities such as getting access to the health sector is due to their practice and belief being a part of their culture. Cultural practices of traditional/faith healing are related to religious beliefs that supports caste factors, thus influence the caste hierarchy.

- **Traditional/Faith healing**

Traditional healers are known as Dhami/Jhakri, who live and work locally in the community. They practise beliefs and rituals regarding communication with the spiritual world and engage in treating people who are affected by spirits/possession (known as *laagu*). One of the reason Dalits are more vulnerable to poor health is their belief in traditional healing and using the Dhami/Jhakri as their first port of call rather than seeking medical help.

> *"Dhami/Jhakri is more common and gets priority over visiting the hospital, especially small children. It still prevails. There is a trend, taking them to a Dhami/Jhakri at first and then to a hospital later. A person from our community who despite living in city/market area visits the Dhami/Jhakri first". (KII1)*

Faith healers are accessed before healthcare services - this may be due to poor health literacy, and cultural values. However, faith healers can be more accessible as they are more easily available and cheap. However, this can delay access to healthcare treatments which can result in greater overall financial burden and poor health which Dalits may not be able to afford. The tradition of using incense and rice has become somewhat less popular, however it still gets priority over medical health.

> *"At first, we go to the Dhami/Jhakris. We go and see if they have laagu. Laagu is our tradition that has been followed for a long time. Children are done more than adults. In case of children, even the people from the Bazaar or the cities they also do it. If it gets better without taking medicine, then why should we take one, so we go to them first. It is a belief. If you believe from heart it will heal". (FGDs3)*

- **Religion conversion**

Religion is important part of life in traditional communities in rural Nepal and the caste system is one of the fundamental features of Hinduism. However, religion also promotes caste inequality, therefore Dalits are made to consider converting from

Hinduism to Christianity, as in Christianity there is no caste/Dalits. This research has identified that Dalits (in response to the discrimination) are changing their religion. They feel that religion has supported this inequal system. It provides some sense of spiritual reliefs.

> *"Of course, we feel that religion has given priority to such caste system. They try to be higher than us even gets priority over. Due to Hindu religion, we have been facing discriminated. In Christianity, or Muslim, I don't think there is such discrimination". (FGDs5)*

Participants explained a level of spiritual wellness such as self-satisfaction or the perception of curing a long-term disease, especially related to spiritual health, and believed they would be treated equally if they abandoned Hinduism. As such, they are no longer invited nor attend Hindu religious ceremonies or social and cultural programmes. Therefore, there is less chance of them associating with Hindu neighbours who discriminate against them, so experience less discrimination and distress related to it.

> *"Well, they convert religion due to the caste discrimination, Bhraminwadi (brahminical) mentality. So, they felt peace and equal being Christian. One main reason of converting religion is discrimination but is not Hindu religion itself but people who twist religious guideline. Christians have separate festivals and programmes so there are not many interactions (ghulmil) with people Hindu upper-caste people". (KII1)*

Participants expressed feeling of peace and less psychological pain:

> *"This discrimination affects them not only physically but mentally and people enjoy where there is no psychological pain that is why I think they are converting into Christians". (KII4)*

6.3.1.4 Law not enforced

Discrimination against the lower caste in Nepal was officially abolished in 1990, but it was two decades later in 2011 that the Bill was passed making caste discrimination

and untouchability illegal (Offence and Punishment Act). However, there remains culturally entrenched caste-based discrimination against the 'untouchable' so-called Dalit minority. This has resulted in Dalits being excluded from education, medical and health facilities, and basic rights. It is evident from the participant experiences that there remains a gap between the law and implementation of the law to remove caste-based discrimination:

> *"Now it is said that law has made such practice illegal so they cannot prevent us from going inside. Instead, they stand at the door so we could not pass. If we get thirsty during meeting and ask for water, they give us water in a bowl. But then they put it outside or somewhere else on side and bring it inside after re-washing it once we are gone". (FGDs5)*

Some thought that the law itself was not the problem but the way it was implemented and not enforced:

> *"There are many laws but still it is not implemented. The law is strong enough, but it has not been enforced". (FGDs1)*

The participants expressed feelings that the government should invest more in implementing the new legislation.

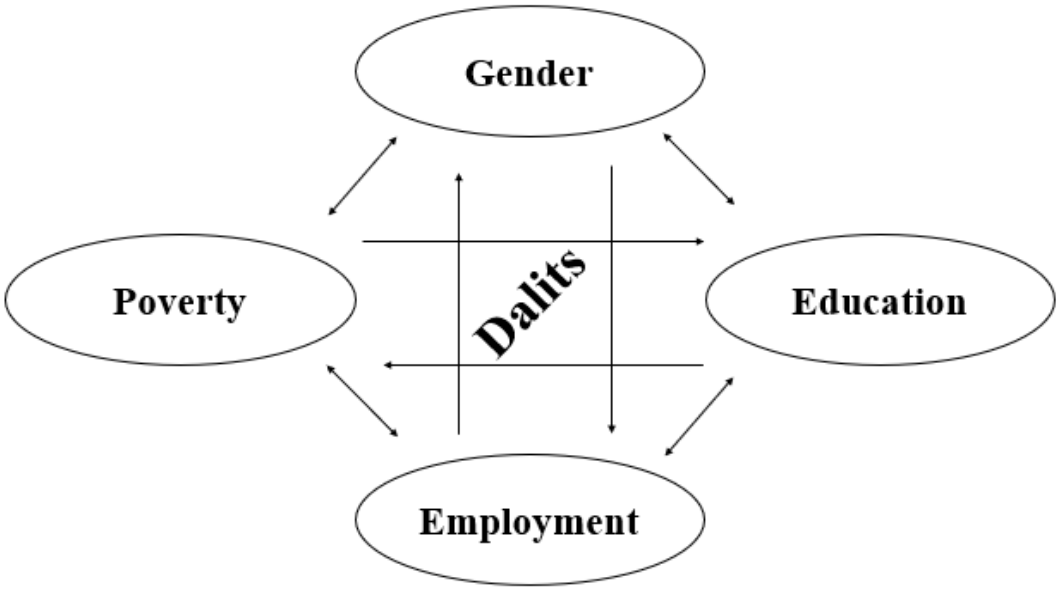
> *"The law has changed but it has not been implied practically. The biggest change is supposed to be brought from government". (KII4)*

Discrimination can be managed and controlled with strong law and its implementation, so that discrimination and health aspects related to it can be controlled only then will there be hope to provide better and equal health services to Dalits.

6.3.2 Other social determinants

Health is influenced by broader social and economic factors. Gender, education, employment, and poverty (see Figure 6.2) are key determinants affecting people's health and therefore also Dalits' health.

Figure 6-2: Other social determinants for Dalits



6.3.2.1 Gender

Participants stated that Dalit women are given very little status and attention within society and hence not valued. For example, there is neither a strong police investigation nor laws to protect women from domestic violence which negatively impacts upon their mental health. In Nepalese society, the status of women is generally lower than that of men. Therefore, to be a Dalit woman means that you are more vulnerable to double discrimination based on both caste and gender discrimination. Dalit women face severe discrimination and find themselves in a daily fight for their

basic rights. However, their access to justice is insignificant, resulting in them being a victim of sexual abuse and violence.

> *"You may also have heard various news about Dalit rape cases. These cases are increasing day by day, however most of time these cases are neither recorded nor investigated. Due to this we fear to perform our daily activities or stay little late outside". (FGDs3)*

It was evident that Dalit women not only experience discrimination more generally in society, but this low status manifested in domestic violence within their own homes,

> *"Among the Dalit men and women, the Dalit women have faced more hardships than men. From the loads, responsibilities to everything. We can do anything eat, drink, men do not see the work that the wife does at their home. Some people might beat them under the influence of alcohol. The men are usually stronger and act crazy. That is why even in Dalits the women face more hardships. Even as a Dalit, the women have more problems within the family". (FGDs2)*

Women generally have lower status in Nepal and Dalit caste women's status is lower still. As such, Dalit women do not see the point in sharing or talking about their experience nor do they value their own existence. Due to this oppression Dalit women are not able to open up about health issues they experience.

> *"Since the women are dependent on the family, they do not have the decision-making rights neither financially stable. Dalit women faces more discrimination than Dalit men even in the society. Women themself who are non-Dalit discriminate against Dalit women. Dalit women are oppressed both at home from the male family members and outside by other society members. Due to this Dalit women used to let the disease wither in their bodies, but not share however, and even if they do, nobody will care. There is still a huge stigma and fear that the husband will leave the wife if she talks about such topics". (KII1)*

Untouchability is practised to such an extent that people do not wish to touch Dalits even if one is in critical health situation and needs support. Dalit women who are

pregnant are limited in receiving healthcare too as non-Dalits refuse to touch a Dalit person or enter their home.

> *"From my own experience while I was there, I witness, they discriminate those who were poor or Dalit. For example, a Dalit Female Community Health Volunteer (FCHV) is discriminated, restricted from entering the house. She should be able to visit the patient. It got difficult to reach the patient. As she could not enter inside, she was told she cannot touch here or there. Similarly, if a Dalit woman is about to have labour, then other non-Dalit FCHV discriminates too…. It is like that". (KII1)*

Another participant added that it is very common in Tarai (Southern part of Nepal), that Dalit women who are healthcare workers are restricted in their ability to provide healthcare services due to the restriction on touch and entering a non-Dalit house.

> *"It is like that here as well. Even more in Terai, I don't need to mention that. FCHV being a Dalit herself isn't allowed to visit patient directly like other FCHV. Are they going to be told to stay just there outside or will the patient be quickly shifted outside; there are differences like that". (KII4)*

6.3.2.2 Education

Dalits are discriminated such that they are barred from entering school buildings, not allowed to sit with everyone in the classroom, touch other students and teacher and participant in any school programmes. This research shows that illiteracy within Dalits is common as many Dalits drop out of study before the fourth or fifth grade (aged around 8-10 years). Others have never even been to school due to the discrimination that occurs in the education sector.

Education is a key factor in breaking the cycle of discrimination and providing better health. Along with recognising their rights, education can help Dalits to understand their health situation and needs.

> *"Our people, people belong to lower caste couldn't study and struggle to get admission in schools. Even if they went to school they would have to sit outside. Dalit kids had to stay outside. The teacher wouldn't even touch our books. Teacher would look at other's notebooks but not the Dalit kids. They would instead make them recite their homework. Then they would point at their notebooks using a stick. We went through this". (FGDs6)*

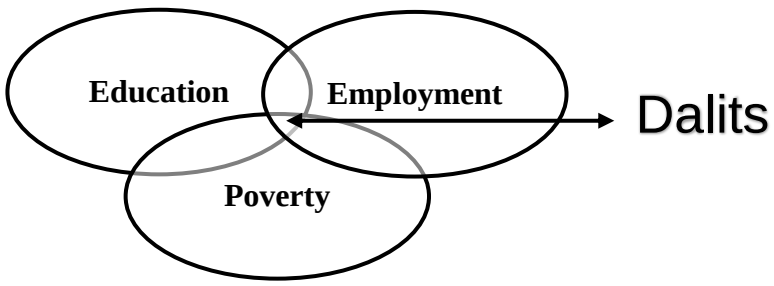
Participants suggested that discrimination is not only from an organisational standpoint such as denying admission, but also works on an individual level from teachers. Feeling of being separated from class and treated differently.

> *"Teachers would not even touch our books and check homework. Teacher would ask us to narrate our work and point out using a stick". (FGDs5)*

Whilst one of the KII was largely blaming Dalits for their poor health:

> *"The main reason is education. Due to lack of health education; they do not pay attention to cleanliness and sanitation, not familiar with health problems due to bearing many children, not aware of their personal health issues therefore result in poor health". (KI1)*

Figure 6-3: Interconnection of education, employment, and poverty in Dalits



Education, employment, and poverty are interlocked determinants (see Figure 6.3) of health aspects. Without education, Dalits are trapped in a vicious cycle of extreme poverty, illiteracy, and discrimination. This also results in poor health, which is perpetuated across the generations.

6.3.2.3 Employment

As previously identified, Dalits often have little education and as such are typically unemployed or working in lower status and/or unhealthy jobs.

> *"I do sew and make cotton mattress. No masks, gloves and other needed Personal Protective Equipment (PPE) are provided by government, and we could not afford to invest on that ourselves. During making, cotton particles go inside that may lead to us having chest infections. I may have it in future". (FGDs3).*

As employment is difficult for those in Dalit communities, many are forced due to financial reasons into dangerous professions that makes them more vulnerable to poor health. For example, waste scavenging involving cleaning human excrement, septic tanks and sewers, without any proper PPE.

> *"We used to do jobs that is manual cleaning of human excrement with our hands and legs covered in it. We do not get any gloves or masks. I myself have done that but now I don't do that anymore. That time I used to be ill often". (FGDs5)*

This research identified that there are few individuals from Dalit communities working in healthcare. Those that do work in healthcare are typically involved in domestic positions such as sweeping or cleaning but not in higher position that may have greater influence in Dalits health.

> *"We do not have anyone who is Dalit and works in a health post despite cleaners. Most of the males they do driving and female whether household work or sewing". (KI3)*

Having more Dalits working in the health sector will help to create an approachable and welcoming environment for Dalits.

Participants also mentioned that another important aspect of health is unemployment and job securities, and that it plays a crucial role in maintaining physical and mental health.

> *"We who stay at home, our main concern is what to eat in a day or feed our kids rather than thinking about what health problems we have or whether to go for check-up. It's just enough for food, no further expenses can be afforded". (FGDs1)*

The fear of losing one's job or not having income also adds mental stress.

> *"Every day, I wonder I will have job or not. Despite it is my own shop but it is not sure I am not sure if I am allowed to sit there (outside that cloth shop) or I will have any customers today, what and how much I will bring home". (FGDs2)*

6.3.2.4 Poverty

The findings from this study identify that most Dalits in this study live in poverty and are less likely to possess registered land compared to upper caste people.

> *"Us people, uneducated and poor, some of us do not have neither house nor land". (FGDs3)*

This research has highlighted that many Dalits face financial distress. They are poor and struggle to manage their day-to-day existence. As such, all family members must work in order to generate a daily wage, and cannot not afford a day-off.

> *"Some Dalits are living under extreme conditions, struggle to cover daily expenses and need to endure many more difficulties. Therefore husband, wife and sometimes including kids have to engage in earning for food". (EI2)*

Whilst the Government of Nepal provides some free health services, they are very limited and may not be easy assessable. Most of the population's healthcare is based on private or paid healthcare services, which are quite expensive, may not be readily available, and could involve travel so are therefore out of reach for Dalits who cannot afford health expenses.

> *"Dalit people may be facing more difficulties for health facilities. Most Dalits have low economic conditions, could not get treatment due to lack of finance". (EI2)*

Participants explained that due to poverty, Dalits despite knowing they may be in poor health have no choice but to ignore symptoms and problems rather than seeking treatment.

> *"Everyone will obviously be concerned about their own health' But it's like this, due to poverty Dalit people do not rush to the hospital as soon as they fall sick. They do not feel the need to get treated for every minor sickness, poverty reminds them that they do not have the luxury to visit a doctor whenever they are ill... This led to illness getting more severe and increase financial burden which they cannot afford. Since they cannot get treated on time, they either die with minor illness". (KII1)*

Poverty not only directly affects an individual's physical health and wellbeing, but also has a negative impact on their mental health and wellbeing.

> *"The poor people mostly suffer from mental illness. The rich ones get it treated any which way. In case of poor ones, they are on the verge of being homeless. It is like this…. talking about the Dalit community's health; the Dalit community itself is mostly poor. We need to understand it like that. I am not trying to say other castes are not poor but due to high impoverishment their health isn't that good. I said it earlier as well". (KII4)*

6.3.3 Healthcare

This research identifies that Dalits' physical/mental health and social wellbeing is affected by discrimination. Participants expressed that experience of discrimination have a profound impact upon their day to day lives. They expressed feeling anxious and worried. Therefore, this research highlights the long-term psychological perspectives of participants. When asked, participants expressed their psychological distress and the effect it had on their mental health.

> *"Being Dalit is not sad, but it is sad to return from someone's doorstep without entering the house just because you are Dalit Discrimination causes mental tension and effect on mental health". (FGDs6)*

6.3.3.1 Health workers' behaviour

Health worker behaviour plays a vital role in Dalit health, whether it comes to returning for health services or getting better health services/facilities. When investigating the behaviour of health workers towards Dalit service users, there were mixed responses. Many participants stated that they have neither experienced nor witnessed discrimination by health workers based on caste and agreed that Dalits received equal services:

> *"No health workers don't exercise such difference, it doesn't exist. No such discrimination is not done by health workers". (FGDs5)*

Participants asserted that, not only did health workers not practise discrimination, they were also welcoming, which can be a motivating factor to use health services.

> *"The hospitals staffs were helpful and friendly towards patients and the family as well. They helped in regulating the medicine taken by patients. They behaved nicely". (EI2)*

However, another participant added that the behaviour could be the result of them not knowing users are from Dalit communities. Thus, no health discrimination was seen.

"They do not do that, may be because they cannot recognise us as Dalits." (FGDs1)

Conversely, interviews with stakeholders highlighted that discrimination could occur directly or indirectly in health services.

"While going for a check-up, where we took tickets; people there (working), kind of ignored them and didn't care. Even doctors, the behaviour towards Dalit and poor people are different. I would not say only Dalit but poor ones too. Their behaviour towards the ones who are a bit less educated, and poor is different. Discrimination based on caste is seen in government hospitals more often than private ones.". (KII1)

Another participant added that, despite health workers' nonacceptance of discrimination, it does happen and can be seen not only in hospital/health services but on a societal level.

"In terms of Dalits, whatever health workers say, there is bias. I have seen biasness in many places. For instance, health workers visit to Bahun, Chettri's [an upper caste] programme leaving their work but not to even drink water in Dalits house who lives next. Both parties could not gather enough courage whether to invite and visit each other. These kinds of daily activities demotivate Dalits and makes them uncomfortable and difficult to utilize health services." (KII2)

6.3.3.2 Lack of health workers

Many participants claimed that there is a lack of healthcare professionals within their communities which resulted in having to wait significant lengths of time to be seen, reducing the chances of timely treatment. As a result, many visited a local pharmacy instead of going to hospital or seeking help from health professionals.

"The main problem is that there are not enough doctors compared to patients they have, and this worsens the situation more because the patients don't receive treatment on time. There is always

shortage of doctors and nurses, and it is also because of that long waiting hours we feel like just going to the clinic instead". (EI5)

This research identified that many Dalits live in isolated rural areas. These rural areas struggle to recruit and retain health workers, especially professional doctors who are not interested to live and work in rural areas. This lack of medical expertise has a negative impact upon the health and wellbeing of Dalits.

"Hetauda, despite being a capital city has not got a specialist so there are no possibilities us in rural areas getting a specialist doctor in our health units. I had run single handed when there were no doctors because it's hard to post doctors in village area". (KII2)

6.3.3.3 Access to resources

This research identified that Dalits' access to healthcare is limited, and this is very frustrating for the participants who feel that the government should be doing more to ensure accessibility of healthcare.

"You should bring a different rule of law for the Dalits, or the demographics of this place should be registered in, so then may be governmental hospital are available and accessible. They should provide free services or discounted fares in treatment". (FGDs2)

Available services are very crowded and offer limited trained staff, medicine and equipment.

"In our community we don't have enough health services. There is a small health post. It has only been some time that some machines are brought here. Here we have no x-ray machines, video x-ray, or other equipment". (FGDs4)

Participant also stated that no additional support and services are provided as a means of persuading Dalits to utilise healthcare.

"This is the situation of Makwanpur district. We do not even have access to local resources and means. The state has not made any

type of arrangement or provided separate facilities for Dalits. Government and responsible person have not been sensible enough to provide facilities." (KII1)

Another participant commented on the means of transportation and associated difficulties in accessing healthcare services.

"Health services are in a fixed place and there is travel issues due to dangerous roads and lack of transport facilities for villagers to travel to health services. Most of the time roads are very dangerous and is not able to travel in need. Therefore, there is no easy access to health services. So, compared to non-Dalits, Dalits do have some difficulties in accessing health services. Their residences are also further from health services". (KII2)

Providing accessible free healthcare services would make it easier for Dalits to be able to access healthcare which in turn would enable better health in these communities.

"If health posts and birthing centre services are available in every ward, then it would be easier for Dalit communities to get such health facilities with ease.". (KII4)

Another participant added that, for the better health of Dalits, there is a need for frequent health check-up programmes or camps (on top of free services).

"There should be frequent health check-ups free of cost. If it is free, then people will attend them. People with low economic condition can afford to go". (FGDs6)

The government introduced a few policies such as list of 72 essential free medicines throughout health facilities. They have also implemented a system of health insurance in government health facilities with the aim to provide easy and affordable access to health services, specifically targeting people who cannot afford medical expenses. However, the bureaucracy of this process was prohibitive as participants expressed.

"The process to getting free medicines is also an extremely exasperating process". (KII1)

One participant stated that the health insurance plan provided by the government has not been much use as most of the medicines, especially expensive ones are not available using health insurance. Due to this Dalits were affected most.'

> *"So, what's the use of insurance if we must buy it from outside? Expensive medicines are not available there". (EI1)*

Furthermore, it was evident from participants that policy holders and direct payers were treated differently.

> *"After he came, we showed our insurance cards, they shouted saying that we could have showed it earlier, so I shouted as well saying why did you not ask for it. I also noticed how quickly they provided treatment to the man who paid the money instead of using an insurance card like I did". (EI3)*

6.3.3.4 Health and awareness programmes

The Government of Nepal has been working to improve the country's health sector. Many health and awareness programmes have been organised such as regular vaccination programmes, family planning, health camps, HIV awareness, and health education programmes such as Dengue awareness. However, when participants were asked, it became apparent that these health programmes were having a limited impact as many participants were not aware of their existence.

> *"We do not have any programmes here. They have not brought anything like that. There is nothing specific to Dalits". (FGDs2)*

However, many participants agreed that health and awareness programmes are much needed.

> *"Yes, it is necessary. If health awareness and safety at work programmes were given, it would be like adding perfume in gold (best). We would better understand and identify health issues and follow safety procedure at work to benefit our health". (FGDs2)*

Another participant added that health programmes would educate them and would be helpful in taking precautions and living a healthy lifestyle.

> *"If we are aware how to take care in pregnancy and take better care to achieve better health, such as even just going for vaccinations. We may do it. For example, now we have Dengue pandemic here we would have taken extra care and precautions if we were educated about it. I wish they organised a programme to educated about health". (FGDs3)*

One stakeholder added that there is a distinct lack of health programmes.

> *"We do not have better health programmes. We have some programmes however, no separate provision for Dalits. It would be beneficial if we can arrange some to distribute health information and help them to understand health related issues which will help to motivated them for check-ups". (KII1)*

Another added that some NGO or private organisation used to do it, but that there was nothing left now after they had gone.

> *"Previously there was some NGOs such as Plan Nepal. They used to do some health programmes. However, they are phased out so no there is not any public health awareness programmes, neither private nor government". (KI3)*

6.4 Chapter summary

This chapter presents qualitative results derived from six focus groups, six in-depth interviews and five exit interviews which were thematically analysed and organised using NVivo 12 software. In total three main themes and twelve subthemes were identified. The participants of FGDs and EI expressed that there was no discrimination by healthcare workers whereas KII participants stated that discrimination exists from healthcare workers towards Dalits. In addition, the participants stated that discrimination based on caste had a negative effect on an individual's physical, mental, and social wellbeing.

Chapter 7 Quantitative findings

7.1 Overview

This chapter presents the survey data collected from health professionals in the Makwanpur district. The quantitative aspect of this research aimed to understand healthcare professionals' perceptions of underlying reasons of health discrimination that occurs in the healthcare sector, the challenges Dalits experience in accessing health services, the behaviour of health workers, and any suggestions for improvement. In total 400 questionnaires were distributed; 211 health workers completed the questionnaire, a total response rate of 52.8%. On checking data quality, nine questionnaires were only partially completed (see Section 5.8) hence the 202 responses in total that met the quality criteria (see Section 5.4.3) were included in the final analysis. The initial plan was to include total sample of health workers available in research area. However, due to Dengue epidemic in Nepal this total sample could not be achieved. As this research is part of a PhD study, with its inherent resource limitation such as having limited data collection time frame and limited funds it was not possible to go for a bigger sample or include another research area.

7.2 Results

7.2.1 Background characteristics of the respondents

Characteristics of survey respondents of such as caste, religion, age, gender marital status, education, profession are listed (see Table 7.1). Note that not all respondents answered all socio-demographic questions hence respondents who responded are listed as well as total respondents in number with each characteristic heading.

A large minority of respondents represented Nepal's lower caste population, as 47.5% were of Dalit and Janajati origin. The Brahman and Chhetri (upper caste) representation was a similar proportion (52.5%). Here responses received for other categories such as Dalits, Janajati and other ethnic minority groups was much lower

than Brahman and Chhetri. Therefore data had to be merged to create a sensible dataset for analysis, this is due to low numbers of overall responses, since Dalits accounted for only 2.6% of all respondents. Thus, the proportion of upper caste and lower caste participation is almost equal, but the lowest group in the caste system, the Dalits, is small. Most of the respondents follow the Hindu religion (85.9%) and the least followed Christianity (3.5%).

Furthermore, a large minority of the respondents (46%) belong to the 18-25 years age group and two-thirds of respondents are female (67.3%). The representation of married and unmarried respondents is of approximately equal proportions with 49.5% and 50.5% respectively. As there was only one respondent who fell under the divorced category, they have been merged with the unmarried group to have sensible data for analysis.

Table 7-1: Characteristics of survey respondents

Characteristics	Frequency (n)	Percentage (%)
Caste/Ethnicity (n=196)		
Brahman	51	26
Chhetri	52	26.5
Dalit and Janajati	93	47.5
Religion (n=198)		
Hindu	170	85.9
Buddhist	21	10.6
Christian	7	3.5
Age (yrs.) (n=202)		
18-25	93	46
26-35	71	35.1
36-45	28	13.9
46 and over	10	5
Gender (n=202)		
Female	136	67.3
Male	66	32.7
Marital status (n=196)		
Married	97	49.5
Unmarried/ Divorce	99	50.5
Education (n=198)		
10^{th} grade or less	13	6.6
11-12^{th} grade	135	68.2
Grade 13 and over	50	25.2
Employment level (n=199)		
Junior health workers*	143	71.9
Senior health workers**	56	28.1
Local resident of health post (n=192)		
Yes	89	46.4
No	103	53.6
Experience as health worker (n=201)		
Less than 1 year	35	17.4
1 to 3 years	63	31.3
3 to 6 years	48	23.9
6 to 10 years	23	11.4
11 years and above	32	16

*Auxiliary Nurse Midwife (ANM), Medical Assistant (MA), Auxiliary Health Worker (AHW), Certified Medical Assistant (CMA), Radiographer and lab technician

** Health Assistant (HA), Nurses and Doctors

The largest education range of respondents is 11-12th grade (68.2%) which is equivalent to A level education in the UK. The education system in Nepal is different from the UK and people in Nepal may spend longer in school before moving on to go to college, especially when they are struggling to complete school-level education.

The employment status of health workers is divided according to their job title into two categories: junior and senior positions. There were several employment positions collected but some frequencies were too low, therefore positions were categorised into the two main categories to have rational data for analysis. Most of the respondents are in lower ranking health workers' positions (71.9%) such as Auxiliary Nurse Midwife (ANM), Medical Assistant (MA), Auxiliary Health Worker (AHW), Certified Medical Assistant (CMA), Radiographer and Laboratory Technician, whereas senior position holders accounted for 28.1% and included professions like Health Assistant (HA), Nurses and Doctors.

Most respondents had up to six years' experience, others recorded that they had one-to-two years (31.3%) or three-to-four years (23.9%) of work experience. Interestingly, over half of the survey respondents (53.6%) stated that they were not local to the health post in which they worked, and therefore had to commute from home.

