Social Exclusion in Maternal and Child Health Services: A Case Study of a Government Hospital in Delhi

Thesis submitted to Jawaharlal Nehru University in partial fulfilment of the requirements for the award of the degree of

DOCTOR OF PHILOSOPHY

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CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH

SCHOOL OF SOCIAL SCIENCES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI-110067

INDIA

2022

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my Inspiration!

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Enrolment No	**06/64/MS/016**
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Date of Submission	**23/05/2022**
Name of Degree	**Doctor of Philosophy**
Subject Key Word	**Social Exclusion**
Coverage (for time periods or spatial regions only)	**Not Applicable**
Language of thesis	**English**
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Acknowledgement

The study would never be complete unless some people are duly acknowledged, who have helped me to complete the entire study.

I am deeply thankful to my research guide Professor Sanghmitra S Acharya, who guided me with her valuable guidance and constant support. Her passionate and patient engagement with my piece of research helped me to complete my research work. This thesis would not have been possible without the encouragement, insightful discussions, and comments that she provided on the drafts.

I express my sincere gratitude to my family for providing me with the strength and support in every hour of need. Their cooperation at the final stage of this dissertation leaves me with no words to express my heartiest gratitude.

All the staff members of CSMCH Office and Documentation Centre; and my dear friends deserve to be specially thanked for the kind support that they extended throughout this dissertation. Finally, the participants of the study who cooperated patiently and supplied me with much-needed information to complete the thesis.

I have tried to analyze the gathered empirical evidence to the best of my ability. The omissions, if any may please be treated as mine.

Sonali Sahni

Abbreviations

ANC- Antenatal Care

ANM- Auxiliary Nurse Midwife

ASHA- Accredited Social Health Activist

AWW Anganwadi Worker

B-SEM- Bristol Social Exclusion Matrix

CASE-Centre for the Analysis of Social Exclusion

CDC- Centre for Disease Control

CHC- Community Health Centre

CGP-Commissariat General au Plan

Covid-Coronavirus Disease 2019

CSDH-Commission on the Social Determinants of health KN-Knowledge Network

CUPSE-Community Understanding of Poverty and Social Exclusion Survey

DDU- Deen Dayal Upadhayay Hospital

EC-European Community

EU-European Union

HDR-Human Development Report

HMIS - Health Management Information System

ICPD- International Conference on Population and Development

ICU- Intensive Care Unit

IFA- Iron Folic Acid

ILO-International labour Organization

IUD- Intrauterine devices

HT- Hindustan Times

Kms-Kilometres

LDC-Less Developed Countries

LHW-Lady Health Worker

LNJP- Lady Harding Hospital

MERS- Middle East respiratory syndrome

MDG-Millennium development goals

MMR- Maternal Mortality Ratio

MUD-Moral underclass discourse

NGO-Non-Government Organization

NHM-National Health Mission

OBC-Other Backward Classes

Outpatient Department (OPD)

PHC-Primary Health Care

RED-redistributive discourse

RMNCH+A Reproductive-Maternal- Neonatal-Child and Adolescent Health

SARI- Severe acute respiratory illness

SARS-CoV-2- severe acute respiratory syndrome corona virus 2

SC-Schedule Caste

SID- Social Integration Discourse

SDH-Social Determinants of health

SEKN-Social Exclusion Knowledge Network

SEU-Social Exclusion Unit

SRS-Sample Registration System

ST- Schedule Tribe

UNDP-United Nations Development Programme

UHC-Universal Health Coverage

UP-Uttar Pradesh

UK-United Kingdom

UN-United Nation

US-United States

VHW- Village Health Worker

WHO-World Health Organisation

Chapter One

EXPLORING THE "CAUSES OF THE CAUSE" OF HEALTH INEQUITIES: AN INTRODUCTION TO SOCIAL EXCLUSION

"Social life is played out within a framework of relationship in which people seek inclusion and belongingness" (Dominic Abrams, 2005).

In the final report titled "Closing the gap in a generation: health equity through action on the social determinants of health" by the World Health Organization's Commission on Social determinants of health in 2008 emphasized action on social determinants of health as a requirement to address the inequities in health and the avoidable health inequalities. The approach to social determinants of health relies on the life course circumstances as well as the response of the system to the illness.

[Existences] of differences in health gets determined by one position of social disadvantages [across the globe]. People's survival and death are shaped by the [interplay] of social forces-socio, economic, and political. Thus, the policy level decisions [play a key role] in determining [and impacting] the circumstances that shape the [chances] of an Individual's survival and development to its fullest potential.

. The report quotes "A girl born today can expect to live for more than 80 years if she is born in some countries – but less than 45 years if she is born in other countries" (WHO 2008).

In this context, country examples explain the living chances of the individual if born in one country vis-à-vis another country or between rich and poor countries. Thus, growing inequities and health inequalities in any contextual reality are bound to shape the chances of health and ill-health of the individuals residing.

Social Stratification is the basis of structural inequality in the social system. Based on a certain individual's or group's social position within the social hierarchy, there exists differential access to social rewards.

Equality and inequality are dimensional terms. Kunst & Mackenbash (2012) have defined health inequalities as: "*Differences in the prevalence or incidence of health problems between individual people of health and lower social orde*r." Although the definition uses the term individuals it becomes more meaningful when it gets linked to the socioeconomic status.

Inequities in health exist in all societies. The social position of an individual based on socioeconomic characteristics determines and shapes their health status and access to health services. The WHO report on Poverty, social exclusion, and health systems in the WHO European Region (WHO 2010) refers to Poverty and Social exclusion as the "*Driving forces of health inequities for millions of people across the 53 Member States of the European regions*". (WHO 2010).

According to the World Health Organisation's Commission on Social Determinants of Health's final report in 2008 "The unequal distribution of income, goods, services and [resultant] chance of leading a flourishing life causes health inequality. [Such inequalities] are often in the interest of the rich and powerful minority over a disempowered majority (WHO 2008).

Social gradient in health affects the people in rich and poor countries alike. As a result, a total of forty percent of the world's population lives on US dollars $ two per day or less than that. Social structures and processes [rooted] deep in the [society] shape the inequities in the conditions of daily living. [Factors triggering] systemic inequities [include] tolerant policies, practices and norms that [let] the unfair distribution of and access to power, wealth, and other necessary social resources [sustain].

In access to health, poverty is an important determinant" (Zurbrigg 1984). Poverty evolves the different health cultures and affects the [people's] perception of illness as well as their utilization of care. Although health inequities are the determining feature of poverty. Within the notion of poverty, income poverty provides a limited discourse on the disadvantages faced due to exclusion from opportunities and common services enjoyed by others. Thus, the notion of social exclusion offers a broader domain of poverty analysis (Sen 2000). Thus, Social exclusion moves beyond poverty and explains the background causes of failure to access the possibilities and benefits offered by the society.

The aspect of the social identity of the individual or a group provides a determining factor in shaping the chances of access to social rewards. In our daily lives, it is our social status that determines almost every aspect of our lives including access to the hospital. To be excluded from the common facilities refers to having an adverse impact on an individual's life. Thus, [Acting] as a bridge over the concept of poverty, social exclusion highlights inequalities in the distribution of deprivation of the poor, whereas, under the focus remains on absolute levels of deprivation, inequality under the concept of poverty scope (WHO 2008).

The Indian society is characterized by a unique hierarchical caste system that decides not only the social status. It also defines "*who enjoys rights and privileges*" as against the "others" who are marginalized and socially excluded in all the spheres of their lives. Thus, such communities of Schedule Caste (SC), Schedule Tribe (ST), and Other Backward Classes (OBC) are historically minority groups thus marginalized and socially excluded. The greater poverty of socially excluded groups, the greater it translates into poor health outcomes particularly. Exclusion based on caste in health varies in different forms such as complete exclusion, partial exclusion, or selective inclusion of certain social groups in health care access. Here, the aspect of gender inequality is another determinant that further shapes differential access to health services.

Given the above backdrop, it becomes imperative to examine the vulnerable social position of the urban poor women belonging to low caste in Delhi, who are surviving poverty in the urban setting and bearing gender inequality in all the spheres of their lives. They undergo exclusionary processes due to the intersectionality of poverty, caste, and gender resulting in further health inequity between them as "others" and the mainstream population. Thus, the intersection of gender and economic deprivation causes multiple disadvantages for women from poor households. These disadvantages further impact all spheres of their lives including maternal health. Not many studies have examined the aspect of maternal health on the axis of social exclusion among the urban poor care seekers when they access a government hospital in Delhi. The study provides an insight into the forms, spheres, and providers' perspectives at the hospital as well as the attitude perception practices among the care users.

1.1 Research Questions:

- What are the common attitudes, perceptions, practices, and contextual factors leading to social exclusion?
- What are the social determinants of exclusion, and how do they impact health?
- How does social exclusion affect the lives of women, especially their health?
- What are the spheres, forms, and providers' perspectives on social exclusion faced by the urban poor women in a government hospital when they seek maternal health care MCH) services?
- What is the impact of the interaction between the dynamic social forces of caste, class, and gender on the exclusionary processes in access to health especially MCH?

- What are the pathway linkages between social exclusion and health inequity and how does it affect the Health System?

The primary goal of this study is to examine the forms, spheres, and perspectives leading to social exclusion to understand the exclusionary processes faced by the urban poor women in a government hospital with maternal health care needs.

1.2 Objectives of the study:

- To understand the exclusionary processes faced by the urban poor women in a government hospital with maternal health care needs by examining the spheres, forms, and provider's perspective leading to social exclusion.
- To analyze within the contextual realities, the attitudes, perceptions, and practices leading to social exclusion and its impact on the general lives of the women.
- To explore the social determinants of exclusion and its impact on health aimed at reversing exclusionary processes, evaluating the impact of policies and actions with the potential to reverse exclusionary processes, promoting equal and full inclusion and greater social cohesion.
- To examine the impact of the dynamic interaction of social forces like caste, class and gender in driving the exclusionary processes.
- To study the pathway linkages between social exclusion and health inequity, also between social exclusion and health system, evaluating the impact of policies and actions with the potential to reverse exclusionary processes, promoting equal and full inclusion and greater social cohesion.

1.3 Study Methodology

The scope of the study includes urban poor married women belonging to the age group of 18 - 45 years, who were either pregnant at the time of the interview or had delivered within the last two years. The study is based on the responses from the care users' visiting Deen Dayal Upadhayay hospital (DDU), which is one of the leading general government hospitals located in West Delhi. The purposive sampling method was done to select the care users visiting the hospitals by conducting exit interviews, snowball sampling and nonparticipant observation were conducted to gather responses from the woman in the community who had delivered in the last two years. Due to Covid 19 and associated lockdown and restrictions, DDU hospital

had turned into a Covid facility in 2020 and the care users were diverted from the CHC to other non-Covid hospitals in Delhi. At this period, responses were gathered from the care users approaching one connected CHC located in Naraina Vihar. Responses were collected through exit interviews. Further, through snowball sampling over the phone, telephonic interviews were conducted to gather responses from the care users approaching alternate government hospitals and private clinics, and private hospitals in Delhi.

The scope also consists of healthcare providers such as doctors, nurses, and other professionals who have direct interaction with maternal healthcare needs. Among the health care providers, the method of sampling has been purposive. In the Covid times, the response from health care providers in other non-covid hospitals has also been taken through snowball sampling (Conducting interviews telephonically through interview schedule). The study is ethnographic in nature. In-depth interviews were conducted with 18 care Dalit users of different age, occupation, nature of stay and place of stay in Delhi.

1.4 Profile of Study area

The National capital of India, Delhi has eleven administrative districts. Delhi inhabits a large population of urban poor who reside in the urban poor habitats such as slums unauthorized resettlement colonies, *jhuggi jhopri* clusters, and urban villages. In the West Delhi district, Deen Dayal Upadhyay Hospital is a government hospital located in the Hari Nagar area of West Delhi. It is one of the major government hospitals that cater to the health needs of the urban poor population located in Hari Nagar and its surrounding areas such as Tilak Nagar, Janak Puri, Vikas Puri, Uttam Nagar, Dwarka, Dabri, and Maya Puri and Naraina Village etc.

The urban poor women in Naraina village at first contact or visit the Maternal and Child Health Centre situated in the same area. There are no government hospitals for delivery or emergencies in Naraina, therefore the patients are either referred to or voluntarily approach Deen Dayal Upadhyay Hospital (DDU) as the nearest hospital situated around 8 km from Naraina in Hari Nagar. During the pandemic DDU hospital was turned into Covid hospital, thus patients were referred to other government hospitals such as LNJP Lady Harding Hospital and Patel Hospital located in Delhi. There is no government hospital in the area. In 2015 government-run maternity home attached to the CHC was closed due to weak infrastructure and lack of capacity to handle complicated deliveries. The nearby government hospital located at a distance of 4.9

kilometres became the major referral hospital to provide maternal care and delivery. The area has a large influx of migrant population – given its residential and industrial/factories set up. In the urban village of Naraina, there are many communities living in this village but the dominant community is 'Raya Tanwar' a Rajput community comprising mostly of landlords, whereas the migrant urban poor population resides as tenants renting outside the mainstream residential area in single rooms of multi-story buildings in the urban village whereas some of the urban poor live in camp clusters located near the industries, whereas others reside in slums and on pavements of the railway line.

1.5 Profile of Urban Poor Women Care Seekers

Urban poor population group is a heterogeneous group of individuals differentiated from the mainstream based on their socioeconomic position in the society. The study focuses on the urban poor women care seekers living in west Delhi, who were pregnant or had delivered in the last one or two years in a government hospital in Delhi. The study also includes married women within the age group of 15 to 45, belonging Schedule Caste and Other Backward Class categories. They have migrated from UP and Bihar and other parts of India in search of better livelihood options in Delhi. Their nature of stay in Delhi is as migrants (first, second or third generation) comprising of lower-income households working mainly as daily wage earners (laborer, construction worker, domestic worker, factory worker, etc). Due to limited means of income in the informal sector, the urban poor women reside at the margins of the city such as resettlement colonies, slums, camps, railway lines, under the metro train pillars, footpaths, and pavements.

Table 1.1:

Profile of Study Participants approaching from resettlement colonies/villages

Variables	Options	Status
Education	Illiterate or Literate	Ranges from no education to 8th or 10th grade
Occupation	Working or Non Working	• Domestic workers • Factory worker s • Construction workers
Husband's Occupation	Working or Not working	Street vendors Factory workers Rickshaw/auto/taxi drivers
Parity of Children	One, two , three or four	Ranges from one to two children
Residency Status	Native, Migrant (1st, 2nd or 3rd Generation)	Migrants 1st and 2nd Generation
Type of Household	Nuclear or Joint	Nuclear
House Set Up	Own or Rented	Rented in one room

Source: Fieldwork data

Table 1.2

Profile of Study Participants approaching slums, camps and streets.

Variables	Options	Status
Education	Illiterate or Literate	None t o primary level
Occupation	Working or Non Working	Street vendors Running stalls outside of their slum Domestic worker Labourer
Husband's Occupation	Working or Not working	Rickshaw puller, factory worker, helpers
Parity of Childbirth	One, two , three or four	Ranges from one to two children
Residency Status	Native, Migrant (1st, 2nd or 3rd Generation)	2nd Generation
Type of Household	Nuclear or Joint	Nuclear
House Set Up	Own or Rented	-

Source: Fieldwork data

1.6 Limitations of the Study

In the hospital setting, the realization of the existence of social exclusion among the care seekers takes a back seat as the evident immediate factors become a priority for the care seekers to resolve in order to get the care they are seeking for.

Immediate and evident challenges that surface at the hospital level such as long waiting hours in the queue, inability to meet the doctor, inability to get medicines, and bed allotment appear to be the normal challenges of a government hospital. For example: one respondent staed, "*Yeh toh sarkari hai, yahan to aisa hi hai*" [*this is a government facility, this is what happens here*]. Thus, the mere perception of the government hospital makes the very existence of social exclusion as a disguised reality'. Thus, social exclusion occurs as a camouflaged reality.

On an often basis, due to paucity of time, limited money for transportation to reach the hospital, and urgency to return home due to informal work or childcare responsibilities, a majority of the care seekers were reluctant to share their lived experiences of social exclusion in the hospital as they felt such treatment is evident in a majority of government hospitals, thus it was a form of normal reality. Secondly, the concept of social exclusion is a policy-level concept and it was hard for the care seekers to understand the context in one go. Discrimination to an extent was used as the word to make them understand what they faced in the hospital sphere. Thus, given the complicated nature of the concept of social exclusion that delves into the background factors to the reality, the care seekers could not connect much.

Further, from the provider's perspective- even if the provider is liberal in approach, s/he may not follow an inclusive approach with the patients, if the immediate and larger system is a follower of the exclusionary processes. This can be understood as the Social Desirability bias- which means a mismatch between attitude and outcome. Provider following exclusionary processes may not reveal or share the same in the interview or refer to it as someone else's experience. This is similar to the case of care seekers too.

Another limitation faced during the study was Covid 19 associated lockdown scenario, which restricted in-person interviews and most interviews were conducted through phone versus face-to-face interviews. A phone interview may have limitations to find the exact perspective of the provider and caregiver.

Chapter Two

SOCIAL EXCLUSION: CONCEPTUALIZATION AND MEASUREMENT

2.1 Genesis of Concept of Social Exclusion

Social Exclusion is a loaded concept, having multiple dimensions, having a dynamic and relative nature. Else Oyen (1997) defines "*Social Exclusion' as an umbrella concept*." Hills et al (2002), *explain that "the element of any unified theory of social exclusion is '*contested'". (Sen A. 2000).

In modern usage, Rene Lenior (1974) of France articulated the concept first. The term 'Les exclude (the excluded or the outcaste) denoted the people administratively excluded by the state or from social protection.

Rene Lenior defined the excluded as: *"Those who were excluded from the welfare state and were considered as socially misfits".*

"The *socially excluded' included the mentally and physically handicapped, suicidal people, aged, invalids, abused children, substance abusers, delinquents, single parents, multi-problem households, marginal, asocial persons, and other social misfits"* (Mathieson et. al. 2008).

With globalization in the seventies and eighties, the term extended the initial definition to include a rise in long-term and recurrent unemployment, as well as growing instability in social relations. Exclusion due to employment was not limited to exclusion from income only. It also extended to include exclusions from participation in the normal activities of the society, social networks and self-worth.

According to Silver (1995), the literature says that the people may be excluded on factors like livelihood, secure permanent employment, earning, property, credit, land, housing, education, skills, and cultural capital; the welfare state; citizenship, and legal equality; democratic participation; public goods, the nation or the dominant race; family and sociability; humanity, respect, fulfilment, and understanding (Mathieson et. al. 2008).

Hills et al (2002) elaborate on the agency and fundamental causes of social exclusion and have identified three schools of thought which are fundamental causative of social exclusion. The first school of thought places an individual's behaviour and moral values at the center stage, the second school of thought highlights the role of institutions and systems, and finally, the third school of thought emphasizes on issues of discrimination and lack of enforceable rights (Mathieson et. al. 2008).

The Social Exclusion Knowledge Network (SEKN), is one of nine such networks set up by the WHO's Commission on Social Determinants of Health in 2008 for action on social determinants of health.