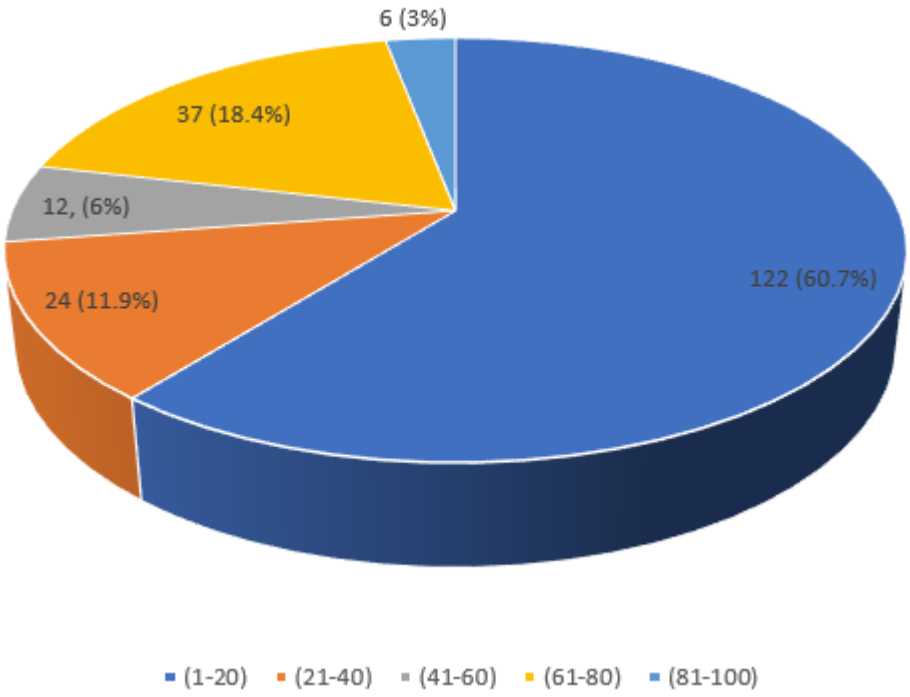
7.2.2 Current health services

This survey collected information on the condition of current health services of the research area, including the rural and urban areas of Makwanpur district. The current health services explored were based on the availability of health services, number of clients using health services, delivery of health information within general and Dalit communities, proportion of service users from Dalit communities, fulfilment of health and medical needs, and other available health services.

Respondents were asked, 'How many healthcare workers are there in your area?' The total responses received (n=201) are presented in a pie-chart (see Figure 7.1). Most of

the respondents (60.7%) agreed to the lowest range (1 to 20) of health workers providing services in their health institution catchment area. This may be due to the fact that many health workers do not live locally.

Figure 7-1: Number of health workers available in their service catchment area



Similarly, when asked, 'In a day, roughly how many patients would you see?' the total responses received was n=195 (see Table 7.2). A large minority of respondents, 44.6% (n=87) stated that they would normally see 21 to 40 service users in a day, whereas 2.6% stated that a health worker may attend to over a hundred service users in a day.

Table 7-2: Number of service users attended by health workers in a day

Service users attended by health workers in a day (n=195)	Frequency (n)	Percentage (%)
1-20 clients	69	35.4
21-40 clients	87	44.6
41-60 clients	9	4.6
61-80 clients	14	7.2
81-100 clients	11	5.6
100+	5	2.6

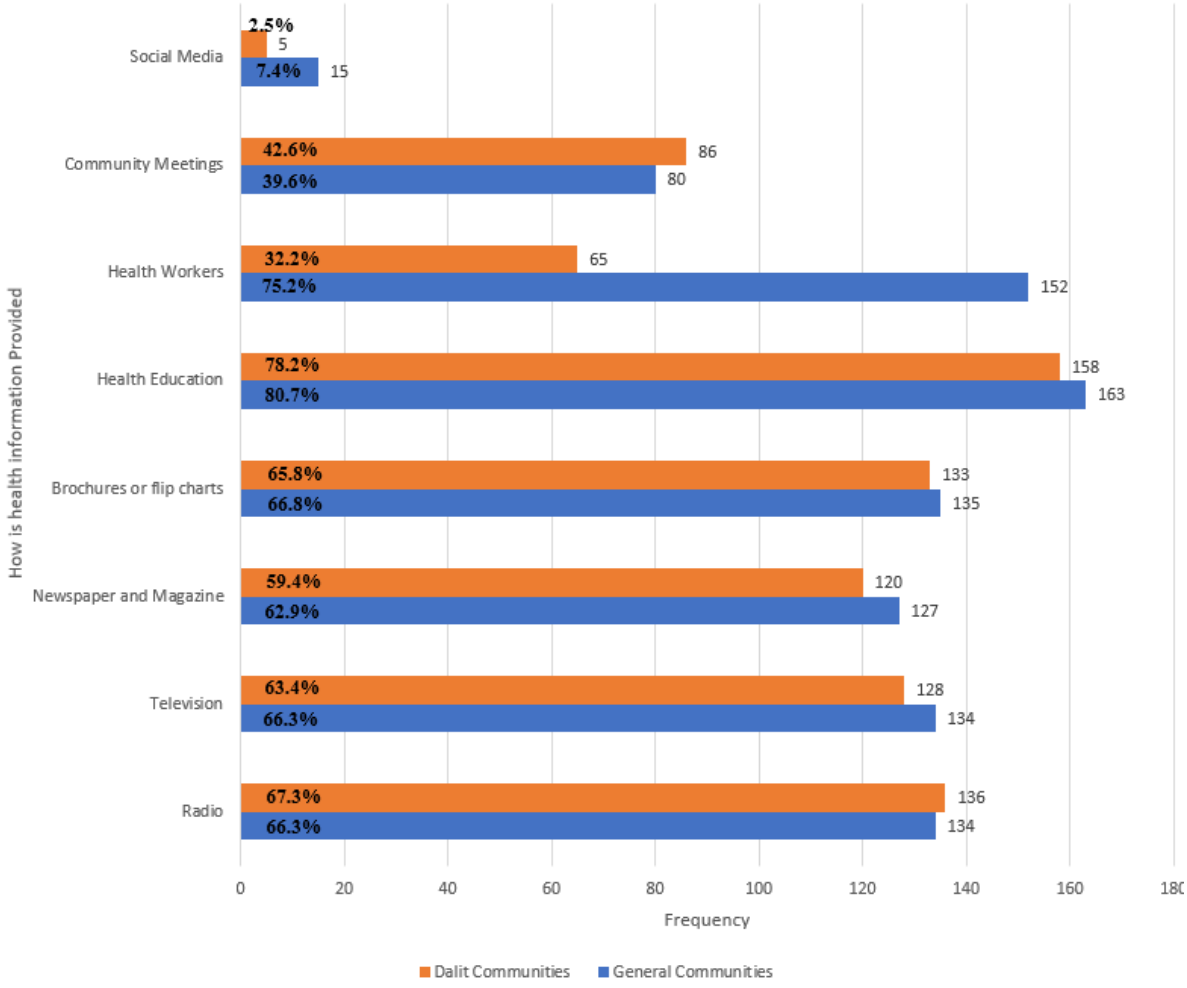
Multiple-choice questions, 'How is health information provided to the community in your catchment area?' and 'How is health information provided to the Dalit community in your catchment area?' were also asked.

It is evident that the most common way to provide health information to both the general population (80.7%) and Dalit communities (78.2%) was through health education programmes. Such health education programmes include health and awareness programmes, camps, posters, hoarding board/ billboard and street dramas. These elements were merged to enable further statistical analysis. The least popular way to distribute health information was through social media accounting (7.4% for the general community and 2.5% in the Dalit community respectively).

A bar diagram (see Figure 7.2) presents a visual comparison of different ways of providing health information within both general and Dalit communities. Based on the frequency of responses, every method of providing health information was slightly higher within general communities as compared to Dalit communities apart from radio (66.3% vs 67.3%) and community meetings (39.6% vs.42.6%), which still show very similar proportions. The figure highlights the huge difference in distribution of health information to Dalit communities versus general population by the means of health workers. Three-quarters (75.2%), the second highest percentage of respondents stated that in the general population, health information is provided by health workers in the form of home visits, conversation with users, direct counselling, Antenatal Care

(ANC) checks, advice seeking and offering designated health information, compared to only 32.2% of health workers providing the same service within Dalit communities.

Figure 7-2: Distribution of health information to Dalit communities versus General Population



When asked, 'What proportion of your patients belongs to Dalit communities from your catchment area'? More than half of respondents (55.5%) answered that between 1% and 20% of service users in their catchment area come from Dalit communities. Table 7.3 presents the proportion of service users belonging to Dalit communities in health workers' catchment area.

Table 7-3: Proportion of Dalit service users

Dalit service users (in health workers' catchment)	Frequency (n)	%
1-20 %	111	55.5
21-40 %	76	38.0
41-60 %	12	6.0
80%+	1	0.5
Total	200	100.0

Table 7.4 presents findings about perceptions of health workers on fulfilment of healthcare needs. Responses related to strongly agree and agree and disagree and strongly disagree were merged in order to be able to conduct a more meaningful analysis due to a low number of responses.

Table 7-4: Perception of health workers on fulfilment of health and medical needs and other health options

Health workers perceptions on	Frequency (n)	%
Communities' health needs are fulfilled (N=193)		
Strongly Agree/ Agree	175	90.7
Neutral	7	3.6
Disagree/ Strongly Disagree	11	5.7
Sufficient medical needs available (N=198)		
Strongly Agree/ Agree	137	69.2
Neutral	15	7.6
Disagree/ Strongly Disagree	46	23.2
Most Dalits go to traditional healer (N=199)		
Strongly Agree/ Agree	104	52.2
Neutral	65	32.7
Disagree/ Strongly Disagree	30	15.1

Almost all respondents (90.7%) believed that the health needs of the local communities had been fulfilled. However, when asked if there are sufficient medical needs available in locality, 69.2% agreed with this statement. Furthermore, more than half of respondents (52.2%) agreed that most Dalits still visit traditional healers to fulfil health needs. One third (32.7%) of respondents remained neutral for this question.

7.2.3 Health discrimination

This section investigates perceptions of discrimination in health sectors towards Dalit service users and identifies health discrimination indicators including how Dalits are identified, and any different approaches and behaviours of health workers towards Dalit service users. In the survey, this multiple-choice question was included to gain insight into health staff members' ways of operating: 'How are Dalits identified'?

Table 7.5 indicates the characteristics of Dalits that separates them from others in the community. Almost all respondents (96.9%) identified that Dalits can be distinguished by their surname, whilst 7.2% stated that Dalit can be identified just looking at them and 1% stated their skin colour may separate them due to their darker complexion.

Table 7-5: Factors by which health workers identify someone as Dalit

Identification factors (Multiple Response)	**Frequency (N=195)**	***Percentage (%)**
Outfit	14	7.2
Skin Colour	2	1.0
Language	4	2.1
Surname	189	96.9
Asking Directly	10	5.1

*Totals more than 100% due to multiple response.

Table 7.6 presents health workers' approach and behaviour towards Dalits and their experience regarding health discrimination. Nearly all respondents (94.5%) felt comfortable providing health services to Dalit service users, whilst 4% of respondents stated they felt uncomfortable providing service to Dalits and 1% chose to stay neutral.

Almost all (97.5%), agreed that health services provided to Dalit communities and general communities are the same, with no different treatment. It suggests that similar health opportunities are given despite of caste. However, 17.6% of respondents responded by saying that Dalits are discriminated in society whereas only 1.5% agreed that discrimination occurs in the health centre.

Table 7-6: Health workers approach and behaviours towards Dalits

Statements	Frequency (n)	%
Health workers are uncomfortable treating Dalits (N=197)		
Strongly Agree/ Agree	8	4.0
Neutral	3	1.5
Disagree/ Strongly Disagree	186	94.5
Treatments are different for Dalit patients compared to other social groups (N=195)		
Strongly Agree/ Agree	5	2.5
Neutral	0	0
Disagree/ Strongly Disagree	190	97.5
Dalits are discriminated in society (N=199)		
Strongly Agree/ Agree	35	17.6
Neutral	45	22.6
Disagree/ Strongly Disagree	119	59.8
Dalits are discriminated in health centre (N=199)		
Strongly Agree/ Agree	3	1.5
Neutral	0	0
Disagree/ Strongly Disagree	196	98.5
Dalits are discriminated based on caste (N=198)		
Strongly Agree/ Agree	27	13.6
Neutral	47	23.8
Disagree/ Strongly Disagree	124	62.6
Dalits are less discriminated if they are richer (N=193)		
Strongly Agree/ Agree	20	10.4
Neutral	56	29.0
Disagree/ Strongly Disagree	117	60.6
Dalits have better health knowledge and understanding than non-Dalits (N=198)		
Strongly Agree/ Agree	17	8.6
Neutral	77	38.9
Disagree/ Strongly Disagree	104	52.5
Its little hard to make Dalits understand health issues (N=193)		
Strongly Agree/ Agree	20	10.4
Neutral	52	26.9
Disagree/ Strongly Disagree	121	62.7
I have witnessed discrimination in health services (N=199)		
Strongly Agree/ Agree	8	4.0
Neutral	14	7.0
Disagree/ Strongly Disagree	177	89.0

Furthermore, when asked if Dalits are discriminated against based on caste and suffer more if they are poor, the majority of respondents disagreed. 62.6% opted for disagree/ strongly disagree that Dalits are discriminated against on the basis of cast, and 60.6% opted for disagree/ strongly disagree that Dalits are less discriminated if they are richer.

Regarding the statement related to health knowledge and understanding, 52.5% respondents disagreed that 'Dalits have better health knowledge and understanding than non-Dalits' in comparison and 62.7% also disagreed that communicating health related information is difficult among Dalits. The great majority of respondents (89%) claimed that they have never witnessed discrimination in health centres.

7.2.4 Health utilisation

This section helps to understand utilisation of health services in communities and whether there are any differences in accessing services for Dalits in comparison to other general community groups.

Table 7-7: Health workers' perception on in accessing local health services

Perception on accessing local health service	**Frequency (n)**	**%**
It is difficult to access local health service in General Communities (N=196)		
Strongly Agree/ Agree	27	13.8
Neutral	15	7.7
Disagree/ Strongly Disagree	154	78.5
Difficult to access local health service for Dalit communities (N=192)		
Strongly Agree/ Agree	20	10.4
Neutral	16	8.3
Disagree/ Strongly Disagree	156	81.3

Table 7.7 demonstrates that the majority of respondents disagreed when asked if it was difficult to access health services, and there was little difference in the proportion of the general communities (78.5%) or Dalit communities (81.3%) who thought this was the case.

7.2.5 Attitude and practice

This section addresses issues surrounding perception of health workers about health practices and their attitudes and behaviours towards Dalit service users. Table 7.8 shows the responses received using a Likert-type scale, in which strongly agree and agree, and disagree and strongly disagree are merged to provide sensible data for statistical analysis.

Data indicates that 24.7% of respondents agreed that Dalits do have higher health risks in comparison to the general population, whilst the largest minority of respondents (47.4%) choose to remain neutral. Furthermore, a statement related to Dalit rights identified that 3.5% of respondents thought Dalits do not have similar rights to higher caste members.

Almost all respondents (99.5%) agreed that they do consider Dalits as friends and also agreed they are willing to provide health services to Dalit service users. However, in another statement, 3% of respondents agreed that they still considered Dalits as untouchables. Additionally, in the statement, ‘Dalit patients should be dealt by Dalit health workers’, a large majority of respondents (83.7%) disagreed.

Table 7-8: Health workers attitude and practice in relation to Dalits

Statements	Frequency (n)	%
Dalit people have higher health risks (N= 190)		
Strongly Agree/ Agree	47	24.7
Neutral	90	47.4
Disagree/ Strongly Disagree	53	27.9
Dalit patients have same rights as upper caste patients (N= 197)		
Strongly Agree/ Agree	189	96
Neutral	1	0.5
Disagree/ Strongly Disagree	7	3.5
I consider Dalits as untouchables (N= 195)		
Strongly Agree/ Agree	6	3.0
Neutral	0	0
Disagree/ Strongly Disagree	189	97.0
I accept Dalits as friends (N= 194)		
Strongly Agree/ Agree	193	99.5
Neutral	1	0.5
Disagree/ Strongly Disagree	0	0
I am willing to provide service for Dalits (N= 197)		
Strongly Agree/ Agree	196	99.5
Neutral	1	0.5
Disagree/ Strongly Disagree	0	0
Dalit patients should be dealt by Dalit health worker (N= 197)		
Strongly Agree/ Agree	10	5.1
Neutral	22	11.2
Disagree/ Strongly Disagree	165	83.7

Table 7.9 presents data related to the recommendation from health workers regarding Dalit health. When asked the multiple-choice question, ‘How should Dalit people deal with health issues?’ all respondents agreed that Dalits should seek medical help first whereas 5.2% of them suggested the use of alternative options such as home remedies, traditional healers and health education programmes. All respondents agreed that they have never discriminated against Dalit patients unintentionally.

Furthermore, when health workers were asked about their opinion on how society has contributed to Dalit health, the largest minority of respondents (37.8%) stated it has done so by providing equal health opportunities, whilst 14.5% stated that there was no discrimination towards Dalits. Similarly, responses presented for health knowledge including health education and awareness programmes and financial relief including free services and financial support were similar, with 26.2% and 25.5% respectively. Responses presented for prioritising help (helping need, giving priority) and health programmes (Dalits programmes, counselling, health participation) were also similar with 11% and 11.6% respectively.

Table 7-9: Health workers recommendation regarding Dalits' health

Statements regarding Dalits and health	**Frequency (n)**	**%**
How should Dalit people deal with health issues (N= 191)		
Medical help	191	100
Other options (home remedies, traditional healer, health education programme)	10	5.2
Have you ever discriminated Dalit patients without meaning to? (N = 183)		
No	183	100
Dalit service users must be dealt with (N=182)		
Positive and equal behaviour	182	100
How can society contribute to Dalit treatment? (N = 172)		
No discrimination	25	14.5
Equal health opportunity	65	37.8
Prioritising help (Helping needy 10, Giving priority 9)	19	11
Health Knowledge (education 11, awareness, 34)	45	26.2
Financial relief (Free services 19, Financial support 25)	44	25.5
Health Programmes (Dalits programmes 4, Counselling 4, health participation 12)	20	11.6

7.2.6 Views on improving the health of Dalits

This section presents health workers' ideas for improving aspects of health education and health centres, and their contribution to promoting and bettering Dalit health. Table 7.10 presents the merged responses received for strongly agree and agree, and disagree and strongly disagree, in order to have sensible data for statistical analysis.

Table 7-10: Health workers perceptions on improving Dalits' health

Statements	**Frequency (n)**	**%**
It is important to inform/educate Dalit communities about health (N= 193)		
Strongly Agree/ Agree	189	97.9
Neutral	0	0
Disagree/ Strongly Disagree	4	2.1
Contribution of health centre in improving Dalit health awareness is very important (N= 195)		
Strongly Agree/ Agree	192	98.5
Neutral	1	0.5
Disagree/ Strongly Disagree	2	1
It is important to contribute as a health worker in improving Dalit health awareness (N= 194)		
Strongly Agree/ Agree	191	98.5
Neutral	1	0.5
Disagree/ Strongly Disagree	2	1
As health worker what is best way to improve health of Dalits (N= 236) (Multiple choice)		
Equal treatment	26	14.9
No discrimination	11	6.3
Financial relief (Free services= 52, Financial support= 1)	53	30.5
Health Knowledge (education =47, awareness =44)	91	52.3
Health Programmes (Dalits programmes= 8, Counselling 11, health participation 9, home visits 4, screening 2)	34	19.5
Health access (easy 7, prioritizing Dalits 14)	21	12
How to make health service more open (N= 634)		
Counselling	118	60.2
Screening	129	65.8
Better services (opening hrs= 48, more HW 66, telemed. 2)	116	59.2
Advertise in community	125	63.8
Outreach (Home visit= 27, Outreach 66)	146	74.5

Nearly ALL respondents strongly agree/agree that it is important to inform/educate Dalit communities about health (97.9%), contribution of health centres (98.5%) and health workers (98.5%) in improving Dalit health awareness is very important. Further, when asked, 'what is the best way to improve health of Dalits as a health worker?' a small majority of respondents (52.3%) identified health-and-education-related programmes as the best approach. A high proportion of respondents stated outreach programmes (74.5%), including home visits, which was a popular option to make health services more open, followed by screening programmes (65.8%) and advertising amongst communities (63.8%).

7.3 Analysis of factors associated with employment level

The following section presents chi-square test analysis to compare presented cross-tabulation of factors potentially associated with employment level (Junior and Senior).

Analysis was carried out to describe the relationships between employment position with socio-demographic characteristics, current health services, health discrimination, health utilisation and health workers' attitude and work practice. This section will allow us to analysis if there is any different behaviour, level of discrimination and service provided based on their position (Junior and Senior). The position has been divided into Junior and Senior, based on the length of time they have been in the job 9as a proxy for experience they have in the job), in order to conduct a decent statistics analysis.

7.3.1 Relationship between socio-demographic characteristics and employment level

Table 7.11 presents an examination of the association between employment level and socio-demographic characteristics; namely caste, religion, age, gender, marital status, education, local resident of health post, and job experience as health worker (in years).

The representation of respondents from Dalit and Janajati (72.8%) communities in junior level employment is slightly higher than Brahman (70.6%) and Chhetri

(70.6%), although relatively similar. However, the percentage of staff in senior level employment is low for both Dalit and Janajati (27.2%) and Brahman and Chhetri (29.4%) communities. However, the difference is not statistically significant. Moreover, religion is strongly associated with employment level ($P<0.05$). A comparatively higher proportion (71.4%) of Christians are involved in senior level employment compared to respondents from Hindu (28.6%) and Buddhist (14.3%) religions.

Another highly significant association with employment level is age ($P<0.05$). All respondents in the age group 45+ years were engaged in junior level employment, whereas less respondents (62%) from 18-25 years age group were engaged in a junior level position. In comparison, 38% of staff from the senior level employment belonged to 18-25 age group, 25.7% belong to the 26-35 age group, and 10.7% were from the 36-45 age group. Interestingly, the proportion of male representation (73.4%) in a junior level position is slightly higher in comparison to female representation (71.1%), and vice versa on a senior level, where males and females represent 26.6% and 28.9% respectively. Further, the proportion of married respondents (75.8%) in a junior position is comparatively high compared to unmarried/divorced respondents (67.7%).

A significantly higher proportion of respondents (91.7%) who completed their education to level 10 or lower ended up in junior positions, whereas the higher proportion of respondents (33.3%) who completed level 12+ education came from a senior level position (See Table 7.2.1). Moreover, the number of respondents that were local residents of the health post and worked in senior level positions was slightly higher (29.2%) than the number of respondents who did not (26%).

Table 7-11: Association between socio-demographic characteristics and employment position

Characteristics	**Employment (N=199)**				P – Value
	Junior HW*		Senior HW**		
	n	%	n	%	
Caste/Ethnicity (n=196)					
Brahman	36	70.6	15	29.4	
Chhetri	36	70.6	15	29.4	
Dalit and Janajati	67	72.8	25	27.2	0.942
Religion (n=198)					
Hindu	120	71.4	48	28.6	
Buddhist	18	85.7	3	14.3	
Christian	2	28.6	5	71.4	**0.015**
Age (yrs.) (n=202)					
18-25	57	62.0	35	38.0	
26-35	52	74.3	18	25.7	
36-45	25	89.3	3	10.7	
45+	9	100	0	0	**0.006**
Gender (n=202)					
Female	96	71.1	39	28.9	
Male	47	73.4	17	26.6	0.733
Marital status (n=196)					
Married	72	75.8	23	24.2	
Unmarried/ Divorce	67	67.7	32	32.3	0.210
Education (n=198)					
10^{th} Grade or less	11	91.7	1	8.3	
$11\text{-}12^{th}$ grade	98	72.6	37	27.4	
12+	32	66.7	16	33.3	0.222
Local resident of health post (n=192)					
Yes	63	70.8	26	29.2	
No	74	74.0	26	26.0	0.621
Experience as health worker (n=201)					
Less than 1year	19	54.3	16	45.7	
1-3 years	43	68.3	20	31.7	
3-6 years	33	68.8	15	31.2	
6-10 years	18	81.8	4	18.2	
10+years	30	96.8	1	3.2	**0.002**

Notes: *=Junior health worker; **=Senior health worker; p-value less than 0.05 ($P<0.05$) indicates statistically significant finding.

Surprisingly, the proportion of respondents who have more years of experience had lower representation in senior level positions. For example, 10+ years of experience (3.2%), 6-10 years (18.2%), 3-6 years (31.2%), 1-3 years (31.7%) and less than a year (45.7%). Again, this was statistically significant ($P<0.05$).

7.3.2 Relationship between current health services and employment

This section analyses the relationship between employment level and current health services in relation to a range of factors including number of health workers, number of attended patients, distribution of health information in general, Dalit communities, Dalit participation in health, whether community health needs are fulfilled, whether sufficient medical needs are easily available, and the use of traditional healers, presented in Table 7.12.

A highly statistically significant association ($P<0.01$) was observed between the number of health workers in the local communities and employment level. The most frequent number of senior health workers available to provide services ranges was 61-80 (59.5%) whereas the least were from the range 1-20, and more than 81 were exactly the same (16.7%). The proportion of respondents who attended to between 1-20 and 41-60 service users in a day is similar (55.8% and 55.6% respectively). Whereas range 21-40, 61-80, 81-100 and 100+ is not very different (77.9%, 85.7%, 81.8% and 80%), nor is there a statistically significant association ($P>0.05$).

The highest proportion of respondents from junior level employment stated that better ways of providing health information in general communities would come through health workers (81.5%) as opposed to other options. Whereas, in general communities, social media (40%) was popular among the senior level health workers. Additionally, similar output regarding information through health workers (90.8%) in Dalit communities has been identified with a higher proportion of respondents. Furthermore, in Dalit communities, social media (3.3%) seems to be the least common channel for health information distribution among senior health workers. Moreover, a

comparatively higher percentage of responses (39.5%) who stated 21-40% of service users attended by health workers are Dalits, were from senior level positions, compared to 0-20%, (23.1%) indicating that there may be less than 20%, or that none could be Dalits users in a day.

More than three quarters of respondents (81.8%) who disagreed/ strongly disagreed that communities' health needs are fulfilled, were from junior level positions. Junior level employees who responded strongly agree/ agree and neutral are equal (71%). A comparatively higher proportion of respondents (82.6%) who disagree/ strongly disagree that sufficient medical needs were available within the communities are engaged in a junior level position. Most respondents strongly agree/ agree that most Dalits still go to traditional healers for health issues. The majority of them (70.6%) are from a junior level position.

Table 7-12: Association between current health services, information and employment position

Variables	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Number of health staff in community (n=201)					
1-20	100	83.3	20	16.7	
21-40	14	58.3	10	41.7	
41-60	9	75.0	3	25.0	
61-80	15	40.5	22	59.5	
81-100	5	83.3	1	16.7	**0.001***
Number of users attended by health workers in a day (n=195)					
1-20	40	58.8	28	41.2	
21-40	67	77.9	19	22.1	
41-60	5	55.6	4	44.4	
61-80	12	85.7	2	14.3	
81-100	9	81.8	2	18.2	
100+	4	80.0	1	20.0	0.069

* P < 0.01 highly significant ** P< 0.05 significant

Table 7-13: Continued

Variables	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Distribution health info general population (N= 202)					
Radio	93	71.0	38	29.0	
Television	90	68.7	41	31.3	
Newspaper and Magazine	88	71.0	36	29.0	
Brochures or flip charts	96	72.7	36	27.3	
Health Education programmes	117	73.1	43	26.9	
Health Workers	123	81.5	28	18.5	
Community Meetings	63	78.8	17	21.2	
Social Media	9	60.0	6	40.0	0.269
Distribution health info Dalit community (N=202)					
Radio	94	70.7	39	29.3	
Television	89	71.2	36	28.8	
Newspaper and Magazine	82	70.1	35	29.9	
Brochures or flip charts	95	73.1	35	26.9	
Health Education programmes	111	71.2	45	28.8	
Health Workers	59	90.8	6	9.2	
Community Meetings	66	76.7	20	3.3	
Social Media	2	66.7	1	3.3	0.833
Dalit Service Users in HW's catchment (n=200)					
0-20 %	83	76.9	25	23.1	
21-40 %	46	60.5	30	39.5	
41-60 %	12	100	0	0	
80%+	1	100	0	0	0.10
Communities' health needs are fulfilled (N=193)					
Strongly Agree/ Agree	123	71.5	49	28.5	
Neutral	5	71.4	2	28.6	
Disagree/ Strongly Disagree	9	81.8	2	18.2	0.760
Sufficient medical needs available (N=198)					
Strongly Agree/ Agree	92	68.1	43	31.9	
Neutral	10	71.4	4	28.6	
Disagree/ Strongly Disagree	38	82.6	8	17.4	0.170
Most Dalits go to traditional healer (N=199)					
Strongly Agree/ Agree	72	70.6	30	29.4	
Neutral	48	73.8	17	26.2	
Disagree/ Strongly Disagree	21	72.4	8	27.6	0.899

* $P < 0.01$ highly significant ** $P < 0.05$ significant

7.3.3 Relationship between health discrimination perceptions and employment

This section presents data about the relationship between health discrimination and the employment position of health workers. Table 7.13 presents findings of cross-tabulation data between the perception of health workers' comfort in treating Dalit service users, their treatment towards Dalits in comparison to the general population, discrimination towards Dalits in society and health centres, based on caste, economic status, Dalits' knowledge and understanding of health issues and employment status (e.g., Senior or Junior level).

To the statement, 'health workers are uncomfortable providing services to Dalit service users' the respondents who responded strongly agree/ agree are entirely, and those who responded disagree/strongly disagree (71.6%) are from junior level. This is also a statistically highly significant association ($P<0.05$). Again, all respondents who strongly agreed/ agreed that treatments are different for Dalit patients compared to other social groups are from junior level employment. Furthermore, more than one third (32.4%) of senior level respondents strongly agreed/ agreed that Dalits are discriminated against in society. Similarly, 100% of respondents from junior level positions strongly agreed/ agreed that Dalits are discriminated in health centres. A comparatively higher percentage stated strongly agree/ agree that Dalits are discriminated based on their caste (42.3%), and also stated strongly agree/ agree that Dalits are less discriminated if they are rich (35%). Both groups were engaged in a senior level position.

Surprisingly, three quarter of respondents (75.2%) who disagreed/ strongly disagreed with the statement 'Dalits have better health knowledge and understanding than non-Dalits' belong to junior level positions. Furthermore, a higher proportion of respondents (78.9%) who agree/strongly agree that it is difficult to make Dalits understand health-related issues are junior level health workers, as compared to neutral (73.1) and disagree/ strongly disagree (70.6%). Again, a higher percentage (75%) of

respondents who responded they agree/strongly agree that they have witnessed discrimination in health services are junior level health workers.

Table 7-14: Association between health discrimination and employment position

Statements	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Health workers uncomfortable treating Dalits (N=197)					
Strongly Agree/ Agree	8	100	0	0	
Neutral	0	0	3	100	
Disagree/ Strongly Disagree	131	71.6	52	28.4	**0.005**
Treatments different for Dalit patients compared to other social groups (N=195)					
Strongly Agree/ Agree	5	100	0	0	
Neutral	0	0	0	0	
Disagree/ Strongly Disagree	132	70.6	55	29.4	0.151
Dalits are discriminated in society (N=199)					
Strongly Agree/ Agree	23	67.6	11	32.4	
Neutral	35	79.5	9	20.5	
Disagree/ Strongly Disagree	82	69.5	36	30.5	0.391
Dalits are discriminated in health centre (N=199)					
Strongly Agree/ Agree	3	100	0	0	
Neutral	0	0	0	0	
Disagree/ Strongly Disagree	137	71.0	56	29.0	0.270
Dalits are discriminated based on their caste (N=198)					
Strongly Agree/ Agree	15	57.7	11	42.3	
Neutral	36	78.3	10	21.7	
Disagree/ Strongly Disagree	88	71.5	35	28.5	0.179
Dalits are less discriminated if they are richer (N=193)					
Strongly Agree/ Agree	13	65	7	35	
Neutral	41	75.9	13	24.1	
Disagree/ Strongly Disagree	83	71.6	33	28.4	0.634
Dalits have better health knowledge and understanding than non-Dalits (N=198)					
Strongly Agree/ Agree	12	70.6	5	29.4	
Neutral	51	66.2	26	33.8	
Disagree/ Strongly Disagree	76	75.2	25	24.8	0.419

Its little hard to make Dalits understand health relation issues (N=193)					
Strongly Agree/ Agree	15	78.9	4	21.1	
Neutral	38	73.1	14	26.9	
Disagree/ Strongly Disagree	84	70.6	35	29.4	0.740
I have witnessed discrimination in health services (N=199)					
Strongly Agree/ Agree	6	75	2	25	
Neutral	10	71.4	4	28.6	
Disagree/ Strongly Disagree	124	71.3	50	28.7	.974

7.3.4 Relationship between health utilisation perceptions and employment

Table 7.14 reports association of employment and perceptions of health workers on difficulty accessing local health services in the general population as well as Dalit communities. Both statements showed no statistically significant associations (P>0.05), with little difference in perceptions of Junior versus Senior health workers.

Table 7-15: Association between health workers perceptions on difficulties in accessing local health services and employment position

Perception on accessing local health service	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Perception on difficulty accessing local health service in general communities (N=196)					
Strongly Agree/ Agree	19	70.4	8	29.6	
Neutral	9	60	6	40	
Disagree/ Strongly Disagree	110	72.8	41	27.2	0.570
Perception on difficulty accessing local health service in Dalit communities (N=192)					
Strongly Agree/ Agree	14	70.0	6	30.0	
Neutral	12	75.0	4	25.0	
Disagree/ Strongly Disagree	110	71.9	43	28.1	0.187

7.3.5 Relationship between health attitude and practices and employment

Table 7.15 reports findings from an analysis of association between employment level and health worker protection on health risks, Dalit rights and their overall attitude towards Dalit service users. A comparatively higher percentage of respondents (82.2%) who strongly agree/ agree that Dalits do have a higher health risk in comparison to the upper caste are junior health workers. More than half (57.1%) of respondents who disagree/ strongly disagree on the statement, 'Dalit patients have same rights as upper caste patients' are senior health workers. Respondents who strongly agree/ agree that Dalits are considered untouchables are equal in proportion (50%). Other statements such as, 'Dalits are friends', and 'there is willingness to provide services to Dalits' received positive responses, except the statement, 'Dalit patients should be dealt by Dalit health workers', where a higher proportion of respondents (88.9%) who strongly agree/ agree were junior health workers, but there was no significant association observed.

Table 7-16: Association between health workers' attitude, practices and employment position

Statement	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Dalit people have higher health risks (N= 190)					
Strongly Agree/ Agree	37	82.2	8	17.8	
Neutral	58	64.4	32	35.6	
Disagree/ Strongly Disagree	39	75	13	25.0	0.079
Dalit patients have same rights as upper caste patients (N= 197)					
Strongly Agree/ Agree	134	72	52	28	
Neutral	1	100	0	0	
Disagree/ Strongly Disagree	3	42.9	4	57.1	0.201
I consider Dalits as untouchables (N= 195)					
Strongly Agree/ Agree	3	50.0	3	50.0	
Neutral	0	0	0	0	
Disagree/ Strongly Disagree	134	72.0	52	28.0	0.240

I accept Dalits as friends (N= 194)					
Strongly Agree/ Agree	136	71.6	54	28.4	
Neutral	0	0	1	100	
Disagree/ Strongly Disagree	0	0	0	0	0.115
I am willing to provide service for Dalits (N= 197)					
Strongly Agree/ Agree	139	72.0	54	28.0	
Neutral	0	0	1	100	
Disagree/ Strongly Disagree	0	0	0	0	0.111
Dalit patients should be dealt by Dalit health worker (N= 197)					
Strongly Agree/ Agree	8	88.9	1	11.1	
Neutral	14	63.6	8	36.4	
Disagree/ Strongly Disagree	117	71.8	46	28.2	0.365

Table 7.16 presents health workers' perceptions on contributions of society towards Dalits health, how Dalits should deal with their health issues, discrimination as a health worker, and its association with employment level. It is interesting to note that 82.8% of respondents who asserted that society's contribution to Dalit health was providing equal health opportunities were junior health workers, whereas 47.4% of senior health workers stated that the contribution was prioritising Dalits in providing services. This was a statically significant finding ($P<0.05$). Questions on how Dalits should treat health issues and whether health workers ever unconsciously discriminated against Dalit patients were not statistically significant ($P>0.05$).

Table 7-17 Association between employment position and health workers perception on health recommendation.

Statements	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
How can society contribute to Dalit Treatment? (N = 172)					
No discrimination	17	68.0	8	32	
Equal health opportunity	53	82.8	11	17.2	
Prioritising help (Helping needy 10, Giving priority 9)	10	52.6	9	47.4	
Health Knowledge (education 11, awareness, 34)	30	71.4	12	28.6	
Financial relief (Free services 19, Financial support 25)	26	65	14	35	
Health Programmes (Dalits Programmes 4, Counselling 4, health participation 12)	12	70.5	5	29.5	0.052
How should Dalits deal with health issues (N= 197)					
Medical help	136	72.3	52	27.7	
Other options (home remedies, traditional healer, health education programme)	8	80.0	2	20.0	0.849
Have you ever discriminated Dalit patients without meaning to? (N = 183)					
Yes	1	100	0	0	
No	127	70.9	50	29.1	0.523

7.3.6 Relationship between employment and perceptions on improving the health of Dalits

Table 7.17 reports the relationship between employment position and health workers perceptions on improving Dalit health such as informing/educating Dalit communities about health, the contribution of health centres as well as health workers towards the betterment of Dalits' health, and ways to make health services more open.

The majority of respondents who disagree/strongly disagree that it is important to inform/educate Dalit communities about health are junior health workers. A

comparatively higher percentage of respondents who strongly agree/agree that contribution of health centres (72%), health workers (71.8%) are important are from junior level health workers.

Furthermore, a comparatively higher proportion of respondents who responded that providing equal treatment (92.3%) is the best way to improve Dalit's health were junior health workers. This was followed by options such as easy health access (89.5%), no discrimination (81.8%) and health-related programmes (81.3%). Similarly, the majority of respondents who stated that providing better services was a popular way of making the health service more open were junior health worker, whereas the majority of respondents who responded with outreach were senior health workers.

Table 7-18: Association between employment position and health workers perceptions on improving Dalit's health

Statements	**Employment (N=199)**				P – Value
	Junior HW		Senior HW		
	n	%	n	%	
Important to inform/educate Dalit communities about health (N= 193)					
Strongly Agree/ Agree	133	71.5	53	28.5	
Neutral	0	0	0	0	
Disagree/ Strongly Disagree	3	75.0	1	25.0	0.878
Contribution of health centre in improving Dalit health awareness is very important (N= 195)					
Strongly Agree/ Agree	136	72	53	28	
Neutral	1	100	0	0	
Disagree/ Strongly Disagree	2	100	0	0	0.559
It is important to contribute as a health worker in improving Dalit health awareness (N= 194)					
Strongly Agree/ Agree	135	71.8	53	28.2	
Neutral	0	0	1	100	
Disagree/ Strongly Disagree	2	100	0	0	0.190
As a health worker what is the best way to improve health of Dalits (N= 174)					
Equal treatment	24	92.3	2	7.7	
No discrimination	9	81.8	2	18.2	
Financial relief	29	55.8	23	44.2	
Health knowledge	59	69.4	26	30.6	
Health programmes	26	81.3	6	18.7	
Health access	17	89.5	2	10.5	0.90
How to make health service more open (N= 196)					
Counselling	83	72.2	32	27.8	
Screening	90	71.4	36	28.6	
Better services	68	79.0	18	21.0	
Advertise in community	92	75.4	30	24.6	
Outreach	88	71.0	36	29.0	0.208

7.3.7 Relationship between caste/ethnicity and health workers perceptions regarding Dalit's health

This section (see Table 7.18) analyses the association between caste/ethnicity and health workers' perceptions regarding Dalits' health issues, needs, risks, education and views on improving Dalit's health. This research investigates the aspects of caste-related health discrimination, however, is not focused on caste inequality within the healthcare profession. Therefore, only data that are relevant for further analysis are considered. No statistically significant association was found between caste and health worker perceptions on the fulfilment of community health, availability of medical needs, traditional healing options, Dalit health risks, health education, contributions as health workers, better health and open services (P>0.05).

Table 7-19 Association between caste/ethnicity and health workers perceptions regarding Dalit's health

Statements	**Caste/Ethnicity (n=196)**						P - Value
	Brahman		Chhetri		Dalit and Janajati		
	n	%	n	%	n	%	
Communities' health needs are fulfilled (n=193)							
Strongly Agree/ Agree	45	26.5	47	27.6	78	45.9	
Neutral	1	14.3	2	28.6	4	57.1	
Disagree/ Strongly Disagree	3	30	1	10	6	60	0.716
Sufficient medical needs available (n=198)							
Strongly Agree/ Agree	34	25.6	37	27.8	62	46.6	
Neutral	6	40	4	26.7	5	33.3	
Disagree/ Strongly Disagree	11	25	8	18.2	25	56.8	0.439
Most Dalits go to traditional healer (n=199)							
Strongly Agree/ Agree	30	29.4	27	26.5	45	44.1	
Neutral	16	25.8	18	29.0	28	45.2	
Disagree/ Strongly Disagree	5	17.2	5	17.2	19	65.6	0.325
Dalit people have higher health risks (n= 190)							
Strongly Agree/ Agree	12	26.1	12	26.1	22	47.8	
Neutral	20	23.0	25	28.7	42	48.3	
Disagree/ Strongly Disagree	16	31.4	12	23.5	23	45.1	0.990

Important to inform/educate Dalit communities about health (N= 193)							
Strongly Agree/ Agree	46	25.1	49	26.8	88	48.1	
Neutral	0		0		0		
Disagree/ Strongly Disagree	2	50.0	1	25.0	1	25.0	0.661
Important to contribute as a health worker in improving Dalit health (n= 194)							
Strongly Agree/ Agree	47	25.4	50	27.0	88	47.6	
Neutral	0	0.0	0		1	100.0	
Disagree/ Strongly Disagree	1	50.0	0		1	50.0	0.831
As a health worker what is the best way to improve health of Dalits (N= 174)							
Equal treatment	5	20.0	7	28.0	13	52.0	
No discrimination	2	18.2	3	27.3	6	54.5	
Financial relief	15	28.8	17	32.7	20	38.5	
Health Knowledge	21	23.6	18	20.2	50	56.2	
Health Programmes	13	39.4	9	27.3	11	33.3	
Health access	4	21.1	5	26.3	10	52.6	0.611
How to make health service more open (N= 196)							
Counselling	27	23.9	29	25.7	57	50.4	
Screening	26	20.8	39	31.2	60	48.0	
Better services	33	29.2	33	29.2	47	41.6	
Advertise in community	34	27.6	35	28.5	54	43.9	
Outreach	40	27.8	42	29.2	62	43.1	0.337

7.3.8 Relationship between gender and current health services

This section (Table 7.19) analyses association between gender and health workers' perceptions regarding Dalit health issues, needs, risks, education, and views on improving Dalit health. The focus of this PhD study is on caste-related health discrimination. However, it also investigates some aspects of gender inequality. Therefore, based on frequency tables, some relevant data that are worth analysing with regards to gender aspects are presented here. There was no statistically significant association with caste between gender and health workers' perceptions regarding Dalit health ($P>0.05$).

Table 7-20: Association between gender and health workers perceptions regarding Dalits' health

Statements	**Gender (n=202)**				P – Value
	Female		Male		
	n	%	n	%	
Communities' health needs are fulfilled (N=193)					
Strongly Agree/ Agree	118	67.4	57	32.6	
Neutral	6	85.7	1	14.3	
Disagree/ Strongly Disagree	5	45.5	6	54.5	0.181
Sufficient medical needs available (N=198)					
Strongly Agree/ Agree	95	69.3	42	30.7	
Neutral	10	66.7	5	33.3	
Disagree/ Strongly Disagree	27	58.7	19	41.3	0.415
Most Dalits go to traditional healer (N=199)					
Strongly Agree/ Agree	71	68.3	33	31.7	
Neutral	42	64.6	23	35.4	
Disagree/ Strongly Disagree	20	66.7	10	33.3	0.886
General Communities (N=196)					
Strongly Agree/ Agree	18	66.7	9	33.3	
Neutral	8	53.3	7	46.7	
Disagree/ Strongly Disagree	105	68.2	49	31.8	0.507
Dalit communities (N=192)					
Strongly Agree/ Agree	11	55.0	9	45.0	
Neutral	8	50.0	8	50.0	
Disagree/ Strongly Disagree	108	69.2	48	30.8	0.162
Dalit people have higher health risks (n= 190)					
Strongly Agree/ Agree	30	63.8	17	36.2	
Neutral	56	62.2	34	37.8	
Disagree/ Strongly Disagree	41	77.4	12	22.6	0.292
Important to inform/educate Dalit communities about health (N= 193)					
Strongly Agree/ Agree	127	67.2	62	32.8	
Neutral	0	-	0	-	
Disagree/ Strongly Disagree	2	50.0	2	50.0	0.096

Important to contribute as a health worker in improving Dalit health (n= 194)					
Strongly Agree/ Agree	128	67.0	63	33.0	
Neutral	0	-	1	100	
Disagree/ Strongly Disagree	2	100.0	0	-	0.101
As a health worker what is the best way to improve health of Dalits (N= 174)					
Equal treatment	19	73.1	7	26.9	
No discrimination	8	72.7	3	27.3	
Financial relief	41	77.4	12	22.6	
Health Knowledge	62	68.1	29	31.9	
Health Programmes	24	70.6	10	29.4	
Health access	9	42.9	12	57.1	0.825
How to make health service more open (N= 196)					
Counselling	76	64.4	42	35.6	
Screening	79	61.2	50	38.8	
Better services	63	54.3	53	45.7	
Advertise in community	84	67.2	41	32.8	
Outreach	96	65.8	50	34.2	0.009

7.4 Analysis of free text responses

The questionnaire facilitated an open response for respondents' perceptions on the question, 'How does a healthcare worker treat people from Dalit communities?'

One respondent stated that they (the health workers) prioritise Dalits:

> *"Service users are treated equally, no difference based on caste. However, prioritising Dalits can help in promoting Dalits to utilise healthcare".*

A total of 182 respondents and 649 responses were collected to the question and were grouped according to the topics. Most however were very short, and an overwhelming number of responses were repetitive. Examples include showing equal behaviour (n=135), prioritising Dalits (n=86), positive behaviour (n=93), no discrimination

(n=105), without any discrimination (n=47), same as other caste (n=35), helpful (n=29), friendly (n=98), welcoming approach (n=21).

7.5 Chapter summary

This chapter presents key findings from the survey carried out with health workers in Makwanpur district. The survey included questions such as their perceptions on current health services, health discrimination and utilisation, attitudes and practices, and response towards Dalits, as well as their socio-economic background. Survey responses were manually entered into SPSS 26 and descriptive analysis was performed. Data were presented in both tabular and graphical formats. Almost half of the respondents were female, from Dalit and Janajati groups, junior level positions, and from the 18-25 age group. Further analysis of the relationship between variables such as current health services and employment, perceptions of health discrimination and employment, perceptions of health utilisation and employment, health attitudes/practices and employment, employment and perceptions on improving the health of Dalits, caste/ethnicity and health workers perceptions regarding Dalits' health and gender, and current health services was performed. The relationships were established as $P< 0.01$ being highly significant, $P< 0.05$ significant and $P> 0.05$ not significant.

Chapter 8 Discussion

This chapter discusses how this PhD research has addressed its aim to investigate caste-based discrimination in Nepal's health sector, particularly focusing on those at the bottom of the caste hierarchy. In this chapter, the qualitative key findings are summarized, assessed, compared, and contrasted with the quantitative findings and further discussed in light of the existing literature. The qualitative research includes FGDs with Dalits (male and female), exit interviews with Dalits who have recently used health services, and key stakeholder interviews including four government workers (medical coordinators) and two non-government organisation (NGO) workers. The quantitative study includes health workers in the study district, focusing on four key areas: (1) social discrimination and its health impacts; (2) roles of other social determinants alongside caste and associated health impacts; (3) status of health and resources; and (4) public health programmes. Within each section, the qualitative findings are interpreted first, followed by quantitative findings highlighting and explaining any similarities and/or differences with reference to the literature. The final section offers methodological reflections on the role of the researcher and the specific limitations and strengths of this PhD study.

8.1 Social discrimination and its health impacts

Identifying underlying reasons for health discrimination in Dalit communities addresses one of the key questions of this study. The FGDs and stakeholder interviews have been very useful in addressing this objective, whilst the survey findings added valuable insights. Three main areas were found to be associated with health discrimination: (a) long established culture (caste system) and untouchability related to it; (b) lack of legislation, specifically the lack of effective implementation and policy of existing laws; and (c) a need for positive and equal behaviour.

8.1.1 Long established culture

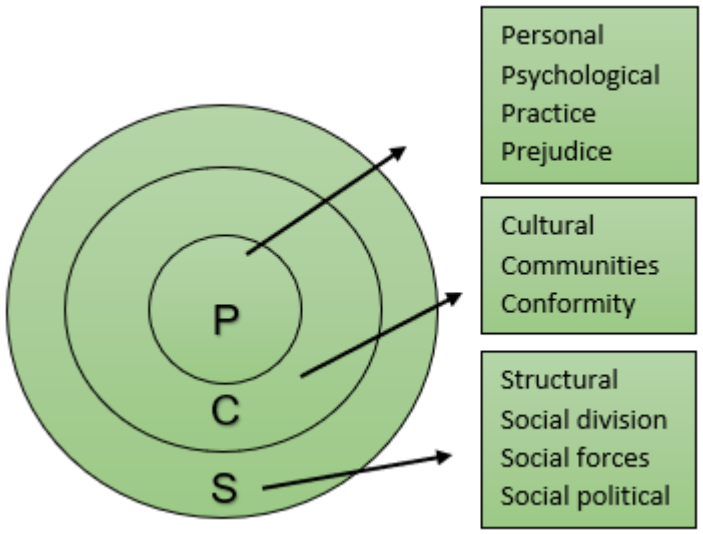
This study reported that caste discrimination is core to the long-established Hindu religion and culture. As caste hierarchy is the foundation of Hinduism, and as most people in Nepal are devoted to Hinduism this helps explain the continuity of untouchability and social exclusion of lower castes (see Section 1.4). The higher the proportion of the population in society who follow Hinduism, the more caste hierarchy is encouraged, leading to an increased possibility of discrimination and continued social exclusion of Dalits.

The qualitative study highlighted that caste discrimination against Dalits still exists (see Section 6.3) especially from people of higher caste backgrounds and/or older people. Many Dalits shared that they face challenges in their everyday lives, such as struggling for food and shelter, using public services, experiencing violence and physical/mental abuse (see Section 6.3.1). Many participants also explained that they have faced discrimination, not only in private places, (in an individual's home, or private properties) but also in public areas such as public water taps, temples, and cultural programmes. Consequently, Dalits have normalised the experience; they may be unable to accept it privately but have come to see it as a static part of their life. This can be defined as internalisation of the stigma (Thompson 2012), where one dominated group accepts the negative behaviours, beliefs, attitudes, ideologies and stereotypes of the dominant group (David et al. 2019). Internalised discrimination is argued to be harmful and may directly impact health outcomes. Examples include internalised homophobia (Newcomb and Mustanski 2010), lower social status (Jackson et al. 2015), stigma related with sickness (Logie et al. 2013) and racism (David et al. 2019), all of which have been associated with damaged psychological health, poorer wellbeing or the expression of behaviours that are dangerous to health. Further, the discriminated group may succumb to the feelings of self- devaluation, self-doubt, low self-esteem and worth, leading them to believe that their situation is hopeless and helpless. (Durso et al. 2012).

As noted previously, discrimination occurs in multiple forms, despite legislation banning caste discrimination in Nepal (Section 6.3.1.4), most Dalits still experience discrimination. As one Dalit participant in the interviews stated, '*they are discriminated in terms of cleanliness and education, however even if they become cleaner and more educated, they still experience discrimination'*. This indicates that the main reason is not their cleanliness or education but a deeper perpetuation of caste hierarchy and untouchability.

Caste discrimination is divided into direct and indirect forms of discrimination. As previously noted, direct discrimination is when one is treated less favourably, because of their protected characteristics (racial or ethnic origin, gender, religion or belief, disability, age, sexual orientation or sex). Whereas indirect discrimination is when one is treated unfairly because of neutral criteria that may not be formally prohibited but is perceived as less favourable to certain groups. An example would be rules or policies that apply to everyone, but deliberately disadvantages groups who share protected characteristics. Therefore, members become excluded or disadvantaged by simply being part of that targeted group (Hajian and Domingo-Ferrer 2012). Moreover, discrimination can take place in three different levels: Personal, Cultural and Structural (PCS). This is known as the PCS model and it presents the power relationships expressed between the individual, groups and society (Thompson 2012). This PCS model helps to understand how and why discrimination takes place and how it can lead to internalised oppression. Furthermore, it explains how personal beliefs, cultural norms and structural institutions work together to promote oppression within society (Thompson 2017).

Figure 8-1: Neil Thompson PCS Model



Adopted from Thompson (2017)

The personal level relates to an individual's opinion and views, where one develops and expresses their values and beliefs based on their interactions with others. It suggests that emotions and thoughts may impact on the unfairness and inequality that is widespread in societies (Nielsen et al. 2016). At the cultural level, acceptance and conformity pertaining to other people's views and opinions is considered in establishing social norms that indicate what is 'good' or 'bad' (Beckett et al. 2017). Cultural values are passed from one generation to the next, which perpetuates discrimination (Tam 2015). Finally, the structural level is where prejudice and oppression are securely rooted into key societal institutions. This level deals with the impacts of various social, financial, and political factors that continuously interact with the individual and society while supporting personal beliefs and cultural norms. Whilst presented separately, these three levels are linked and manage to reinforce each other (Thompson 2017). In the context of this thesis, discrimination at a structural level includes educational and government health policies, healthcare practices at an organisational level. The cultural level addresses the cultural views and how they impact the individual practice of healthcare workers. Dalits are discriminated based

on their caste/ethnicity, resulting in rejection for jobs and better education, with double discrimination present in terms of gender (International Dalit Solidarity Network 2020). Additionally, Dalits are discriminated indirectly based on lower education, poverty, poor hygiene, etc. (Verma and Acharya 2018). More recently, the government has made "reservations" or "quotas" that are granted to groups of people based on their caste. This government quota system has also become a way of labelling Dalits as it has become an eternal entitlements that promotes social class division, nurture mediocrity and control political discourse (Dunning and Nilekani 2013).

However, the survey with healthcare workers has indicated that all participating healthcare workers believed there was no discrimination against Dalits in terms of accessing and utilizing health services (see Section 7.5.2). Dalits are provided similar health services as the rest of the population in the eyes of health workers. Similarly, 100% agreed that Dalits must be supported using a positive approach via the demonstration of equal behaviours and no discrimination (see Table 7.2.6). Though respondents also stated that Dalits are not discriminated against, they did note that their characteristics separate them from others. This uniqueness of Dalits that separates them from other communities increases their level of vulnerability to discrimination. There would be less chance of discrimination if one could seamlessly integrate and not be easily separated from groups.

Discrimination is not unique to Dalits. Experiences of social discrimination remains prevalent in the USA, for example amongst Black, Hispanic and Asian communities, (Daniller 2021). Particularly, Native Americans lag far behind in any measure of health factors and continue to have a lower average life expectancy (4.4 years less than the average US population) (Smith 2017). Similarly, research shows that in New Zealand non-European diasporas, including Māori, Asian and Pacific people, experience racism and potential impacts on health outcome such as poor primary health experiences, limited healthcare utilisation, and unmet healthcare needs, as well

as influenced healthcare system design, function and quality of care (Talamaivao et al. 2020).

From research conducted in Australia, Indigenous children aged 5-10 years old also confessed to a more frequent experience of racial discrimination and its association with health outcomes such as poor mental health including emotional and behavioural difficulties, sleep issues, asthma and obesity (Shepherd et al. 2017). Similarly, "Gypsy, Roma and Traveller" are terms used by policymakers and researchers, including the UK-wide Census 2021 which 'added 'Roma' to ethnic categories for first time (Office for National Statistics 2021a). However, in common terms 'Roma' was a term commonly used in the UK and across Europe to describe a range of ethnic groups that travelled worldwide since the 16th century. Gypsy, Roma and Traveller are the most disadvantaged people in the UK with the poorest outcomes in health and education (Parliament 2019). The 2011 Census for England and Wales identified that 14% of gypsies/travellers - more than twice as much as white British –- described their health condition as "bad" or "very bad" (Office for National Statistics 2014). Research suggested that these conditions are due to barriers to health service utilization that is related to health system organisation, service user characteristics, culture and language, economic barriers, and discrimination (McFadden et al. 2018).Thus, race discrimination remains prevalent across the world.

Research has established a connection between social exclusion and health inequities and documented that people who experience discrimination have worse health outcomes comparing with people who do not (DuBois 2003; Blas and Kurup 2010). *Healthy People 2010*, a comprehensive, health promotion and disease prevention agenda in the USA listed social discrimination as one explanation for many of the health disparities (Almond et al. 2006). Similarly, WHO also reported discrimination as a key issue; achieving SDGs 2030 targets will not be possible unless strong efforts are made to address stigma and discrimination, such as the concept of leaving no one behind (WHO 2021).