Given the contested definitions of the concept of social exclusion, the knowledge network viewed that social exclusion was driven by unequal power relations, it was multi-dimensional and dynamic in nature. The network adopted a relational approach to defining social exclusion. Under the SEKN model, a continuum of inclusion/exclusion gets created by the interplay of the exclusionary processes operating and interacting at different dimensions (social, political, cultural, and economic) and levels (individual, household, group, community, country, regional and global). The interplay of the inclusionary and exclusionary forces affects the distribution of resources, access to capabilities, and rights that creates conditions for a sustainable environment system that goes beyond basic needs and moves towards a cohesive and participatory social system that values diversity, guarantees human rights and peace. (WHO 2008).

2.2 Conceptualizing Social Exclusion

2.2.1 Background of Poverty and deprivation

According to Haan et al (2004) the usage of the term 'social exclusion *"is an attempt to partly bridge the gap between describing and explaining poverty. He explains that exploration of the notion of social exclusion started in wake of the welfare state crisis, with debates around new poverty forms and development studies. Focusing on the subject, An IFS Bulletin in 1998 emphasized the common aspects of the poverty definition (a) It is a multi-dimensional phenomenon, (b) the institutions and processes that lead to poverty cause and reproduce deprivation*" (Mathieson et. al. 2008).

2.2.2 Capability approach

Amartya Sen in the paper 'Social Exclusion: Concept, Application, and Scrutiny (2000)' emphasizes the significance of the concept of "Social Exclusion". He views the concept of social exclusion from a capability perspective. The capability approach links the concept of social exclusion with the notion of poverty and deprivation. He emphasizes the importance of studying social exclusion as an approach to poverty where social exclusion is viewed from a general perspective of poverty which is capability failure and also other related concepts such as capability poverty, capability deprivation, capability failure, and limited living

opportunities. Constructively, social exclusion can be a part of capability deprivation, whereas it can be a cause of diverse capability failure instrumentally.

2.2.3 Basic rights and Human Development framework

UNDP Human Development Report (HDR) (2000) emphasized "a close linking of rights with development. In addition, it highlights freedom from discrimination as a pre-condition for human development. Further, it links equal opportunities and choices to the core pillar he human development. The outcome of development is not only income expansion but the achievement of quality of people's well-being. Denial of rights, opportunities, or choices is human deprivation of the disadvantaged groups. The societal processes of exclusion hinder human development through differential treatment and unequal access". (UNDP 2000).

2.2.4 Welfare approach

Appasamy et al (1996) in an International Labour Organization study in India define "*Social Exclusion' in terms of exclusion from few basic welfare rights (WHO 2008).* The study attempts to identify the individuals with no or inadequate access to the dimensions of health, education, housing, water supply, sanitation, and social security as the various determinants of social exclusion".

2.2.5 Participatory framework

The framework focuses on voluntary and involuntary participation. Le Grand (1999) at the Centre for Analysis of Social Exclusion, UK examines voluntary and involuntary Social Exclusion. A Socially Excluded individual is the one who despite being a geographical resident is unable to participate in the society in terms of the citizen's normal activities that s/he would like to do (Burchardt et al, 2002, pp 30, 32) (Levitas R. 1999). Barry (1998) states that, on an often basis, people voluntarily also decide not to participate. This could be based on the decision that such participation is not desired. Example- During the Apartheid regime in South Africa, black did not want to go to 'Whites Only' cities. Barry (Ibid) thus suggests that socially excluded groups are the ones, who are either denied the opportunity to participate whether they actually desire to participate or not (Levitas R. 1999).

2.2.6. Voice and knowledge dimension

Examining the elements of deprivation, Haan et al (2004) in their paper explain how people's participation, in particular voice and knowledge, are important determinants of poverty

analysis. Lack of representation as well as the knowledge of the systems- both political and administrative activities is an element of deprivation.

2.2.7.'Discrimination' perspective

Discrimination is an important determinant of the exclusionary process. Being embedded in the social structures and social relations, discrimination contributes to sustaining deprivation as it gets expressed through conscious and unconscious actions. It also forms and impacts the expectation and behaviour of the discriminated group. Untouchability is a clear expression of discrimination, whereas it exists in different indirect ways in a more subtle and hidden manner. Thus, it requires a careful understanding of the attitudes, beliefs, and corresponding active behaviour toward both the deprived and non-deprived groups.

2.2.8 Relational approach

Social Exclusion Knowledge Network (SEKN) is one of the nine knowledge networks formed under the WHO's Commission on the Social Determinants of Health of 2005. The knowledge network adopted a relational approach to defining social exclusion. The approach focuses on the following:

(a) Wider lens to explore the causes and consequences of unequal power relations.
(b) It focuses on the interaction of different relationships and outcomes at different levels of both active and passive exclusion.
(c) It links exclusion with a right-based approach to the social determinants of health.
(d) It recognizes that exclusionary processes impact different groups and/or societies in different ways, degrees and times.
(e) It recognizes a continuum of inclusion/exclusion where inequitable inclusion, extreme exclusion as well as differential inclusion/exclusion among the different dimensions exists as possible scenarios (Mathieson et. al. 2008).

2.3 The SEKN Model on Social Exclusion

The SEKN model on Social Exclusion (Mathieson et. al. 2008) explains the existence of the exclusionary processes within social systems at different levels.

The model suggests a complex interaction between biology and society and this has a powerful influence on health. Within the social system interactions, a hierarchical system of social

stratification along the lines of caste, class, gender, age, ability, ethnicity, etc gets generated through the relational dimensions of power- social, political, economic, and cultural.

Social stratification causes exposure to different health-damaging circumstances. Further, it reduces the people's capacity to protect themselves from such circumstances. Thus, the exclusionary processes restrict access to health and other services.

2.4 Typology of actors in the exclusionary process under the SEKN Model (Mathieson et. al. 2008) includes the State-led policies/actions, the Role of Community action and NGOs, and action from private sectors and agencies at the multi-lateral levels. Under the State led policies/actions, SEKN focuses on Conditional Cash Transfers (CCT) to incentivize the poor people to adopt socially appropriate behaviour. Under the NGOs and community action, actions are based on autonomous action, community engagement, and direct provisioning of services and other support. SEKN divides Private sector action into service provision and corporate social responsibilities. The Multi-Lateral agencies include global agencies for policy-level intervention and action to potentially reverse the exclusionary process. It also involves the role of state and national government in strengthening the existing policies, and services to meet the needs of the most severely affected groups due to the exclusionary processes.

2.5 SEKN's Recommendations for action on social exclusion

2.5.1 Advantages of the meaning of the concept of social exclusion

The Social Exclusion knowledge network (Mathieson et. al. 2008) informs the importance of the concept of social exclusion. It provides a unique social determinant framework for effective action against health inequalities.

Some key points of focus for the stakeholders (international agencies, national governments, civil societies, and private sector) include:

- To recognize the underlying relationship between social inclusion and human rights.
- Reversing the exclusionary process through action on promotion and protection of human rights and promotion of social cohesion.
- The policy and action framework through the promotion of public debate on the pros and cons of the social exclusion concept.
- Usage of the term 'social exclusion when more accurate descriptors of the targeted phenomena is unavailable. Example- racism or food security.

- Rather than focusing only on conditions experienced by 'socially excluded' groups, the focus is to be on the multi-factorial relational processes that drive the different inclusion and conditions of extreme exclusion.
- Development, implementation, and evaluation of policy and action to attend to all the dimensions of exclusionary processes- social, political, cultural, and economic.
- To be clear with the value added by the concept to understand the target problem and actions.
- Consider the usage of the SEKN conceptual model as a valuable tool to address social exclusion for developing a more comprehensive policy, action, and evaluation framework.

2.5.2 The primacy of universal rights and full and equal Inclusion

The SEKN model (Mathieson et. al. 2008) discusses that the policies and actions aimed at reversing exclusionary processes should be to focus on:

- Aiming at reversing the exclusionary processes, the policies and action should:
- Focus on the promotion on equal and full inclusion in social systems.
- Provide all the members of the society, access to universal and socially acceptable living standards.
- Provide access to health, education, safe water, cultural diversity and 'decent work' as defined by ILO as promoting opportunities for women and men to obtain decent and productive work, in conditions of freedom, equality, security, and human dignity (IILO, 1999a, p. 3).
- To address action on forms of social exclusion such as unequal inclusion and extreme exclusion

2.5.3 Responsibility of the State

The SEKN model (Mathieson et. al. 2008) discusses the primary responsibility of the State to reverse the exclusionary processes by

- Protection of Human rights
- Provisioning of universal healthcare, education, and social protection
- Accountability and transparency of the political and legal systems
- Promotion of full and equal inclusion of all groups and with respect to cultural diversity.

- Resistance to any action or influence from the international agency to avoid widening the exclusionary process.
- Promotion and support of community empowerment activities.
- empowerment through promotion and support.

2.5.4 Social movements and community empowerment

These are crucial for full and equal inclusion and to reverse exclusionary processes.

The state plays an important role to regulate action against social movements that are not with positive force. However, it can inadvertently undermine the action of civil society and other stakeholders.

To harness the full potential of the social movements and community involvement with participation and empowerment, civil society, and national and international organizations are required to create and maintain conditions of [greater] accountability, transparency, and participation in the political and legal systems. (Mathieson et. al. 2008).

2.5.5 The role of multilateral agencies and donor agencies

They are major contributors to reversing exclusionary processes by promoting full and equal inclusion for all social groups and respecting cultural diversity. However, these same actors drive the powerful exclusionary forces. Thus, a minimum requirement of such agencies is to ensure their policies and action 'do the poor no harm'. They must develop ways of assessing the exclusionary/inclusionary impact of their own policies and actions, and those of others, and acting on the results. Thirdly, they take action to reverse exclusionary processes and promote positive inclusion through positive action. (Mathieson et. al. 2008).

2.5.6 The limitations of targeting and conditionality

The limitations of targeting and conditionality inform about the potential of such an act to stigmatize and disempower [the beneficiaries]. It has the potential to exacerbate and reproduce exclusionary processes and inequities. Thus, in the policy discourse conditionality should build social cohesion guarantee human rights, universal access to essential services, and socially acceptable living standards. Further, it should be less stigmatizing, it should be located at the level of communities and groups to promote local participation. (Mathieson et. al. 2008).

2.5.7 The limitations of insurance-based approaches

Providing an important funding mechanism, the National Social Insurance system supports a universal and comprehensive welfare system that is free at the point of use. Such means-tested subsidized insurance has private sector involvement. They get promoted by the [governing bodies] government, non-government and international organizations as a way to protect against the risks experienced by people most severely affected by exclusionary processes (Mathieson et. al. 2008).

2.5.8 The need for policy/action co-ordination

Due to the complexity and multidimensional nature of exclusionary processes, the responses to the policy/action require coordination at all levels of the government departments and sectors. Thus, there is a need for initiatives that aim to support greater coordination across sectors and actors (Mathieson et. al. 2008).

2.5.9 The role of the private sector

Under the SEKN model, the role of the private sector is not seen in reversing exclusionary processes but it stressed that this sector does the provisioning essential services. However, a majority of the social corporate responsibility (CSR) initiatives are voluntary in nature, having a relatively modest reach. Such CSR initiatives are philanthropic values-based and they have a tendency to reinforce the exclusionary processes through paternalistic attitudes and discrimination. Thus, the private sector must abide by the national and international legislation, they must publish their gains [to allow responsive accountability].

2.5.10 Measurement, monitoring, and evaluation

Systems to support policy and action development, implementation and evaluation should include:

- Dynamics of the exclusionary processes
- The indicators to be inclusive of objective and subjective, to incorporate both qualitative and quantitative data
- Data and stories to be inclusive of the different dimensions of the exclusionary processes.
- Evidence-based impact on the health status and health inequalities by the exclusionary processes.

- Policy and Action to give attention to the factors and outcome of the implementation in its evaluation.

Analysis

The strength of the Social Exclusion knowledge network lies in its holistic analysis of the concept of social exclusion. It has also been successful in bringing into light the role of the state that has been missed by other knowledge networks. It has also been able to incorporate learnings from the other knowledge networks such as globalization knowledge networks, employment knowledge networks, and health system knowledge networks in its final report. The model suggested brings out the dynamics of social, cultural, economic, and political dimensions with the caste, class, gender, and race variables.

Shortcoming

- The network talks about the positive role of the private sector in dealing with the problem of exclusion. The causal factor bringing marginalization of the working force in the employment sector is due to redundancy to the public sector by the private sector. The network does not focus on strengthening the much-needed public sector but on the other hand, seeks to discover ways such as privatization causing exclusion can also be useful in some form.
- Question of redistribution of resources needs more attention from the network and it needs to focus on the prominent role of the state in achieving social justice.
- The network explains the dynamics of the social, economic, political, and cultural dimensions and the impact on the caste, class, gender, and race factors leading to differential consequences and vulnerabilities in the context of health outcomes. What the network misses is a discussion on how the variables like caste, class, and, gender interact and impact each other with the changes in the outer environment and its resultant impact on health. Also, there is a need to focus on the systemic approach to find the linkages between social exclusion and the health system.

Specific conceptual layout

The conceptual framework for the study is built on the above-listed major recommendations of the Social Exclusion Knowledge Network. The pathway linkages between exclusion and health contribute to ill-health. Under the constitutive pathway, the restriction on participation in socio-

economic, political, and cultural relations negatively impacts health and well-being. Whereas, under the Instrumental pathway, these restrictions further cause deprivations such as poor working conditions, and exclusion from paid work causing low or no source of income. This further has an impact on the nutritional intake of food, as the ability to afford gets adversely impacted. It once again causes ill-health. Further, the conceptual framework also includes measures to overcome the listed shortcomings of the Social Exclusion Knowledge Network i.e., by focusing on contextual factors to understand the exclusion process, explaining how the variables like caste, class, and gender interact and their impact on health, etc.

Chapter Three

DECODING SOCIAL EXCLUSION IN HEALTH

Social Exclusion is a dynamic term with contested definitions. The existence of social exclusion is relational, occurring as a "state", "process" or a combination of both depending on the contextual realities of the interplay of the social factors. Being dynamic and relational in nature, the measurement of social exclusion too is complex. Thus, countries across the world have used the term in a tailored fashion and revised it over a period of time. Given the varied existence of the terminology and its usage, below are certain concrete highlights of the major characteristics of Social Exclusion.

Figure: 3.1

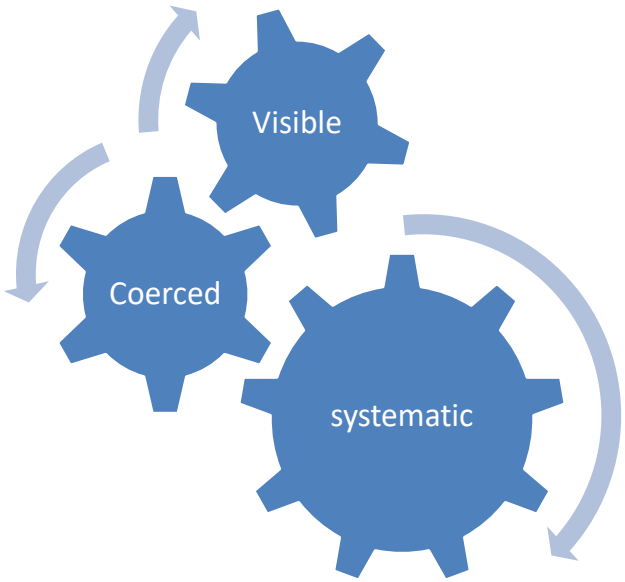
Source- Researcher

Figure 3.1 highlights the accepted characteristics of social exclusion as being an umbrella term, with contested definitions and existence in varied forms. As no one size fits all, the existence of social exclusion is context-specific, relational and dynamic in nature.

3.1 Nature of Social Exclusion

The interplay of social factors such as caste, class, and gender in our society is deeply rooted in our social structures. Being located in the social fabric of the society, the expression of social exclusion as an outcome of this interplay is not an accident but a systematic act reflected in different forms and spheres of an individual's life. Given the intersectionality of the social patterns, the occurrence of social exclusion is not voluntary in nature but is deeply embedded in the social structure. Also, the expression of social exclusion is not always a passive experience. It is also openly done and active in nature (Refer Figure 3.2).

Figure 3.2



Source-Researcher

3.2 Definition of Social Exclusion: A Contested Reality

There is no universal definition of s exclusion. It has been defined as a state as well as a process. It is multifaceted in nature. It is defined as "*the processes embedded in unequal power relationships that create inequalities or as a state of multiple disadvantages*" (Bhat & Kesavan 2018).

The concept of 'social exclusion is contested and has multiple meanings. These meanings are continuously redefined over time in line with the contextual realities and thus, shaping different policy implications.

Duffy 1995 refers to Social Exclusion as the '*inability to participate effectively in economic, social, political and cultural life, alienation and distance from the mainstream society', capability deprivation and the resultant further deprivation of the disadvantaged groups*" (Scutella et al 2009).

3.2.1 Consensus on Definition

The Commission on Social determinants of health's Social Exclusion knowledge Network forms a consensus on the definition of Social Exclusion. It defines Social Exclusion as,

"*Social exclusion processes which result in a continuum of inclusion/exclusion characterized by inequalities in, access to resources (means that can be used to meet human needs), capabilities (the relative power people have to utilize the resources available to them), and rights. This continuum results in health inequities. Social exclusion influences health directly through its manifestations in the health system and indirectly by affecting economic and other social inequalities that influence health. These inequalities contribute to social exclusion processes, creating a vicious circle*".

3.3 Changing Notion of Social Exclusion across countries:

The usage of the term social exclusion casts different meanings, thus reflecting its varied interpretations and dynamic characteristics. Kadun & Gadkar 2014 highlighted some of the country examples and focus areas of social exclusion are given below:

***Peru: Focus area Participation*:** Social exclusion occurs due to the inability to participate in the three dimensions of social life- political, economic, and cultural. These dimensions are the significant aspects of social life.

India: ***Focus area Welfare Rights***: Freedom to participate in social and economic rights is an essential part of the welfare state. Denial of basic welfare rights causes exclusion in the citizen's life.

Thailand: ***Focus area Citizenship Rights:*** Social exclusion is a process where citizenship rights are not recognized and respected. However, such rights are crucial determinants to

ensuring the livelihood and living standards of the people. Under such a process, rights are challenged and defended through negotiations and conflict.

Russia: ***Focus on Objective and Subjective*:** Social exclusion has both objective and subjective elements. The objective feature is characterized by material deprivation and lack or denial of social rights. On the other hand, the subjective element is characterized by feeling socially inferior or due to a loss of prior social status.

Tanzania: ***Focus on State and Process:*** When focusing on 'State', Social exclusion is similar to relative deprivation. Whereas, when referred to as a 'Process', it informs on the social structures and processes which hinder access to the resources (economic, social goods, and institutions) of some individuals, thus limiting their life chances.

Yemen: ***Focus on Social Integration*:** Acting as an opposite of Social Integration, the notion of social exclusion is present when some individuals and groups are unable to participate or are not recognized, as full and equal members of society, at the local community or national level.