8.1.2 Health impacts due to lack of law and its implementation

Another barrier identified in achieving better health outcomes is effective law, especially the lack of commitment and enforcement from government as well as people in the implementation of laws banning caste-based discrimination. Many FGD participants noted that the Government of Nepal had introduced legislation against caste discrimination but had failed to implement it. Participants expressed that nobody adheres to the law resulting in many individuals in Nepal continuing to discriminate based on caste and its health consequences (see Section 6.3.1). Laws of the country play a crucial role in removing or reducing discrimination. If a law is effective and functioning, then it often contributes towards protecting people from injustice and discrimination at the structural level. However, in the case of caste-based discrimination, the rule of law has remained non-existent (Bennett 2005). The Caste-based Discrimination Act 2011 criminalised discrimination with a provision of up to three years imprisonment. However, due to weak implementation and policing of the law, many cases including health issues do not even register, let alone reach court (Human Rights Watch 2001). The regulation of the country stands as a foundational determinant of health that outlines socioeconomic, cultural and political factors connected with health outcomes (Pinzon-Rondon et al. 2015).

Participants from stakeholder interviews also stated that the existing health gap is associated with the continuity of discrimination, due to lack of strong law and effective implementation. This research identifies that the government has not been successful enough to eliminate it (see Recommendation section 10.3) at a cultural and personal level (see Page 149-150, PCS model). The healthcare system in Nepal has not been able to meet international standards and disease prevalence is considerably greater in comparison to other South Asian countries (Acharya and Subba 2008). Strengthened law and its effective implementation would help to acknowledge the health challenges faced by the country, thus would contribute in achieving the health outcomes as stated in the 2030 agenda (Dingake 2017). It is also identified that the rule of law has independent association with life expectancy, infant mortality rate, diabetes and

cardiovascular disease; the stricter the law adherence, the better the health outcome (Pinzon-Rondon et al. 2015).

Furthermore, most Dalits do not report discrimination due to the risk of being shunned by their communities, since they are required to live in the same society as those who accept discrimination. Some also stated that discrimination often goes unreported formally, including health discrimination, and that even reported discrimination is not acted upon effectively or in a timely manner. So, if they do not raise concerns, the government cannot investigate offending individuals. Despite the fact that, if there is concern raised then proper investigative measures should be taken, the literature suggests that this is not always the case. A report in India 2018 stated that a doctor refused to touch a Dalit service user during a medical check-up. Although this was a punishable crime, no formal complaint was lodged (Nigar 2018).

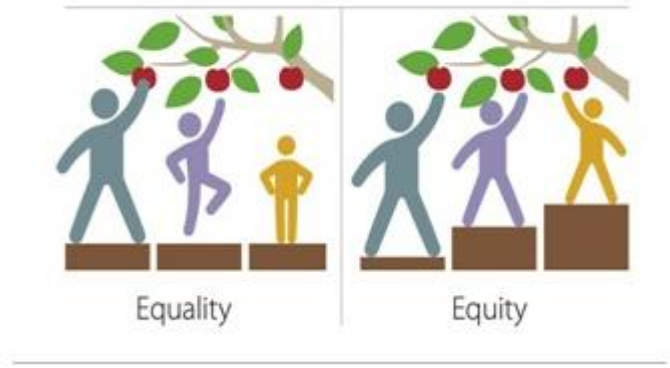
They added that, since the law has declared caste-based discrimination illegal, it has gone underground and is more difficult to see due to its insidious nature. It now mostly exists in private places, and in the form of indirect discrimination such as in the name of education, poverty or personal hygiene and wellbeing to discrimination, and that they (Dalits) have learned to live with it. Discrimination is hidden in society, so it has been difficult to identify discrimination and assess its impact on health outcomes (Jungari and Bomble 2013). There is no doubt that the establishment and implementation of law has been an issue because of its relation to the cultural roles and norms of caste hierarchy (Coulter et al. 2008) that is deeply ingrained in the better health of Dalits. Another implementation challenge has been the denial (by some) of the very existence of discrimination, whether it is within society or by national leaders (Thorat and Madheswaran 2018). However, this research shows that people are gradually educating themselves and becoming familiar with the law and its consequences, including the understanding that better health and wellbeing fall under their human rights.

8.1.3 Equality is not equity

The main reason for health inequality among Dalits is a lack of health equity. Almost all health workers (97%) who took part in the survey stated that they provide equal health services and treatment regardless of service users' caste status. They also thought there were equal health opportunities, as the same health awareness programmes are provided to both Dalit and non-Dalit users. Similarly, participants of the exit interviews (see Section 6.3.3.1) also confirmed that they received similar services and were treated equally. A similar view was reported by the FGD participants. Furthermore, when interviewing stakeholders, some stated that health-related programmes and policies are not separated by caste, therefore similar services are provided whether it is health access, services, opportunities, and programmes. However, equality is not equity thus, providing as well as receiving equal services is not sufficient to shorten the existing health inequality gap.

Although they sound similar, health equality and health equity are different terms (see Figure 8.1), inequality refers to not receiving sameness and indicates the unequal distribution of health or healthcare resources, whereas inequity refers to unfairness and indicates that people are not able to access similar healthcare opportunities because of poor governance, corruption, and cultural disparities (Global Health Europe 2009). A recent study in the UK stated that inequality in health may have several meanings, such as differences in people's health, dissimilarity in care they receive as well as variances in the opportunities available to them in order to live healthy lives (Heaslip et al. 2022). Implementation measures to achieve one outcome for the general population can result in dramatically different outcomes for marginalised populations (Braveman and Gruskin 2003). Equality refers to allocating the same opportunities or resources to each individual or group, whereas equity means providing opportunities or resources tailored to different circumstances or populations in order to meet equal targets (Temkin et al. 2018).

Figure 8-2: Equality versus Equity approach



Adopted from Temkin et al. (2018)

In terms of health equality, the same health services and treatments are provided to the entire population. This sounds fair but to achieve it everyone needs to be at the same level, have the same needs, and the same kind of access to services and treatments (Global Health Europe 2009). For example, the health system of Nepal includes everyone equally, such as even distributions of health or healthcare resources (World Health Organization 2007). Dalits are not able to access healthcare opportunities equally, often due to poor education, not understanding the health system, poverty, transportation, and cultural disparities (see Section 6.3.3.3). In reality, sub-groups in society often have different circumstances; people with disabilities, diseases, mental health problems and those who live in remote areas and/or areas where health services are limited will have different requirements to achieve the same level of health and welfare (Culyer 2015). Dalits fit into such disadvantaged subgroups. This is because Dalits have higher levels of physical and mental health issues (see Section 6.3.1), very limited awareness about health (see Section 6.3.3.4) and live in isolated areas with limited health services (see Section 6.3.1.1).

Health equity considers factors that influence health such as economic and social status, employment, food, housing transport etc. It recognizes different circumstances

and needs so that that preexisting health conditions or other social barriers do not restrict the ability to achieve an equal output. Equity brings social justice or fairness; equity in health can be described as the non-existence of social inequality or unfair health disparities (Temkin et al. 2018). Health equity offers special attention to the allocation of resources and other involved processes that may result in certain kinds of health disparities between advantaged and less advantaged social groups (Braveman and Gruskin 2003).

Researchers in the UK recently concluded that lack of equity in health services, which leads to health disparities, are linked to wider determinants of health (Heaslip et al. 2022), such as power, prestige, socio-economic position, better education, employment and participation in politics (Kabir et al. 2018). This study identified a similar outcome. Caste discrimination and other social determinants also affects Dalit health (see Section 6.3.2). Inequalities related to health service access are preventable; people who are disadvantaged and not easy to reach have higher chances of experiencing health inequalities and are prone to poorer health outcomes (Hui et al. 2020). Inequality of health or resources is one measure of inequity, which is applicable where one might expect equality. It can be claimed that global health inequity takes place when countries fail to achieve their global health targets, such as sustainable development goals (Global Health Europe 2009).

8.2 Roles of other social determinants alongside caste

One of the main non-medical factors that influence health consequences are social determinants of health. These factors play an essential role in maintaining health equity and can create unethical and needless differences in health status within communities and countries (World Health Organization 2010a). Social determinants discussed in this chapter are poverty, education, employment, and gender. These factors are based on the conditions such as where people are born, live, work, grow and age. Therefore, Dalits who have limited access to these factors suffer most (Priya and Sathyamala 2007).

8.2.1 Role of poverty on caste-based health discrimination

Most participants in the qualitative studies, both in the FGDs and KII, agreed that the majority of Dalits live in poverty and struggle in their daily lives as compared to upper caste people. They often neither own a house nor land and struggle to access food. In the qualitative study, participants stated that due to caste and poverty (double discrimination) they experience worse health outcomes (see Section 6.3.2.4). According to the WHO (2021), poverty is the largest social determinant of health, and poor health is a barrier to social and economic development. Furthermore, people across the world face high levels of health inequity and disparities caused by differences based on social status. It implies that higher socio-economic status lowers the chances of bad health and a reduced lifespan. (WHO 2021). A study in Nepal highlighted that people with lower socio-economic conditions have more severe health consequences such as chronic illness, resulting in more out-of-pocket payment, most usual method in Nepal. Thus, every individual trapped in this vicious cycle (Sapkota et al. 2021). In the context of India, one-third and Nepal, two-fifths of the population are multidimensionally poor. In India about 47% of the multidimensionally poor population suffered from worse health spending as compared to the multidimensionally non-poor population. A similar pattern was found in Nepal (Mohanty et al. 2017).

Participants also stated that caste discrimination limits their access to better education, employment and income therefore confines them to a cycle of long-term poverty. They highlighted that Dalits, as daily labourers, must work every day to feed their families, and cannot take–a day off - even for health checkups. This limits the possibility for preventative public health measures. Poverty on top of equality plays a vital role in health aspects, such as travelling to health services, paying for health services, or losing the opportunity of daily earning (see Section 6.3.2). Similar outcomes, such as lack of education, financial stability, economic pressure, and domestic burdens including caste discrimination and gender aspects have been identified in a study conducted in Nepal among Dalit women (Sharma Gautam and Hearn 2019). The

Marmot Review in the UK describes the social gradient in health as a particular challenge whereby, in terms of socioeconomic position, less advantaged people have worse health and shorter lives than people who are more advantaged. Furthermore, in places where access to health and healthcare resources are severely deprived, the social gradient in mortality could arise from degrees of absolute deprivation. Social status, health and mortality from a wide range of diseases have an extreme inverse relationship (Marmot 2020). Poverty limits people's options and opportunities to participate and profit from developmental progress. Thus, people living in extreme poverty can be 'left behind'. The Sustainable Development Goals 2030 (see Section 2.7) has pledged to ensure that no one will be left behind and will continuously endeavour to reach the furthest behind first" (Kharas et al. 2019).

Along with poverty, health is also related to ethnicity and social status, in that a higher social status leads to lower possibilities of health discrimination. It follows then that the lower the social status the higher the possibilities of health discrimination (Thorat and Madheswaran 2018). Poverty can affect people's chances to have healthy and better lives along with access, opportunities and benefits provided to the people living within society. Research has identified that race and ethnicity in terms of a hierarchical system often defines a person's socioeconomic status (American Psychological Association 2017), see further, section 2.4. These ethnic differences demonstrate their adverse impact on health in many places within Asia, Africa and America (Smedley 2012). A survey conducted by Research demonstrates that Black Americans experience poorer outcomes on health indicators in comparison to white and Latin Americans (Brodie 1995; Taylor 2019). Other research has highlighted that Black or African Americans are disproportionately burdened by injury, disease, disability and death compared to White Americans (Taylor 2019). Additionally, in the USA, both health inequities and all-cause mortality rates of the Black population are substantially higher than White populations (Centers for Disease Control and Prevention 2005; Benjamins et al. 2021). Similarly, in a survey of 2,600 participants in the UK, ethnic minority communities have been shown to suffer from twice the level of

discrimination compared to the white population when accessing health services, 52% Asian, 50% Black and 19% white population (Royal Society of Arts 2021).

The health sector of low-income countries like Nepal seems to be affected by poverty. Poverty can be measured by economic growth based on Gross Domestic Product (GDP) per capita. The GDP of Nepal in 2020 was 33.66 billion USD, ranking it 99th out of 196 countries (Adhikari 2020). Compared to people from higher castes, lower castes such as Dalits, Adivasis and Chepangs have been unable to develop equitable ties in social, educational, political, and economic areas, resulting in vulnerability (Cameron 1998). This creates a huge health gap between the marginalised and non-marginalised people. Every year, of all the people from Indigenous communities and Dalits who lose their lives, the majority of deaths are from very common diseases such as the influenza virus, due to no accessibility to pharmaceuticals and other health services compared to their higher caste counterparts (Bhandari et al. 2009). The economic condition of these marginalised populations does not enable them to afford out-of-pocket spending for health treatments, which in turn results in depression, long-term diseases, and higher mortality rates (Polit 2005). Even buying paracetamol and a packet of *Jeevan Jal* (oral rehydration salts) can be a struggle to these marginalised populations including Dalits (Shrestha 2009). In 2009, in Jajarkot and Dailekh where most of the population is made up of Indigenous groups such as Dalits, there was a massive spread of diarrhea which resulted in many deaths among the poor. One of the identified main reasons for their death was a lack of access to basic health services and medicines on time (Bhandari et al. 2009).

Although the Nepalese healthcare system is mixture of public, private and non-government organisations, the Government of Nepal provides some free health services and medicine, but they are very limited and not readily accessible (World Health Organization 2007). Therefore, the importance of using private health services has grown rapidly in recent years (Pandey 2018). However, such services are expensive and therefore not accessible for many Dalits (see Section 2.6). A study

conducted in rural Nepal concluded that people are more likely to use private care over public. It also highlighted the longer waiting times when it came to accessing public care. As a result, people who are poor and less educated have higher health barriers (Ashworth et al. 2019). Similarly, a USA study found that people with lower income used less health services or struggled more to afford health services in comparison to people with higher income (The Commomwealth Fund 2020). The reasons behind this were a lack of health accessibility, knowledge, acceptability, and affordability (Ashworth et al. 2019). Wealthier individuals (including in Nepal) mostly preferred private doctors who are always readily available to fulfill their health needs at any time and without delay.(Dutton 1986; Ranabhat et al. 2020). On the other hand, those living in poverty (e.g., Dalits) cannot easily afford private doctors, therefore must wait longer in queues and usually need to travel further for basic health treatments (see Section 6.3.2).

The Government of Nepal established a Social Health Security Development Committee in 2015 as a legislative framework to begin implementing a social health security system (SHS). The initiative aims to improve access to healthcare for poor and disenfranchised people. However, due to the funding issues, the aim has not been fulfilled (Mishra et al. 2015). The policy makers of Nepal should focus on providing quality health for people who are unable to afford health services (see Recommendation section 10.3).

8.2.2 Role of education on caste-based health discrimination

Most participants from the FGDs agreed that Dalits are not as educated when compared to people from higher castes. Participants added that the core reason is due to Dalits having fewer opportunities for education, discrimination related to caste aspects/ untouchability, and poverty. A few participants stated that they live in an area where there is limited availability of education, or that people have to travel for better education, which they cannot afford. While some claimed that even if they manage to go to school, they experience discrimination from teachers as well as fellow students.

A study in the western Nepal, revealed that participation of Dalit children in education is strongly affected by inclusive schools (different caste people are included) and community factors. Thus, it is important to identify and address community barriers (e.g. different caste students possibility of caste discrimination) in inclusive in order to benefit from inclusive education (Khanal 2015). Similarly, Dalit students in India have to experience caste-based discrimination at various levels such as schoolmates, faculty, and administration (Maurya 2018). Furthermore, participants also highlighted that they (Dalit children) leave education early due to poverty in order to get jobs that can help their family generate income. The Government of Nepal's economic survey report shows the recent retention rate up to grade 12 was 29.2%, whilst grade 10 was 64.6% (Ministry of finance 2021).

Stakeholders mentioned that one of the reasons Dalits are left behind in terms of societal development is a lack of access to education in comparison to the rest of the population, therefore possess less understanding of health/health-related risks (so-called health literacy), leading to poor health and wellbeing (see Section 2.4). Most participants from FGDs, who are Dalits, stated that their health has been affected due to lack of health education and awareness. They added that a lack of understanding when it came to disease prevention, and the importance of Personal Protective Equipment (PPE) affected their health such as chest infection while working with cottons (prevention for dengue). Dalit women participating in the FGDs also indicated that a lack of education also influenced child marriage and resulted in a higher maternal mortality rate, due to factors such as gynaecological and chronic diseases. Participants also raised health issues due to education such as lack of hygiene knowledge, importance of using toilets and hand hygiene, and a lack of understanding on the importance of safe drinking water (see Section 6.3.2.2). The survey also highlighted the need for health education among the Dalit population. However, the healthcare workers agreed that the situation is improving as there is an apparent increase in understanding of the importance of education, resulting in the younger generation benefitting from education and awareness with regards to health aspects.

Dalit participants expressed that they now understand the importance of education in life to secure better jobs, earn higher wages, and improve both their health and status within society, therefore they want their children to receive this education. This becomes apparent from the quantitative data, as the younger generation are shown to be getting higher education despite their caste (see Table 7.2.1). According to the education system of Nepal individuals in 11-12th grade are usually aged between 18-25 (Ministry of finance 2021). Comparing highest age and education range further highlights that, younger participants are more aware of education needs, at least completing A level education.

Education prepares the mind to sense and process information; therefore gaps in health inequalities are brought to light (Raghupathi and Raghupathi 2020). Similarly, it gives us the aptitudes and attributes that directly impact our long-term health outcomes (Karasimopoulou et al. 2012). Education is not limited to reading and writing, but also fosters various factors such as employment, economic standards, social status and equality (Smith 2002). Although there are no formal restrictions made on any group for acquiring the basic educational needs in Nepal, the Dalits are discriminated against caste that limit their access and demotivate them in achieving education. Similarly, their various need such as supporting their family for financial income or taking care of their siblings plays role in dropping education. The notion of untouchability, though diminished, is yet not eliminated. The majority of the Dalit population still suffers unfair treatment due to practices that restrict their opportunity to receive better education (Bishwakarma 2004; Poudel 2007; Parmar 2020).

Education is key to better health as educated people would have (a) more knowledge to prevent sickness and disease, i.e., health literacy, which is essential to live healthy and productive lives, and (b) their education gives them access to better jobs that pose less risk to their health. Even in the US, a high-income country, it has been observed that less-educated individuals are more prone to worse health outcomes when compared to the rest of the population (Zajacova and Lawrence 2018). Data from

UNESCO's Global Education Monitoring Report indicates that the achievement of higher levels of education among mothers is beneficial towards their children as it increases rates of their children's nutrition and vaccination as well as reduces preventable child deaths, maternal mortality and HIV (English 2016).

In terms of the relationship between education and health, research has identified three basic mediators, namely: economic; social, psychological, and interpersonal; and behavioural health (Ross and Wu 1995). Income and employment as economic variables mediate education and health relationships by limiting and regulating access to acute and preventative medical care (Andersen 1995). Social, psychological, and interpersonal variables will help people with different levels of education to access coping processes and resources (Wheaton 1983), thus enabling them to take charge of their own health (Manton et al. 1997). These variables will also help with problem solving and conscious intellectual capabilities to tackle poor health consequences such as stress (Harper and Dawes 1994). Behavioural health allows well educated people to identify systems of poor health in a timely manner and seek medical help (Currie et al. 2009).

Furthermore, the positive relationship between education and health indicates better health achieved in the sense of higher self-reported health and lower morbidity, mortality and disability when people are well educated (Marx et al. 2017). Educated individuals focus on their health by taking regular health check-ups and the correct medications. They are also less involved in risky health occupations and are likely to have health insurance (Baru et al. 2010; Baker et al. 2011). Educated people have more frequent use of health services and access to hospitals as they have better health understanding and access to preventative measures. People who have a higher level of education have better health and a lower mortality rate compared to less educated people. Higher levels of education particularly influences infant mortality, child vaccination and life expectancy (Raghupathi and Raghupathi 2020). Further, a meta-analysis revealed that understanding the risk of disease, applying prevention methods

and reducing mortality is highly affected by one's intelligence/education level (Baker et al. 2011).

8.2.3 Role of employment on caste-based health discrimination

Many participants stated that employment and earnings are other strong factors that impact health outcomes of Dalits. Participants in the FGDs stated that most Dalits engage in low status employment and are therefore poorly paid. High numbers of Dalits are engaged in sewing and making cotton mattresses; this is work associated with an increasing risk of respiratory diseases (see Section 6.3.2.3). Some claimed involvement in unhygienic jobs such as manual cleaning of human excrement with no personal protective equipment. Research highlighted a significant connection between job insecurity and individuals' health and wellbeing as it is linked with the risk of depression, emotional exhaustion, and anxiety, along with more comparison to others and lower overall life satisfaction (Llosa et al. 2018). Another study also concluded a similar outcome that people who are unemployed or in low-income employment have worse mental health outcomes such as suffering from anxiety, trauma, Alzheimer's, or other mental and physical disorders in comparison to employed/higher paid individuals (Saleem 2015). A report in the UK reflected that ethnic/caste minorities and women are more prone to have job insecurities and health consequences (Barlow 2022). Unemployment and job insecurities can cause stress which in future may lead to long-term physiological health impacts and can have adverse consequences for an individual's mental health (Paul and Moser 2009). The issues related to employment not only affect the individual but also their children. Research shows that children who live in unemployed households are almost twice as likely to obtain poorer educational results in comparison to children who live in households where the adults are employed (Department for Work and Pensions 2017).

Many female participants also stated that unemployment and job insecurities are another common issue within Dalit communities that affect their physical as well as mental health. Many females mentioned that they live in fear of losing their job, or

their partner losing their job, and that increases their stress levels. Stakeholder interviews also highlighted the same outcome, that many are jobless and take risky jobs for better income. Research highlighted that job insecurities increase stress levels and control coping mechanisms thus influencing individuals' wellbeing and affecting their psychological condition (Darvishmotevali and Ali 2020). People who have better jobs and income are less likely to suffer from poverty and related health consequences in comparison to Dalits (see Section 6.3.2.3) therefore more likely to live healthy lifestyle. However, some factors such as education, physical ability and often caste/ethnicity restrict their ability to find and keep jobs (Mohindra et al. 2006). The National Sample Survey Office (NSSO) in India also indicated that social discrimination and socioeconomic experiences increase the difficulties faced by the lower caste in the labour market. It further highlighted that job challenges have become worse and job creation are decreasing (Governemnt of India 2022). This increases suffering in the workforce and the people who are at the bottom of caste hierarchy suffer most. This hierarchical social discrimination increases the number of hurdles faced by low caste communities in the labour market (Thorat 2018).

Employment helps to generate income which helps to attract education and eradicate poverty, thus boosting health outcomes. But Dalits are not able to benefit from these aspects due to lack of better employment and income (see Section 6.3.2). A study suggested that better employment is both protective and beneficial as well as increases health consciousness, affordability, accessibility, and understanding (Saleem 2015). Education, poverty, and employment are interlocked as one strong factor that helps to establish social status as well as access and control over resources and power. The social status of an individual commands an ability to influence the nature, magnitude, and availability of health in low-income, middle-income, and high-income generating countries (Blas and Kurup 2010).

Taking higher and lower-economic countries like the UK and Nepal, the majority of people in the UK look after their eating habits, health, hygiene, and sanitation and are

aware of proper health maintenance and prevention. This seems to be the salient reason why the UK is able to provide such excellent health services in terms of equity of access and ensure that financial hardship does not impact people's health in their time of need (Crisp 2008). Similarly, a study in Nepal in 2019 highlighted that out of all total deaths, 71.1% of deaths are due to non-communicable diseases, 7% due to injuries and still 21.1% are due to communicable, maternal, neonatal and nutritional diseases (Nepal Health Research Council (NHRC) et al. 2019). These kinds of health issues are common in minorities which often can be prevented by better income opportunities that enable people's capacity to have good education, awareness and prevention of disease as well as access to nutritious food (Henseke 2018). Furthermore, the adverse effect of unemployment on mental health is relatively higher in countries where economic development is weak, distribution of income is not equal, or an ineffective employment protection system is in place (Paul and Moser 2009). This research states that Dalits do not have better income and job securities thus suffer more from health consequences. This emphasizes the necessity for effective, stabilising policies, most especially focused on employment aspects of caste-based health discrimination.

8.2.4 Role of gender on caste-based health discrimination

Many female FGD participants explained that their hardship was due to double discrimination based on caste and gender in comparison to men; some male participants also agreed to this assessment. They added that the majority of women are engaged in work that is not secure and need to travel place to place to earn their daily wage, making them more vulnerable to physical violence and abuse. Gender influences health behaviours, vulnerabilities, and exposures, and impacts the responses of the health system. It is also interconnected with other social determinants of health such as socioeconomic status, caste/ethnicity, and ability (Bates et al. 2009). Biological differences between the genders often influence determinants and consequences of disease, therapies and drugs to produce different health outcomes (Vlassoff 2007). Gender-based discrimination is connected to health risks through

various factors including discriminatory culture, beliefs, values, norms and practices, and differential exposures and vulnerabilities to disease, injuries and disabilities, discrepancy in the health system and prejudice in health research, thus impacting health and wellbeing (Matthews 2015).

Participants further added that Dalit women are more likely to experience physical exploitation compared to other women. Men and women in Nepal hold different assigned gender-based roles and responsibilities that helps to determine their position in both their family and the wider community (Scaria 2017). These difference affect the level of health-related risks they take, increase exposure and vulnerability and their efforts to maintain a better health condition as well as response of the health system with regards to their needs (Men et al. 2013). For example, in many societies, women are more exposed to violence and abuse, sexual harassment, sexually transmitted disease, and are more prone to unintended pregnancies and malnutrition, as well as mental issues including depression (Read and Gorman 2010). A survey in India, 2006 presented that violence against women belonging to the scheduled caste and tribes was much higher in comparison to women from other groups (Sujatha 2014). Key stakeholder interviews also highlighted that Dalit women are not only pushed down by those outside their caste, but they also experience discrimination by men within their family and in the same caste. Due to this, women are not able to openly express themselves, resulting in mental stress. They are unwilling to share details about any physical and mental illness due to stigma and fear that their family and husband will not accept them with these conditions. Research makes it evident that discrimination based on gender is committed by their own caste men; Dalits, towards Dalit women (John Packianathan 2012; Sabharwal and Sonalkar 2015). This form of discrimination, known as Dalit Patriarchy, also includes violence and harassment such as domestic violence against alcoholism (see Section 6.3.2.1), dowry, husband's suspension, extramarital marriage and inter-caste marriage (Sujatha 2014). Non-Dalit women as well as Dalit men score much higher on human development indicators such as

literacy, poverty, health and longevity, than Dalit women (Sabharwal and Sonalkar 2015). Thus, Dalit women are trapped in multiple layers of discrimination.

The FGDs also identified that Dalit women find it more difficult to access ANC or manage their health due to other pressures such as daily household work, taking care of kids and/or pressure to generate income for food. Gender aspects of discrimination also restrict women from accessing health related information and much needed health services. That is influenced by mobility restrictions, less power to independently make decisions, limited financial access, lower education level and health workers discriminatory practice (World Health Organization 2021). Some research in Nepal argued that a woman's caste does not directly contribute to receiving quality of healthcare delivery except in cases of disability (Devkota et al. 2017) and adolescent pregnancy (Devkota et al. 2018). However, many studies in Nepal have emphasised that Dalit women lack essential health information, and face difficulties in reaching health facilities/receiving adequate and appropriate healthcare (Bishwakarma 2004; Acharya et al. 2018; Sundari 2020). Dalit women are far behind when it comes to utilising prenatal care (Sharma Gautam and Hearn 2019) and antenatal care. They lack health education and awareness when compared to other mothers (Awasthi et al. 2018).

It is evident that in both low income and high-income countries women are more likely to suffer from health conditions in comparison to men. United Nations global report, 2020 states that around 90% of the global population has some sort of gender discrimination against women (United Nations Development Programme 2020). Existing research documented that inequities in health outcomes are strongly associated with gender and race in the USA (Williams et al. 2019). However, the condition of low-income countries is even worse. In low-income countries, women are usually expected to perceive 'being sick' as a normal condition, and to only seek medical help or take time from their daily routine for a check-up at comparatively later stages of sickness (Navsarjan Trust India et al. 2013). However, these conditions may

vary significantly across cultures and communities (Irudayam et al. 2006). A recent study, in India highlighted that caste, supported by gender and class among other many things, affects millions of populations, influencing their health and socio-economic life (Jadhav et al. 2016). Another study found illness which are not treated on time, (resulting in death) are found predominantly in lower castes and women (Navsarjan Trust India et al. 2013). Thus, women from a lower caste group has a greater chance of dying in comparison to higher caste women (Sen and Iyer 2012). A further study documented that, among lower caste groups, symptoms of a woman's ailment such as back pain, headaches and leg pain are common, with higher birth related diseases, epilepsy and accidents and incidents compared to upper caste women (Scaria 2017). In an Indian study, being a woman and from a lower caste group is associated with anxiety, stress and depression (Housen et al. 2017). To reduce health inequities and to offer better access to health services, multiple axes of inequities such as caste and gender must be considered by policy makers and health service planners.