An analysis of the above notions of Social Exclusion informs that the term has a varied understanding across the globe yet a common consensus on its core. These different perspectives can be summarized in the following:

1. Social Exclusion is a wider term encompassing the political, economic, social, cultural and other dimensions of the society. This is an umbrella term not limited to mere social aspects of the society, as cited in the above definitions.
2. While some countries refer to social exclusion as a feature in people's lives, others see it as a 'process', whereas for some it is a 'state' of denial and deprivation of rights. Thus, social exclusion exists in a continuum of human relationships, it is prevalent both in the process of social relations as well as determines and constitutes the result as a 'State'.
3. Relationship and participation are the words being mentioned in the majority of the definitions, whereas lack of these features enables prevalence of social exclusion, which has been cited as the opposite of social integration causing a denial of basic human rights.

4. An analysis of the above definitions also informs that social exclusion as both a process and state is a negative outcome of social forces that impacts social relations and dynamics in society.
5. Social Exclusion as a state is referred to in both objective and subjective ways- while social exclusion could lead to material deprivation on the objective front. It is equally important to know that at the subjective level, it impacts the feelings of a person or group who may undergo a mixed bag of feelings from inferiority, isolation, betrayal or humiliation, dismay, and 'othering'.
6. Social Exclusion impacts both individuals and groups. Further, it is present at all the levels of human interactions and it impacts relationships not only at individual and group levels but also extends to the social system and its stratifications.

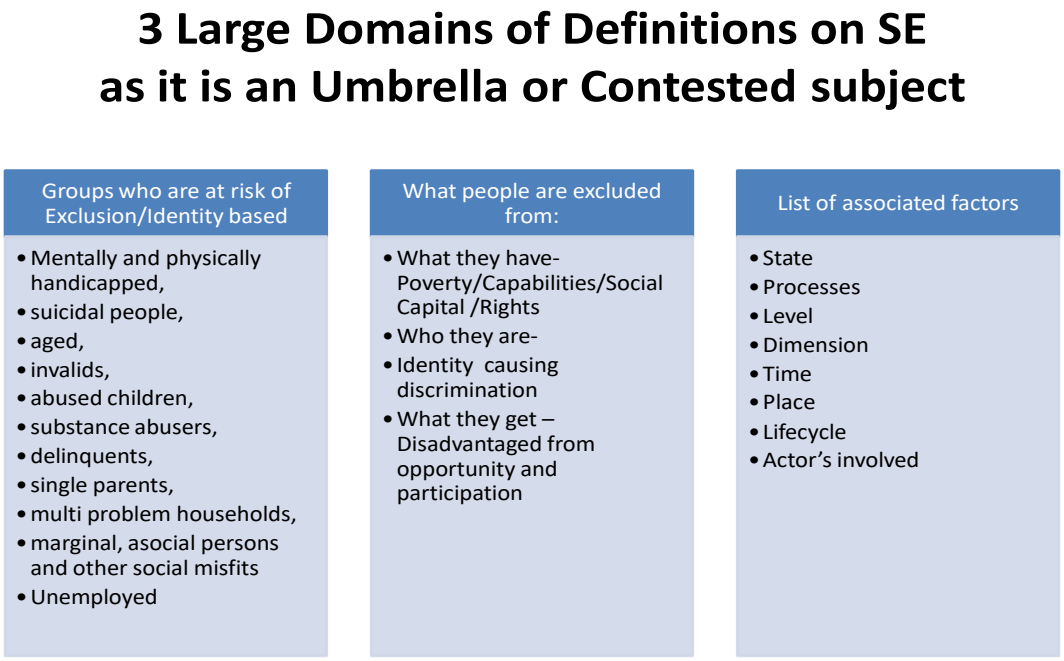
Limitations:

7. Onus of ensuring bridging of the exclusionary processes is the responsibility of the State.
8. Lack or denial of participation and enjoyment of rights is recognized as a primary factor for causing social exclusion. However, these definitions do not inform on the role of the State to ensure measures in reducing or controlling it. There is also a distinction between schools of thought. While one school of thought focuses on the lack of participation of the members in society, whereas, the other school of thought identifies social exclusion as a lack of access to citizenship rights for members of particular group, community, society, or country.

3. 4 Domains of Social Exclusion

In Figure 3.3 given below it can be seen that Nature of Social Exclusion can be broadly classified under three domains: (i) Groups who are at risk of Exclusion/Identity based, (ii) What people are excluded from, (iii) List of associated factors.

Figure: 3.3



Source: (Mathieson et al 2008)

3. 5 Characteristics of Social Exclusion

As regards the characteristics of social exclusion, it important to understand the process, affected individuals and/or groups, reason, context and agents who induce social exclusion are important. The nature in terms of being active or passive social exclusion, multi-layered and /or relational also attributes to its characteristics (Figure 3.4) In the following paragraphs a brief discussion has been attempted.

1. **State or Process:** Social Exclusion can be referred to as a shorthand label for "*what can happen when individuals or areas, suffer from a combination of linked problems*". These problems could range from unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown etc. (Social Exclusion Unit, UK, SEU 1997) (Scutella et al 2009). The existence of social exclusion can be in the form of a "state" where it is a cause for greater social exclusion. For example, the poor are socially excluded from mainstream society. Here, social exclusion is a "state". On the other hand, social exclusion can be a reason for greater exclusion. For example, being

socially excluded from mainstream society becomes a cause for further exclusion from access to health, decent work, and standard of living. Here, socially exclusion becomes a "process" as well as a "State".

2. **Individual/Group:** Social Exclusion exists at multi-levels among individuals and groups.
3. **Objective/Subjective:** Objective refers to the material deprivation on the account of exclusion, whereas subjective refers to the emotional feeling an individual or group undergoes as lived experience.
4. **Dynamic/Context Specific:** Social exclusion is not static in nature. Dynamic changes owing to time and contextual realities make it evolving in nature and unique experience of the individuals or groups.

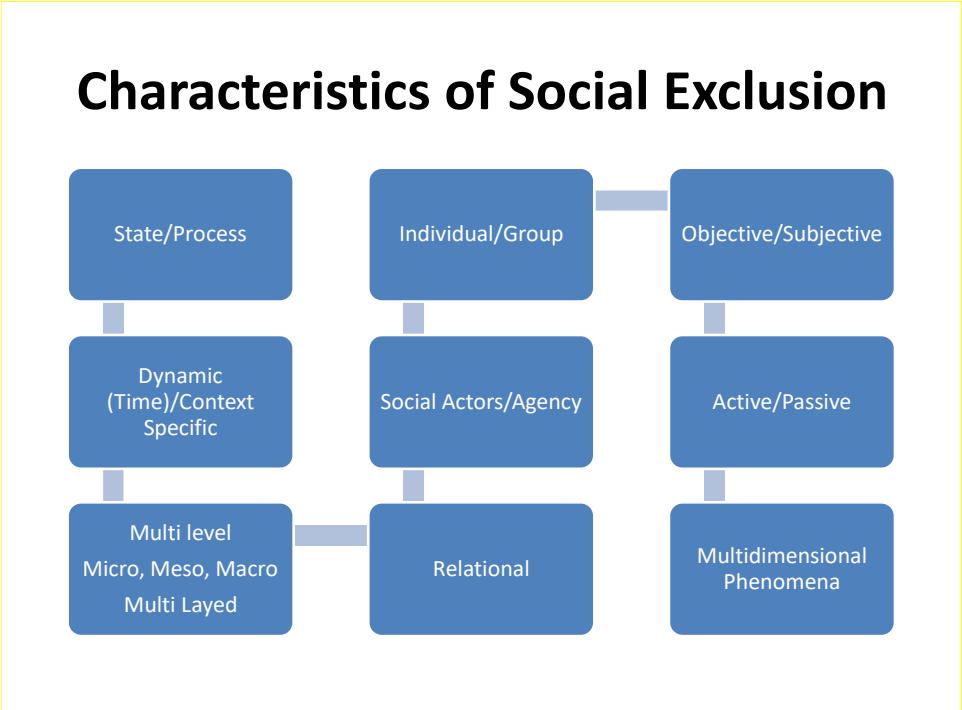
   One definition state that, '*the dynamic process of being shut out ... from any of the social, economic, political and cultural systems which determine the social integration of a person in society.* (Walker and Walker 1997:8).

   Thus, the analysis of Social Exclusion requires a multifaceted, dynamic, and relational approach (Scutella et al 2009).
5. **Agents:** In terms of who or what is driving exclusion, the attention is directed towards the 'agents' who play an important role in the exclusionary processes. Although scant literature is available on the agency, who are most affected by exclusionary forces. However, enough evidence is available from other sources that they are rarely passive victims (Mathieson et al 2008).
6. **Active/Passive:** Under the active social exclusion, the interplay of the determinants causes social exclusion as an active episode. On the other hand, passive social exclusion involves its subtle form or indirect nature. An example of active social exclusion- is an open denial of the Dalits to a religious place owing to the notion of purity and pollution. Under passive social exclusion, a health care provider may not say anything but s/he simply ignore the physical check-ups of the Dalit care seekers.
7. **Multi-layered:** By being deeply embedded in the social structure, social exclusion influences its presence at all levels: Micro, Meso, and Macro. At each layer, the determinants of social exclusion intersect with the social factors of caste, class, and gender. As a consequence, social exclusion exists as a "State", "Process" or a combination of both.
8. **Relational:** In connection to the contextual realities, its sphere, the forms of social exclusion may vary. One dimension of the relational perspective focuses on ruptures in

social relations on the account of a lack of participation, integration, protection, and power. On the other hand, as a consequence of such unequal social relationships causes differential power, the way societies are organised (Ibid.)

9. **Multi-dimensional:** Being a subjective and objective reality, social exclusion is multi-dimensional in nature.

Figure 3.4



Source: (Mathieson et al 2008)

Social Exclusion and Proximal terminologies: Given the varied axis of Social Exclusion, proximal terminologies have often been used interchangeably with social exclusion and therefore require careful attention. Some of the proximal terms include discrimination, extreme poverty, deprivation, vulnerability, disadvantage, and marginalization. Social Exclusion term has also been used interchangeably with poverty, discrimination, disadvantage, deprivation, vulnerability, and marginalization. However, social exclusion is a distinct concept, thus calling for the need to differentiate the meanings. Based on the accident of life and resultant 'what you have' results in poverty. Income poverty and time poverty are forms of poverty. Social Exclusion, on the other hand, goes beyond the income or time poverty to explain how poverty as a determinant could lead to social exclusion in various spheres of life including health. Based on the accident of birth and resultant 'who you are' results in discrimination on the basis of

caste, class, gender, and religion. In the Indian context, caste is a proxy for the poor. Hence, the accident of being born as a Dalit also leads to an accident of life as a poor. Gender too shapes further vulnerability making the poor Dalit women the most vulnerable. Poverty makes an individual or a group excluded from the mainstream society in terms of low capacities, social capital, the standard of life, decent work, and access to health care services. Here, social exclusion appears as a "state" of a poor person as well as a "process" that triggers their further exclusion the society. The proximal terms used are defined below:

Discrimination: Meyer (2003) defines Social Discrimination as: "*the differentiating treatment of an individual based on their actual or perceived characteristics (e.g., race/ethnicity, age, gender, income status or medical condition" (Anna, L.A. et al 2018*).

Further to this, Hall et al 2015 highlight that health-compromising outcomes of social determinants contribute to greater morbidity and mortality among the minorities when compared with the non-Hispanic whites. The contributory social determinants include healthcare avoiding behaviour, care seekers disengagement, inadequate compliance to the medical treatment and heightened physical stress responses (Ibid)).

Disadvantage: Based on the accident of life, the disadvantage perspective focuses on 'what you become' and whether you are able to participate in socio-economy and, political spheres. Being socially excluded, an individual or a group is in a disadvantageous position in society.

Deprivation: Being a disadvantaged individual or group, you become deprived of 'What you don't get,' due to your social position which could be a result of an accident of life or birth. Social exclusion here is in the form of "State" as deprivation is a result of poverty, and being disadvantaged.

Vulnerability: 'What you become' owing to the multiple socio-economic factors. Poverty, discrimination, disadvantage, and deprivation cause vulnerability. Social exclusion in this context is both a "state of vulnerability" as well as a "process of further exclusion".

Marginalization: The intersectionality of social factors such as poverty, discrimination, disadvantage, deprivation, and vulnerability cause marginalization. Social Exclusion here is a "state" of being marginalized and therefore completely excluded. As a "process" marginalization leads to further exclusion of the individuals and groups in various other spheres of life and in different forms (Refer to Table 3.1).

Social Exclusion and Related Terminologies: In contrast, some of the related terms such as Social Inclusion, Social Integration, Social Cohesion, Social Justice, and Human Rights as a shared goal and Social Network operate in a converse relationship with Social Exclusion (See Table3.2).

Table 3.2 Proximal Terminologies of Social Exclusion

Proximal Terminologies of Social Exclusion			
Discrimination	**Extreme Poverty**	**Deprivation, Vulnerability, Disadvantage**	**Marginalization**
"Who you are"	"What you have"	"What you don't get and then what you become"	"End result of all these steps"
Here Social Exclusion exists as a "State"	Here Social Exclusion exists as a "State" as well "Process"	Here Social Exclusion exists as a "State"	Here Social Exclusion exists as a "State"

Source: (Kabeer 2013)

Table 3.2

Social Exclusion and Related Concepts	
Social Inclusion	It is defined as "*the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice, and respect for rights*". (United Nations 2016)
Social Integration	It is a "*process in which newcomers or minorities are incorporated into the social structure of the host societ"y*. (Richard & Victor 1997)
Social Cohesion	It refers to "*the extent of connectedness and solidarity among groups in society. It identifies two main dimensions: the sense of belonging of a community and the relationships among members within the community itself*" (Manca 2014).
Social Capital	It is for the "*effective functioning of social groups through interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity*" (Lexico Dictionaries 2021)
Social justice, Human Rights and shared goal	Refers to the "*process of ensuring that individuals fulfill their and receive societal roles what was their due from society*" (Clark 2015).
Social Network	"*Social structure is made up of a set of social actors (such as individuals or organizations), sets of dyadic ties, and other social interactions between actors. [It] provides a set of methods for analyzing the structure of whole social entities as well as a variety of theories explaining the patterns observed in these structures. The study of these structures uses social network analysis to identify local and global patterns, locate influential entities, and examine network dynamics*." (Wasserman et al 1994)

3.6 Measuring Social Exclusion

Quantifying a social phenomenon such as Social Exclusion is complex. Given there is no one consensus on the definition of Social Exclusion, its measurement itself also cannot be universal in nature. The review of literature informs that across the globe, different countries have

identified key variables as the indicators to measure Social Exclusion. These variables are country-specific and therefore vary from one country to another. However, it is to be noted that the indicators cannot merely be generalized at the country level given there are various socially excluded groups and one set of indicators may not fit the entire country. There is no single universal measure of social exclusion. The prevalence of social exclusion varies widely according to the way it is quantified.

The definition of Social Exclusion has no consensus. Thus, quantifying this social phenomenon becomes complex. Across the globe, countries have identified social exclusion indicators in line with their contextual needs as "no one size fits all" or no one set of indicators of measuring social exclusion could be replaced in another setting. Given the unique nature of social exclusion indicators to the particular setting, the generalized indicators fail to deliver outcomes as they lack the contextual element of that setting. Thus, to develop and target a policy, its implementation and impact information on the nature and scale of 'social exclusion'.

3.6.1 Importance of Measuring Social Exclusion: Serving as a barometer or [an effective tool] for effective policy measurement.

Measures of social exclusion can contribute to the monitoring and assessment of policies and programmes. It serves as a barometer for accountable policy decisions to reduce exclusion, poverty, and inequality. It focuses attention on the diverse causes and consequences of poverty and enables the study of trends across the countries and regionally and identifying disparities between the countries, regionally and globally. (Mathieson et al 2008).

3.6.2 Analytical models for measuring Social Exclusion

Vertical Model- Social Exclusion and Poverty: It involves an understanding of poverty that goes beyond low income and addresses the multiple dimensions of deprivation. Further, the overall poverty as defined by the 1995, Copenhagen World Summit on Social Development, involves a lack of sustainable livelihoods due to a lack of income and productive resources, increased morbidity and mortality from illness, hunger, malnutrition and illnesses, social exclusion, discrimination, and unsafe environments, inadequate housing and homelessness, lack of participation in decision making and in civil, social and cultural life (United Nations 1995: 57).

An analysis of the above definition informs challenges in separating even analytically social exclusion and multiple deprivations as both are multi-faceted, representing a set of indicators

than single ones. Further, opinions over the nature of social exclusion and its causal linkages with poverty determine the selection of significant indicators. Such opinions often remain more implicit than explicit.

Thus. the basis of Social Exclusion is derived from poverty. Measurement of poverty has moved from the traditional way of having its basis in the income to the dimension of the basic needs such as food, shelter, schooling, health services, sanitation facilities, employment opportunities, and even touches on opportunities for community participation (Scutella et al 2009).

Horizontal Model: Discrimination- Based on the understanding of 'Who you are' (Kabeer 2005). Structural determinants of inequality such as caste, class, and gender define the social identity of an individual gets defined at birth. "Accident of Birth" explains the differential treatment of individuals in society, based on birth. For example, an individual who is born in a lower caste, class, or gender is at heightened risk of facing discrimination as the basis of such discrimination is at birth that gets embedded in the structural milieu of the society.

Disadvantaged Model: Further to the 'Accident of Birth', the disadvantage Model focuses on the "Accident of Life", based on "What you get [become] (Kabeer 2005),". Social Identity at birth shapes the chances of whether an individual is able to participate in the socio-economic, political, and other societal spheres. Social Exclusion and discrimination cause differential access to the sphere of life, opportunities, and rights. An individual born in a lower caste, class, or gender is in a disadvantaged position in society in terms of access to different spheres, rights, and opportunities. Due to lack or denial of participation, inclusion in spheres of society, opportunities, and rights, they face discrimination and become socially excluded individuals.

SEKN Model: The definition of social exclusion remains contested. There is no universal set of measuring social exclusion indicators since it has multidimensional facets and occurrence as a *state* or process. Different countries have adopted their own specific set of indicators to measure social exclusion over time to time, as it suits their contextual needs.

The final SEKN report summarised that "*social exclusion processes result in a continuum of inclusion/exclusion characterized by inequalities in; access to resources (means that can be used to meet human needs), capabilities (the relative power people have to utilize the resources available to them) and rights. This continuum results in health inequities. Social exclusion influences health directly through its manifestations in the*

health system and indirectly by affecting economic and other social inequalities that influence health. These inequalities contribute to social exclusion processes, creating a vicious circle".

In other words, a continuum of inclusion and exclusion gets generated as an outcome of the exclusionary processes. Such a continuum results in generating further health inequities to impact the health system and health in both direct and indirect manner.

Gradient Model: The social gradient in health [explains] that everyone is affected by health inequities (WHO 2021). Under the gradient approach, an individual's social position in society is deemed to have an effect on his health condition. For example- the lower an individual's position is in the social hierarchy or the social pyramid, the lower would be his health. In comparison, the individual who is step-wise up in his social position would be better off than him, whereas, the individual who is step-wise low, would have a lower level of health than him. Thus, our social position in society is reflective of our health.