8.2.4.1 Intersectionality

This study has highlighted the intersectionality of low caste status, gender, age and other overlapping pluralities. The concept of intersectionality usually considers the complexity and dynamic way in which race/ethnicity, class, sex, sexuality, age, ability, religion and citizenship shapes ones identifies and social life (Tefera et al. 2018).

Many studies highlighted that being female, poor, have had less education, having a disability, being from certain ethnic groups means people are less likely to be listened to, or even not at all, especially in health settings (Shayo et al. 2012; Bolsewicz Alderman et al. 2013). These intersections are often considered as a common accepted discourse and as evidence of domination or prejudice, which is one of fundamental factor that exclude marginalized population that holds unique characteristics (Crenshaw 1990; Crenshaw 2018).

In this research study I have identified discrimination against Dalits and its intersection of social dynamics of gender, class and social hierarchy; and its effect on multiple dimensions such as social status, education, employment, poverty and health. Research also highlighted overlapping intersectionality with caste unfold wider gaps in access to healthcare (Mahapatro et al. 2021).

Dalit communities are extremely multi-layered with the existence of caste, class, gender, economic status divisions that fuel inequality and abuse. The concept of intersectionality has helped not only to understand inequality across social class but also identify that the burden of inequalities is not experience the same among all Dalits, for example economic class borne by difference in caste and gender. Thus, intersectionality pulls attentions to individuals' and groups' multiple positionalities. The term intersectionality and positionality (see Section 8.6) are often used in the way where multiple social identities can interconnect to establish a structure of discrimination and oppressions (Carter-Sowell and Zimmerman 2015).

Discrimination against Dalits can be compared to racism to understand it at a more international level. Social science researchers into race argue that racism builds rates of mortality, morbidity and general wellbeing that are depended on socially assigned race. One of emerging interdisciplinary term is 'Critical Race Theory' (CRT) that has helped to understand that race is artificially created social division that associates between various set of individual characteristics. CTR explains how social system such as labour, education, housing, justice, as well as health system are layered with racism that are embedded in laws, policy, procedures and regulations that produces different outcomes by their race (Christian et al. 2019). In addition, Crenshaw (1990) highlighted that Black women suffered higher level of discrimination because of intersection of race and gender rather than of being whether Black or female only. Similar outcome has been identified in this research, Dalit women rather than being only female or ethnic groups they suffered more due to intersectionality as one makes

other works such as low social status, less likely to get education, get low pay and/or dangerous jobs, low economic status, trapped in forever poverty (see Figure 6.2).

8.3 Status of health and resources

In this section we discuss inequity in health due to access to health services, availability of health resources and lack of workers in the health sector. Access and availability of health and resources have largely been responsible for existing and even widening the gap in health outcomes. A complete healthcare system is a combination of health services, availability of health supplies, effective equipment, and health workforces. Limitations in any of these factors may result in poor health outcomes (Daniel et al. 2012). Health policies were supposed to maintain distribution of health and resources, however the availability of health services is still uneven. This may be due to differences in infrastructure, finance, health supplies, health distribution systems and human resources (Baru et al. 2010).

8.3.1 Access to health services by Dalits

This research highlighted inequity in access to health services by Dalits (see Section 6.3.3.3). Many participants from FGDs and some interviewees stated that health services are extremely limited in number and therefore difficult to access for everyone, especially Dalits. The word “access” indicates a wide concept that involves five measurements; accessibility, availability, accommodation, acceptability and affordability (Penchansky and Thomas 1981). Enabling access to healthcare is referred to as allowing people to receive better healthcare in order to enhance their health. If health services are easily available and supply of health resources is sufficient, only then will the people have access to health services. However, there is no doubt that the extent to which people receive access to healthcare is also varied based on organisational, financial, cultural and social hurdles that control the utilization of health services (Gulliford et al. 2002).

Furthermore, FGD participants stated that they live in an isolated area within their community that is usually far from many services including health, thus seeking help always includes travelling. Several participants in FGDs identified that there is only one health centre (health post) where they can access healthcare. On top of travelling issues and limited health services, even those health centers that are available to them often lack health equipment. Transportation access to health services is a major aspect of quality health. It is a basic but key step for travelling to healthcare and medication access. There can be no doubt that transportation barriers result in higher burdens on health aspects which may influence the relationship between poverty and transportation availability (Syed et al. 2013). A systematic review suggested that transportation barriers affect those who are vulnerable people and are likely to have a higher burden of chronic disease the most. It further states that improved transportation services will lead to hospital utilization, pre-natal and maternal care, cancer screening and management of Chronic diseases (Starbird et al. 2019). Similarly, participants in exit interviews claimed that if free health services and free medicines were readily available and services did not need major travel, (locally available health centers) Dalits would be able to access them and thus improve their health. Dalit service users usually receive poor medical services in comparison to non-Dalits who receive better medicines and consultations (George 2015a). Research in low-income countries shows that providing free health services increases its utilization (Gurung 2009). The Government of Nepal addresses health as a fundamental right and introduced free basic healthcare for all in 2007 (Department of Health Services 2007). However, due to lack of awareness, Dalits are excluded from benefitting from the facilities (Gurung 2009). As a result, both awareness programmes and infrastructure development within vulnerable communities are essential for easy access.

Common issues regarding transportation barriers include travelling long distances, shortage of vehicles, lack of sufficient public transportation, financial burdens, and inadequate infrastructure. Research in Nepal suggested that if easy transportation were available, the percentage of people residing within five minutes of any public

healthcare facility would be increased by 62.3% (Cao et al. 2021). Even countries like the USA have not been able to address this issue. Around 3.6 million Americans are deprived of access to medical care due to lack of quality transportation each year (Association 2017). Thus, for a low-income country like Nepal, transportation has been a major issue due to its geographical structure; many communities live in isolated rural areas. Additionally, there exist cultural and gender aspects. A report in Nepal stated that the rugged landscape of Nepal (hills and mountains) and poor road transportation creates a huge travel barrier to health facilities. Consequently, use of health facilities decreases where distance to travel healthcare increases (Tegegne et al. 2018). The 2011 Nepal Living Standard Survey reported that 41% of households do not have access to a health post/services and around 80% do not have access to a local publicly-funded hospital (Central Bureau of Statistics 2011). Similarly, a NDHS in 2016 stated that, in order to access the nearest government health facility, 34% of households in the lowest quintile have to travel for more than an hour (Ministry of Health 2016). Therefore, transportation has become a major health barrier when seeking healthcare services, especially in the rural population of Nepal. A study conducted in the rural area (terai) Nepal revealed that the majority (around 92%) of rural households do not access healthcare due to lack of a personal vehicle or having to depend on alternative means of transportation (Ashworth et al. 2019). Many participants in this study stated that their access to health is limited due to financial constraints. Some said they do not have enough funds to pay health service expenses while others explained they could not afford to lose their daily earning to visit health services. It has been identified that many countries, especially low-income ones, are unable to provide equal access to health services as they are too expensive.

As noted earlier, many participants also highlighted that financial factor were a barrier in accessing health, therefore many ignore health issues that could have been treated on time. In recent years due to COVID-19, many countries' economic conditions are worsening, unemployment rates are high and health costs are constantly escalating. This has resulted in many people unable to afford healthcare (Parikh et al. 2014). The

fees associated with healthcare have major consequences on healthcare access due to affordability (Sen and Iyer 2012). It is important to understand that financial barriers to health do not only include official health service fees and medicine, but also informal expenses such as missing out on daily earning in order to seek healthcare, and travel expenses to visit health services (Silal et al. 2012).

Health fees are a common aspect of the healthcare system in low-income countries. Theoretically, in Nepal, everyone has free access to primary care services and some groups including Dalits are protected from secondary costs (Department of Health Services 2021). However, these policies have been challenged by lack of funding in the health sector; only 7.8% of the total budget (GDP) was allocated to the health sector in Nepal for the year 2020-21 (Ministry of Health and Population 2020). Thus the burden lies to a large extent on service users (McPake et al. 2013). In 2015, the Government of Nepal introduced a social health security scheme and insurance system which was intended to improve the access of health services to the marginalised, the poor, and those living in isolated areas (Mishra et al. 2015). However, uptake of this health insurance scheme has not been much satisfactory. This is due to reasons such as lack of available drugs, unpleasant behaviour of health workers, and indifferent behaviour to scheme holders (Ranabhat et al. 2020). Thus, there is a need to revise the existing health policy.

It is worth remembering that health security depends on various dimensions such as available choices, consequences of related risk, source of income and its distribution, strategies to reduce costs and existence of specific and secondary insurance. It is evident that most of the countries are struggling to expand health coverage (Ellis et al. 2014).

Financial limitations in receiving health services not only acts as a barrier to accessing healthcare but is also related to poor health such as depression and anxiety. In the USA national health interview survey of 3,923 patients with chronic kidney disease, mild to moderate psychological distress was reported by 15%, and serious psychological

distress was reported by 11% of participants. The study further highlighted that the financial barrier is highly associated with psychological distress in people with chronic kidney disease (Choi et al. 2019). In a country such as Nepal, where poverty is widespread, health costs have become a major barrier in accessing health services. Most of the health services require payment and are very expensive, resulting in health services being out of reach as well as many households being pushed into poverty when health calamities occur in the family (World Bank and WHO 2017). The removal of health costs may help to improve health coverage. In the UK for example, free publicly funded healthcare is provided through the National Health Service (NHS), and everyone has access to healthcare without financial barriers. A report by the Commonwealth Fund ranking healthcare system performance based on five indicators such as access to care, care process, administrative efficiency, equity and healthcare outcomes, ranked UK in 10th place (Schneider et al. 2021).

8.3.2 Availability of health resources

This study indicates that a key reason for inequity in health status is lack of availability of health resources such as medicine and supplies, and utilities such as x-rays or other medical equipment. Participants from FGDs mentioned that very few healthcare providers are available, and they are always running out of medicines. Other participants added that free medicine provided by the government is never available. Participants from exit interviews also made similar observations. Furthermore, they said when asked for free medicines, they were informed that they were out of stock, but that the commercial pharmacy next to the health post is always full of the very same medicines. However, they are private and therefore not free. Additionally, survey data showed that 69.2% of healthcare workers stated that they thought there are sufficient medical drugs available in the local area, thus raising a question as to how health needs are meet without the availability of sufficient medical resources.

Availability of health resources is a challenging but essential component of the healthcare system, particularly a publicly funded system. It refers to the connection

between the quantity and type of necessary items and those available items. Regular availability of essential health utilities is vital to provide the best healthcare services (Kuwawenaruwa et al. 2020). The World Bank and the WHO stated that almost half of the entire world's population suffer from not receiving essential health services. One major reason for healthcare not being available is cost associated with it (see Section 8.3.1).

Exit interview participants shared their experience saying that they must pay for every service such as blood tests, X-rays, and medicine, all of which are very expensive. Thus, it is a challenge for them to access these services. Every country needs guidance on maintaining availability of essential health services regarding their epidemiological profile, capacity of health system and availability of resources to ensure high quality healthcare services. However, low- and middle-income countries need even more support especially due to the outbreak of COVID-19 pandemic (Blanchet et al. 2020). In countries within Africa and Asia, the WHO identified wide gaps in the availabilities of health services. Basic healthcare services such as infant immunisation and family planning are becoming more available, yet it is still a challenge in these regions due to the financial distress related to obtaining these services (World Bank and WHO 2017). The Management Sciences for Health (MSH) price reference of generic medicine indicated that, in Asia, the local medicine price is often as twice as high as the international reference price (McFayden 2002).

In countries like Nepal, healthcare access for all is constitutionally preserved, and the SDG of 'Good health and wellbeing' is adopted. However, a significant level of inequity still exists, largely due to distortions in health resource allocation (World Health Organization 2007). Global spending on health has almost doubled and, within high income countries, around 80% of spending is dedicated to the public health sector, however no evidence can be found that the existing health financing procedure allows equitable utilization of health resources (Torres et al. 2011). Policy makers and health service planners should give the first priority that Dalits' access to essential and

appropriate healthcare services, and its availability and utilisation are on time in order to have effective benefits of health programmes.

8.3.3 Health workforce

This study reported that health services are always in short supply (see Section 6.3.3.2) and that shortage of staff often means there are no health workers locally available, especially at the senior level. The main concern is staffing. Staff are not always readily available to provide service or are too busy due to a higher number of service users in comparison to the number of available health workers. Lack of health workers (in both senior and junior positions) has been identified as one of the main concerns in achieving better health of everyone including Dalits, especially in rural areas. A healthy health workforce is an essential factor in expanding health coverage and attaining the highest possible level of health outcomes. Better health outcomes are dependent on health worker availability, accessibility, acceptance, and quality of service (WHO 2021). Lack of healthcare workers who can diagnose and treat efficiently can limit the provided and timely service. Lack of health professionals is a major barrier to healthcare and has become one big obstacle in achieving quality health services (Blanchet et al. 2020).

The WHO has been working continuously towards better health for all, supporting and coordinating towards health emergencies as well as promoting the workforce. Furthermore, in order to show appreciation of health workers for their dedication during the pandemic, 2021 was designated as the international year of health and care workers (World Health Organization 2018a). In 2006, the WHO reported a global shortfall of about 4.3 million physicians, midwives, nurses, and other health professionals. Furthermore, more than half of the countries on this planet are estimated to be listed as the countries that have the minimum number of people in their health workforce, 2.3 per 1000 people. Additionally, the report estimates that 18 million health workers along with 9 million nurses and midwives are required by 2030 in order to reach SDG 3 on health and promote healthy living (WHO 2021). This shortfall is a

major issue in Low-Middle Income Countries as these countries do not have adequate financial provisions to import the health workforce from other countries.

Many FGD participants also highlighted the recent trend of travelling abroad as health workers, since Nepal offers low health salaries and limited career opportunities. Similar responses were received from the stakeholder interviews. They raised travelling abroad, especially to high-income countries for better career opportunities, as a major concern. A similar report in other studies in countries such Zimbabwe, Nigeria, Ghana, Zambia, South Africa, India, and Nepal identifies that they are experiencing a huge outflow of the health workforce, whereas high-income countries like North America, Europe, and Oceania are already prepared for importation of health labour in order to dismiss the current or predicted shortages (Grignon et al. 2013). In the context of Nepal, the country has a far lower number of health workers than the WHO recommends (see Section 2.6) (Ministry of Health and Population 2019). Migration of health workers from low-income countries who are struggling to deal with their own health issues has become a global and controversial issue (Afzal et al. 2012). Thus, the poorer countries of Asia and Africa are suffering from a one-way culture of emigration of trained health workers. The major reasons for this culture are an underfunded healthcare system, ethnic and political violence, better opportunities, and in the context of countries such as Nepal, providing financial support at home. This has resulted in a lack of health workers in the home country (Sapkota et al. 2014).

Similarly, another major factor behind the continuous shortage of the health workforce is staff retention and staff availability in local areas, often resulting in crowded health services. The majority of survey participants responded that they have one to three years of experience and most of the respondents are not local residents, therefore travel to work (see Section 7.2.1). Moreover, in the health sector, issues related to staff shortages are already present. Retaining skilled health workers is a common issue for rural and remote communities globally, thus negatively impacting access to health

services, resulting in poor health (Araujo and Maeda 2013). There are range of factors including financial and economic factors such as revenue and other facilities, organisational and professional factors such as career opportunities and workload, social factors such as childcare, education of family member, individual factors and the characteristics of their own local community (Abelsen et al. 2020). Additionally, the lack of a health workforce to provide centralized services which are hard to access and costly in comparison therefore acts as a barrier in the accessibility, availability, and affordability of marginalised populations including Dalits. Moreover, this will make them more hesitant to visit these services (Mandal 2014). Thus, due to the lack of health accessibility and illiteracy amongst the people in this community, resulted malnutrition, gynaecological diseases, cancer, and other chronic or long-term diseases that may drive a person's life towards death (Bishwakarma 2004). Nepal is continuously working towards improving health and promoting health workers. The Nepal Health Sector Strategy (NHSS) 2015-2020 was originally introduced based on the concept that health is an integral and indivisible part of a country's socioeconomic improvement, and investment in the health sector is essential to further improvement of the country (World Health Organization 2018a).

8.3.4 Health workers' behaviour

This research highlights the importance of health workers in the effective use and delivery of health services. Exit interview participants stated that they experience very friendly and helpful behaviour from health worker and are given prompt care. FGD participants also stated that they neither witness nor experience any different behaviour from staff towards different groups of health service users.

Health workers such as doctors, nurses or midwives are front line workers and their behaviour towards health users determine the quality of delivered health services. The positive motivation of these key workers helps to maintain quality of care, thus enhancing individual or group health outcomes (Brener et al. 2013). A recent WHO report stated that the quality of healthcare can only be maintained when it includes

factors such as providing service on time, not differing in the quality of services based on one's gender, ethnicity, socio-economic status, and geographic location. The quality of care is a key element of better health outcomes as it has been identified that, due to the poor quality of health services, nearly a quarter of overall deaths each year in low-and-middle income countries occur (WHO 2020). Hence, the behaviours and the motivation of the health professionals in this particular field are the factors that drive extrinsic and intrinsic motivation and enhance the health performance of an individual (Ryan and Deci 2000; Fritzen 2007).

Many participants, whether from FGDs or in exit interviews highlighted positive and welcoming behaviour from health workers. They also stated that they are happy with health worker behaviours, therefore would use the same services/institute in cases of need again, as well as recommend the services to others. Similar results have been derived from survey data. Respondents stated that they would provide similar services despite caste, and their behaviour towards all service users was welcoming.

However, key stakeholders stated things quite differently. For example, one Dalit key stakeholder shared poor behaviours of health workers and pointed out that caste-based discrimination is often seen in health, especially in government funded hospitals. Another stakeholder stated that a health worker may not behave unfairly or present unfair treatment in a hospital or their institute, but the same person will do it on a societal level. Furthermore, survey data showed that the majority of health workers think that there is still some unfair treatment, and a need for more equal and friendly behaviour to encourage more Dalit service users to come forward for healthcare.

The behaviour of the health workers who provide direct service to users is one of the core determinants in maintaining the quality of care and health services. Where the positive behaviour of health workers may help to build trust towards the health worker or health service provider, negative behaviours will have the opposite effect (Gilson et al. 2005). It is often seen that the behaviour of healthcare workers seems to vary according to their age, gender, economical background, urban-rural residence, and

ethnicity (Dubay and Lebrun 2012). Issues such as internal and external migration of health professionals, the unequal geographic distribution of health personnel, low morale, and informal charging, are created by humans themselves. Among other concerns, these issues are now widely acknowledged as a result of the health sector's lack of attention towards human resource issues (Campbell et al. 2013). The behavioural impact of health workers towards service users can be seen as mental as well as physical (Hanafiah and Van Bortel 2015). Certain attitudes of health workers may cause patients to opt against further doctor visits, lower their will to live, increase physical illnesses like heart disease, obesity, and respiratory diseases and can sometimes lead to reduced mortality (Morgan et al. 2007).

Similarly, it has been identified that discrimination or unfair behaviour of health workers towards marginalised populations result in poorer health outcomes (Blanchet et al. 2020). In countries where the marginalised populations are higher in number, such marginalised groups have a higher chance of suffering from behaviour-related health issues such as alcohol use, smoking, obesity, sexual behaviour, physical activities, correct medication, screening and vaccinations (Conner and Norman 2017). Furthermore, in Nepal also it has been identified that the differences created by the actions and behaviour of health workers has an adverse impact, especially on women, disabled people and Dalits (Devkota et al. 2019). However, this PhD study reported that health worker behaviour is very positive and there appears to be no different treatment between any service users. This suggests that further study among health workers with a large sample size is needed to validate these results, as this study included samples from only one district.

The study highlighted an interesting outcome that non-Dalit and urban health service workers have more positive attitudes towards the service users regardless of their caste in comparison to Dalit health workers. A report identified a similar outcome, the health workers from Dalit communities are often found to try and avoid communication and maintain distance due to the ill practice of society such as social status, language

barriers and lack of training (Devkota et al. 2019). Where the positive behaviour of health workers improves health outcomes, their negative behaviours may push patients to seek private–care - a completely out-of-pocket matter. For Dalits, affording such expensive health options is almost impossible, therefore they suppress health issues, do not seek treatment or seek treatment at later stages of the disease, ending up with a much more serious illness. If they were to take a loan that would increase their debt, which in turn could increase their chances of succumbing to mental illness, higher mortality, and lower life expectancy (Devkota et al. 2017; Verma and Acharya 2018). Thus, the relation between health service providers and service users may influence the health outcomes and make Dalits more vulnerable.

8.4 Public health programmes

Many FGD participants explained that there are not any health awareness programmes organised in their communities. One elderly participant said they had neither participated nor heard about any health programme in their lifetime, while some added that they only knew about immunization programmes. Key stakeholders also stressed the lack of health interventions in communities, especially for Dalits. This would be seen as Nepal version of Black Life Matters (BLM), since life of Dalits are not taken seriously in the same way as the Black ethnic minorities in the USA, the UK and elsewhere. BLM movements started with police violence as the backdrop against African American includes all forms of violence and oppression that are targeted against Black Americans (The Movement for Black Lives 2020).

BLM movements have gained international recognition and already been a subject of scholar publication. Thus, has been able to highlight the intersection of social determinants of health and racism against Black (Taylor 2016). Despite having similarities between caste issues in Nepal and race issues in countries like the USA and the UK, caste issues have been overlooked. However, BLM has been trending across South Asia and has started to reflect that their own minorities communities has not been treated equally. In the context of Nepal, BLM has helped to outline the

‘#DalitLivesMatter’ issues and highlighted the gaps within (Rijal 2020). Similarly, recording and register of Dalit discrimination and killings has been started in order to fulfill information gap and to educate people regarding caste discrimination and regulations in place (Bajracharya 2022).

The stakeholders added that an NGO used to run programmes such as immunization, eye camps and other free health camp, but not any longer. The survey also identified 43% less distribution of health information and education promotion materials in Dalit communities compared to general communities. Further analysis of NDHS data suggests that public health programmes have not been able to reach and meet the need of those people of Nepal who are comparatively poor, including Dalits (Ghimire et al. 2019).

Public health programmes help to raise public awareness about health consequences, predicting health risks, and resolving health related issues more quickly and substantially. It is also a key factor that communicates the type and volume of information related to health that is needed to service users in relation to health facilities and services (Nawaz 2017). Public health programmes work in order to protect and improve the health of the community and, in turn, promotes a healthy lifestyle, and support prevention of disease and research (Rajendranath Group of Institutions 2020). There is no doubt that these programmes establish a channel of communication to deliver health related information to society, help them to understand and live a healthy life, educate them about health hazards and familiarise them with government health policies and advertisements (Nawaz 2017).

This study also highlighted that health professionals believed that Dalits experienced issues in understanding and communicating health information. More than half (about 53%) of the survey participants stated that Dalits do not have better health knowledge and understanding in comparison to other groups in society. A similar report that has been identified in a study conducted in Nepal concurs that Dalits lack adequate knowledge or information about symptoms, risk and prevention of disease in

comparison to non-Dalits who have more understanding of diseases and can identify and cure at the early stages (Daniel et al. 2012). Another study highlighted that lower health seeking behaviour and utilization was due to limited information, knowledge and awareness about health risk (Awasthi et al. 2018).

Public health programmes help to access the require health services and facilities while making sure everyone, regardless of socio-economic background, can utilise their rights (Blas and Kurup 2010). Public health must remain an important health segment of government interventions. It helps to improve health at the community level rather than purely the individual level.

8.5 Strengths and Limitations of the study

Every piece of research has its strengths and limitations, and it is important to present mine in this PhD thesis. Although limitations are potential weaknesses of the study, identifying them shows research consideration on their impacts, so therefore may strengthen the overall study (Denscombe 2017).

8.5.1 Strengths of study

The strengths of research study include:

- Using a mixed-method research approach, though not without weaknesses, did also strengthen the study by allowing to combine both qualitative and quantitative methods to investigate caste-based discrimination in healthcare. The significant strength of using mixed methods is that it can help to broaden understanding of the overall research problem. In addition, triangulation of data helped to provide quality insights, combining qualitative and quantitative findings.

- This study included various approach of qualitative method such as FGDs, stakeholder interview and exit interviews as well as diverse participants for

each method such in terms of age, gender, Dalit groups, and Dalits who have recently utilised health services. This helped the researcher to gain insight into complex issues related to Dalit health from different perspectives.

- The quantitative part of study included a medium-sized survey with health workers. This was provided to ensure a better opportunity for quality analysis and validity of research. Similarly, it helped to produce completely different perspectives, such as discrimination related to health providers and their approach.

- This study also has methodological strengths. A semi-structured guideline was used to collect qualitative data, whereas structured questionnaires were used for survey data. It allowed the researcher to stay on track and collect useful data for research.

- Further, the researcher being bilingual added rigour when it came to language issues, such as an ability to transcribe and translate more meaningful experiences of respondents. It also helped to improve the quality control mechanism and assure quality of translations as another bilingual Nepalese supervisor checked the translation of study tools in Nepalese and responses to English. Similar outcomes from both bilingual Nepalese provided further assurance of the quality of translations.

8.5.2 Limitations of the study

Along with strengths, this research has some limitations which are articulated below:

- This study selected only one research area, the Makwanpur district of Nepal. Therefore, a generalisation of the research findings cannot extend to the entire country. The reason behind choosing one district is due to time and resource constraints, and the links that the researcher (being Nepali) had to the local

community. This helped in utilizing existing relationships with stakeholders and granted easy access to participants/data. In addition, the Dalits in Makwanpur have not been as researched as those in Kathmandu, the capital.

- Another limitation is that conducting mixed-methods research can divide the researchers limited time and effort between two approaches. If only qualitative methods were used, then more interviews could have been included, or age stratified groups could have included and compared. Similarly, if only quantitative methods have been used, then more respondents could have been included, and a stronger statistical analysis would have been undertaken.

- The quantitative part of study is entirely based on the perspectives of health workers and does not explore caste issues in-depth from the perspectives of health workers. This is due to the nature of the study, 'caste inequality in healthcare', and not 'perspectives of health workers towards caste'.

- During data collection, Nepal experienced a Dengue epidemic (spread by mosquitos) and Makwanpur district was severely– affected - the district was a high alert zone. Thus, necessary safety protocols had to be followed such as not going out at dawn and dusk (high risk of being bitten by a mosquito at these times), using anti-mosquito spray/coil (in Nepali commonly referred to dhoop). The risks include with travelling (one research area to another) made it difficult to arrange participants.

- Another limitation of this research is the impact of COVID-19 impact on the research. Although, my data collection was completed just before COVID-19 lockdown, it did impact on my data analysis and thesis writing. Due to COVID-19 my husband was stuck outside the country leaving me with two children and hence far less time to concentrate on my studies. Similarly, working from home was new concept and took time to manage such as university services

and trainings that are helpful for thesis as well as to manage devices to fully work from home.

- Further, this research was conducted with Dalits, who are from socially vulnerable groups. This presented a challenge as they are not very open nor willing to discuss their experiences or participate in research without any financial benefits. Thus, organizing focus groups in a short period of time (PhD time limitation) was a struggle.

- Gender aspects also played a vital role, as in some male focus groups, the participants were a little more hesitant to discuss sensitive topics such as their experiences and health issues with the opposite sex (female researcher).

- The researcher, although Nepali, was an outsider and not from the Dalit community. The researcher felt that some participants were hesitant to open up and some may have been thinking that the student was there to receive money in the name of Dalit research. However, the researcher explained her position and the purpose of study in detail, and she showed respect to all Dalit participants to indicate that their research participation was valued.

8.6 My Reflection for the thesis

This section presents looking back into my experience of overall thesis and analyses the experience. The experiences collected throughout research can be described as learning experience, personal experiences, strengths and limitations (see Section 8.5) of study and researcher self-reflexive positionality (see Page 190).

This research is a part of PhD study and is focused on Dalits and their health. It has helped me to understand Dalits every life experience, their health obstacles, become a part of their emotional stories. However, after collection data from mixed methods interpretation and analysis has been done considering possible biasness. With the help

of supervisor, this research process has helped me to look on data with different lens, by understanding researcher biasness. Similarly, it has helped me to boosts my personal skills and experiences, such as time management, decision making skills, develop my communication skills and relationship with another PhD researcher.

This section follows the submitted version paper titled ‘Researching Dalits and healthcare: Considering positionality’. The paper was submitted to be published in Health Prospects, Nepal on 25th November 2022.