Discrimination Model: Measuring Social Exclusion through the lens of Discrimination in Health. Discrimination is the barrier to universal access to health care. It is a cultural trait that expresses itself in a variety of forms. Measuring discrimination has been categorized under four categories (Srivatsan 2015):

Discrimination in any form causes a barrier to access to health care. To measure social exclusion through the lens of discrimination, Srivatsan 2015 in his work has categorized four categories of discrimination to measure the extent of social exclusion. The categories are the following:

- **Domain:** Under this category, based on the historical and existing social structures in the society, discrimination occurs in the domains of caste, gender, and tribes.

- **Register**: Under the second category, the experience of discrimination could be measured as subjective and objective in nature.

- **Temporality**: the third category of discrimination denotes, the time duration of discrimination. The event of discrimination could be temporary or if continued over a period of time, then chronic in nature.

- **Intensity**: Under this category, it is gathered if the intensity of a discriminatory event is pinprick, hurting, or in the extreme form to be devastating or even fatal. The measurement of the intensity is either through the subjective experience of the individual or through observations of others to be objective measures. An example of subjective experience by an individual could be public humiliation, whereas objective observation could be lynching or as demonstrated by the population such as low birth weight, early death, or culturally submissive conduct, clothing, etc.). This last is an expression of what Nancy Krieger theorizes as embodiment – the way the individual's body carries a history of the discrimination it has been subjected to (Srivatsan 2015).

3.7 Manifestation of Discrimination and Social Exclusion

In the health centre, discrimination may be practiced in access to and utilization of health care services in the spheres such as diagnosis, dispensing of medicine, laboratory test, while waiting in the health centre, and paying of the user fee.

- **At the diagnosis sphere**: discriminatory practice could be observed in the duration of time spent by the provider with the care seeker in understanding their concern. Further, insights could be gained while observing if the provider makes the [needful] touch to the user in a sympathetic manner over the diagnosis of [the health issue].
- **Dispensing of medicine**: Another sphere of contact between the provider and the care user is at the level of dispensing of medicine. Here, the discriminatory practice could occur on how medicines are dispensed such as whether the medicines are placed on the palm [of the hand] of the [care seeker] or kept on the window sill/floor [for collection or] asking someone else to give them.
- **Laboratory tests:** At the level of conducting the laboratory tests, the provider comes in contact with the care user. Here discriminatory practice could be whether or [not] the provider makes the [needful physical contact] /touch to do the lab tests of the care users.
- **While waiting in the health centre**: In the waiting area, discrimination can be measured by [observing] the duration of wait [for the Dalit population], [waiting] space, and the [reason why they need to wait for long durations] [coupled with the] attitude of the paramedics towards them through this period.
- **Paying the user fee**: Once again, this sphere involves provider and care users' interaction. Discrimination can be measured by [observing] the actual amount being paid, time for waiting to pay, and space for waiting for (separate queue)

Besides, the health centre, discriminatory practice can occur in spheres outside the health centre such as at home. For example- Discriminatory practice could be observed in the choices of the provider in entering the house of the care user. Second, while touching the user. Third, whether the provider wishes to sit in the house. Fourth, whether the provider consumes any food or drinks offered by the user. Fifty, whether there is any touch involved with giving medicine to the user.

Apart from these direct discriminatory practices, discrimination also occurs in an indirect manner such as through selective information dissemination on the health camps or programs. Secondly, through the practice of untouchability that is based on the notion of purity and pollution. (Acharya 2010):

3.8 Forms of Social Exclusion based on discrimination in access to health care:

1. **Complete exclusion or complete denial of health care services-** Although the State health care envisages providing services to all without discrimination. However, when an individual or group is completely excluded from availing of services for any reason, it is termed complete exclusion.
2. **Partial denial or selected exclusion of health care services-** This occurs when some people are able to access specific services and not other services. There exists discrimination against the care users by the service providers. This is *partial denial or selected exclusion*. Further, this selected exclusion could be differential treatment or unfavourable inclusion, or forced inclusion.

3.9 Global and Country Specific Measurement of Social Exclusion

World Health Organisation's Commission on the Social Determinants of health in 2008 had identified a set of indicators as determinants of health to be worked on. However, one set of indicators could not hold applicability across the globe as the felt needs of each excluded group vary in terms of their specific contextual realities. Different countries have selected sets of Social Exclusion indicators suiting their contextual realities by clarifying one underlying definition and causal relations as well as supporting with a statement of reasons for prioritization between the indicators.

3.9.1 Country Perspectives:

European Union (EU): To measure the fight against poverty and social exclusion in European Union, the indicators called 'Laeken indicators' were based on four domains- health, education, economic participation, and economic resources. The list of the indicators included (i) poverty incidence and persistence, (ii) the poverty gap, (iii) the distribution of income, (iv) unemployment, (v) jobless households, (vi) early school leavers, (vii) life expectancy, (viii) self-assessed health, quality of housing and social participation (Social Protection Committee 2001 and Atkinson et al 2002).

United Kingdom: In the UK, the measurement of social exclusion has also been varied. Some of the major models and dimensions suggested are as follows:

(i) **Outcome-based Model:** Burchardt, Le Grand, and Piachaud (1999, 2000) from the Centre for the Analysis of Social Exclusion (CASE), London School of Economics as cited in (Mathieson et. al. 2008) adopted this model. It was based on seeking participation in four types of activity –(i) *Consumption:* (ii) *Production:* (iii) *Political engagement* (iv) *Social Relationships*.

(ii) **Building on the above model at CASE,** Stewart (2002) examined the following five dimensions of wellbeing and exclusion to include: (i) material wellbeing, (ii) health, (iii) education, (iv) literacy; and (v) participation in two spheres – productive and social.

(iii) Levitas (1998) developed a model which identified three different approaches to measure social exclusion:

Redistributive discourse (RED)- The approach sees social exclusion as a consequence of poverty.

(ii) **Social integration (SID)-** Under this approach, the key element is labour-force attachment, where paid work is represented as the primary or sole legitimate means of integrating individuals of working age into society. Thus, excluded are those who are 'workless', or, in the case of young people, at risk of becoming become so.

(iii) **Moral underclass discourse (MUD**)- Under the third approach emphasis is on the moral and cultural causes of poverty and is centrally concerned with the moral hazard of 'dependency', and thus with workless households rather than individual labour market attachment.

Australia: Scutella et. al. 2009 in Measuring Poverty and Social Exclusion in Australia: A Proposed Multidimensional Framework for Identifying Socio-Economic Disadvantage inform about the dimensions of Social Exclusion.

Under the Poverty and Social Exclusion (PSE) approach, Gordon et al (2000) and Pantazis, Gordon & Levitas (2006) inform four dimensions of social exclusion:

- Income poverty
- Exclusion from Labour marker
- Exclusion from Public and Private services
- Exclusion from social relations

Further, the 2006Community Understanding of Poverty and Social Exclusion Survey (CUPSE) identifies three forms of social exclusion:

1. Economic exclusion is based on restricted access to economic resources and low economic capacity.
2. Disengagement due to lack of participation in social and community activities.
3. Service exclusion is based on a lack of adequate access to key services when needed.

Headey (2006) listed seven 'life domains' for the measurement of social exclusion: (1) material resources; (2) employment; (3) education and skills; (4) health and disability; (5) social; (6) community; and (7) personal safety.

India: Health disparity among the population groups informs the existence of health inequities. An inquiry into the factors causing health inequity informs the role of social forces that causes the exclusionary processes. In the Indian context, social stratification based on caste, class, gender, and other variables has a historical legacy and therefore is deeply embedded in our society. Social stratification determines and positions an individual within the social hierarchy and therefore has a defined social status. A defined social status leads to differential access to and utilization of all services, including health services. Such differential access further causes disparity in the outcome of delivery of health care services and the individual's health status.

Inequalities in the Health Service System in India: Within the health service system, inequities surface in its different domains. For example:

(i) Resource Distribution- Refers to the disparity in the rural and urban health service systems. The example includes uneven distribution in medical personnel or equipment in the Primary Health care in a rural area, vis-à-vis its supply in the specialized hospital in the urban area.

(ii) Inequities in Access-Within the health care institutions, inequities in access to health exist in different forms and within the different spheres. It is through the lived experiences of the care seekers that, such events of health inequities could be recorded. Further, the perceptions of the health care providers on the care seekers' experience and their views on health inequities also sight insights on inequities in access to health.

(iii) Inequities in Participation: Policy-level planning and decision-making have a profound impact on the functioning of the entire system. With regard to the healthcare system, the role of participation of the healthcare workers, who are at the frontline or at the periphery should be included in policy-level decisions through their active participation. Whereas, without such participation, Inequities exist within the health system.

(iv) Inequities in Health Status: Social stratification based on the interplay of social forces such as caste, class, and gender are deeply embedded in our society. Caste is referred to as a proxy of poverty thus, the poor also happen to be from a lower caste. Adding a gender dimension, a Dalit woman would be at a heightened risk to face inequities in access to health. Measuring the extent of social exclusion faced by them is through gathering their life experiences in access to and utilization of health care services. Thus, social identity places an individual in an unequal hierarchal based society, where their access to health care services as well as utilization gets impacted and it influences their overall health status.

(v) *Health and Health Care Utilization: Health Outcome Indicator* (Nayar 2007): Referring to caste as a proxy of socioeconomic status and poverty (Nayar 2007) states, in the Indian context, schedule caste. Schedule tribes are in some cases the other backward caste is considered socially disadvantaged. Thus, they are identified as poor with higher chances to live in poverty and adverse conditions. Indication of social exclusion and its linkages with poverty and health is indicated by the health

status and utilization patterns of these groups. Thus, indicators for measuring the extent of social exclusion focus on examining broad linkages between caste and some select health/health utilization indicators among different caste groups in India.

(vi) *Access to Health Care: Identity-based Perception Indicators*- Identity-based perception of self has an influence on determining access to and consequent utilization of health (Verma, S et al 2007). Identity plays an important role in understanding social interaction in access to health care services. Identity is socially located thus; it is through this concept that personal and social are connected Patil (2014). It is relational in nature and constructed through social relations of difference, such as 'us' and 'them' Srivatsan (2015). Further Perception of self is both a collective and an individual phenomenon (Acharya 2013). It has elements of the image created by others.

Caste-based discrimination is permanent. It is the identity of the individual which links the personal and the social, self and society and is relational. It is constructed through relations of difference, such as 'us' and them'. In India, caste-based discrimination is evident with Dalits being placed in the last social realm of the stratified society. Among the Dalits, it is the Dalit women, who remain at a heightened risk of suffering social exclusion resulting in a denial of access to healthcare resources owing to their social identities and deprivation from universal health coverage.

3.9 Indicators of Complete, Partial, or Unfavourable Social Exclusion (Acharya 2010).

- **Forms** – The forms of social exclusion may vary. Some examples are the Duration of interaction between the care seeker and care provider. Second, whether the care seeker is physically touched (sympathetically) by the provider. Third, whether the provider speaks gently to the care seeker. Fourth, whether the provider refers to the care user without using demeaning words and if a Dalit is made to wait for a longer duration in access to care.
- **Spheres** - visit / by the provider; dispensing of medicine; counseling; conduct of pathological test; and seeking a referral for further care
- **Provider perspective** – Providers include doctors, nurses, lab technicians, etc

- **Extent of Exclusion-** It depends on the dimensions experienced as well as the time duration (Scutella et al 2009). Accordingly, it is categorized as: **Chronically excluded-** Individuals experiencing multiple dimensions of exclusion that persist over time. **At the risk of chronic exclusion-** Individuals experiencing multiple dimensions of exclusion at various points of time will be identified as **Marginally excluded-** Individuals with limited dimensions are classified as 'marginally excluded'. **No dimension of exclusion-** The remaining group includes individuals exhibiting at any observed point in time.

3.10 Impact of Social Exclusion - Social exclusion is a multidimensional phenomenon, which debars disadvantaged individuals in many ways. At the societal level, there is a denial of participation and opportunities, whereas, at the individual level, it leads to the denial of basic rights and dignity.

- **Intangible or invisible dimension- Dignity:** The Universal Declaration of Human Rights provides safeguards to the aspects of human rights and human dignity. Human Dignity in health is an intangible and non-clinical dimension. All Individuals possess dignity and violation of dignity accounts for injustice. Social exclusion is an unfair phenomenon and therefore unjust. Individual experiences of Social Exclusion often result in dignity violation or deprivation, thus denial of basic human rights.
- **Tangible or visible dimension- Embodiment:** Individuals' physical and mental well-being is based on many circumstances (Srivatsan 2015).

3.11 Limitations to Measuring Social Exclusion (Mathieson et al 2008)

Existing approaches to measuring social exclusion suffer from a number of limitations owing to the very nature of Social Exclusion. Some of the major limitations are listed below:

(i) The definition of social exclusions remains contested thus, [there is no one size that fits all. Thus, measuring the extent of social exclusion has to be tailored as per the contextual realities of the target concerned and in that defined timeline].

(ii) There is no common consensus on the indicators/domains/dimensions.

(iii) There remain [lack] of clarity concerns over social exclusion and its proximal terms, especially poverty.

(iv) The existing global indicators of social exclusion inform the perspective of the developed world. [Such an approach lacks attention to the specific issues faced by the developing or underdeveloped world].

(v) There exist clarity concerns on the items included in the indicators are causes, risk factors, or outcomes of social exclusion causes concern about the selection, prioritization, and quality of the indicators.

Conclusion

The nature of social exclusion is dynamic with no universal definition. Given the multidimensional facets of the concept, the measurement of social exclusion is challenging. Due to this reason, countries from time to time have come up with their own country-specific measuring models on social exclusion. Since measurement of social exclusion plays a significant role in informing the "causes of the cause". Measuring Social Exclusion thus becomes imperative to understand the extent of social exclusion especially in health and more specifically in maternal and child health as it has an impact on the lives of the vulnerable in population groups. Thus, based on the above, in the next chapter, the research focuses on understanding experiences of social exclusion in maternal and child health faced by women in Delhi. It would be done by examining the perception of women accessing health care services. Based on their social identity, their perceptions would be analyzed to examine the presence and extent of social exclusion in maternal and child health based on social identity. In-depth interviews would be conducted among both the social identities to know if any form of social exclusion exists in access to health care services and utilization. The next chapter focuses on examining the background determinants of social exclusion in the lives of the urban poor care seekers who access hospitals for maternal health care.

Chapter Four

SOCIAL EXCLUSION IN ACCESS TO MATERNAL HEALTH: EXPERIENCE OF URBAN POOR WOMEN

Maternal health needs are crucial in having an impact on the overall health and well-being of both mother and the child. Distress on the account of social exclusion manifested in the general lives adversely impacts health and access to health care services. The interplay of the structural, social, and individual determinants of exclusion shapes the lived experiences of urban poor

women. These are primarily the background factors that explain the pre-existence of social exclusion and vulnerability among the urban poor women before she reaches any health care facility to access care for their maternal and child health needs. Thus, the background factors showcase the umbrella factors responsible for making the urban poor women very weak and vulnerable in the challenging and socially excluded environment of being the "Other" in an urban setup.

4.1 Social Exclusion & Urban poor women's maternal health

Social exclusion mainly refers to the inability of our society to keep all groups and individuals within reach of what we expect as a society to realize their full potential (Nayar 2007). Social Exclusion moves beyond poverty and instead focuses on wider causes, processes, and consequences causing social inequalities and marginalization and exclusion of some over the others. However, there is no universal definition of social exclusion and it remains a contested reality over the definition. The meaning of social exclusion is relative in dynamic in nature having different expressions and policy implications.

A consensus on the definition is arrived at by the WHO's Commission on Social Determinants of health's knowledge network as a : (a) multidimensional, encompassing social, political, cultural, and economic dimensions, and operating at different social levels; (b) dynamic, impacting in different ways to differing degrees at different social levels over time; and (c) relational (Mathieson et.al 2008).

The World Health Organisation formed the Commission of Social Determinants of Health's Social Exclusion Knowledge Network (SEKN) states that "social exclusion processes result in a continuum of inclusion/exclusion characterized by inequalities in access to resources (means that can be used to meet human needs), capabilities (the relative power people have to utilize the resources available to them) and rights. This continuum results in health inequities. Social exclusion influences health directly through its manifestations in the health system and indirectly by affecting economic and other social inequalities that influence health. These inequalities contribute to social exclusion processes, creating a vicious circle".

Given the varied axis of Social Exclusion, proximal terminologies have often been used interchangeably with social exclusion and therefore require careful attention. Some of the proximal terms include discrimination, extreme poverty, deprivation, vulnerability, disadvantage, marginalization, etc. Discrimination is based on "who you are" (Kabeer 2005), here the notion of social exclusion is of a "state", whereas under extreme poverty, which is based on "what you have" (Kabeer 2005), the notion of social exclusion is both of a "state" of poverty as well as "process" that one goes through in terms of the vicious circle of time poverty. On the other hand, the terms deprivation, vulnerability, and disadvantage reflect on "what results in when you are debarred or unable to get compared to the mainstream population". Under this scenario, social exclusion operates as a "process" and "state". Finally, the terminologies of marginalization, subjugation, and alienation result in social exclusion. Here, Social Exclusion is once again operating as "state" and "process". In contrast, some of the related terms such as Social Inclusion, Social Integration, Social Cohesion, Social Justice, and Human Rights as a shared goal and Social Network operate in a converse relationship with Social Exclusion.

As defined by World Health Organisation (WHO 2021):

"*Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Some key facts on Maternal Mortality (WHO 2021) are: (i) Every day in 2017, approximately 810 women died from preventable causes related to pregnancy and childbirth. (ii) 94% of all maternal deaths occur in low and lower-middle-income countries".*

In India, for the period 2016-18, the National Sample Registration System (SRS) data records the Maternal Mortality Ratio (MMR) as 113/100,000 live births, declining by 17 points, from 130/100,000 live births in 2014-2016, (Ministry of Health and Family Welfare 2021).

Reduction in maternal mortality counts for improving maternal health. A majority of maternal death causes are preventable if effective treatment and medical intervention are received on time. This reiterates the significant importance of universal access to health care services. In contrast, Social Exclusion brings out the already existing cracks in the society reflected through social inequalities at the structural, social, and individual levels and how the intersection of these determinants shapes the chances of the vulnerable urban poor women belonging to a lower caste, having an excluded and socially disadvantaged position in the society, to access a government hospital for her specific maternal health needs. The axis of social exclusion influences the general lives of the urban poor women impacting their health and well-being. Maternal health is the core aspect of the health status of the study participants, who belong, to the reproductive age group, and have maternal health needs in the new urban setup. Access to health care services for maternal health needs is an indicator of their care utilization pattern. However, there exist social barriers in the form of determinants of exclusion that limits their chances of accessing health care services.

4.2 Exclusionary processes influencing the lives of urban poor women

The development divide between the urban and rural population in the country along with poverty and poor socio-economic conditions compel the rural poor to migrate to the urban cities for better opportunities. Being the national capital of the country, Delhi is a hub of developmental activities and therefore is a prominent destination of migrants from across the country.

As an indicator of attraction, Delhi has the highest share of inter-state migrants. The influx of migrants is due to marriage, work, and business (Kawoosa 2019). As per the 2011 census, there exists a 23% rise in Delhi's population due to migration where a majority is from adjacent states. According to the Perceptions survey 2013 conducted by the Institute for Human Development, Delhi's migrants include 47% from Uttar Pradesh and 31% from Bihar (Singh S 2017).