See BURO
https://eprints.bournemouth.ac.uk/38254/

Chapter 9 Conclusions

9.1 Overview

This chapter concludes the key findings of this thesis exploring Caste-based healthcare inequality in Dalit communities in Makwanpur, Nepal. This is presented under four headings: (1) Discrimination in society, (2) Social determinants as key barrier to better health, (3) Poor health status, and (4) Lack of public health programmes.

9.2 Discrimination in society

This PhD study reports that caste related discrimination and practice of untouchability is still prevalent in Nepalese society, even though people perceive the caste system as an oppressive, discriminatory, and exclusionary practice (see Section 2.4 and 6.3.1). Whilst the government of Nepal banned discrimination against Dalits, it remains hidden but deeply rooted in society. Dalits experience various kinds of discrimination every day including physical and psychological, and this occurs in both private (refusing to dine with Dalits, restricted in private run places, denial to entry in temples) as well as public places (see Section 8.1.1). The caste system has a foundation in Hinduism, but the concept is human-made and is created to suppress and sustain the power by upper caste people in the country and disregard the law of human rights. Discrimination can take place in the name of a long-established culture of untouchability, lack of law and its implementations, and providing equality but not equity.

Both untouchability and discrimination towards Dalits are parts of Hindu culture and has been in society for a long time, and this research highlights it is still a prevalent issue today. Due to the discrimination Dalits face, they struggle to live their lives on a daily basis, commonly having to wait in queue after upper castes or even accessing separate taps to get drinking water. Dalits are not entitled to enter the homes of upper caste people, are often restricted from visiting temples and have limited employment

prospects due to poor education (see Section 6.3.1). One participant also stated they are treated as less than a dog. It has also been noted that, not only must they fight for food, shelter and use of public services, but Dalits also suffer from violence and abuse, physical and mental, outside in society as well as within their own homes by male partners. Due to this longstanding cultural discrimination, the have become part of Dalit life and they have learned to live with it.

This study also reported that the legislation banning caste discrimination has led to it becoming hidden within society. Thus, Dalits are discriminated against in different terms such as poverty, limited education, and poor hygiene. However, the key reason for discrimination is caste and untouchability related to it, the other aspects are just additional to this. Despite this, quantitative results stated that Dalits are not discriminated against and are treated equally in health service areas. However, it was also pointed that more equal treatment and friendly behaviours are needed towards Dalits (see Section 7.4). This also suggests discrimination is often hidden in society. Further, the quantitative study identified that Dalits are recognized by their outlook, language, and (mainly) from their surname. They can be separated easily within society due to their characteristics, thus are more exposed to possible discrimination. Therefore, this long-established culture and norm is one of the key reasons that untouchability and discrimination towards Dalits are still active concepts in society. Discrimination related to caste is the root cause of Dalit struggle - mental and physical abuse and struggle to have basic needs fulfilled leads to poor health outcomes.

Additionally, this research also highlighted the need for efficient law and its effective implementation to address discrimination towards Dalits. The government of Nepal is working continuously (see Section 2.8) to address caste-based discrimination. The government has banned caste-based discrimination and people are aware of the regulation. However, implementation of these laws is not effective. This study reports that despite many cases of unfair treatment and social injustice, only some are recorded and fewer still are processed further. Participants stated that they would not rely on

constitutional provisions. Dalits struggle for education rights, property rights, socio-cultural rights, constitutional rights and even the basic human right of freedom. This has also changed their mindset and has led to them accepting the daily challenges. Therefore, lack of social justice and poor implementation of constitutional provisions are some of the major reasons behind caste discrimination and Dalit struggle.

This research suggests that people are becoming more aware and understanding of caste discrimination and its consequences. Consequently, the younger generation discriminate less in comparison to people from older generations (see Section 6.3.1.2). Hence there is some form of duality which exists among participants. It can be argued that the younger generation knows less about the caste system and discrimination related to it, therefore there is less of a chance to reproduce it. Even though many are aware of violations of constitutional provisions and human rights, and are against caste-based discrimination, not all can challenge societal structure and fight against the system. Therefore, Dalit struggles start with caste-based discrimination and the stigma of untouchability practice of upper caste people towards Dalits and continues due to lack of effective law and its efficient implementation (see Section 8.1.2). It has been seen that, due to this long run practice of discrimination, the social setting that concerns caste-based discrimination has been shifted to a less significant extent, which is not enough to address the issues of the whole Dalit population. Therefore, people being aware and understanding of the caste system that excludes Dalits, not accepting all aspects of it, and effective laws and their implementation is important to eliminate discrimination from society, thus boosting the health prospects of the lower caste.

9.3 Social determinants as key barrier to better health

This research including theoretical aspects of discrimination (see Section 2.3) highlighted that those belonging to the upper caste have better social determinants of health such as more income, better education and employment while those who belongs to lower caste, in particular the Dalits and Dalit women due to gender aspects have poorer social determinates.

Poverty is one of the key determinants of health and this research identified that Dalits typically live in poverty as well as in isolated areas, far from many services. Therefore, they suffer most from double discrimination poverty and caste. Caste and hierarchy systems often impact a person's socioeconomic conditions which can in turn negatively impact health prospects (see Section 8.2.1). Research including this PhD study identified that the majority of Dalits in comparison to upper caste people are poor and often do not own a house or land. They must struggle to live their everyday life and earn low daily wages in order to eat. Due to extreme poverty and lack of bespoke programmes to address their poor health (see Section 6.3.3.4), they are not able to look after their health, and suffer worse health outcomes as. Firstly, Dalits are often unable to visit health services as they cannot afford to take time off work. Secondly, they are not able to afford travel expenses to visit services (see Section 8.3.1). Thirdly, they are not able to pay fees for treatment and medicine (though some services and medicine are free they are not readily available) (see Section 6.3.3.3 and 8.3.2). Due to all this, they avoid visiting health centres for check-ups and miss out on early identification of illnesses, having better treatment and understanding precautions and prevention methods (see Section 8.4). Finally, these continuous socioeconomic pressures and discriminatory aspects of caste cause psychological effects such as depression.

In addition to poverty, Dalits also experience lower quality education. This is a result of caste acting as a barrier to receiving educational opportunities which promotes poverty and impacts health outcomes (see Section 8.2.1). Research including this PhD identified that education and poverty are interrelated. Dalits often must travel to education centres due to lack of services and must bear the brunt of associated travel costs. Going to school limits their ability to support the family financially. Even when they manage to go to school, Dalits experience unfair treatment from classmates and teachers such as asking them to sit separately, pointing to their work using a stick and refusing to even touch them (see Section 6.3.2.4). Therefore, many Dalits end up with poorer educational attainment due to leaving school early, which impacts upon future

employment opportunities. With low-quality education, Dalits often have poor health literacy due to poor health awareness, poor understanding of disease prevention, and limited opportunities to use safety equipment. They also end up committing to jobs that prove a risk to their health (see Section 8.2.3).

The research identified the need for education as well as public health programmes in order to boost their health (see Section 8.4). At the same time, among the youth, education and globalisation are significant factors in understanding how one perceives the caste system. The more people are educated and have awareness, the more are they mindful of the negative consequences related to the caste system. The Dalit youth do not identify themselves just as a part of the caste hierarchy system neither other caste youth label them just as Dalits. As research highlighted that Dalits are becoming aware of the importance of better education that contributes to better health prospects such as understanding of health consequences, identifying early issues and having an awareness of precautions and preventative measures.

Education influences one's access to better employment and income, which is one of the most important factors that impact health outcomes. This research recognised that the majority of Dalits are engaged in low-paid jobs and jobs that are a risk to an individual's health. The majority of Dalits are involved in tailoring jobs including making cotton mattress and many suffer from respiratory diseases due to lack of proper training and use of safety equipment. They are also engaged in unhygienic jobs such as the manual cleaning of human excrement. Health risks are not only physical but also psychological. Most Dalits have jobs that are not secure, and many are unemployed. This situation creates the constant fear of losing their jobs or their partner losing their job, which can result in mental distress and increases the chances of experiencing depression, anxiety, trauma, or other mental illnesses. Poverty, education, and employment are part of an interlocking cycle in which Dalits are trapped. These factors help to maintain social status, power, and access to resources, and thus influence health. Research has stated that people who do not have better jobs,

income and education are likely to have poorer health outcomes in comparison to those that do.

On the other hand, gender aspects of caste also influence health outcomes. This research highlighted the double discrimination towards Dalit women due to their gender as well as their caste (see Section 6.3.2.1). Most Dalit women work on daily wages where they have to go to places to place to earn money. This makes them openly vulnerable to physical abuse, violence, and sexual assault. It has been recognised that Dalit women are not only discriminated in wider society, but also within their own homes. It has also been identified that, due to the pressures of household responsibilities, childcare and earning for daily food, Dalit women do not have enough time to take care of themselves and their health, not even to visit regular ANC. Due to this suppression, they are not able to discuss their health-related issues even with their partners and families. They fear that their partner will leave them if they discover that they are struggling. As such, they hide their illness, which could be easily cured if identified on time (see Section 8.2.4). Dalit women often perceive being sick as a normal condition and only look for help at the more serious stages of illness.

9.4 Poor health status

This research study identified that Dalits' poor health outcomes are related to barriers in accessing health services, limited availability of health resources and a lack of health workers. Research demonstrated inequity in healthcare and Dalits are among those who suffer most (see Section 6.3.3.3). Access to health services has been identified as a key problem among Dalits. Dalits usually reside in isolated areas, far from health centres, with very few healthcare services available locally for them. Thus, a lack of locally available healthcare acts as a barrier to health access. Moreover, limited availability of health resources including medicine and treatment facilities such as X-rays or other such health equipment in a timely manner is another reason for Dalits not having better health outcomes (see Section 8.3.1).

Furthermore, lack of locally available health centres and health resources include travel and costs related to it, especially the possibility of missing out on daily earning. It is difficult for Dalits to manage these additional costs, as they are already suffering from poverty. Another major issue is fees related to healthcare. Private health services in Nepal are quite expensive. If one needs better and timely service, they must use private services. Despite the government providing a few free health services and medicines, this research revealed that the majority of free services are often not available in the area, or that medical stock has run out (see Section 8.3.2). Thus, Dalits end up paying for health services, and the majority are not able to afford this financial burden. This usually results in them ending up with life threating health conditions.

Another global issue that affects health outcomes is a lack of human resources in the healthcare sector. Health workers key factors that not only provide health treatments but also communicate health related aspects. Research identified that health centres are not fully staffed, thus are unable to provide timely and quality service (see Section 8.3.3). The majority of participants highlighted that health centres are flooded with service users, due to lack of staff. Many also stated that, due to crowds, Dalits try to avoid visiting health centres as it will take almost a day to get service (see Section 6.3.3.2). Likewise, in the context of Nepal, there is always a shortage of health workers in the remote areas where Dalits reside. As well as this, little to no Dalit health workers are available. This makes a visit to the health centre less appealing for Dalits. It has been acknowledged that an extremely limited number of public health workers are designated to remote areas to provide service, and that health workers are not available on placed services. They prefer to run their own private services or work privately for better income. Research highlights that many skilled health works have average of 2-3 years of experience. This is an issue related to staff retention. Low-income countries such as Nepal struggle to retain skilled health workers due to an inability to provide better pay and career opportunities. Because of this, many health workers migrate to countries with better pay and opportunities (see Section 8.3.3). This has resulted in severe shortages to an already under-resourced national health system.

9.5 Lack of public health programmes

This research highlighted that public health programmes are not provided to the public. People who are educated can understand health related issues on time and follow precautions and preventative method. However, people who are not educated, particularly members of Dalit population, would not be able to understand these health-related aspects. Thus, it is especially important to communicate health topics within Dalit communities, and public health programmes can be helpful in achieving that. This study highlighted a lack of distribution of health information in communities, moreover 43% less in Dalit communities by comparison. Health programmes help people to understand health risks and treat health issues in a timely and effective manner. As the research highlighted, Dalits have comparatively less health knowledge and understanding. Therefore, it is very crucial to provide distributed health information, precaution and prevention methods, information related to accessing health services and facilities, and any government provided health benefits in order to promote a healthy lifestyle and better health outcomes.

9.6 Original contribution to this research

Health and health related inequity has been a global issue. Many studies identified relationship between health, human rights, exclusion in society. This research identified that there are much research done (published paper found) regarding Dalits and their health related however very less available in Nepal. However, they failed to examine the contribution of these factors in health disparities specially in terms of caste exclusion. Such as large studies (see Section 3.2) lacks in exploring underlying for health discrimination and health uptake of Dalits.

This research bridged the gap in Dalits' health and health access. In addition, it adds value by creating better understanding of Dalits' overall life experience and challenges they face and how it affects their health and wellbeing.

It is well known that despite legal regulation Dalits are still discriminated in Nepal. This research also stated the same level of discrimination however the interesting fact is Dalits do see discrimination and they do talk about discrimination, but they do not see neither talk about health discrimination. It has been identified that Dalits do not recognised health as a key problem as they do not prioritise health in their life and understand relationship of discrimination with health. It seems like they are not able to understand health and outcome of health due to discrimination as well as understand health facilities provided for them.

This can be the result of lack of education as Dalits usually drop school early due to various reason expenses related to schooling, caring of their siblings, work for food. Therefore, low education is common among Dalits which will lead to them working dangerous or low paid jobs, resulting poverty. This circle affects their health outcomes less understanding and awareness of health, accepting jobs that are harmful to health due to lack of education, cannot leave a day off from job losing their daily earning and risking food for the day, afford travel expenses when needed, afford to pay health expenses, due to financial limitations. Thus, it reflects impact of people's ability to access healthcare even they are available to them.

Further, this research includes perception from health workers and their behaviour towards Dalit service users allows comparison between service users and providers. This research concluded that they do not directly discrimination Dalit service users and provide equal type of services. However, research explained that equal is not equity (see Section 8.1.3). Thus, created gap in Dalit health. It also highlighted not accepting direct discrimination but accepting need of equal treatment, identified a grey area for further research.

Another unique contribution is my discussion about positionality as researchers in Nepal do not tend reflect on their position and role in the research process as their counterparts do in high income countries (see Section 8.6).

9.7 Chapter summary

Dalits are still discriminated against in society due to their lower caste status and the practice of untouchability. One of the reason caste-discrimination can survive so long is a lack of proper law and its effective implementation. Caste-based discrimination also limits their ability to receive better education, income, employment, and health. This has made Dalits more vulnerable to health, thus resulting in poorer health outcomes, both physically and psychologically. However, with better education, the younger generation look upon the present caste hierarchy system as a discriminatory practice that ignores lower caste people and untouchables. Further, they see it as an element of culture that must not be reproduced in the future. That being said, it does not seem plausible that the caste system will completely disappear from the social hierarchy any time soon.

Chapter 10 Recommendations

10.1 Overview

Following on from the Conclusions, this chapter focus on key recommendations for (1) further research, (2) policy makers, (3) training and education, and (4) health workers in order to improve Dalit people's health and wellbeing.

10.2 Recommendation for further research

This PhD research is focused on casted based discrimination and health aspects of the Dalit community in Makwanpur district Nepal. Health inequity is a global issue and in the context of Nepal, without addressing Dalit health issues, it is impossible to achieve equity in health as well as achieve SDGs target. It is therefore recommended that further research should be carried out to investigate the following:

- This research is based on a limited number of participants from Dalit communities and results derived from it. Ethnographic research and unrestricted access to research participants may help to reveal much more about Dalits and their health experiences.
- Moreover, due to the limited research area of this thesis, further research is recommended to explore the shifting progress of Dalits across different areas in Nepal.
- Further research could focus on measuring the quality of health services provided as well as satisfaction among the Dalit communities utilizing health services.
- Also, further research should look into more details on the effects of socio-economic aspects such as education, poverty, employment and gender in relation to utilization of health services and health outcomes (see Section 8.2). As this research has pointed out, socioeconomic factors are fundamental causes of Dalit health outcomes. Further research may examine how these

determinants impact health outcomes and how a better healthcare system can be built together.

- Furthermore, due to the limited number of health workers who participated, and the nature of humans not accepting whether they have participated in any wrongdoing, the outcome derived responses may need further validation. Thus, further research is also recommended to study the relation of health workers' attitudes and the health outcomes of Dalits (see Section 8.3.4).
- Finally, this research also highlighted some emotional and psychological health issues among the Dalit population. Therefore, further research is required to address mental issues such as anxiety and depression using validated tools with a larger sample size.

10.3 Recommendation for policy maker

This PhD research has identified some recommendations aimed at the government of Nepal that may also be helpful in other countries in order to work toward reducing health gaps. The findings of this thesis illuminate various key areas that policy makers could focus on, in order to improve Dalit health.

- Research recognized poor implementation. Thus, the first recommendation is that the government should make eliminating discrimination a priority. Policymakers and policy implementers should enforce laws to end any mistreatment and abuse when it comes to caste discrimination in all three (personal, cultural and structural) levels to promote equity. This includes discrimination within the health sector.
- A public campaign should be organised to provide information related to caste discrimination and its consequences. Due to a reduced literacy rate, local radio, television, and mobile phones can be beneficial to attract attention. It should also focus on investigating caste discrimination as well as consulting with Dalit communities on further positive progress.

- Research identified lack of health workers and crowded health centres. Therefore, the government should develop policies to recruit much-needed health workers, retain health workers and reduce international poaching of health workers. The plan can also focus on recruiting locals as well as Dalits as health workers and promoters and should explore the use of advanced nurse practitioners who can assess, diagnose a treat in these areas.
- The Government of Nepal should focus on access to health services. For this purpose, the government should work on improving road conditions and availability of transportation in isolated areas where Dalits reside. They should also work to develop easy access and readily available health services such as utilities and equipment, and making affordable health services or free services where possible.
- Dalits are also restricted due to other social determinants such as poverty, education, employment and gender. Thus, the government should enact and enforce policies that help to eliminate poverty, create equal opportunities for education and employment and reduce gender-based discrimination in order to achieve quality health for people who are not able to afford health services.
- The Government should act on policy or launch public health programmes that focuses on Health equity rather than equality. Further, they should also find an ideal way to motivate people, especially Dalits who often have very little health knowledge, to participate in these programmes. Public health programmes should focus on providing health awareness and information of seasonal diseases as well as precaution and prevention methods. On top of that, it should also educate service users on how to access free health services provided by the government.
- Finally, although the Government of Nepal has introduced policies for Dalits, implementation of these policies is poor (thus ineffective). Therefore, the government must take strong effective actions to implement policies related to Dalits. For this purpose, collecting public health data on the health experiences of Dalits and then acting on the data accordingly would be helpful.

10.4 Recommendation for training and education

This research found that the majority of the Dalit population had either no education or only a primary level education, specifically Dalit women. Thus, some recommendations are made here:

- This study recommends running health education and awareness programmes in order to ensure that Dalits are better informed about health risks, precaution and prevention measures.
- Training should also aim to improve knowledge of Dalits regarding caste-based discrimination and their rights, as well as facilities provided by governments including health aspects.
- Health promoters and health workers should receive training to understand the importance of public health programmes and participation of the community. Training should also focus on generating innovative ideas and creative ways to make promotion of health more effective. This can be achieved by involving a local member as a health promoter.
- Additionally, it is impossible for the government to go door to door or attend every issue. Thus, the government should introduce a plan to collaborate with local people or other local non-governmental organisations. That will help to fill the gap in health services not provided by the government.
- Finally, these public health programmes should be communicated through media such as TV, radio and mobile phones to effectively distribute information regarding caste-based discrimination and health aspects related to it.

10.5 Recommendation for health workers

The outcome of this research includes survey data conducted among health workers. Therefore, some recommendations for health workers/professionals are listed below:

- Health promoters and health workers may initiate more (i.e., health outreach programmes, counselling service users, explain exclusive health services provided to Dalits) to motivate Dalits and encourage them to attend health centres for regular check-ups. This should also include aspects to include Dalit women.
- Health workers should act as health promoters and received the necessary training.
- Local people, or Dalits specifically, could be recruited as health promoters as well as health workers to attract Dalit service users.

10.6 Chapter summary

The finding of this research study has offered comprehensive evidence for further researchers, policy makers, training and education, and health workers. This PhD research adds to our understanding of the experiences of Dalit people and the challenges they must face, and the condition of their health status in Makwanpur district, Nepal. It is hoped that the findings and recommendation of this study may help to contribute to a better and more equal society.

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Appendix 1 Participant agreement form for Qualitative Assessment

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धि अध्ययन, मकवानपुर जिल्ला, नेपाल
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सूचना संकलन पहिले भर्नुहोस

भाग एक: अध्ययनमा भाग लिन सम्झौता
तपाई तलका सबै जानकारी र गतिविधिहरूसँग सहमत हुनुहुन्छ भने मात्रै यस अध्ययन भाग लिनुहोस्।

मैले सहभागी सूचना पत्र (संस्करण 1) पढेको र बुझेको छु र बीयुको अनुसन्धान सहभागी गोपनीयता सूचनाको पहुँचबारे जानकारी दिइएको छ। जसले व्यक्तिगत जानकारी संकलन र प्रयोग कसरी गरिन्छ बारे जानकारी दिन्छ। (https://www1.bournemouth.ac.uk/about/governance/access-information/data-protection-privacy)।
मलाई प्रश्नहरु सोधे अवसर दिइएको थियो।
म बुझ्दछु कि मेरो सहभागी स्वेच्छिक हो। म बिनाकारण कुनै पनि समयमा अनुसन्धान गतिविधिहरूमा आफ्नो सहभागिता अन्त्य र कुनै विशेष प्रश्नको(हरू) जवाफ दिन अस्वीकार गर्न सक्नेछु।
म बुझ्दछु कि, यदि म यस अध्ययनबाट निष्किए भने, मेरो सूचनाहरुको थप प्रयोगमा रोक गर्नसक्छु जबसम्म सूचनाहरु गोप्य (पहिचान गर्न नसकिने) वा अध्ययनकालागि अनुपयुक्त हुदैनन्।
म बुझ्दछु कि, मेरो पहिचान गर्न नसकिने सूचनाहरु बीयु को अनलाइन अनुसन्धान डाटा भण्डारमा सङ्ग्रह हुनसक्छ ।

	सहमति जनाउनुहोस
म माथि(संस्करण १) उल्लेख भए अनुसार यस अनुसन्धान मा भाग लिन सहमत छु ।	
म बुझ्दछु कि, मेरो पहिचान गर्न नसकिने सूचनाहरु अनुशन्धानकर्ताले अन्य अध्ययन, प्रकाशन, रिपोर्ट वा प्रस्तुतीकरणमा प्रयोग गर्न सक्नेछन्।	

सहभागीको नाम	मिति	हस्ताक्षर (वा निरक्षर भए क्रस (×) गर्नुहोस)
अनुसन्धानकर्ताको नाम	मिति	हस्ताक्षर

Appendix 2 Participant information sheet for FGDs

Bournemouth University

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धि अध्ययन, मकवानपुर जिल्ला, नेपाल
समूह छलफलमा सहभागीताकोलागी सूचनापत्र

नमस्कार! मेरो नाम रक्षा थापा हो। म बेलायतस्थित, बोर्नमाउथ युनिभर्सिटीमा पीएचडी अध्ययनको क्रममा जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धी अध्ययन गर्दैछु। तपाईलाई अनुसन्धानमा सहभागी हुन अनुरोध छ। कृपया यस जानकारीलाई सावधानीपूर्वक पढ्नुहोस र चाहनुहुन्छ भने अरूसँग छलफल गर्नुहोस्। यदि कुनै कुरा स्पष्ट छैन वा यदी थप जानकारी चाहनुहुन्छ भने कृपया मलाई सोध्नुहोला।

यस अनुसन्धानको उद्देश्य के हो?
यस अध्ययनले मकवानपुर जिल्लामा स्वास्थ्य पहुँच र सेवा उपयोगमा जातीय भेदभावको अनुसन्धान गर्नेछ। हामी दलितहरुको स्वास्थ्य सेवा उपभोगको अनुभव र चुनौतीहरू, स्वास्थ्य कार्यकर्ताहरूको दलित सेवा प्रयोगकर्ताहरूप्रतिको दृष्टिकोण तथा यस्तै अन्य समस्याहरु बुझ्न चाहन्छौं। तपाईलाई मकवानपुर जिल्लाको दलित समुदायहरूको सदस्यको रूपमा यस अनुसन्धानमा भाग लिन आमन्त्रित गरिएको हो। प्रत्येक समूहमा ६-८ जना सहभागि हुनेछ।

के मैले भाग लिनु पर्छ?
भाग लिने कि नलिने निर्णय तपाईको हो। यदि तपाईले भाग लिने निर्णय गर्नुहुन्छ भने, यो सूचना पत्र दिइनेछ र सहभागी सहमति फारममा सही गर्न अनुरोध गरिनेछ। तपाई बिनाकारण कुनै पनि समयमा अनुसन्धानमा आफ्नो सहभागिता स्थगित सक्नुहुन्छ। यदी तपाईले आफ्नो सहभागिता स्थगित गर्ने निर्णय गरेमा तपाईको पहिचान गर्न सकिने जानकारी हटाइने छ।

सहभागिता कस्तो हुनेछ?
छलफल करिब ६०-९० मिनेटको हुनेछ र तपाईको सहभागीता केवल एकैपटक मात्र हुनेछ। तपाईलाई, तपाईको जीवन अनुभव, समाजमा दलितहरूको स्थिति, स्वास्थ्य सेवाको प्रयोग गर्दा सामना गर्नुपर्ने चुनौतीहरु र तपाईको स्वास्थ्यमा यसको असर बारेमा सोधिनेछ। कुनैपनि जवाफ सही वा गलत भन्ने छैन त्यसैले नहिचकिचाई जवाफ दिनुहोस्।

भाग लिने फाइदाहरू र सम्भावित बेफाइदाहरू के हो?
केही व्यक्तिहरू आफ्नो अनुभव बाड्न रुचाउछन्, साथै यस अनुसन्धानले स्वास्थ्य सेवाको प्रयोग गर्दा जातिमा आधारित स्वास्थ्य भेदभावलाई अध्ययन गर्न र दलित समुदायको स्वास्थ सेवा उपयोग गर्दाको अनुभव तथा चुनौतीलाई बुझ्न सहयोग गर्छ। यस छलफलमा भाग लिदा हुनसक्ने बेफाइदा निकै न्यून छ। सामुहिक छलफल हुनाले तपाईको कुरा अन्य सहभागीले सुन्नेछन् तर हामी प्रत्येक सदस्यलाई जानकारी गोप्य राख्न अनुरोध गर्नेछौं। कुनै बिशेष प्रश्नले तपाईलाई असहज बनाएमा त्यस्तो प्रस्नको जवाफ दिन जरुरी छैन।

मबाट कस्तो जानकारी चाहनुहुन्छ र अनुसन्धानका उद्देश्यहरू प्राप्त गर्न यस जानकारी किन प्रासंगिक छ।
हामी तपाईको जीवन अनुभव, स्वास्थ्य अवस्था, स्वास्थ्य सेवा खोज्न इच्छुकता, आय, चुनौती र जोखिम सम्बन्धी जानकारी संकलन गर्नेछौं। यस जानकारीहरु सान्दर्भिक छ किनभने यसले दलितहरुले दिनहुँ भोग्नुपर्ने जातीय भेदभाव, रोजगारीमा भेदभावका साथै समाजमा दलितहरुको स्थिति र त्यसले उनीहरूको स्वास्थ्यमा पर्ने प्रभाव पहिचान गर्न सहयोग गर्छ। हामी प्रत्येक सहभागीको सामाजिक-आर्थिक र जनसांख्यिकीय जानकारी पनि संकलन गर्नेछौं।

के म रेकर्ड हुनेछु र यसको प्रयोग कसरी गरिनेछ?
छलफल अडियो रेकर्ड गरिनेछ र रेकर्डिङहरू ट्रान्सक्रिप्शन पछि नष्ट गरिनेछ। तपाईंको लिखित अनुमति बिना कुनै अन्य प्रयोग गरिनेछैन, र परियोजना बाहिर कसैको पनि कुनै पनि रेकर्डिङमा पहुँच अनुमति दिइनेछैन।

मेरो जानकारी कसरी राखिनेछ?
अनुसन्धानका सबै जानकारीहरु बेलायतको सूचना संरक्षण ऐन अनुसार गोप्य राखिनेछ। अनुसन्धान विश्वविद्यालयको मुख्य कार्य हो जुन सार्वजनिक रुचिमा गरिन्छ। बोर्नमाउथ युनिभर्सिटी (बीयू) सूचना नियन्त्रकको रुपमा संकलित जानकारीको सुरक्षा र उपयोगको जिम्मेवार हुनेछ। बीयूको गोपनीयता सूचनाले सूचना संरक्षण ऐन अनुसार हाम्रो जिम्मेवारी र तपाईहरुको अधिकारको थप जानकारी दिन्छ। हामी तपाईलाई गोपनीयता सूचना पढ्न र बुझ्न अनुरोध गर्छौं।

प्रकाशन
कुनै पनि रिपोर्ट वा प्रकाशनहरूमा तपाईलाई पहिचान गर्न सकिनेछैन।

सुरक्षा र पहुँच नियन्त्रण
संकलन गरिएको जानकारी गोप्य र सुरक्षित राखिनुका साथै पासवर्ड सुरक्षित गरी कम्प्युटरमा राखिनेछ।

व्यक्तिगत जानकारीको साझेदारी र थप प्रयोग
तपाईले प्रदान गर्नुभएको अज्ञात बनाइएका जानकारी अनुशन्धानकर्ताले भविष्यमा अन्य अध्ययन, प्रकाशन, रिपोर्ट वा प्रस्तुतीकरणमा प्रयोग गर्न सक्नेछन्। अध्ययनको दौरान संकलन गरिएको अज्ञात बनाइएका जानकारीहरु बीयू को डेटा भण्डारमा असीमित अवधिको लागि राखिन्छ र जुन सार्वजनिक रूपमा उपलब्ध हुनेछ।

थप जानकारीको लागि सम्पर्क गर्नुहोस्:
रक्षा थापा, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६२०५१; इमेल: rthapa@bournemouth.ac.uk

डा. प्रमोद रेग्मी, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६३०२५; इमेल: pregmi@bournemouth.ac.uk

श्रीमान् राम चन्द्र सिलवाल, देश निर्देशक, ग्रीन तारा नेपाल, +९७७-१-४४३२६९८; इमेल: info@greentara.org.np

अध्ययनको बारेमा कुनै पनि गुनासो भए निम्न ठेगानामा सम्पर्क गर्नुहोस्:
प्रो. भनोरा हण्डली, सहायक डीन, अनुसन्धान तथा व्यावसायिक अभ्यास, बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायेत,
टेलिफोन: +४४१२०२९६५२०६, इमेल: researchgovernance@bournemouth.ac.uk

यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद।

Appendix 3 Discussion guide for FGDs

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभाव, मकवानपुर जिल्ला, नेपाल
समूह छलफल निर्देशिका

मिति:

अन्तर्वार्ता लिनेको नाम:

अन्तर्वार्ता लिईएको स्थान:

छलफल सुरु समय: **छलफल अन्त्य समय:**

अन्तर्वार्ता दिनेको विवरण:	लिंग	उमेर	जाति	शैक्षिक योग्यता	पेशा
सहभागी १					
सहभागी २					
सहभागी ३					
सहभागी ४					
सहभागी ५					
सहभागी ६					
सहभागी ७					
सहभागी ८					
सहभागी ९					
सहभागी १०					

योग्यता: सहभागी दलित समुदायबाट र १५-६५ वर्षको हुनु पर्छ।

मुख्य जानकारीहरु:

- कुनै पनि जवाफहरू सही वा गलत हुदैनन्।
- तपाईं कुनै पनि समय बोल्न सक्नुहुन्छ तर कृपया एक समयमा एक व्यक्तिले मात्रै बोल्नु होला।
- सबैजनासँग बोल्ने बराबर अधिकार छ।
- सबैको राय र जवाफ उत्तिनै महत्त्वपूर्ण छ।
- तपाई अरुको राय र जवाफ संग सहमत नहुन पनि सक्नुहुन्छ।
- सहभागीहरुबाट केहि प्रस्न आएमा कृपया त्यसको पनि जवाफ दिनुहोला।
- कुनै बिषेश प्रश्नले तपाईलाई असहज बनाउछ भने उक्त प्रस्नको जवाफ दिन जरुरी छैन।
- गोपनीयता कायम राखिनेछ।

यस अनुसन्धानमा, तपाईंलाई तपाईंको आफ्नो समग्र जीवन अनुभव, समाजमा दलितहरूको अवस्था, स्वास्थ्य सेवाको प्रयोग गर्दा सामना गर्नुपर्ने चुनौती र तपाईंको स्वास्थ्यमा यसको असरको बारेमा सोधिने छ।

मुख्य विषय	छलफल प्रस्नहरु
जीवन अनुभव	१. मलाई दलितहरुको दैनिक जीवन अनुभवहरू कसरी उच्च जातिहरुको भन्दा फरक छ भन्ने जान्ने इच्छा छ। २. दलित पुरुषहरु र महिलाहरुको जीवन अनुभवको अंतर। ३. अन्य जातिका मित्रहरुसंघको सम्बन्ध र उनीहरुको व्यवहार। ४. तपाईको जीवनमा आध्यात्मिक विश्वासको भूमिका।
सामाजिक अवस्था	१. तपाईको समुदायमा कस्तो प्रकारको सामाजिक भेदभाव छ? २. सामाजिक कार्यक्रममा तपाईको सहभागिताको बारेमा बताउनुहोस्। ३. तपाईको सामाजिक अवस्थाले तपाईको जीवनमा खेल्ने भूमिका। ४. समाजमा दलितहरूलाई कसरी पहिचान सकिन्छ? जस्तै भौतिक गुणहरू। अनि बच्चाहरू कसरी जातीय भिन्नताको बारेमा सिक्छन्?
स्वास्थ्य उपभोग	१. तपाईको समुदायमा के-कस्ता स्वास्थ्य सेवाहरू उपलब्ध छन्। [स्थानीय पारम्पारिक उपचार] र कसरी स्वास्थ्य सम्बन्धी समस्याहरू समाधान गरिन्छ? २. तपाई स्वास्थ्य आवस्यकताको समयमा कसलाई प्राथमिकता दिनुहुन्छ र किन? ३. स्वास्थ्य सुविधाहरू उपयोग गर्दा कस्तो चुनौतीहरु सामना गर्नुभयो? तपाईको बिचारमा, उच्च जातिहरूले पनि त्यस्ता चुनौतीहरूको सामना गर्छन्? [सकारात्मक पक्ष पनि खोज्नुहोस] ४. स्वास्थ्यकर्मिको तपाईप्रतिको व्यवहार कतिको भिन्न लग्यो?[जस्तै ध्यानपूर्वक सुन्नु, विचार बुज्नु , सम्मान गर्नु, चिहिदो समय दिनु] ५. तपाईको समुदायमा, दलितहरुका लागि कस्ता स्वास्थ्य सेवा वा कल्याण कार्यक्रम हुन्छन, कसले संचालन गर्छन् र त्यसले कसरी मदत गर्छ।[उदाहरणहरू खोज्नुहोस्]
स्वास्थ्य प्रभावहरू	१. तपाईको बिचारमा, स्थानिय समुदायमा के-कस्ता स्वास्थ्य समस्याहरू छन्? २. तपाईको दृष्टिकोणमा, यी स्वास्थ्य समस्याहरूको कारण के हो? ३. तपाईको सामाजिक अवस्थाले तपाइँको स्वास्थ्यलाई कसरी असर गर्छ? ४. तपाईको विचारमा, के-कस्तो परिवर्तनले स्वास्थ्य प्रणालीमा सुधार आउछ?
दलित स्वास्थ्यको बारेमा अरु थप जानकारी दिनुहोस्।	

"यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद"

Appendix 4 Participant information sheet for Key Stakeholders Interview

Bournemouth University

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धि अध्ययन, मकवानपुर जिल्ला, नेपाल
प्रमुख सम्बन्धित सरोकारवाला अन्तर्वार्तामा सहभागीताकोलागी सूचनापत्र

नमस्कार! मेरो नाम रक्षा थापा हो। म बेलायतस्थित, बोर्नमाउथ युनिभर्सिटीमा पीएचडी अध्ययनको क्रममा जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धी अध्ययन गर्दैछु। तपाईलाई अनुसन्धानमा सहभागी हुन अनुरोध छ। कृपया यस जानकारीलाई सावधानीपूर्वक पढ्नुहोस र चाहनुहुन्छ भने अरूसँग छलफल गर्नुहोस्। यदि कुनै कुरा स्पष्ट छैन वा यदी थप जानकारी चाहनुहुन्छ भने कृपया मलाई सोध्नुहोला।

यस अनुसन्धानको उद्देश्य के हो?
यस अध्ययनले मकवानपुर जिल्लामा स्वास्थ्य पहुँच र सेवा उपयोगमा जातीय भेदभावको अनुसन्धान गर्नेछ। हामी दलितहरुको स्वास्थ्य सेवा उपभोगको अनुभव र चुनौतीहरू, स्वास्थ्य कार्यकर्ताहरूको दलित सेवा प्रयोगकर्ताहरूप्रतिको दृष्टिकोण तथा यस्तै अन्य समस्याहरु बुझ्न चाहन्छौं। तपाईलाई जिल्लाको प्रमुख सम्बन्धित सरोकारवालाको रुपमा यस अनुसन्धानमा भाग लिन आमन्त्रित गरिएको हो।

के मैले भाग लिनु पर्छ?
भाग लिने कि नलिने निर्णय तपाईको हो। यदि तपाईले भाग लिने निर्णय गर्नुहुन्छ भने, यो सूचना पत्र दिइनेछ र सहभागी सहमति फारममा सही गर्न अनुरोध गरिनेछ। तपाई बिनाकारण कुनै पनि समयमा अनुसन्धानमा आफ्नो सहभागिता स्थगित सक्नुहुन्छ। यदी तपाईले आफ्नो सहभागिता स्थगित गर्ने निर्णय गरेमा तपाईको पहिचान गर्न सकिने जानकारी हटाइने छ।

सहभागिता कस्तो हुनेछ?
यस अन्तर्वार्ता ३० देखि ४५ मिनेटको हुनेछ। तपाईलाई स्थानीय स्वास्थ्य सेवाहरुको उपलब्धिता, दायरा र अवस्थाका साथै स्वास्थ्य सेवा नीतिहरूको बारेमा सोधिनेछ। कुनैपनि जवाफ सही वा गलत भन्ने छैन त्यसैले नहिचकिचाई जवाफ दिनुहोस्।

भाग लिने फाइदाहरू र सम्भावित बेफाइदाहरू के हो?
केही व्यक्तिहरू आफ्नो अनुभव बाड्न रुचाउछन्, साथै यस अनुसन्धानले स्वास्थ्य सेवाको प्रयोग गर्दा जातिमा आधारित स्वास्थ्य भेदभावलाई अध्ययन गर्न र दलित समुदायको स्वास्थ सेवा उपयोग गर्दाको अनुभव तथा चुनौतीलाई बुझ्न सहयोग गर्छ। यस छलफलमा भाग लिदा हुनसक्ने बेफाइदा निकै न्यून छ। कुनै बिशेष प्रश्नले तपाईलाई असहज बनाउन सक्छ त्यस्तो प्रस्नको जवाफ दिन जरुरी छैन।

मबाट कस्तो जानकारी चाहनुहुन्छ र अनुसन्धानका उद्देश्यहरू प्राप्त गर्न यस जानकारी किन प्रासंगिक छ?
हामी तपाईबाट स्वास्थ्य सेवा उपयोगमा आईपर्ने चुनौती र समस्याहरु, यस्ता समस्याहरु समाधान गर्ने नीतिहरूका साथै स्वास्थ्य सेवाहरुको उपलब्धता र अवस्थाका बारेमा जानकारी संकलन गर्नेछौं। यस जानकारीहरु सान्दर्भिक छ किनभने यसले दलितहरुले दिनहुँ भोग्नुपर्ने जातीय भेदभाव, रोजगारीमा भेदभावका साथै समाजमा दलितहरुको स्थिति र त्यसले उनीहरूको स्वास्थ्यमा पर्ने प्रभाव पहिचान गर्न सहयोग गर्छ।

के म रेकर्ड हुनेछु र यसको प्रयोग कसरी गरिनेछ?
छलफल अडियो रेकर्ड गरिनेछ र रेकर्डिङहरू ट्रान्सक्रिप्शन पछि नष्ट गरिनेछ। तपाईको लिखित अनुमति बिना कुनै अन्य प्रयोग गरिनेछैन, र परियोजना बाहिर कसैको पनि कुनै पनि रेकर्डिङमा पहुँच अनुमति दिइनेछैन।

मेरो जानकारी कसरी राखिनेछ?
अनुसन्धानका सबै जानकारीहरु बेलायतको सूचना संरक्षण ऐन अनुसार गोप्य राखिनेछ। अनुसन्धान विश्वविद्यालयको मुख्य कार्य हो जुन सार्वजनिक रुचिमा गरिन्छ। बोर्नमाउथ युनिभर्सिटी (बीयू) सूचना नियन्त्रकको रुपमा संकलित जानकारीको सुरक्षा र उपयोगको जिम्मेवार हुनेछ। बीयूको गोपनीयता सूचनाले सूचना संरक्षण ऐन अनुसार हाम्रो जिम्मेवारी र तपाईहरुको अधिकारको थप जानकारी दिन्छ। हामी तपाईलाई गोपनीयता सूचना पढ्न र बुझ्न अनुरोध गर्छौं।

प्रकाशन
कुनै पनि रिपोर्ट वा प्रकाशनहरूमा तपाईलाई पहिचान गर्न सकिनेछैन।

सुरक्षा र पहुँच नियन्त्रण
संकलन गरिएको जानकारी गोप्य र सुरक्षित राखिनुका साथै पासवर्ड सुरक्षित गरी कम्प्युटरमा राखिनेछ।

व्यक्तिगत जानकारीको साझेदारी र थप प्रयोग
तपाईले प्रदान गर्नुभएको अज्ञात बनाइएका जानकारी अनुशन्धानकर्ताले भविष्यमा अन्य अध्ययन, प्रकाशन, रिपोर्ट वा प्रस्तुतीकरणमा प्रयोग गर्न सक्नेछन्। अध्ययनको दौरान संकलन गरिएको अज्ञात बनाइएका जानकारीहरु बीयू को डेटा भण्डारमा असीमित अवधिको लागि राखिन्छ र जुन सार्वजनिक रूपमा उपलब्ध हुनेछ।

थप जानकारीको लागि सम्पर्क गर्नुहोस्:
रक्षा थापा, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६२०५१; इमेल: rthapa@bournemouth.ac.uk

डा. प्रमोद रेग्मी, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६३०२५; इमेल: pregmi@bournemouth.ac.uk

श्रीमान् राम चन्द्र सिलवाल, देश निर्देशक, ग्रीन तारा नेपाल, +९७७-१-४४३२६९८; इमेल: info@greentara.org.np

अध्ययनको बारेमा कुनै पनि गुनासो भए निम्न ठेगानामा सम्पर्क गर्नुहोस्:
प्रो. भनोरा हण्डली, सहायक डीन, अनुसन्धान तथा व्यावसायिक अभ्यास, बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायेत,
टेलिफोन: +४४१२०२९६५२०६, इमेल: researchgovernance@bournemouth.ac.uk

यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद।

Appendix 5 Questions guide for KI

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभाव, मकवानपुर जिल्ला, नेपाल
प्रमुख सम्बन्धित सरोकारवाला अन्तर्वार्ता निर्देशिका

मिति:

अन्तर्वार्तालिनेको नाम:

अन्तर्वार्ता लिईएको स्थान:

अन्तर्वार्ता दिनेको पद:

अन्तर्वार्ता सुरु समय: **अन्तर्वार्ता अन्त्य समय:**

स्वास्थ्य सेवा प्रदायक		सार्वजनिक स्वास्थ्य अधिकारी		ग्रामीण नगरपालिका प्रतिनिधि		अन्य (कृपया उल्लेख गर्नुहोस्):	
एनजीओ / आईएनजीओ प्रतिनिधि		स्वास्थ्य नीति निर्माता		महिला समूह प्रतिनिधि			

योग्यता: जिल्लाको प्रमुख सम्बन्धित सरोकारवाला

मुख्य जानकारीहरु:

- कुनै पनि जवाफहरू सही वा गलत हुदैनन्।
- कुनै बिषेश प्रश्नले तपाईलाई असहज बनाउन भने तेस्तो प्रस्नको जवाफ दिन जरुरी छैन।
- गोपनीयता कायम राखिनेछ।

मुख्य प्रश्नहरू:

१. तपाइँको बिचारमा, स्थानीय क्षेत्रमा स्वास्थ्य सेवा, दबाइ र अन्य स्वास्थ्य सुविधाहरु उपयोग गर्दा आउने समस्याहरु के के हुन्?
२. दलितहरु प्राय: कतिको मात्रामा स्वास्थ्य सेवा उपयोग गर्छन?
३. स्थानीय समुदायहरूमा कस्तो स्वास्थ्य जागरूकता कार्यक्रमहरु आयोजना गरिन्छ? [घटनाहरूको परिमार्जन अन्वेषण गर्नुहोस् (जस्तै, एफएम, पोस्टर), कार्यक्रम कसले संचालन गर्छ (जस्तै, एनजीओ), यी कार्यक्रमहरूको प्रतिक्रिया]
४. यस प्रकारका कार्यक्रमहरूमा दलितहरू कसरी संलग्न हुन्छन्?
५. तपाईंको दृष्टिकोणमा, दलितहरु आफ्नो स्वास्थ्य र भलाईबारे कति चिन्तित छन्? [किन? अन्वेषण गर्नुस]
६. तपाइँको बिचारमा, दलित स्वास्थ्यलाई असर गर्ने कारकहरू के हुन्?
७. स्वास्थ्य सेवाहरू उपयोग गर्दा दलितहरुले कस्तो समस्याहरु भोग्नुपर्छ?
८. दलितहरु चिकित्सा स्वास्थ्य तथा अन्य स्वास्थ्य विकल्पहरू मध्य कुन बढी उपयोग गर्छन र किन?
९. दलितहरुलाई स्वास्थ्य सेवाको प्रयोगमा आकर्षित गर्न कस्ता विशेष कार्यक्रम तथा नीतिहरु छन्?
१०. तपाइको बिचारमा, हामी कसरी स्वास्थ्य भेदभावलाई कम गर्न सक्छौं?
११. दलित स्वास्थ्यको बारेमा अरु थप जानकारी दिनुहोस्।

"यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद"

Appendix 6 Information sheet for Exit Interview

Bournemouth University

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धि अध्ययन, मकवानपुर जिल्ला, नेपाल
बहिरगमन अन्तर्वार्तामा सहभागीताकोलागी सूचनापत्र

नमस्कार! मेरो नाम रक्षा थापा हो। म बेलायतस्थित, बोर्नमाउथ युनिभर्सिटीमा पीएचडी अध्ययनको क्रममा जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धी अध्ययन गर्दैछु। तपाईलाई अनुसन्धानमा सहभागी हुन अनुरोध छ। कृपया यस जानकारीलाई सावधानीपूर्वक पढ्नुहोस र चाहनुहुन्छ भने अरूसँग छलफल गर्नुहोस्। यदि कुनै कुरा स्पष्ट छैन वा यदी थप जानकारी चाहनुहुन्छ भने कृपया मलाई सोध्नुहोला।

यस अनुसन्धानको उद्देश्य के हो?
यस अध्ययनले मकवानपुर जिल्लामा स्वास्थ्य पहुँच र सेवा उपयोगमा जातीय भेदभावको अनुसन्धान गर्नेछ। हामी दलितहरुको स्वास्थ्य सेवा उपभोगको अनुभव र चुनौतीहरू, स्वास्थ्य कार्यकर्ताहरूको दलित सेवा प्रयोगकर्ताहरूप्रतिको दृष्टिकोण तथा यस्तै अन्य समस्याहरु बुझ्न चाहन्छौं। तपाईलाई भर्खर स्वास्थ्य सेवाहरू प्रयोग गर्नुभएको स्थानीय समुदायहरूको सदस्यका रुपमा यस अनुसन्धानमा भाग लिन आमन्त्रित गरिएको हो।

के मैले भाग लिनु पर्छ?
भाग लिने कि नलिने निर्णय तपाईको हो। यदि तपाईले भाग लिने निर्णय गर्नुहुन्छ भने, यो सूचना पत्र दिइनेछ र सहभागी सहमति फारममा सही गर्न अनुरोध गरिनेछ। तपाई बिनाकारण कुनै पनि समयमा अनुसन्धानमा आफ्नो सहभागिता स्थगित सक्नुहुन्छ। यदी तपाईले आफ्नो सहभागिता स्थगित गर्ने निर्णय गरेमा तपाईको पहिचान गर्न सकिने जानकारी हटाइने छ।

सहभागिता कस्तो हुनेछ?
यस अन्तर्वार्ता ३० देखि ४५ मिनेटको हुनेछ। तपाईलाई स्वास्थ्य सेवा उपयोग र तपाईप्रती स्वास्थ्यकर्मीहरूको व्यवहार सम्बन्धि अनुभवहरू बाढ्न अनुरोध गरिन्छ। कुनैपनि जवाफ सही वा गलत भन्ने छैन त्यसैले नहिचकिचाई जवाफ दिनुहोस्।

भाग लिने फाइदाहरू र सम्भावित बेफाइदाहरू के हो?
केही व्यक्तिहरू आफ्नो अनुभव बाड्न रुचाउछन्, साथै यस अनुसन्धानले स्वास्थ्य सेवाको प्रयोग गर्दा जातिका आधारित स्वास्थ्य भेदभावलाई अध्ययन गर्न र दलित समुदायको स्वास्थ सेवा उपयोग गर्दाको अनुभव तथा चुनौतीलाई बुझ्न सहयोग गर्छ भन्ने आशा छ। यस छलफलमा भाग लिदा हुनसक्ने बेफाइदा निकै न्यून छ। कुनै बिशेष प्रश्नले तपाईलाई असहज बनाउन सक्छ त्यस्तो प्रस्नको जवाफ दिन जरुरी छैन।

मबाट कस्तो जानकारी चाहनुहुन्छ र अनुसन्धानका उद्देश्यहरू प्राप्त गर्न यस जानकारी किन प्रासंगिक छ?
हामी तपाईको स्वास्थ्य उपयोग गर्दाको अनुभव, चुनौती र जोखिम, स्वास्थ्य कार्यकर्ताको तपाईप्रतिको व्यवहार र उपलब्ध स्वास्थ्य सेवाहरूको बारेमा तपाईको धारणा सम्बन्धी जानकारी संकलन गर्नेछौं। यस जानकारीहरु सान्दर्भिक छ किनभने यसले दलितहरुले दिनहुँ भोग्नुपर्ने जातीय भेदभाव, रोजगारीमा भेदभावका साथै समाजमा दलितहरुको स्थिति र त्यसले उनीहरूको स्वास्थ्यमा पर्ने प्रभाव पहिचान गर्न सहयोग गर्छ।

के म रेकर्ड हुनेछु र यसको प्रयोग कसरी गरिनेछ?
छलफल अडियो रेकर्ड गरिनेछ र रेकर्डिङहरू ट्रान्सक्रिप्शन पछि नष्ट गरिनेछ। तपाईको लिखित अनुमति बिना कुनै अन्य प्रयोग गरिनेछैन, र परियोजना बाहिर कसैको पनि कुनै पनि रेकर्डिङमा पहुँच अनुमति दिइनेछैन।

मेरो जानकारी कसरी राखिनेछ?
अनुसन्धानका सबै जानकारीहरु बेलायतको सूचना संरक्षण ऐन अनुसार गोप्य राखिनेछ। अनुसन्धान विश्वविद्यालयको मुख्य कार्य हो जुन सार्वजनिक रुचिमा गरिन्छ। बोर्नमाउथ युनिभर्सिटी (बीयू) सूचना नियन्त्रकको रुपमा संकलित जानकारीको सुरक्षा र उपयोगको जिम्मेवार हुनेछ। बीयूको गोपनीयता सूचनाले सूचना संरक्षण ऐन अनुसार हाम्रो जिम्मेवारी र तपाईहरुको अधिकारको थप जानकारी दिन्छ। हामी तपाईलाई गोपनीयता सूचना पढ्न र बुझ्न अनुरोध गर्छौं।

प्रकाशन
कुनै पनि रिपोर्ट वा प्रकाशनहरूमा तपाईलाई पहिचान गर्न सकिनेछैन।

सुरक्षा र पहुँच नियन्त्रण
संकलन गरिएको जानकारी गोप्य र सुरक्षित राखिनुका साथै पासवर्ड सुरक्षित गरी कम्प्युटरमा राखिनेछ।

व्यक्तिगत जानकारीको साझेदारी र थप प्रयोग
तपाईले प्रदान गर्नुभएको अज्ञात बनाइएका जानकारी अनुशन्धानकर्ताले भविष्यमा अन्य अध्ययन, प्रकाशन, रिपोर्ट वा प्रस्तुतीकरणमा प्रयोग गर्न सक्नेछन्। अध्ययनको दौरान संकलन गरिएको अज्ञात बनाइएका जानकारीहरु बीयू को डेटा भण्डारमा असीमित अवधिको लागि राखिन्छ र जुन सार्वजनिक रूपमा उपलब्ध हुनेछ।

थप जानकारीको लागि सम्पर्क गर्नुहोस्:
रक्षा थापा, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६२०५१; इमेल: rthapa@bournemouth.ac.uk

डा. प्रमोद रेग्मी, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६३०२५; इमेल: pregmi@bournemouth.ac.uk

श्रीमान् राम चन्द्र सिलवाल, देश निर्देशक, ग्रीन तारा नेपाल, +९७७-१-४४३२६९८; इमेल: info@greentara.org.np

अध्ययनको बारेमा कुनै पनि गुनासो भए निम्न ठेगानामा सम्पर्क गर्नुहोस्:
प्रो. भनोरा हण्डली, सहायक डीन, अनुसन्धान तथा व्यावसायिक अभ्यास, बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायेत,
टेलिफोन: +४४१२०२९६५२०६, इमेल: researchgovernance@bournemouth.ac.uk

यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद।

Appendix 7 Questions guide for Exit Interview

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभाव, मकवानपुर जिल्ला, नेपाल
बहिरगमन अन्तर्वार्ता निर्देशिका

मिति:

अन्तर्वार्तालिनेको नाम:

अन्तर्वार्ता लिईएको स्थान:

अन्तर्वार्ता सुरु समय: **अन्तर्वार्ता अन्त्य समय:**

अन्तर्वार्तादिनेको विवरण:				
जाति	लिंग	उमेर	शैक्षिक योग्यता	पेशा

योग्यता: सहभागीले भर्खरै स्थानीय स्वास्थ्य सेवाको प्रयोग गर्नु पर्छ।

मुख्य जानकारीहरु:

- कुनै पनि जवाफहरू सही वा गलत हुदैनन्।
- कुनै बिषेश प्रश्नले तपाईलाई असहज बनाउन भने तेस्तो प्रस्नको जवाफ दिन जरुरी छैन।
- गोपनीयता कायम राखिनेछ।

मलाई तपाईले हालै स्वास्थ्य सेवाको उपभोग गर्दाको अनुभवहरु जान्ने इच्छा छ, त्यसैले:

१. कृपया तपाईले भर्खरै भ्रमण गर्नुभएका स्वास्थालयमा उपचारको अनुभवका बारेमा मलाई बताउन सक्नुहुन्छ? तपाईंलाई कस्तो व्यवहार गरियो?
२. तपाईले स्वास्थालयको भ्रमण गर्दा तपाई कस्तो महसुस गर्नुहुन्छ?
३. तपाई कति समयसम्म स्वास्थालय बस्नु भयो?
४. तपाई स्वास्थ्य सेवाहरूको प्रयोग प्रायः कति गर्नुहुन्छ?
५. स्वास्थ्य सेवाहरूको प्रयोग गर्दा तपाईले कस्तो चुनौती सामना गर्नुभयो?
६. अन्य बिरामी तुलनामा तपाईप्रति स्वास्थ्यकर्मिको व्यवहारमा कस्तो भिन्नता भेट्टाउनु भयो?
७. दलित समुदायप्रति कस्तो प्रकारको फरक व्यवहार गरिन्छ?
८. तपाईले देख्नु वा भोग्नु भएको स्वास्थ्य भेदभावक बारेमा बताउनुहोस।
९. अन्य स्वास्थ्य विकल्पहरू (धामी, झाक्री) का बारेमा तपाईका धारणा कस्तो छ? अनि तपाईको पहिलो प्राथमिकता कसलाई दिनुहुन्छ र किन?
१०. चिकित्सा सहायता चाहिएमा तपाई यहाँ फर्केर आउनुहुन्छ वा अरुलाई सिफारिस गर्नुहुन्छ?
११. तपाईको बिचारमा स्वास्थ्य सेवा सजिलो बनाउनको लागी कस्तो परिवर्तनको अवासेकता छ।
१२. दलित स्वास्थ्यको बारेमा अरु थप जानकारी दिनुहोस्।

"यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद"

Appendix 8 Questionnaire for quantitative Survey

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभाव, मकवानपुर जिल्ला, नेपाल
सर्वेक्षण प्रश्नावली स्वास्थ्यकर्मीहरुका लागि

मिति:_____ / _____ / _____ **HWQ** _____
दिन / महिना / वर्ष

गाँउ / नगरपालिकाको नाम: _____

वडाको नाम र नम्बर: _____

कृपया तलको उदाहरणका हेर्नुहोस्:

१.०१	*तिमी लिंग के हो?* *(जस्तै अन्य भएमा)*	१. महिला २. पुरुष ३. अन्य (कृपया ऊलेख गर्नुहोस्) .....तेस्रो लिंगी.....				
१.०२	*तपाईको विचारमा, स्थानीय समुदायहरूमा पर्याप्त चिकित्सा आवश्यकताहरू उपलब्ध छन्? (जस्तै*	कडा सहमत ✓	सहमत	तटस्थ	असहमत	कडा असहमत

खण्ड १: सामान्य जानकारी		*प्रतिक्रिया*
१.०१	तपाईको लिंग के हो?	१. महिला २. पुरुष ३. अन्य (कृपया ऊलेख गर्नुहोस्) .....
१.०२	तपाईको जात के हो?	१. ब्राह्मण २. क्षेत्री ३. दलित पहाड ४. दलित तराई ५. जनजाती पहाड ६. जनजाती तराई ७. मुस्लिम ८. अन्य (कृपया ऊलेख गर्नुहोस्) .....
१.०३	तपाई कुन धर्म मान्नु हुन्छ?	१. हिन्दू २. बौद्ध ३. मुस्लिम ४. किरात ५. क्रिश्चियन ६. अन्य (कृपया ऊलेख गर्नुहोस्) .....
१.०४	तपाई कति वर्षको हुनुभयो?	वर्ष ☐ महिना ☐
१.०५	तपाईको वैवाहिक अवस्था के हो?	१. विवाहित २. अविवाहित ३. तलाक / सम्बन्ध बिच्छेद ४. एकल महिला ५. अन्य (कृपया ऊलेख गर्नुहोस्) ....