Upon coming to Delhi, given their socially disadvantaged position, they succumbed to additional challenges such as exclusion from opportunities, quality housing, decent work, and adequate work that would enable them to gain better control over their health and lives (Singh 2017). Challenges of meeting the survival needs and earning a livelihood render the urban poor

to join the vicious circle of time poverty and social exclusion. Among this population group, the urban poor women face acute social exclusion on account of additional gender determinants of exclusion. Patriarchy, gender roles, and gender disparity influence women's health and their chances to access health care services. Maternal health needs critically impact the overall health and well-being of the mother, child, and family. Distress on the account of social exclusion manifested in the general lives adversely impacts the health as well as the access to the health care services by the urban poor women. The urban poor women are a heterogeneous group, consisting of individuals who are different from each other owing to their individuality and contextual factors, yet clubbed as "Urban Poor Women" to highlight and inform on their individual struggles, agony, and exclusion faced by them and when seen collectively as a group who is vulnerable subject to exclusionary processes determined by structural, social and individual determinants in an urban context and when they have specific maternal health needs.

In the Indian context, caste may be considered broadly as a proxy for socio-economic status and poverty (Nayar 2007). Thus, urban poor belonging to low caste, class, and gender have a higher probability of being the most vulnerable with their socially disadvantaged position. A majority comprises of the migrant poor women belonging to low caste who have essentially migrated to Delhi with their husbands and so with children too for secure livelihoods from the different parts of the country. A majority migrated soon after their marriage along with their husband and are experiencing pregnancy in a new setting. The reason for coming has been shared as a potential work opportunity for the husband. Due to the dominance of patriarchy in the social system, it is the husband who acquires the specialized work opportunities in urban areas, whereas women remain at home with a burden of household chores, child care, and working in the informal sector that makes them further disadvantaged and vulnerable. The urban Poor Women suffer from multiple forms of marginalization of the exclusionary processes in different spheres of their life. These spheres could be categorized into personal spheres and public spheres, where the household or family circle refers to private spheres and societal interaction as public. In the private sphere, social exclusion varies from subordination, and male domination based on power relations of patriarchy and domestic violence. Gender plays a crucial role in determining the attitude towards women. In the case of the urban poor women, who have a secure livelihood, no permanent place to stay, and poor and unhygienic living standards, they succumb to subordination, patriarchal control, and domestic violence from husbands. The urban poor women participants of the study shared experiences about facing violence from their husbands on daily basis, due to their sole dependency on their

husbands for survival in urban areas and constant fear of being sent back to the village in case of any differences. This adds to the perpetuation of male dominance and the patriarchal system. In families, roles and exclusionary processes operate due to gender, poverty, caste, and patriarchy. These are reflected through attitude and lived experience. Exclusion gives rise to the practice of silence along with persisting domestic violence.

Within the private sphere, urban poor women often face isolation as they are already excluded from the mainstream society as they are "outsiders" who need to quickly adapt themselves to the new urban setting. After being abused by their husband, they are solely responsible for the household chores, and taking care of the child. Care seekers who are nursing infants have shared experiences of not having time to breastfeed the baby owing to the burden of responsibilities thus causing gaps in feeding practice leading to malnourishment of the infants. Once done with their daily responsibilities, urban poor women are expected to go out of the house and earn for their families. The nature of work varies from semi-skilled to unskilled work. A majority of urban poor women are working as factory workers, labourers, and domestic helpers or maids, vegetable or stall vendors. The precarious position of females in these urban settings added to the perpetuation of male dominance and the patriarchal system, where women bear multiple burdens of responsibilities. "*Aadmi maarta hai aur gaon laut jaane ki dhamki de kar darata hai". (Husband beats, threatens to return back to the village).* Respondent (R1) who is 24 years, staying in a slum near a railway line in Naraina.

In terms of the public sphere (working in the unorganized/informal sector), the exclusionary processes based on the intersecting social forces of caste, class, and gender subject the urban poor women to the margins of society and out of the public spheres. Discrimination and the presence of exclusionary processes are deeply embedded in our society, defined by stratification. These cause the presence of such exclusion as ordinary or presented as camouflaged reality. In the public sphere, the urban poor migrant women get engaged in the informal sector with insecure working conditions and low wages. In general, many women resort to work activities such as being household maids, cleaners, and cooks. daily wage earners, and migrant laborers in construction and factory workers. Outside the private sphere of the four boundaries of their house, women also face unequal treatment in the labour market, where they are available on cheap labour and made to work for long hours sometimes without any proper wages. Lack of say in the decision-making of family planning and the number of children leaves the women vulnerable to the patriarchy in the social system. The financial burden and hardships in the life of urban poor women are added with irregular and meagre

income that makes it hard able to meet the family needs, afford to pay room rent, utility bills, transportation, food, clothing, etc. This highlights the presence of exclusionary processes embedded in our society, where the social exclusion of poor lower caste women is predominantly based on their vulnerable and insecure status in the existing social system. Being the isolated and vulnerable segment away from the mainstream society, the urban poor women face multiple challenges in their daily living that impact their health and access to health care at the government hospital. The varied axis of Social Exclusion makes its measurement even more complex and therefore has to be contextualized and captured through the lens of lived experiences in the different forms and spheres of their lives.

Regarding the maternal health needs of the urban poor women, a majority of the urban poor migrant women respondents shared that they faced daily cumulative challenges adversely impacting their access to and utilization of maternal health needs from a health care facility. Due to time, poverty, overlapping responsibilities of household chores, caring for children, and outside work responsibilities in the unorganized sector, many respondents admitted their conscious negligence, and ignorance of the notion of "self-care" in terms of taking care of one's nutrition, consumption of IFA and calcium tablets, proper rest to avoid fatigue during the period of pregnancy. Given the multiple levels of responsibilities at home, the urban poor women remain excluded from prioritizing their own health needs and that becomes further crucial when it comes to maternal health needs. "*Gharwala bimaar rahta hai, bachoon ko dekhne wala aur koi nahi hai, toh mein hospital kaise jaon".* (Husband remains unwell, no one to look after the children, how could I go to the hospital). Respondent (R2) who is 32 years, staying in a rented room in Nariana Village is unable to visit the Deen Dayal Upadhayay, a government hospital in West Delhi for antenatal check-ups, as her husband is an alcoholic, whom she refers to as "unwell".

Regarding their migratory status, the majority of the study participants shared their insecurities undergone by them. They were brought to Delhi only for securing a livelihood, removing the debts incurred in the village, and leading a better life. However, given the ever-rising economic hardships in the metropolitan city, they fear returning to their village anytime on the account of survival need challenges, risk on livelihood due to loss of work and wages, and inability to pay rent. It was also evident from the empirical data that, their basis of staying in Delhi is dependent on their husband's job and his discretion to stay. Most respondents shared that their husbands were rickshaw pullers, vendors, servants, cleaners, and engaged in other petty work. Generally, factors such as fights at the workplace with a colleague or employer, loss of daily

wage on the account of leave, rude behavior of the employer, or being left with no money to pay the room rent, food, or household items amount to immediate triggers that cause their husbands to resort to consumption of alcohol. Due to the poverty and problem of alcoholism in the family, many respondents shared about staying anxious all the time as they fear their husbands' taking an abrupt decision of leaving everything in one go and returning to the village. Also, the times' respondents shared about their husbands resorting to domestic abuse and then threatening reverse migration. Under all these circumstances, the respondents find themselves caught in a limbo where they neither belong to the city nor to their village and are solely dependent on their partner's will. Having no say in the decision-making in the family, many urban poor women suffer in silence and remain stressed and depressed due to their helpless condition. Another factor hampering access to government hospitals and utilization of services is the uncertainty of the husband's job as most of them work in the informal economy. Sudden loss of job, no wages, or no work on the account of the pandemic are some of the common reasons causing reverse migration. Under these circumstances, women's access to a government hospital for maternal health needs makes no case to stay back as survival challenges are paramount. However, without any means of livelihood, it is impossible for them to stay.

4.3 Determinants of exclusion and processes

Reducing the direct causes of maternal deaths requires action for maternal health. It requires timely action for prevention and treatment through skilled health care professionals in a supportive environment. Exclusionary processes inform the existence of multiple determinants of exclusion operating at different levels of the society-structural, society, and individuals. These determinants are the background factors or conditions shaping the chances of the urban poor woman to access a government hospital for her maternal health needs. To reduce maternal mortality, it is important to address the background determinants of exclusion impacting the health outcome of urban poor women during pregnancy, childbirth, and the postpartum period. Structural, social, and individual determinants constitute the social determinants of health. However, when reversed the same constitutes as deterrents to health and therefore act as drivers or social determinants of exclusion. To explore the extent of social exclusion in the general lives of the urban poor women, it is important to focus on the determinants largely categorized under three major domains:

1. Structural Determinants
2. Social Determinants
3. Individual Determinants

The intersectionality of structural factors such as caste, poverty/class and gender have a profound impact on the general lives of the urban poor women. All these variables make the lives of the urban poor women socially disadvantaged and socially excluded and isolated experience, aloof and segregated from the mainstream society. Besides, these structural factors defining the very basic stratifications in our society, the second determining aspect impacting the general lives of the urban poor women is the social determinants that add to the next layer of their lived experience of social exclusion. Lastly, the individual factors that are unique to each person depending on the contextual realities, they too impact the lived experience and shape the extent of their exclusion from the mainstream society (Table 4.1).

Table 4.1: Determinants of Social Exclusion in access to Maternal health among Urban Poor Women

Domains of Social Exclusion		
Structural Determinants	**Social Determinants**	**Individual Determinants**
"Accident of Birth"	"Accident of Life"	"Individual factors and daily living conditions"
"Who they are in the society"	"Where they are"	"How individual factors play out"
Caste	Migration status	Illiteracy
Class/Poverty ***Time Poverty**	Urbanization *Household location and amenities	Health seeking Behaviour * Socio-cultural beliefs *Health Practice *Awareness
Gender/Patriarchy/Power relations ***Decision making and burden of responsibilities**	Health System's Preparedness	MCH care *Experience of birthing in an urban setting

Source-Researcher

4.3.1 Structural Determinants:

Refer to the broader determinants in the social structure. Here, the social stratification is on the grounds of the individual's identity at birth. If an individual is born in a higher caste, class, and gender (male) order of society, the individual is privileged to have better life chances and opportunities in spheres of life. This contrasts with an individual, who is born in a low caste, class, and gender (female). Here, due to mere accident of birth, the individual suffers social inequalities and exclusionary processes operating in the society, this further adverse impact on the health inequities and social exclusion in health. Major structural determinants are discussed below:

(a) Caste-based exclusion:

Caste may be considered a proxy of poverty and poor socio-economic status (Nayar 2007). The experience of caste-based social exclusion has rarely been in a direct way, rather it is manifested through its deep embedment in our society in the hierarchy and its visible impact. The caste system is based on the division of people into social groups in which civil, cultural, and economic rights of each individual caste are predetermined or ascribed by birth and made hereditary. Ambedkar (1936) articulated that the caste at the top of the social order enjoys more rights at the expense of those located at the bottom of the caste hierarchy and has fewer economic and social rights.

Ambedkar (1936) articulated that the caste at the top of the social order enjoys more rights at the expense of those located at the bottom of the caste hierarchy and has fewer economic and social rights. Further, Caste-based exclusion is associated with *untouchability, where the* untouchable caste is considered impure and polluting, and unfit for social association and interrelation with the caste above. Being at the bottom of the caste hierarchy, they suffer most from unequal assignments and entitlements of rights which include civil, cultural, and economic. Further to this, social stigma and identities have a great bearing not only on their socio-economic status but on health status as well, as they suffer apathy towards their problems and taboos related to their caste and religious identities. (Kadun & Gadkar 2014).

Why Identities matter: Identity is important in understanding social interaction. It is socially constructed and based on the generalizations that one evolves about 'self' and 'others. It draws on the 'similarities' and 'differences' and it is relational in nature. The generalizations form into attitudes and standardized perceptions about self and society. Charles Horton Cooley

(1864-1929) in his 'The Looking Glass Thesis' through the process of internalizing his own perceptions of thoughts about others, specifically significant others, around the individual perceive him, the individual forms his identity or self-concept. The individual tends to believe and accept the judgments, definitions, and evaluations he sees in other individuals in his social environment. Thus, the individual conception of the responses of other individuals towards him, instead of the actual responses of others, formulate an essential element of one's self-development. The stages in the Looking Glass Thesis include:

i. We imagine how we seem or appear to others.
ii. [Based on our perception of their reactions to our presentation of self, we imagine how others judged us of their reactions to our presentation of self.
iii. We engage in a self-evaluating conversation with ourselves when we decide on how we interpret feelings gives us feel about ourselves.
iv. Taking the role of the other towards ourselves, we respond to ourselves in the same way others might respond to us
v. It is from our social context (i.e norms) that we derive our self-image, self-worth, and self-esteem. (Rousseau 2002).

Caste is not simply a matter of ritual status and religious belief but extends beyond class and religion to shape economic life and opportunities. Thus, caste identity is a unique phenomenon that touches each aspect of people's lives and has deep-rooted linkages with exclusionary forces in the society shaping or limiting access to the health and health status of communities at large. Historically, Indian society is divided into four varnas, or the division of a group of people on the base of their birth (Kadun & Gadkar 2014).

- The Brahmins [who belong to the upper caste] should cultivate the knowledge
- The Kshatriya [the warrior class, in the middle] should bear arms
- The Vaishya [next in the caste hierarchy] should trade
- The Shudra [at the lowest level of the caste hierarchy], should serve all the above three classes. Dalits are the most marginalized and excluded community in India.

In contemporary times, Dalits which is a Marathi word that means 'broken men' are categorized and classified as Scheduled Caste in the Indian Constitution for administrative purposes. They are subjected to social, economic, political, and cultural exclusion deeply embedded in social practices. Caste is an important variable in shaping deprivation — but not the only one (Jodhka 2017). In India, a number of groups of people (Dalits, tribals, minorities,

women, and children) remain deprived of full membership in society. Discrimination on the basis of caste, race, ethnicity, religion, gender, language, etc has continued for ages in our society. Being defined as someone having a Dalit identity, that individual faces discriminatory behavior in the different spheres of his hospital. Since all acquired and innate attributes get superseded, a Dalit identity individual faces discrimination such as not placing the medicine on the hand or not being allowed to sit in the designated place in fear of being insulted. On the other hand, measures such as assertive recognition of self or end of the social identity scale would reduce the level of discrimination. (Acharya 2010). Urban Maternal health brings out inequities more starkly than any other area. Sufferings due to pregnancy are a common cause for the poor. In the case of urban poor Dalit women, the phase of pregnancy until childbirth is the most sensitive phase as they are already vulnerable and subject to exclusionary patterns in private spheres and also in terms of the society where they live as major contributors to the development of the economies yet being hardly able to meet their daily survival needs to be given the limited and irregular income. Family Roles and Exclusionary processes operating due to gender, poverty, caste, and patriarchy impact the attitude and lived experience.

(b) Poverty, Social Exclusion, and Health:

Poverty serves as a significant determinant in access to health care services (Djurfeld and Lindberg 1976; Zurbrigg 1984). Among the poor, most are Dalits, thus informing that most Dalits are poor (Nayar 2007). Being a Dalit place the individual in a specific realm he is subjected to discrimination since his attributes acquired or innate gets superseded. Poverty and its dimensions of income poverty and time poverty along with social exclusion are the driving forces and well as sustaining forces of health inequities. Since poverty is dimensional- Income Poverty measures economic disadvantage based on income and resources. On the other hand, Time Poverty explains the vicious trap of poverty and the resultant dearth of time to overcome the daily survival needs and challenges such as the inability to cook a proper nutritious basic meal in a day, pay room rent, bear the medical expenses, transportation fare and child care and other household needs. Among the urban poor population group, the worst affected are the urban poor migrant women, who face the brunt of income poverty, time poverty along with social exclusion in all the spheres of their lives. Thus, a different health culture is evolved by poverty evolves that affects the perception of illness and utilization of care and different spheres in life. Among the urban poor women, self-care remains low on the account of time poverty. Besides patriarchy plays

out giving importance only to the husband, due to the subordinate role of the woman, their health, and maternal health needs such as antenatal and postnatal visits are often neglected or ignored unless there is an emergency.

(c) Gender Identity and Patriarchy:

Gender Identity, patriarchal setup, and power relations play a crucial role in determining gender roles placing women in a subordinate position in society. The Women and Gender Equity knowledge network of the WHOs Commission on Social Determinants of Health (WHO 2008) states that, despite the allocation of power, resources, authority, and control by men, the devastating impact of gender inequality is affecting both the sexes. Thus, to reduce the health inequities and provide effective use of health resources, the network report calls for attention to take action on improving gender equity in health to address women's right to health. The report highlights the significance of equal and universal rights to the heath of all people without any discrimination on the basis of caste, class, gender, age, disability, location, sexual orientation, or economic [reasons] (WHO 2008). The network considers concern for consistent and smoother implementation of human rights as the cause of mobilizing people, especially women, government, etc. The network considers concern for consistent and smoother implementation of human rights as the cause of mobilizing people, especially women, government, etc. It promotes intersectoral coordination, as addressing the problem of gender inequality requires actions both outside and within the health sector because gender power relations operate across such a wide spectrum of human life and in such an inter-related way. It recognizes the interplay of gender with society, where power is embedded in the social hierarchy. Lastly, the social structures governing gender systems have similarities across different societies. However, the variations may occur in the manifestation of beliefs, norms, organizations, behaviours, and practices.

(d) Gender Inequalities and Social Exclusion

Indian society is dominated by the deep-rooted patriarchal system causing the women to suffer in silence. At the household level, the burden of responsibilities in terms of the daily chores, producing and rearing children, and working outside for livelihood makes the women get trapped in a vicious circle of work and responsibilities without having any time for self-care and access to health care services. *"Ghar ke aur baahar ke kaam ka bojh itna hai ki apna dyaan*

kisko hai" So much work at home and outside leaves no scope for self-care. Respondent (R3) who is 29 years, staying in an urban village in Naraina.

The culture of silence at home gets internalized as a reaction to the patriarchy. Subsequently, this gets reflected in the other spheres of her life such as the workplace, society, and access to health care services. Such perceived notions sustain the exclusionary processes operating in society on gender inequalities and social exclusion. The position of urban poor women is far more vulnerable to the intersection of gender inequalities with the axis of social exclusion or multiple determinants operating at the structural, social, and individual levels. At a global level also, India has been faring rather poorly. A recently released UN report stated that in India, on average, Dalit women die around 14.6 years earlier than upper-caste women. (Khullar 2018). The World Economic Forum's Gender Gap global report of 2019 ranked various factors related to gender disparities such as education, health, and employment. India stands among one of the bottom five countries with a global ranking position of 112. Our country fared poorly, particularly in women's health and survival (rank 150) and economic participation by women (rank 149) (PTI 2019).

(e) Intersectionality of Caste, Class/Poverty, and Gender

At the structural level, the urban poor woman becomes a victim of the intersectionality of caste, class, and gender forces interacting in society. These social forces play an active role in setting up exclusionary processes in the society that excludes the urban poor women belonging to low caste as the most excluded one. The divide between the rich and the poor in the economic sphere impacts the social spheres causing denial or loss of opportunities and resources to the poor who are socio-economically weaker than lower-class and caste The Intersectionality of caste, class, and gender has a manifold impact on the general lives of the urban poor women. The gendered dimension of urban poverty informs about the multiple burdens on the lives of urban poor women. Caste, class, and gender are overlapping creating multiple levels of social injustice in the form of triple discrimination (caste, gender, poverty) and resulting in exclusion from the society faced by the urban poor women. The complex interplay of socioeconomic factors and political factors affects the lives and the overall health status of women. The gendered dimension of the urban poverty explains the disadvantaged position of the urban poor woman, who despite making a significant contribution to the city's development remain disadvantaged in terms of equitable access to basic needs of health education, work, living

conditions assets, and representation in urban governance and formal institutions. Chant (2011) (Tacoli 2012).

4.3.2 Social Determinants of Exclusion

Under the second domain (see Table 1) of the determinants of Social Exclusion in access to Maternal health among Urban Poor Women. Social determinants are the interim determinants based on the social conditions of the living place or the environment in which the individual grows, lives, and works The draft discussion paper of the Commission on Social determinants of health of 2005 explains that the social determinants of health (SDH) as the social conditions in which people live and work, or in Tarlov's (WHO 2010) phrase "the social characteristics within which living takes place." The Social Determinants of Health point to both specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts. Thus, social determinant of health that merit attention is those that can potentially be altered by informed action (Ibid). The life experiences of the urban poor women in Delhi, their health, well-being, and access to maternal health care services get influenced by urbanization, migration, and the health system preparedness as it represents the major social characteristics in which living takes place. No social determinant operates in isolation from another, it is the interplay of migration, urbanization, and health systems preparedness determinants that shape the lived experiences of the urban poor women.

(a) Urbanization:

Urbanization and urban setting is referred to as health determinants by the WHO's Commission of Social Determinants of health's urban setting knowledge network. Globally, the urban population in developing countries is expected to grow to 3.9 billion in 2030 from 2 billion in 2000 (UN 2006). As per the knowledge network, one in three of the total urban population of the world lives in slums, rising to almost half of all urban dwellers in the developing regions, and four of five urban dwellers in the Lower Developed Countries (LDCs).

Around two-thirds of the world's urban population are from developing regions, these regions account for 85% of the world's slum dwellers. The report states about an increase in urban poverty with the slum formation and rapid urbanization in the cities (WHO 2008). According to the 2003 Global Report on Human Settlements (UN-HABITAT 2003), 43% of the urban population in developing regions lives in "slums". A range of social determinants limiting the

slum dwellers' ability to take action to improve their health vulnerability and deprived urban living environment include poor quality and often insecure, hazardous, and overcrowded housing; limited or no safety net*;* inadequate income; high prices paid for many necessities causing health risks; inadequate, unstable, or risky asset base; inadequate provision for infrastructure and services (including water and sanitation) (WHO 2010). In resolving this the economics of urban health development brings out the crucial role of good governance, supportive public health policies, and financing of infrastructure.

(b) Migration:

Refers to the movement of the individuals from one place to another. It is a complex phenomenon bringing a change in the population density at the home/village level and destination place. Being a national capital of the country with modern developments of metro trains, sky-high offices and workplaces, advanced industries, and factories, it attracts labor from the nearby villages and different states in the country. The challenges in the rural areas due to poverty, lack of employment opportunities, low wages, poor working conditions, lack of education, and health facilities attract the rural laborers to migrate to Delhi for livelihood, better wages, opportunities, and quality of life. However, living in Delhi in the informal settlements such as unauthorized colonies, jhuggi jhopri clusters, resettlement colonies, and slums systematically excludes the urban poor people from the mainstream strata of the society and from their mainstream standard of life characterized by better housing, living conditions, opportunities and wages, and means to access better health services in private and tertiary hospitals. Given the limited means of income and meager wages, they reside in urban villages, near railway tracks or camps, and other socially excluded areas away from the mainstream residential areas. On the other hand, being migrants with temporary living duration status in Delhi, the urban poor are socially excluded from opportunities, quality housing, decent work, and adequate income that would enable them to gain better control over their health and lives.

(c) Living conditions of Urban Poor Migrants in Delhi

Quality of the natural environment and lack of basic amenities: Insecure Housing: A constant fear of eviction among the slum dwellers results in insecure housing conditions and menial livelihood options. Household location: Given the secluded location of the household, the place of living is not fit for living. Migrants living in the urban villages often rent out a single room that is in most cases overcrowded and has a poor standard of living. Slum-dwellers too stay in unhygienic, overcrowded living conditions.

For migrants, livelihood is the primary aspect determining their duration of stay in Delhi. Given the temporary nature of stay and a meagre amount of income, many urban poor migrants reside in the peripheries of the mainstream residential areas. These peripheries include urban villages, slums, camps, and railway tracks located on the outskirts of main residential areas. Given the excluded spaces, these camps/ slums have unhygienic conditions and a dearth of basic amenities. Open garbage and filthy living conditions are environmental determinants adversely impacting the population's well-being. Working in the unorganized sector involves insecure livelihood, limited, low or irregular wages, and poor working conditions. However, trapped in the vicious circle of poverty in the base location (home), migration attracts an opportunity for a better life, however working under insecure conditions, the informal sector does not ensure a secure livelihood. Under the urban setting, Time Poverty further excludes the individual from participation in society and restricts their action to only meeting the survival needs of the family to be able to live in the urban setup. In desperation for livelihood needs, many migrants end up working under hazardous conditions under low wages and extreme conditions thus risking their lives for meagre amounts to be able to sustain themselves in Delhi. Belonging to a heterogeneous group, the urban poor migrants undergo varied living experiences, their duration of stay in Delhi, and the ability to make social contacts or social capital is also an important factor in the exclusionary process. Respondents who have been in Delhi as first-generation migrant feels more excluded than the second or third generation who are better informed, aware, and have social contacts.

(d) Health System's Preparedness:

The health systems are seen as encompassing *'all the activities whose primary purpose is to promote, restore, or maintain health' (WHO 2000).* The health system as a social determinant of health equity pertains to social stratification, differential access and use of health care, differential experiences of health care use, differential consequences, health inequity by health system intervention in the form of intersectoral action for health, social empowerment, primary health care, health care financing, and organization, redistribute welfare, financial protection from health care costs, respectful treatment, etc (WHO 2008). Further, the perception of self has elements of the image created by others. While the positive images enhance confidence, the negative images particularly emanating from biases and stereotypes are resented. Thus, the attitude of the provider, if devoid of empathy is likely to affect access (Acharya 2018).

The differential in the access to healthcare services is evident in many forms. One such is a refusal to observe certain mandatory caregiving norms, which includes violations in rendering care to the marginalized care seekers, particularly Dalits and Muslims. Differential access, use of health care, differential experiences of health care use, and differential consequences shape the perceptions and health-seeking behaviour among the care users in accessing to access health care services. Manifestation of differential treatment in different forms and spheres of the health care services. Such forms include refusal to touch the care seeker, enter the premises, share seating space, share transportation, water, or food. Whereas, the spheres include the 'spaces' care providers and care seekers come in contact with each other in care centres, [mother and child clinics, hospitals] or care users' houses (Acharya 2010). Thus, differential access, use of health care, differential experiences of health care use, and differential consequences shape the perceptions and health-seeking behaviour among the care users in accessing to access health care services.

4.3.3 Individual Determinants:

Beyond the structural and social determinants, individual determinants play a key role in shaping the lived experiences of the individuals. These are the determinants unique to the individual and cannot be generalized. Key Individual determinants influencing access to government hospitals among the urban poor women.

(a) Health Seeking Behaviour

Awareness, information, knowledge, and a conducive environment are the key factors to determine one's access to any public service facility including a hospital. On the other hand, a conducive environment is likely with the availability of infrastructure empathetic health care provider, the user's ability thus enabling all. On the contrary, such an environment is only conducive to some as against the others [who are socially excluded]. (Palmer 2008; Rundall & John 1979). Thus, it is the combination of various factors such as economic propensity, health infrastructure, and social identity of the user and provider of health care services that determine the health-seeking behaviour of the user.

On the other hand, if care seekers and providers are devoid of empathy and sensitivity, it is likely to affect access, thus making way for discriminatory access to health (Acharya 2003, 2010, 2013, 2018). Similarly, the background environment of the care seeker also plays an

important in determining access to health care services. For example, the attitude of the husband and family members towards the maternal health needs if devoid of empathy and sensitivity would limit the access to health care services. "*Check-up ke liye jaane mein mushkil hoti hai, gharwala kahta hai agar dard nahi hai toh hospital kyun jaana hai?*" (Face difficulty in accessing hospital for antenatal check-up as husband questions on the need to visit the hospital without having any pain?) Respondent (R4) is 24 years old and from Naraina urban village. Further, socio-cultural beliefs from our habits and our way of life. Socio-cultural beliefs followed at home determine the chances of the significant importance of self-care and maternal health needs by the care user and her family and whether and if the care user is able to prioritize herself in a patriarchal setup in the family. Following this is the birthing order, previous birthing experience favourably assists with a better awareness of pregnancy, maternal health needs, availability, and access to health care services. Finally, in today's world, digital advancements, and information on maternal health are readily available on digital platforms. However, due to a lack of proper education on, financial and digital illiteracy, many care users are solely dependent on their husbands for information on access to health care services. Owing to lack of funds, the care users are unable to buy a smartphone, or internet packages rendering them excluded from the digital world and access to the online information available on applications for booking vehicles to approach the health care services, location of the health care services, etc. Knowledge and information gap on the account of the digital divide between the urban poor and the mainstream widens their social exclusion in health.

Conclusion

The axis of varied uncertainties in the lives of the urban poor migrant women makes them socially excluded from mainstream society. The unpaid work at the household level provides a comfortable opportunity for their husbands to engage in meaningful work outside and contribute their hard work in nation-building and development. Despite, her significant role in nation-building and development, the urban poor women's own significant maternal health needs remain a challenging experience due to the exclusionary process that plays out in different spheres and in different forms in her life. Additionally, the axis of social exclusion through its exclusionary processes shaped by the determinants operating at the structural, social, and individual levels creates a vicious circle of exclusion in every sphere of their lives. The intersectionality of the determinants of Exclusion at the domain level as well as at the inter-domain level reflects the multiple factors causing social exclusion of the urban poor women in maternal health and deepening of social inequalities and health inequities. The intersectionality

of the structural determinants of caste, class, and gender along with social determinants and individual determinants explain the vulnerable and disadvantaged position of the urban poor women in this population group. Gender plays a crucial role in determining the attitude towards women. Forms of social exclusion vary but patriarchy and power relations play a key role in sustaining the exclusionary processes to perpetuate gender disparity. Besides, caste and class/poverty render the urban poor women more vulnerable and disadvantaged than the mainstream women population.

Under the second domain of the determinants, social determinants are the social conditions operating in the social context. Being the national capital of the country, Delhi offers opportunities that attract migrants from different parts of the country for livelihood. Here, social determinants of migration, urbanization, and the health system preparedness play out as major factors determining the health, well-being, and access to the maternal health needs of the urban poor women. The third domain refers to the individual determinants, these are specific to the conditions and circumstances of the individual and cannot be generalized. The intersectionality of determinants of exclusion at structural, social, and individual levels at Intra ('*within*') and inter ('*between*') levels reflects the multi-dimensional nature of the determinants operating at different levels. These determinants are dynamic and relational in nature. The exclusionary processes thus sustained by these determinants further shape the chances of an urban poor woman to overcome her socially excluded identity and be able to access the government hospital for her maternal health concerns.

The analysis of the lived experiences of the care users belonging to the voiceless set of the urban poor thus confirms, the presence of exclusionary processes in our society and the need to raise voices and propose policy suggestions for the reversal of such processes in order to sow the seeds of social cohesion and inclusiveness in all the spheres of an urban poor women's life. The following chapter examines the lived experiences of the care seeker as well as of the providers on social exclusion in a hospital setting.

Chapter Five

MEASURING SOCIAL EXCLUSION: ACCESS TO HOSPITAL

Over the last decade, the delivery of health care has made improvements, yet social exclusion has caused persistent negative health outcomes in the lives of marginalised women. In the healthcare setting, this manifests in the opinions, beliefs, behaviours, and attitudes of healthcare providers, significantly impacting the urban poor care seekers. Groups and categories who are *'set apart* from others, of being *'locked out* or *'left behind* in the health setting in our society are captured by Social Exclusion. Social exclusion influences health directly through its manifestations in the health system and is observed through lived experiences of the care seekers in the different spheres of the hospitals as well as by providers' perspectives. Indirectly, social exclusion affects economic and other social inequalities that influence health.

5.1 Identity and Perceived Social Exclusion

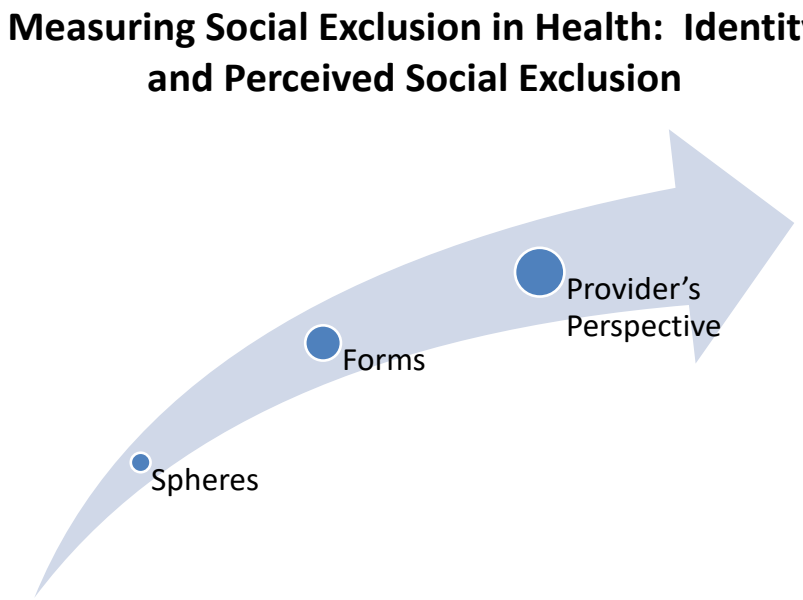
Identity determines the social position as well as interaction in society. Lived experiences of social exclusion are perception-based and therefore captured through examining the different spheres, forms, and perceptions.

In the analysis of The Looking Glass Self theory (Rousseau 2002), Charles Horton Cooley (1864-1929) explains why identity matters and that our self (self-worth, self-image, and self-esteem) can be seen as derived from our societal context (norms). Social identity impacts health outcomes. Social Identity of an individual defines the presence of Social Exclusion in the context of access and utilization of health care services that come with a general outcome such as –

- Inclusive: When proper access and utilization of health care services if social identity;
- Excluded: When partial or no proper access exists for the excluded social identity. Thus, causing discrimination, deprivation, or denial of access and utilization. In the case of the Urban poor women, their Social Identity is that of an individual whose life chances revolve around the unjust social axis of caste, class, and gender.

The varied axis of Social Exclusion makes its measurement even more complex and therefore it needs to be contextualized. To measure social exclusion among the urban poor women when they access a government hospital for their maternal health needs. Measurement of social exclusion is captured through their lived experiences at the government hospital. To contextualise it, their lived experience has been divided into "Spheres", "Forms" and "Perspectives" (Figure 5.1).

Figure-5.1



Source- Researcher

The term "Sphere" refers to an area of activity, interest, or expertise. Similar to "sphere" are terms such as "domain", "field", "area", "territory", "realm" etc. In simple terms, Sphere explains the location aspect. In the study context, spheres were selected based on the health care seeker's potential place of one-to-one interaction with the health care provider such as (i) Visit to the hospital, (ii) Allotment of beds, and (iii) Dispensing of medicines.

The term "Form" refers to the ways in which things exist or appear. At the government hospital, the forms of social exclusion could be varied, however for the study purpose following forms have been shortlisted to identify the presence of social exclusion during the one to one interaction of the care seeker and provider, these include (i) provider's involvement with the care seeker such as asking questions, (ii) whether the care user was being touched

(sympathetically), (iii) whether the provider spoke gently or referred the care seeker to the provider without using demeaning words, (iv) whether they were made to wait for longer durations than due while accessing care, (v) listening to patients, (vi) showing concern and non-avoidance behaviour.

The term "Perspective" has a Latin root meaning "look through" or "perceive" and all the meanings of perspective have something to do with looking. In the context of the study, the provider's perspective is crucial to understanding their mindset, perception, and mindset about the urban poor patient, who approach the hospital to access care. This gives a fair idea of their approach, behaviour, way of interaction, and their discrimination against the patients.

Social exclusion can be distinguished as an attribute of individual social exclusion focusing directly on the nature of lives people live and the disadvantages they suffer. The following part examines spheres, forms, and perspectives of expressions of Social Exclusion in Maternal health as experienced by the urban poor women in Delhi.

Sphere of Visit to Hospital: Health is a human right and that makes access to health care in a hospital a legal right and an entitlement of the urban poor care users seeing access to maternal health needs. It is the responsibility of the government hospital to ensure fair, inclusive, and equitable access to health care services to all without discrimination from the provider and regardless of their social position in society. The condition of government hospitals remains ill-equipped given the lack of proper infrastructure, manpower, and logistics support. On the other hand, due to poverty and low socioeconomic status, a majority population of the urban poor women has to rely on the government hospital for access to their felt health needs. However, there exist perceived barriers that cause non-utilization of maternal health services:

Over Crowding and Long Queues: Long waiting hours outside the Out Patient Department (OPD) often makes the care seekers compel urban poor women to either go back home without seeking the required care or refrain from accessing the government hospital in the first place as a waiting period starts from morning 5 am for an appointment at the hospital. Due to long hours of wait, many care seekers shared rejecting this option in the first place, as it is additional stress during their pregnancy. To reach 5 am at the gate of the hospital for access to felt maternal needs, she needs to get up early at 3 pm, and complete the household chores. Due to the long queue, respondents shared about coming to the hospital early in the morning just to be able to join the queue. "One respondent shared that "*hum toh paanch baje hi aa jate hai line me lagne ke liye kyunki doobara aane mein auto ka kiraya kharch hota hai"* [We (I along with

my husband) have come at five in the morning to join the queue as coming again would involve paying the auto-rickshaw fare.] While waiting in the queue, respondents felt being an involuntary part of the overcrowding at the hospital that did not let them take a break from the queue owing to the fear of getting missed from the queue and then joining from the last. They also restricted themselves from using unhygienic toilets. Due to overcrowding and long queues, many care seekers feel it is always better to go to a private hospital but due to lack of affordability, they feel helpless and compelled to access the government hospital.

Apathy and Neglectful Behaviour from the health care provider: In general, the care users feel apathy or avoidance behaviour as a major deterrent in terms of getting proper treatment. Due to the general apathy and avoidance behaviour of the provider to empathize with their maternal felt need, many care seekers feel often unwelcomed and alienated from having a proper individualized doctor-patient relationship. This further causes hesitancy among the care seekers in access to the hospital. The hesitancy further gets escalated into delay from care seekers' side in seeking assistance and finally denial of assistance towards the felt need.