१.०६	तपाईको शैक्षिक योग्यता के हो?	१. प्राथमिक [१-५ कक्षा] २. निम्न माध्यमिक [६-८ कक्षा] ३. माध्यमिक [९ देखि एसइइ] ४. उच्च माध्यमिक [११ र १२] ५. विश्वविद्यालय [स्नातक र माथि] ६. अन्य (कृपया ऊलेख गर्नुहोस्)				
१.०७	तपाई के काम गर्नुहुन्छ? (कृपया ऊलेख गर्नुहोस्)					
१.०८	तपाई यो स्वास्थ्य चौकी नजिकै बसोबास गर्नुहुन्छ।	१. बस्छु २. बस्दिन				
१.०९	तपाई स्वास्थ्यकर्मी भएर काम गरेको कति भयो?	वर्ष ☐ महिना ☐				
१.१०	तपाईले कुन स्वास्थ्य सुविधामा रिपोर्ट गर्नुहुन्छ? (कृपया ऊलेख गर्नुहोस्)					
खण्ड २: बर्तमान स्वास्थ्य सेवा		***प्रतिक्रिया***				
२.०१	तपाईको क्षेत्रमा कतिjana वटा स्वास्थ्यकर्मीहरु छन्?	स्वास्थ्यकर्मिको संख्या				
२.०२	तपाई दैनिक लगभग कति जना बिरामी हेर्नुहुन्छ?	बिरामीको संख्या				
२.०३	तपाईको स्वास्थ्य समुदयक क्षेत्रमा स्वास्थ्य जानकारी कसरी प्रदान गरिन्छ? (अधिक प्रतिक्रिया दिन सकिन्छ)	१. रेडियो २. टेलिभिजन ३. अखबार र पत्रिका ४. ब्रोशर वा फ्लिप चार्टहरू ५. पोस्टर, बोर्ड / बिल बोर्ड होल्डिंग ६. सडक नाटक ७. घर-घरमा गएर ८. सामुदायिक सभाहरू ९. अन्य (कृपया ऊलेख गर्नुहोस्)				
२.०४	तपाईको स्वास्थ्य समुदयक क्षेत्रमा दलित समुदायलाई स्वास्थ्य जानकारी कसरी प्रदान गरिन्छ? (अधिक प्रतिक्रिया दिन सकिन्छ)	१. रेडियो २. टेलिभिजन ३. अखबार र पत्रिका ४. ब्रोशर वा फ्लिप चार्टहरू ५. पोस्टर, बोर्ड / बिल बोर्ड होल्डिंग ६. सडक नाटक ७. घर-घरमा गएर ८. सामुदायिक सभाहरू ९. अन्य (कृपया ऊलेख गर्नुहोस्)				
२.०५	तपाईको स्वास्थ्य संस्थामा कति प्रतिशत दलित बिरामीहरु आऊछन्?	(०-२०)%	(२१-४०)%	(४१-६०)%	(६१-८०)%	८०% भन्दा माथि
२.०६	यस सामुदायिक क्षेत्रको स्वास्थ्य आवश्यकताहरु पूरा भएको छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत

२.०७	प्रायः दलितहरू पारंपरिक उपचारमा विस्वास गर्छन।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
२.०८	स्थानीय समुदायहरूमा पर्याप्त रुपमा चिकित्सा सुबिधाहरु उपलब्ध छन्।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
खण्ड ३: स्वास्थ्य भेदभाव		***प्रतिक्रिया***				
३.०१	दलितहरुले कसरी पहिचान गर्न सकिन्छ?	१. आवरण २. छालाको रङ ३. भाषा ४. थर अन्य (कृपया ऊलेख गर्नुहोस्)				
३.०२	स्वास्थ्यकर्मीहरूले दलितहरूको उपचार गर्न हिचकिचाऊछन्।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०३	दलितको उपचार बिधि अन्य जातिहरुको भन्दा फरक हुन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०४	दलितहरुलाई समाजमा भेदभाव गरिन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०५	स्वास्थ्य चौकीमा दलितहरुप्रति भेदभाव गरिन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०६	दलितहरू जातिमा आधारमा उपहेलित हुन्छन।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०७	धनाड्य दलितहरुप्रतिभने जातिमा आधारमा कम भेदभाव गरिन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०८	दलितहरुलाई उच्च जाति भन्दा राम्रो स्वास्थ्य ज्ञान छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.०९	दलितहरुलाई स्वास्थ्य सम्बन्धि कुरा बुझाउन अलिक कठिन हुन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
३.१०	मैले स्वास्थ्य सेवामा रहेको भेदभाव देखेको छु।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
खण्ड ४: स्वास्थ्य उपयोगिता		***प्रतिक्रिया***				
४.०१	स्थानीय समुदायहरूको लागि स्थानीय स्वास्थ्य सेवा उपभोग गर्न गाह्रो छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
४.०२	दलित समुदायहरूको लागि स्थानीय स्वास्थ्य सेवा उपभोग बढी गर्न गाह्रो छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
खण्ड ५: व्यवहार र प्रयोग		***प्रतिक्रिया***				
५.०१	दलितहरुलाई स्वास्थ्य जोखिम उच्च छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
५.०२	दलित बिरामीहरुलाई पनि उच्च जातिको बिरामीले जस्तै पाउने सुबिधा पाउने अधिकार छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
५.०३	म दलितहरू पानि नचल्ने जात मान्छु।	कडा	सहमत	तटस्थ	असहमत	कडा

		सहमत				असहमत
५.०४	म दलितहरुलाई साथी बनाउन तयार छु।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
५.०५	म दलितहरुलाई स्वास्थ्य सेवा प्रदान गर्न अग्रसर छु।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
५.०६	दलित बिरामीहरुको उपचार दलित स्वास्थ्यकर्मीले नै गर्नु ठिक हुन्छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
५.०७	स्वास्थ्यकर्मीले दलितहरुलाई कसरी व्यवहार गर्छ? (कृपया ऊलेख गर्नुहोस्)					
५.०८	तपाईको विचारमा, दलितहरुले स्वास्थ्य समस्याहरू कसरी समाधान गर्दा ठिक हुन्छ?	१. घरायसी उपचार २. चिकित्सा उपचार ३. पारंपरिक उपचार ४. आफै ठिक हुन समय दिने ५. अन्य (कृपया ऊलेख गर्नुहोस्)				
५.०९	समाजले दलित समुदायहरूको उपचारमा कसरी योगदान गर्न सक्छ?					
५.१०	के तपाईले नचाही-नचाही पनि दलित बिरामीहरुप्रति भेदभाव गर्नुभएको छ?					
खण्ड ६: दलितहरू प्रतिको प्रतिक्रिया		***प्रतिक्रिया***				
६.०१	दलित समुदायलाई स्वास्थ्य र भलाईकaa बारेमा सूचित/शिक्षित गर्नु धेरै महत्वपूर्ण छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
६.०२	दलित स्वास्थ्य जागरूकतामा स्वास्थ्यसंस्थाको योगदान महत्वपूर्ण छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
६.०३	स्वास्थ्यकर्मीको रुपमा, दलित स्वास्थ्य जागरूकतामा तपाईको योगदान महत्वपूर्ण छ।	कडा सहमत	सहमत	तटस्थ	असहमत	कडा असहमत
६.०४	स्वास्थ्यकर्मीले दलितहरूको स्वास्थ्य सुधारका लागि के गर्न सक्छन्?					
६.०५	स्वास्थ्य सेवा अधिक सहज बनाउन के गर्न सकिन्छ?	१. घर-घरमा गएर २. परामर्श ३. स्क्रीनिंग कार्यक्रमहरू ४. खुल्ने समय बढाएर ५. समाजमा प्रचार-प्रसार गरेर ६. समुदायमा आउटरीच ७. थप स्वास्थ्य सुविधाहरू ८. अन्य (कृपया ऊलेख गर्नुहोस्)				
दलित स्वास्थ्यको बारेमा अरु थप जानकारी दिनुहोस्।						

"यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद"

Appendix 9 Permission for research - Makwanpurgadhi

मकवानपुरगढी गाउँपालिका

गाउँ कार्यपालिकाको कार्यालय

स्वास्थ्य तथा सामाजिक विकास शाखा

मकवानपुरगढी गाउँपालिका वार्ड न.०३ मक्रान्चुली मकवानपुर

३ नं.प्रदेश नेपाल

प.स.:- २०७६/७७ मिति :- २०७६/०५/११

च.नं.:- ३५ / स्वास्थ्य तथा सामाजिक विकास शाखा

बिषय :- **सर्वेक्षण अनुमति सम्बन्धमा ।**

श्री रक्षा थापा

हेटौडा उपमहानगरपालिका वार्ड नं.०५ पिप्ले मकवानपुर

हाल : बोन माउथ युनिभर्सिटी

बोन माउथ,संयुक्त अधिराज्य

प्रस्तुत बिषयमा तपाईलाई यस गाउँपालिका, सम्बन्धित प्रदेश सरकार,नेपाल सरकारको सबै प्रकारको नीति,निर्देशिका भित्र रही यस शाखाको प्रत्यक्ष निगरानी र निर्देशनमा रही यस गाउँपालिका अन्तर्गतमा संचालनमा रहेको ८ वटा नै स्वास्थ्य संस्थाहरुको कार्यक्षेत्रमा बसोबास गर्ने दलित समुदायको स्वास्थ्य सेवामा पहुँच, दलित समुदायको सहभागिता र स्वास्थ्यकर्मीको दलित सेवाग्राही र निजहरुले उपयोग गर्ने स्वास्थ्य सेवा लगायतका कार्यको बिध्याबराधि अध्ययनको प्रसंगमा अनुसन्धान अध्ययन गर्ने क्रममा बिबिध तिन प्रकारको क्रियाकलापको सर्वेक्षण तथा छलफल गर्न यो अनुमति प्रदान गरिएको छ ।

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भोला चौलागाई

जन-स्वास्थ्य निरीक्षक

स्वास्थ्य संयोजक

(प्रभारी)

बोधार्थ :-

श्री आमभन्ज्यांग / मकवानपुरगढी / सुकौरा / बुढीचौर स्वास्थ्य चौकी

श्री आपंटार / मक्रान्चुली / शहिद रुद्रस्मृति / डुम्रेकुना सा.स्वा.ई. :- आबश्यक सहयोग गरि दिनु हुन ।

Appendix 10 Permission for research - Manahari

मनहरी गाउँपालिका
गाउँ कार्यपालिकाको कार्यालय
रजैया, मकवानपुर
०३ प्रदेश नं., नेपाल

प.स. ०७६/०७७
च.नं. : १५३

मिति : २०७६/०५/१०

बिषयः- अनुमती सम्बन्धमा ।

श्री रक्षा थापा(बिद्यावारधी बिद्यार्थी)
बोर्नमाउथ युनिभर्सिटी युके

प्रस्तुत बिषयमा तपाईले आफ्नो PhD आध्यायनको "जातिगत आधारमा दलित समुदाय प्रति गरिने बिभेद" बिषयमा सोधपत्र लेखन कार्यकोलागि देहाय बमोजिमको कृयाकलापहरू गर्न यस गाउँ पालिका क्षेत्र छनौट गरेको जानकारी गराउदै सो कार्यको लागि अनुमती पाँउ भनि दिनुभएको निवेदन अनुसार सो कार्यमा लिएका तथ्याङ्क तथा सामाग्रीहरू सोधपत्र लेखनमा मात्र प्रयोग गर्ने गरी अनुमति प्रदान गरिएको छ ।

कृयाकलापहरू

- समुह छलफल (यस गा.पा. क्षेत्रका ६-८ जना दलित समुदायका व्यक्तिहरू रहेको समुहगत छलफल) २ वटा
- स्वास्थ्य सेवा लिने र दिने बिचको अनुभुति बिषयमा सर्वेक्षण
- स्थानिय सरोकारवाला संगको बिषयगत अन्तरवार्ता

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हरिचन्द्र सापकोटा
नि.प्रमुख प्रशासकीय अधिकृत

Appendix 11 Permission for research - Hetauda

हेटौंडा उपमहानगरपालिका
जगर कार्यपालिकाको कार्यालय
हेटौंडा, मकवानपुर
३, प्रदेश, नेपाल
उपमहानगरपालिका
कार्यपालिकाको कार्यालय,
हेटौंडा, मकवानपुर
नं. प्रदेश, नेपाल

पत्र संख्या :-
शाखा/उपशाखा/इकाई :-
चलानी नं. :-६९०

मिति : २०७६।०५।१२

विषय : अध्ययन अनुसन्धानको लागि अनुमति दिइएको सम्बन्धमा ।

श्री रक्षा थापा
हेटौंडा उपमहानगरपालिका वार्ड नं. ५ पिप्ले, मकवानपुर

प्रस्तुत विषयमा तपाईलाई यस हेटौंडा उपमहानगरपालिका सम्बन्धीत प्रदेश सरकार नेपाल सरकारको सबै प्रकारको नीती, निर्देशिका मित्र रही यस शाखाको प्रत्यक्ष निगरानी र निर्देशनमा रही यस नगरपालिका अर्न्तगत सचालनमा रहेका १२ वटा नै स्वास्थ्य संस्थाहरूको कार्य क्षेत्रमा वसोबास गर्ने दलित समुदायको स्वास्थ्य सेवामा पहुच, दलित समुदायको सहभागिता र स्वास्थ्यकर्मिको दलित सेवाग्राही र निजहरूले उपयोग गर्ने स्वास्थ्य सेवा लगायतका कार्यको विध्यादर्शाधि अध्ययनका प्रसंगमा अनुसन्धान अध्ययन गर्ने क्रममा विविध दिन प्रकारका क्रियकलापहरूको सर्वेक्षण तथा छलफल गर्न यो अनुमति प्रदान गरीएको छ ।

बोधार्थ
श्री हर्नामाडी स्वा.चौ /हटिया स्वा.चौ /चुरियाभाई स्वा.चौ/ पदमपोखरी स्वा.चौ /बसामाडी स्वा.चौ/ चौघडा स्वा.चौ
श्री नागस्वती श.स्वा.ई/ कमाने श.स्वा.ई/नवलपुर श.स्वा.ई/ज्यामिरे श.स्वा.ई/९ नं श.स्वा.ई/मगुरधाप श.स्वा.ई
आवश्यक सहयोग गरिदिनु हुन

भीमप्रसाद तिमल्सिना
प्रवन्धक
सामाजिक विकास महाशाखा

Appendix 12 Participant information sheet for Survey

Bournemouth University

जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धि अध्ययन, मकवानपुर जिल्ला, नेपाल
सर्वेक्षणमा सहभागीताकोलागी सूचनापत्र

नमस्कार! मेरो नाम रक्षा थापा हो। म बेलायतस्थित, बोर्नमाउथ युनिभर्सिटीमा पीएचडी अध्ययनको क्रममा जातिका आधारमा दलित समुदायप्रति स्वास्थ्य सेवामा गरिने भेदभावसम्बन्धी अध्ययन गर्दैछु। तपाईलाई अनुसन्धानमा सहभागी हुन अनुरोध छ। कृपया यस जानकारीलाई सावधानीपूर्वक पढ्नुहोस र चाहनुहुन्छ भने अरूसँग छलफल गर्नुहोस्। यदि कुनै कुरा स्पष्ट छैन वा यदी थप जानकारी चाहनुहुन्छ भने कृपया मलाई सोध्नुहोला।

यस अनुसन्धानको उद्देश्य के हो?
यस अध्ययनले मकवानपुर जिल्लामा स्वास्थ्य पहुँच र सेवा उपयोगमा जातीय भेदभावको अनुसन्धान गर्नेछ। हामी दलितहरुको स्वास्थ्य सेवा उपभोगको अनुभव र चुनौतीहरू, स्वास्थ्य कार्यकर्ताहरुको दलित सेवा प्रयोगकर्ताहरूप्रतिको दृष्टिकोण तथा यस्तै अन्य समस्याहरु बुझ्न चाहन्छौं। तपाईलाई स्थानीय स्वास्थ्य कार्यकर्ताका रुपमा यस अनुसन्धानमा भाग लिन आमन्त्रित गरिएको हो।

के मैले भाग लिनु पर्छ?
भाग लिने कि नलिने निर्णय तपाईको हो। यदि तपाईले भाग लिने निर्णय गर्नुहुन्छ भने, यो सूचना पत्र दिइनेछ र सहभागी सहमति फारममा सही गर्न अनुरोध गरिनेछ। तपाई बिनाकारण कुनै पनि समयमा अनुसन्धानमा आफ्नो सहभागिता स्थगित सक्नुहुन्छ। यदी तपाईले आफ्नो सहभागिता स्थगित गर्ने निर्णय गरेमा तपाईको पहिचान गर्न सकिने जानकारी हटाइने छ।

सहभागिता कस्तो हुनेछ?
यस सर्वेक्षण पूरा गर्नको लागि ४५ मिनेटजति लाग्नेछ। तपाईलाई दलित समुदायमा रहेको स्वास्थ्य भेदभावका कारणहरु, त्यसप्रती तपाईको दृष्टिकोण तथा स्वास्थ्य सेवा उपयोगमा चुनौतीहरूप्रति तपाईको धारणा अभिव्यक्त गर्न अनुरोध गरिन्छ। कुनैपनि जवाफ सही वा गलत भन्ने छैन त्यसैले नहिचकिचाई जवाफ दिनुहोस्।

भाग लिदा हुने फाइदाहरू र सम्भावित बेफाइदाहरू के के हुन्?
केही व्यक्तिहरू आफ्नो अनुभव बाड्न रुचाउछन्, साथै यस अनुसन्धानले स्वास्थ्य सेवाको प्रयोग गर्दा जातिमा आधारित स्वास्थ्य भेदभावलाई अध्ययन गर्न र दलित समुदायको स्वास्थ्य सेवा उपयोग गर्दाको अनुभव तथा चुनौतीलाई बुझ्न सहयोग गर्छ भन्ने आशा छ। यस छलफलमा भाग लिदा हुनसक्ने बेफाइदा निकै न्यून छ। कुनै बिशेष प्रश्नले तपाईलाई असहज बनाउन सक्छ तर यस सर्वेक्षण गोप्य हुने हुनाले तपाईलाई पहिचान गर्न सकिदैन त्यसैले नहिचकिचाई जवाफ दिनुहोस्।

मबाट कस्तो जानकारी चाहनुहुन्छ र अनुसन्धानका उद्देश्यहरू प्राप्त गर्न यस जानकारी किन प्रासंगिक छ?
हामी तपाईको अनुभव, स्वास्थ्य कार्यकर्ताका रुपमा देखिएका समस्या र चुनौतीहरू, स्वास्थ्य क्षेत्रमा रहेको भेदभाव सम्बन्धी जानकारी संकलन गर्नेछौं। यस जानकारीहरु सान्दर्भिक छ किनभने यसले दलितहरुले दिनहुँ भोग्नुपर्ने जातीय भेदभाव, रोजगारीमा भेदभावका साथै समाजमा दलितहरुको स्थिति र त्यसले उनीहरूको स्वास्थ्यमा पर्ने प्रभाव पहिचान गर्न सहयोग गर्छ। हामी प्रत्येक सहभागीको सामाजिक-आर्थिक र जनसांख्यिकीय जानकारी पनि संकलन गर्नेछौं।

मेरो जानकारी कसरी राखिनेछ?
अनुसन्धानका सबै जानकारीहरु बेलायतको सूचना संरक्षण ऐन अनुसार गोप्य राखिनेछ। अनुसन्धान विश्वविद्यालयको मुख्य कार्य हो जुन सार्वजनिक रुचिमा गरिन्छ। बोर्नमाउथ युनिभर्सिटी (बीयू) सूचना नियन्त्रकको रुपमा संकलित जानकारीको सुरक्षा र उपयोगको जिम्मेवार हुनेछ। बीयूको गोपनीयता सूचनाले सूचना संरक्षण ऐन अनुसार हाम्रो जिम्मेवारी र तपाईहरुको अधिकारको थप जानकारी दिन्छ। हामी तपाईलाई गोपनीयता सूचना पढ्न र बुझ्न अनुरोध गर्छौं।

प्रकाशन
कुनै पनि रिपोर्ट वा प्रकाशनहरूमा तपाईलाई पहिचान गर्न सकिनेछैन।

सुरक्षा र पहुँच नियन्त्रण
संकलन गरिएको जानकारी गोप्य र सुरक्षित राखिनुका साथै पासवर्ड सुरक्षित गरी कम्प्युटरमा राखिनेछ।

व्यक्तिगत जानकारीको साझेदारी र थप प्रयोग
तपाईले प्रदान गर्नुभएको अज्ञात बनाइएका जानकारी अनुशन्धानकर्ताले भविष्यमा अन्य अध्ययन, प्रकाशन, रिपोर्ट वा प्रस्तुतीकरणमा प्रयोग गर्न सक्नेछन्। अध्ययनको दौरान संकलन गरिएको अज्ञात बनाइएका जानकारीहरु बीयू को डेटा भण्डारमा असीमित अवधिको लागि राखिन्छ र जुन सार्वजनिक रूपमा उपलब्ध हुनेछ।

थप जानकारीको लागि सम्पर्क गर्नुहोस्:
रक्षा थापा, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६२०५१; इमेल: rthapa@bournemouth.ac.uk

डा. प्रमोद रेग्मी, स्वास्थ्य तथा सामाजिक बिज्ञान संकाय,बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायत,
टेलिफोन: +४४१२०२९६३०२५; इमेल: pregmi@bournemouth.ac.uk

श्रीमान् राम चन्द्र सिलवाल, देश निर्देशक, ग्रीन तारा नेपाल, +९७७-१-४४३२६९८; इमेल: info@greentara.org.np

अध्ययनको बारेमा कुनै पनि गुनासो भए निम्न ठेगानामा सम्पर्क गर्नुहोस्:
प्रो. भनोरा हण्डली, सहायक डीन, अनुसन्धान तथा व्यावसायिक अभ्यास, बोर्नमाउथ युनिभर्सिटी, बोर्नमाउथ, बेलायेत,
टेलिफोन: +४४१२०२९६५२०६, इमेल: researchgovernance@bournemouth.ac.uk

यस अनुसन्धानमा भाग लिएर सहयोग गर्नु भएकोमा धन्यवाद।

Appendix 13 Ethical approval letter from BU

Bournemouth University

Research Ethics Checklist

About Your Checklist	
Ethics ID	22373
Date Created	27/09/2018 15:50:23
Status	Approved
Date Approved	22/07/2019 09:14:14
Date Submitted	04/07/2019 17:46:19
Risk	High

Researcher Details	
Name	Raksha Thapa
Faculty	Faculty of Health & Social Sciences
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, EngD, EdD)
Course	Postgraduate Research - HSS
Have you received funding to support this research project?	No

Project Details	
Title	Caste Exclusion and Health Discrimination in Makwanpur District, Nepal
Start Date of Project	16/04/2018
End Date of Project	16/04/2022
Proposed Start Date of Data Collection	31/12/2019
Original Supervisor	Pramod Regmi
Approver	Research Ethics Panel

Summary - no more than 600 words (including detail on background methodology, sample, outcomes, etc.)

Background:

Studies on health service utilisation usually focus on limitations of physical factors (such as travel distance to facility), lack of medical facilities, resources (such as lack of service providers, lack of appropriately trained staff or electricity). This research will highlight caste aspect of health discrimination.

Discrimination impacts upon the wider determinate of health such as education, work, income, housing, as well as other social and environmental determinants. Caste based discrimination is a highly sensitive issue and a major barrier in achieving health equity in Nepal and to explore caste discrimination it is important to understand the caste system and identification of 'Dalits'. In Hindu caste system there are four division of caste namely 'Brahmins', priests, 'Kshetriyas', warriors, 'Vaishyas', merchants, and 'Sudras' servants. Underneath these castes the lowest (outcaste) groups is the Dalits, also known as untouchables.

Despite legislation banning the caste system in Nepal, discrimination in accessing health services still continues due to a general lack of

Appendix 14 Ethics approval letter from NHRC

Government of Nepal
Nepal Health Research Council (NHRC)
Estd. 1991

Ref. No.: 325

4 August 2019

Ms. Raksha Thapa
Principal Investigator
Bournemouth University
United Kingdom

Ref: **Approval of thesis proposal** entitled **Inequalities in health care services in Dalit communities of Makwanpur district, Nepal**

Dear Ms. Thapa,

It is my pleasure to inform you that the above-mentioned proposal submitted on **23 May 2019** (**Reg. no. 332/2019)** please use this Reg. No. during further correspondence) has been approved by Nepal Health Research Council (NHRC) Ethical Review Board on **24 July 2019**.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol. Expiration date of this proposal is **April 2022.**

If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission. The researchers will not be allowed to ship any raw/crude human biomaterial outside the country; only extracted and amplified samples can be taken to labs outside of Nepal for further study, as per the protocol submitted and approved by the NHRC. The remaining samples of the lab should be destroyed as per standard operating procedure, the process documented, and the NHRC informed.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their project proposal and **submit progress report in between and full or summary report upon completion.**

As per your thesis proposal, the total research amount is **Self-Funded** and accordingly the processing fee amounts to **Rs 10,000.** It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please contact the Ethical Review M & E Section at NHRC.

Thanking you,

Prof. Dr. Anjani Kumar Jha
Executive Chairperson

Tel: +977 1 4254220, Fax: +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.gov.np, E-mail: nhrc@nhrc.gov.np

Appendix 15 Research permission in Makwanpur District

प्रदेश सरकार
सामाजिक विकास मन्त्रालय
स्वास्थ्य निर्देशनालय

स्वास्थ्य कार्यालय मकवानपुर

प्रदेश न.३, हेटौडा, नेपाल

०५७-५२०७१८
Email:dho.makawanpur1@gmail.co

पत्र संख्या : २०७५/०७६
चलानी नं : ४६६

मिति : २०७६/ ०१/२२

बिषय : सिफारिस सम्बन्धमा ।

प्रस्तुत विषयमा "Bournemouth University.UK" मा अध्ययनरत PHD का विधार्थी श्री रक्षा थापाले यस जिल्ला अन्तर्गत "Caste- based inequality in healthcare focusing on Dalit Communities" in Makawanpur, Nepal. विषयमा अध्ययन सोध कार्य गर्न नेपाल स्वास्थ्य अनुसन्धान परिषदबाट स्वीकृति लिने प्रयोजनको लागि निजले यस कार्यालयमा सिफारिस पाउँ भनि दिनु भएको निवेदन अनुसार सिफारिस गरिएको छ ।

२०७६/०१/२२

शशिकान्त सिंह
प्रमुख
स्वास्थ्य कार्यालय मकवानपुर