Inequality in access to health care: Preferential treatment to "some", who are from "well to do backgrounds", have better education, well dressed and English speakers with a good social connection within the spheres of the hospital play a vital role in easy access to the doctor, s/he has freedom from joining any queue, getting quality maternal health care in a timely and friendly environment. Whereas, for an urban poor care seeker, such treatment is far from reality, as there exist health inequities. With preferential treatment to some over others, these gaps further advance health inequalities.

Sphere of Allotment of Bed: Care seekers shared a shortage of beds in the government hospital. Care seekers also shared about times when some care seekers had to share beds or be on the floor. Thus, informing the infrastructural gaps in provisioning that require the immediate attention of the government. Barriers in this sphere exist in the form of preferential treatment for some in bed allotment and a perceived sense of discrimination against the urban poor who lack social capital. Discrimination in bed allotment is due to preferential treatment: Care seekers did not hesitate to share that some beds are previously allotted and they don't come to know how beds are allotted from before. As per the respondents, there exists discrimination in bed allotment and they feel excluded.

Sphere of Dispensing of Medicines: Care seekers share a lack of information on the sphere for dispensing of medicine. On an often basis, the care seekers rely on the patients, visitors,

and cleaning staff of the hospital to navigate them towards the medicine counter. Care seekers shared about the stock of medicines available but at times, some medicines are not available which adds to their dissatisfaction as to come back again an additional limited resource. Lack of reception support in the hospital leaves the patients at the mercy of standing by patients, visitors, and cleaning staff in the hospital to find directions for dispensing medicines.

Experience

1. **Feeling Alienated/Isolated due to Lack of Individual approach resulting in perceived low dignity**: At the government hospital, care seekers shared about feeling Isolated due to perceived low Dignity. Due to a lack of Individual approach or personal touch, they feel alienated from having a proper provider and care seeker's experience. Perceived low dignity on the account of getting scolded, shouted, language/ tone, stopping the patient from talking. In the words of care users- *"Sarkaari mein daant laga dete hai, bahut bura bura bhi bolte hai, pata nahi kyun"* [*In the government hospital, scolding is done, don't know why "On the day of my delivery, I was scolded badly by the nurse for not having the card made and coming on delivery day as an emergency. However, I was unable to get the card made before as I became aware of my pregnancy late"*]. On an often basis, care seekers shared that they became aware of the pregnancy at very advanced stages. This is associated with time poverty that seldom allowed time for self-care. Linked to this was the lack of proper knowledge of nutrition, anemia, IFA, and calcium supplement. Care seekers shared that IFA and calcium supplements are with them but they often miss taking them regularly due to multiple workloads on their shoulders.
2. **Feeling of helplessness due to no Informed Consent**: care seekers also shared experiences about their helplessness in the government hospital due to lack of awareness pertaining to the family planning measures. Care seekers shared being aware when coercive family planning measures were applied to their known people. One care seeker stated that "soon after the delivery, the doctor and nurse decided on the family planning measure for her and informed her to come for copper IUD after a gap of few days from delivery. Owing to fear of coercive family planning measures, the care seeker did not visit the hospital for her post-natal care as she feared coercive family planning measures.
3. **Compromise on the quality of care**: Due to poverty and lack of funds, access to a government hospital is the last resort owing to the inferior and socially excluded

treatment. Preference on the other hand is towards the Private Hospital where quality care is assured but comes with a price, that they are unable to afford. Having extremely limited means of income, many respondents shared about incurring debts to get admission to private hospitals to avoid exclusionary processes at the government hospital. For maternal health needs and pre-existing morbidities, the practice is to approach a nearby chemist or unqualified practitioner. The reason cited was that they at least listen to what they suffer and that often gives them comfort and trust that their advice or medicine would definitely help. Due to the poor availability of services at government hospitals, care seekers often switch to antenatal and post-natal care at private clinics. Many respondents shared about incurring debts for quality care at the private clinics and resorting to government hospitals only for delivery or complication.

How social exclusion is perceived as normal by Care Seeker

Social Exclusion is camouflaged as Normal: Forms of Social Exclusion experienced as perceived as "Normal" and "Used to" treatment. *Kyunki paisa nahi hai, isliye Sarkari mein aaye hai, ab yahan aisa hi hota hai. Agar Paisa hota toh nijee mein hee dikhate*" [Since we don't have money we have come to the government hospital and things work like this here. If we had money we would have gone to private practice.]

Corruption and bribes as a reason for Preferential treatment: Preferential treatment to "some" who are rich and powerful is perceived owing to corruption. There are long queues and people who are better dressed and known to the doctor or anyone in the hospital are given preferred treatment. Sometimes people give bribes at the main gate, so they are seen early such people do not join any queue and they are able to meet the doctor while we keep waiting in the queue.

Power Relations: There exist power relations in every sphere of our society, and a hospital is no exception. Providers hold the knowledge and authority; therefore, their actions are unquestionable by the care seekers, who are at the receiving end and therefore powerless having no education or knowledge background. "One care seeker shared how she could not understand the doctor's prescription and therefore requested the doctor to explain again to her husband. But, in response, she was scolded by the doctor for not listening carefully the first time. Due to rude behaviour as well as a paucity of time at the end of the doctor, the care seeker could not explain that the barrier was not in listening but in understanding the medical prescription.

Having seen no time availability or effort from the care provider, the care seeker had to ask for help at the chemist shop nearby her house". Such experience of the care seekers reflects the powerlessness of the recipient at the hands of the provider that requires a sensitive approach. Inequalities in access to healthcare at the hospital exist not only between the rich and poor but also among the poor and those with additional vulnerabilities. Such is the case of the urban poor women, a heterogeneous group. "An urban poor woman who is working outside, having her income, who is aware of the way to the hospital, bus number and roads is sound to reach the hospital more easily. Further, if the care seeker is able to make connections in the hospital with the support staff, then access to the doctor gets easier as they become aware best time to come or get a call from them to start from the house, so they save time and do not miss work. This is unlike a new migrant urban poor woman who has no connections or income or awareness about the way to the hospital and about the hospital".

Common practice among the Care Users to cope with the exclusionary processes

- **Hiding Caste or its Shadow:** On Often basis Caste is hidden before Providers/Employers by referring to themselves as belonging to different caste or by using Pseudo names and surnames as shared by the mainstream community in Delhi. The urban poor care users shared about hiding their social identity at the levels possible for social acceptance by the mainstream population in Delhi. A majority of the urban poor care users work as domestic workers. They shared about using pseudo names and Delhi-based surnames that help their easy acceptance in mainstream society. For example: In a Hindu Sikh and Hindu Rajput dominant residential community of Naraina Vihar, domestic workers from low caste tend to give modern names often a four-word easy to recollect name for the house owners to call them for work. Care seekers shared that if the house owners come to know their lower caste social identity, then, there are high chances of job loss. Care users shared that access to the hospital becomes less challenging for people with similar social identities unlike them.

- **Making use of Social Capital and Networking:** Any sort of social connection based on similar background or affiliations (whether similarity in region, religion, language, dialect, caste, etc) with the provider or anyone in the chain of health system assists in providing to easy access to the hospital and the doctor on time**.** Care seekers shared

how similar identities built on social capital within the hospital spheres that assisted "some" to approach the doctor directly without having to join any queue.

- **Migrant Status and Experience of life in Delhi**: An urban poor woman who is a first-generation migrant with a short duration of stay in Delhi and having no social contacts and having first pregnancy then the patient faces more problems in accessing the services compared to someone the other who has some sort of social connections and experience of living in Delhi. Further, those urban poor women who have migrated to Delhi for a long period of time around a year or so, and who are aware of Delhi and its whereabouts are much more able to make their access easier than the newly arrived migrant women in the hospital.

- **Culture of silence** is invariably perceived to be women. Internalized the ethic of nobility in suffering such that experience of social exclusion is accepted as the very essence of their life in the patriarchal society. On an often basis, the care seekers who somehow understood the concept of social exclusion often quickly reacted by stating that it did not happen with them but they believe it happened with someone they know. Thus, it appeared to the researcher that, when the care seekers were assisted by one or the other family member or if they felt that people around were noticing them speaking, they were not willing to accept the very existence of social exclusion in their lives. This made the researcher understand that not many care seekers wanted to openly discuss get into the background factors due to varied reasons such as – time poverty, the complex nature of the concept, the and realization that such discussion would not help them directly to provide a quick access and quality health care services in the hospital, where they seek immediate relief to issues surrounding access and quality care services.

Impact of Social Exclusion: On Care Users' Access to Hospital

Access to health care Institutions is adversely impacted by perceived experiences of Social Exclusion. This may lead to the following extent of Social Exclusion in accessing government hospitals: *Complete or extreme Exclusion:* Poverty and lack of affordability would reduce their chances of complete exclusion from accessing government hospitals since private hospitals are beyond their reach given the affordability issues. Return to the parental home in the village appears as a culturally safe option for many urban poor migrant

pregnant women. *Partial Exclusion*: Accessing the government hospital is just before the delivery, or complications or an emergency, otherwise they prefer going to a private hospital. The urban poor women, who do not return to their village, incur debts and loans for getting quality care at the private clinics and leaving access to government hospitals only for emergencies. *Unfavourable Inclusion*: Urban poor women shared about not being asked for any informed consent in the application of family planning measures. Thus, Fear of coercive family planning measures often restricts women from accessing government hospitals after delivery.

How Social Exclusion is Perceived: Providers' Perspective

In a hospital, a provider who is a doctor, nurse, health care practitioner, or lab attendant plays a dominant role in determining the provider and care user's relationship. At times, the providers were quick to outrightly reject the very existence of social exclusion in their hospitals. Since the response was so quick, it makes the researcher believe that providers often felt reluctant to initiate a discussion on this topic thinking of its critical nature. Further, they were unwilling to introspect or critically reflect on the system, where they too form a 'part or such limitations could be due to varied reasons such paucity of time, interest, willingness, and personal biases.

An account of Social Exclusion expressions gathered from the providers' perspectives is shared below:

1. Overload of Work justifies mechanical approach: Health Care providers in the government hospital shared about the large volume of patients they need to see at the OPD each day and see their ways of talking to them sometimes in a rude manner to be an outcome of the huge workload. *"Hame toh 200 se 250 patients dekhne hote hai, hum kya karen*….[we cannot give immediate attention. 200-250 patients are seen by four doctors from morning to evening. We are overloaded"].

2. Camouflaged notion of Purity and Pollution prevails: Refusal to touch care users based on the notion of purity or pollution is not referred to as discrimination but as a hygiene issue:… *"Yeh log apne aap ko saaf nahi rakte hai" , "dekhte hee pata chal jaata hai ki do-do teen teen din nahi nahate hai", "Hum unhe bolte hai naha ke aao"* [These people are not clean, we know by seeing them that they do not bathe for 2-3 days, we ask them to do so before coming for check-up].

3. **The "Preferred few" get treatment first**: Selective treatment to some is associated with higher power relations in the system- *"Jab Political Pressure aata hai toh HWC "Handle with Care" karna padta hai, jisme doctor se le kar bed allotment aur treatment sab jaldi se and badiya hota hai"* [when there is political pressure we have to handle with care, bed allotment and doctor treatments are done properly]. Thus, selective treatment to some is associated with higher power relations in the system.

4. Indifferent attitude towards vulnerability*:* Rude and arrogant behaviour is seen as justified given cumulative factors such as - overcrowding, workload, being short of staff, patient ignorance, and lack of proper facilities at the hospital [Power relations between the doctor and patient]. *"*Sometimes, we get rude after explaining the prescription again and again. Despite explaining repeatedly, they want it to be told to their husband *"Ek baar hamare aadmi ko bata do",* and they have a blank face. This all irritates the doctor and we have more than a hundred two hundred patients waiting. Indifferent attitude towards the vulnerability of the patients: "Only those who have time come here". "It takes a patient to wait for a longer time, hence the patients who approach have time to wait". This seldom informs the concerns of the voiceless urban poor.

5. Poor management and under-investment are reduced to care users blaming attitude:

Verbatim of Provider 1: "Due to illiteracy, patients first try going to quacks and different clinics. When they don't get relief, they come to us. Now, we cannot start working on someone else's prescription. Home deliveries are happening everywhere".

Verbatim of Provider 2: These people don't know what ANC is all about, they think of going to the hospital is for injection and we cannot counsel them as we are overburdened"

Verbatim of Provider 3: Patients ask "Dawai kahan se milegi", "Test kahan se karvana hai". Ab iske liye guard hai na baahar, usse pooch, yeh doctor ka kaam nahi hai". They ask for directions to know where medicines are available, where they need to go to get the test done. Explaining directions for all this is not the doctor's job, it is for the guard, who sits outside.

The outcome of Social Exclusion in Maternal and Child health

The dynamic nature of Social Exclusion sustains its existence in all the spheres of life in an active or passive manner. Although active or direct forms of social exclusion are less visible in

the hospital setting, there exist patterns of behaviour among the providers that have their roots in the exclusionary forces based on caste, class, and gender. The persistence of exclusionary processes and discrimination on the account of caste, class, and gender perpetuates poor access and inferior utilization of health care in the government hospital. However, lower caste care seeker's consciousness of the exclusionary processes based on caste, class, and gender and being victimized on its account remains low. On the other hand, in the perception of the lower caste care seeker, such experiences are due to gaps in infrastructure, corruption, and other reasons not associated with them. Unequal power relations exist between the provider and user in the hospital and these are based on larger social inequalities in the system, where a health system is on one subsystem. Access to health care Institutions is adversely impacted by perceived experiences of Social Exclusion. This may lead to the following extent of Social Exclusion in accessing government hospitals:

- **Complete or extreme Exclusion**: Poverty and lack of affordability would reduce the chances of complete exclusion since there is no alternative available and private hospitals are beyond the reach.
- **Partial Exclusion**: Accessing the government hospital is just before the delivery, or complications or an emergency.
- **Unfavourable Inclusion:** Fear of unfavourable inclusion in terms of coercive family planning measures

Provider's Perspective: Social exclusion in health occurs in varied forms. Among the providers, refusal or ignorance to follow the procedures or protocols when interacting with a Dalit care seeker is itself a cause of social exclusion from the provider. Literature review in the work of (Anna, L.A. et.al. 2018) informs on the forms of social discrimination based on healthcare providers' biases ranging from [denial or hold] of treatment options in the belief (conscious or unconscious) that acceptance to certain therapies would be a challenge to certain patients. Hall et al (2015). Further, social discrimination has been linked to disparities in self-reported physical and mental health Mays et al (2017) with the greatest risk of poor health outcomes for racial and ethnic minority groups Hall et al (2015). Similarly, in the study context, there exist varied perceptions among the care providers that influence their interaction with the care seekers. While a majority perceives, care seekers from urban poverty backgrounds as a

homogenous group characterized by poverty, hygiene issues, and ignorant behaviour. Some providers accepted "them" as heterogeneous individuals requiring unique individual backgrounds.

For some providers, there exists an inherent system of discrimination, subconscious prejudice, also called implicit bias often impacts the course of interaction with care seekers. Further, the notion of purity and pollution still exists in a concealed manner, whereby no direct action is observed by the care seeker but observed during interaction with the researcher On such example is as shared by one provider that shared that *" yeh log naha ke nahin aate, hum inhe bolte hai naha kar agle din aaoo"*. [These people come without taking bath and we tell them to bathe and come on the next day]. Here the notion of purity and pollution is very much evident but in an indirect way. Care seeker is judged from a distance that she has not taken bath and therefore needs to come on the next day. This form of refusal to touch informs the notion of purity and pollution. Additionally, some providers perceive that sometimes their rude and arrogant behaviour towards the care seekers is justified as overcrowding, excess workload, care seeker's ignorance and lack of proper infrastructural facilities at the hospital explain their own helpless situation and therefore it is justified. Here, social exclusion against the care user is camouflaged as mere management and infrastructural gaps in the hospital, where such behaviour is seen as justified. Furthermore, the power relations between the provider and care seekers along with systemic failure get reduced to patient blaming attitude. Insensitivity towards the patients is justified- "Only those who have time come here". This seldom informs the concerns of the voiceless urban poor who refrain from asking questions given the existing power relations between the two.

Coping Mechanisms among the Socially Excluded Women

- **Hiding Caste or its Shadow:** On Often basis Caste is hidden from the Provider/Employers by referring to themselves as belonging to a different caste or by using Pseudo names and surnames as shared by the mainstream community.
- **Social Capital and Networking:** Any sort of social connection based on similar background or affiliations (whether similarity in region, religion, language, dialect, caste, etc) with the provider or anyone in the chain of health system assists in providing easy access to the hospital and the doctor on time**.**

- **Experience of stay in Delhi**: An urban poor woman who is a first-generation migrant with a short duration of stay in Delhi and having no social contacts and having first pregnancy then the patient faces more problems in accessing the services compared to someone other who has some sort of social connections and experience of living in Delhi.

Conclusion

Social Exclusionary processes have been embedded deep in our society with the intersectionality of caste, class, and gender. The axis of social exclusion and its processes are dynamic in nature. In our daily lives, we interact with such processes and get influenced by its outcome. The health care system is no exception, the societal exclusionary forces have a dominant role in determining the provider and care seeker interaction. Social Exclusion in health is an expression of the ongoing dominant health inequities. In the context of a government hospital, Social Exclusion in the health care setting is manifested in the providers' perspectives, opinions, beliefs, behaviour, and attitude against the socially excluded disadvantaged populations.

Social discrimination has been linked to disparities in self-reported physical and mental health (Mays et al 2017; Eisenberger, Lieberman, & Williams 1996) with the greatest risk of poor health outcomes for racial and ethnic minority groups (Hall et al 2015; Nelson 2003; Williams, Neighbours, & Jackson 2003.

However, the explanation of social exclusion cannot be reduced to mere behavioural issues of some individuals over the majority of others. Further, it is due to the failure of a society that an institutionalized form of inequality exists. It is due to the society's failure to extend the social recognition as well as the economic resources they need in order to participate fully in the collective life of the community.

Social inequalities sustain health inequities. Poverty, caste, and gender differences at the societal level operate to form expressions of health inequities in the form of Social Exclusion in health that excludes the urban poor women care users from proper access and utilization of health care. There exists an inherent system of discrimination due to existing power relations between the provider and care seeker. The determinants of power relations are dominated by structural, social, and daily living determinants of social exclusion that cause health inequities to sustain. Social exclusion faced at the level of a government hospital has been analyzed in

terms of spheres- access to the hospital, allotment of beds, and dispensing of medicine. In the hospital setting, exclusionary processes are embedded.

Access and Utilization of Health Care are impacted by exclusionary processes operating in different spheres and in different forms. Power Relations between the provider and patient influence access and utilization of services. Subconscious prejudice also called implicit bias regarding urban poor women in several ways can affect the interaction between provider and care seeker. Further to their interaction, these biases also get reflected in the decision-making of the nature of treatment offered or denied depending on the social position of the socially excluded individuals. Gaps in knowledge, authority, social class, caste, and gender are attributed to holding of power in the hands of the provider and care seekers as powerless and on receiving end. This results in health inequities in the social exclusion of patients. Social determinants of exclusion (Structural and Intermediate) operate along the social forces intersecting caste, class, and gender. This continuum results in inclusion/exclusion.

Findings

- Urban women did not openly attribute the intersectionality of independent social factors of being a lower caste urban poor woman as the direct cause of their social exclusion in health. Instead, they attributed overcrowding and long queues as reasons for difficulty in having proper access to the hospital. Further, some care seekers shared about being aware of "some" preferred individuals to be given quick and quality access unlike them. In general, care seekers were unable to classify the "preferential some" but explained them as rich individuals, who are better dressed, have social connections, and speak English.
- Care seekers shared about compromised quality of care where the provider lacks in providing a personal touch and deals in a mechanical way.
- Owing to the barriers faced in accessing the government hospital given the exclusionary forces operating in different spheres and in different forms, access to the government hospital becomes a compulsion than a choice.
- From the demand side, the urban poor migrant population relies heavily on the government hospital for catering to their health care needs (including maternal health needs). However, due to the limited supply side at the government hospital in terms of

infrastructure, logistics, and manpower, there exists inequities in provisioning as well as access to quality health care services for all.

- Urban poor care seekers are heterogeneous individuals. Despite being lower caste and class, those individuals who have some amount of financial stability in terms of having a job such as domestic workers or factory labourer, tend to be better off than women who are without any source of income. Variations among the urban poor population group depend on unique individual factors that differentiate one individual from another. A care seeker who is digitally literate has a smartphone than a woman who has no information on digital platforms, who lacks access to information as shared by government, media, and other sources of digital platforms. Further to this, care seekers who have social capital and more experience in terms of duration of stay in Delhi become more familiar with routes to access the hospital and the different means of transport available. They become more equipped to handle emergencies on their own by approaching the government hospital in an auto-rickshaw in times of need. In contrast, a woman who has just arrived will require social support if her husband is away for work at the time of an emergency during her delivery time.
- Social connections within the hospital, social, political system, or, the affluent background is an important medium for quick access to the health care facility and access to quality care from the provider. This stands as a contrast to those urban poor vulnerable women who live at the margins of the city. They feel socially excluded from mainstream society as well as from the providers in the hospital causing their social exclusion in health.

Provider perspective findings

- Flaws in the public health delivery system are not counted as gaps causing problems to the care users. Issues of poor access and adverse health outcomes of Dalits are side-lined as sheer supply-side problems. It hence allows the perpetuation of caste practices by practitioners in the health services without being adequately noticed.
- Inability to classify the "Some" Preferred people. Chances of Caste-based discrimination and resulting social exclusion could get camouflaged in the general problems of health care.

- There is a rare explicit expression of exclusion shared by the providers who majorly belong to the middle and upper class, male and female providers. Given the inherently stratified society with structural inequalities – Subconscious prejudice or implicit bias has an impact on the way patients are dealt with. Thus, there exist multiple layers and levels of social exclusion and can be analyzed through spheres, forms, and perspectives in any contextual setting.
- The attitude of the provider forms the perspectives of the care seekers. Discrimination on refusal to touch is associated with the historical notion of purity and pollution. Although it is not observed in a direct manner. Some providers shared that the care seekers wear filthy clothes and smell bad, so they have to counsel them to back home, take bath and then come on the next day. Here the notion of discrimination on the basis of purity and pollution is not direct yet enforced through the channel of general cleanliness.
- Rude and arrogant behaviour of the provider is sometimes justified on cumulative external grounds such as overcrowding of patients, increasing workload, patient's ignorance and lack of proper infrastructure and facilities at the hospital, and power relations between the provider and care seeker.
- Poor management and under-investment get reduced to patient blaming attitude. Further Lack of individual attention, follow up and monitoring is referred to as a system's failure. Also, the insensitivity towards the patients is justified- "*Only those who have time come here*". This seldom informs the concerns of the voiceless urban poor who refrain from asking questions given the existing power relations between the two.
- Labelling shortfalls in the patients are identified as a barrier than being for their health system's inadequacies.

In the next chapter, the study focuses attention on understanding Covid 19 and its impact on maternal health among the urban poor care users with the felt need for maternal health care.

Chapter Six

COVID 19 PANDEMIC: PLIGHT OF THE SOCIALLY EXCLUDED

The human race is under tremendous pressure due to the outbreak of Coronavirus disease (COVID 19), which is an infectious disease caused by a newly discovered coronavirus. With the genesis of the outbreak in the year 2019, the global public health emergency, 'a pandemic' has now spread to countries, causing infections, causalities, and recoveries. This global public health emergency is posing challenges to individuals, health care systems, and governments across many continents in general. In addition to this, for the people who are socially excluded, their interaction with the health care services is at heightened risk as they experience social exclusion in the different forms, spheres, and from the providers, which requires careful analysis.

6.1 Origin

The outbreak of the disease Covid 19 a public health emergency was declared by the World Health Organization (WHO) on 30/01/2020. The outbreak origin was recorded in the city of Wuhan, located in Hubei province of Central China. In India, on 30 January 2020, the first laboratory-confirmed case of COVID-19 was reported from Kerala. As of March 31, 2020, a total of 2,245 cases and 56 deaths were reported in India (Gonzalez, S. 2020),

6.2 Context

COVID 19 has precedence: The word 'unprecedented' is being applied in the discourses around Covid 19. However, looking back into history, such pandemics are not new. During the 15th century, the Bubonic plague had shaped public health in Europe (Gonzalez 2020). Secondly, in the 19th century, Edwin Chadwick brought the sanitary revolution to England to counter cholera and retro fitting British cities with sewers, running water, and the water closet that transformed daily life. Thus, drawing from past experiences, we are using the tools such as Masks, PPEs, sanitizers, etc as our response to the pandemic.

6.3 About the virus

Covid 19 is an evolving virus, and the world has suffered different waves of the virus. Until March 2022, the country has witnessed three waves of the coronavirus, with the second wave as the deadliest wave. Though the population of different age groups is being vaccinated, there remains daily news statistics on Covid 19 showing the number of cases getting infected by Covid 19. Presently (30 Mar 2022) China is witnessing another wave of Covid 19 and has major cities in lockdown, whereas, in India restrictions and curbs are now been removed but the country needs to stay vigilant on the developments in China.

6.3.1. Adaptability: The news information as per HT dated 01 May 2020, the virus tries to adapt to a new environment and change its genetic makeup to utilize the host's body in favour of its survival (Nandi 2020). Such trends have been seen in Kerala, Gujarat, and West Bengal so far.

6.3.2. Symptoms: In terms of the symptoms, so far it is known that COVID-19 waves have affected people differently, especially the high-risk elderly, pregnant, and co-morbidities persons who have been at a heightened risk. Each wave of the virus had distinctive symptoms...

6.3.3. Response: Many countries are working day and night to identify a vaccination for this disease. Similarly, therapies such as plasma therapy are also under trial. However, the challenge is there is a lack of a concrete understanding of this disease and how interventions need to be tailored to meet the requirement.

6.3.4. Endemic in Nature: The present time demands pandemic be dealt with as an efficacious vaccine. However, until then, the pandemic may become endemic. This requires refiguring our lives in terms of the new reality, our cities, environment, and health care systems.

6.4 Maternal Health in Covid 19

Maternal health is the most crucial aspect of a woman’s life.

The 1994 International Conference on Population and Development (ICPD) at Cairo emphasized the importance of reproductive health, especially maternal health. Subsequently, India adopted reproductive and child health programmes at the national level. Previously, the Millennium Development Goal (MDG) and at present Sustainable Development Goal 3 includes the focus on reducing maternal, newborn, and child mortality.

Today, the world is grappling with multiple variants of Covid 19 and new waves of the pandemic, this has brought a loss of lives, sickness, and increased sufferings in the different spheres of life. The Hindu Newspaper on 03 April 2021 in the article "Covid 19, led to rising in maternal deaths, stillbirth" has cited the report published in The Lancet Global Health Journal on 31 Mar 2021. The report has cited 40 studies across 17 countries including India.

The major finding of the report:

- The Covid 19 disruptions have caused avoidable deaths of both mothers and babies.
- Reduced access to care is the account of the failure of the "inefficiency of the healthcare system and their inability to cope with the pandemic" instead of strict lockdown measures.
- It is the marginalized in different settings who suffered the most. Example- In Nepal, hospital deliveries decreased most markedly among disadvantaged groups. In the U.K., 88% of pregnant women, who died during the first wave of the pandemic, were from black and minority ethnic groups, the study states.
- Further, wider societal changes could have also led to deterioration in maternal health including intimate-partner violence, loss of employment, and additional care responsibilities because of the closure of schools.
- The report states an increase of 28% in stillbirth, and a one-third increase in the risk of mothers dying during pregnancy or childbirth There was also a rise in maternal depression.
- The authors recommend that personnel for maternity services not be redeployed for other critical and medical care during the pandemic and in response to future health system shocks (The Hindu Newspaper 2021).

6.5 Indian Context

Under the National Health Mission (NHM), Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A) form the main programmatic component. The achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs is envisaged by NHM.

NHM's endeavours to reduce MMR to 1/1000 live births. In working towards its achievement, the Government of India 2013 adopted a framework of Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A). Further, through various schemes under the NHM such as Janani Shishu Suraksha Karyakram, Janani Suraksha Yojana, and initiatives like LaQshya and Pradhan Mantri Surakshit Matritva Abhiya, India has made advances in achieving the United Nations Sustainable Development Goals (SDG) 70 births/100,000 live births by 2030.

In 2016-18, India's maternal mortality rate (maternal deaths/100,000 live births) decreased from 407 in 2000 to 113 (Sample Registration System (SRS) Bulletin 2020).

Given the above achievements, the onset of the pandemic in 2019 has led to a decline made in reducing maternal mortality so far. The social media reports since the pandemic and especially in the second wave of Covid 19 in April 2021 have informed about a large number of deaths of pregnant women. Given the urban poor women already suffer exclusion in their access to health and health care services given the pathways of health inequities and social inequalities they are surrounded with. The impact of the waves of Covid 19 has been severe among urban poor women. It was only in Jan 2021, that the Covid vaccination for pregnant and lactating women was stressed to be prioritized by the Federation of Obstetric and Gynaecological Societies of India (Allana 2021).)

Covid 19 increases the chances of preterm birth, which increases the possibility of hospitalization for the neonate. There is an increased risk of preterm birth and other adverse pregnancy outcomes. Also, women with preexisting morbidities, advanced maternal age, and high body mass index are at heightened risk. In the Indian context, an analysis of HMIS data by the Population Foundation of India. Upon comparing the period of national lockdown from April to June 2020 when the national lockdown was implemented with the same period in 2019, it was observed that there was a drop of 27% in pregnant women receiving four or more ante-natal check-ups. Further, there was a decline of 28% in the institutional deliveries and of 22% decline in prenatal services. (The Hindu Newspaper 2021).

6.6 Covid 19, Health Inequities and Social Exclusion

According to the WHO's Social Exclusion Knowledge Network (SEKN) of the Commission on Social Determinants of Health (CSDH). According to the WHO's Social Exclusion Knowledge Network (SEKN) of the Commission on Social Determinants of Health (CSDH), a continuum of inclusion/exclusion results from the social exclusion processes. The continuum is characterized by inequalities in access to resources, capabilities, and rights. This continuum results in health inequities. Creating a vicious circle, the social exclusion processes influence health directly through manifestations in the health system and indirectly by affecting the economic and other social inequalities that influence health. (SEKN, 2008).

The Social Gradient approach as explained by Marmot in 2004 reflects on the stepwise or liner disease in health that comes with a decrease in the social position, thus resulting in health inequities. The extent of health inequities is typically proportionate to the level of disadvantage, with populations experiencing poverty and social exclusion having fewer opportunities for health than those in more privileged positions (Marmot 2004). Thus, there are strong pathway linkages between poverty, social exclusion, and health inequalities. When poverty informs about the income inadequacies, social exclusion reflects on the causes of poverty and the linkages with health inequities inform about the stepwise or linear decrease in health that comes with a socially disadvantaged position.

The outbreak of the Covid 19 pandemic has negatively impacted all the population across the globe. However, the adverse effect of the pandemic is being suffered by the already vulnerable and socially excluded groups and people. Given the economic inequalities in terms of the income gradients, many countries have reported disparities in terms of the number of cases and fatalities counted. The different countries' experiences so far inform that, even though Covid 19 is a pandemic, it doesn't affect all segments of the society in an equal manner who have limited or no resources, lack of social support, basic amenities to cope with the lockdown, fea r of movement, loss of employment opportunities, migration, and increased xenophobia.

In India, social inequalities are outcomes interplay of social forces such as caste, class, gender, and other forces. The pandemic has seen the experience of discrimination and social exclusion from the social forces to the segments of the population who are marginalized. Poverty impacts the individual in manifold ways. Covid 19 pandemic has exposed gaps in society and its

consequent health inequities. Series of Lockdown has caused additional barriers the access to the hospital for all. However, due to the gendered and unequal role of women in society, the barriers and impact of the pandemic on access to the hospitals are different for girls and women as compared to boys and men. Further, caste proxy in poverty renders the urban poor women at heightened risk in the context of Delhi. Being from marginalized groups, urban poor women face multiple hardships. With the addition of the pandemic, their hardships have increased manifold in terms of increase in care work, household chores, provisioning of food, fetching of water, and child care.

The present situation of the pandemic has altered the advanced made in improving maternal health. Our Health Care System is already grappling with varied deficiencies at the system level along with limitations on the grounds of structural and social determinants. Covid 19 has brought into light the existing inadequacies in the health system. Under the deficient health care system, it is urgent to examine the maternal health condition of the vulnerable urban poor women in regard to their basic access to the government hospital. Pandemic has caused lockdowns, curfews, and restrictions but there cannot be a halt to the basic health care needs of pregnant women. Among them, urban poor women face social exclusion based on structural, social, and individual determinants. Urban poor women have unique health needs. Living on the margins of the city, they face social exclusion from mainstream society in all the spheres of their lives and in varied forms. As a result of the pandemic and its associated restrictions, their access to hospitals is adversely impacted by low access to general health care services for care seekers with co-morbidities, and maternal and reproductive health care for pregnant care seekers.

Due to the lockdown situation led by the pandemic, many urban poor women have returned to their native villages due to sudden loss of livelihood and resultant no means to survive in Delhi. With the sudden reverse in migration, many respondents have left their maternal health care needs unattended. Those respondents who have decided to stay in Delhi are in a state of constant fear of contracting the virus upon stepping out of the house. Respondents over the phone informed about feeling uncomfortable due to fear of virus to travel in public transport which anyways is less due to lockdown and contracting infection when accessing the hospital.

6.7 Media expressions of the lived experience of the impact of Covid 19 restrictions on maternal health during the first wave of Covid 19 in India (2020)

1. **Exclusion due to unavailability of provider and health care facility**: A 35-years old pregnant woman from North East Delhi could not contact ASHA (accredited social health activist) or any worker when her labour pain started. Thereafter, she went to the maternity clinic where her antenatal check-up had been done but the clinic was closed for the day when she got there. She was then told to go to [a government hospital] Kasturba hospital, about 6km away. "*She did not know how to get there and she was already in a lot of pain. So, she decided to call a midwife home. She gave birth to a baby boy, who died soon after*" said Sulekha Singh, a health activist, who helped the woman take her baby to [another government hospital] Chacha Nehru Bal Chikitsalay afterward (Dutt 2020).
2. **Excluded due to Covid 19 infection among the Staff of the hospital:** In another case, a pregnant woman who from Jahangirpuri [area of Delhi], was unable to access the government hospital Babu Jagjivan Ram Memorial Hospital, where she used to go for 75 health workers tested positive for Covid 19. She was helped by the police to reach Deep Chand Bandhu Hospital. Over there, she told to approach Ambedkar hospital for delivery since it was closer to her place. Finally, the care seeker could not get admission to Ambedkar hospital too as someone turned Covid positive (Ibid).
3. **Excluded from health care due to her locality**: A 25-year-old pregnant woman from Nizamuddin Basti was turned away from six hospitals and maternity clinics in 48 hours before she finally gave birth outside the All-India Institute of Medical Science. In her case, the area from where she came was declared a containment area. Even though she was not covid positive, still she was turned away due to her area of residence (Ibid).
4. **Similar to the above,** during the second wave of Covid 19 in April 2021, a 25-year-old pregnant woman nearly waited for 48 hours to get access to the emergency services for her pregnancy and delivery. Since the care seeker was a native of a "red zone" area designated by the authorities, she was denied admission to Delhi's leading hospital. Over the 2 days span, she had approached six public and private hospitals. This happened at a time when public transportation was completely suspended and mobility was severely restricted. She had repeatedly faced denials, exorbitant cost estimates from a private hospital, and facilities that lacked the necessary infrastructure to deal with her

condition and medical history. Given, that the lack of non-COVID-19 ambulance services at a government hospital and in other government hospitals had delayed her access to health care, heightening the risk to her health and life (Pal 2020).

6.8 Verbatim of respondents during snowball sampling done over the phone:

5. Respondent 1 (snowball sample over the telephone) shared about being in confusion about access to the hospital at this time due to fear of contracting the virus from the hospital. Respondent is three months pregnant living in a resettlement colony in Shadipur. She is avoiding an Antenatal check-up due to fear.
6. Respondent 2 (snowball sample over the telephone) shared about panic due to lack of transport and no money to book private transport cabs to reach the government hospital. "I am not educated so I don't know much about this disease." Respondent 2 stays in Naraina village, she is unable to attend Antenatal due to access issues and fears the infection, and has no proper information.
7. Respondent 3 (snowball sample over the telephone) shared about the rumours of change of Non-Covid into Covid only hospitals. This is her first pregnancy, she is newly migrated to Delhi, and stays in Naraina near railway stations. She is facing challenges in handling pregnancy in an unfamiliar environment along with the lockdown.

Table 6.1: Major barriers among care seekers: Spheres, Forms, Outcome, and Impact

Barrier 6.1.1: Covid led Lockdown, curfew and restrictions

Sphere	Forms/Output	Outcome Access to Hospital	Impact	
			Maternal Health	General lives
Personal/ Home Workplace	Loss of livelihood	Loss of income is the primary cause of low access to hospitals. An increase in poverty levels poses urgent attention to survival needs challenges where access to the hospital for maternal health needs takes a back seat.	Ignorance of felt need to approach the hospital The severity of problems for women with comorbidities Increase in unattended ailments and morbidities Unattended maternal needs at ante, peri, and post-natal. Low consumption of IFA tablets due to multiple responsibilities at home, forgetfulness, and time poverty	Increase in poverty Reduced or no level of Income Material deprivation Inability to afford a balanced diet food, medicines Lack of Self Care due to time poverty

(Source- Adapted from the empirical evidence and media)

Barrier 6.1.2: Covid led Lowdown, curfew, and restrictions

Sphere	Forms/Output	Outcome Access to Hospital	Impact	
			Maternal Health	General lives
Home	**Restrictions and fear** to step out of the house among the care seekers and their families	Restricted Access to Hospital due to time poverty gave an increase in responsibilities of household chores and no child care support	De-prioritization of maternal health needs, Unattended maternal health needs Access is limited only for delivery and emergency	Restrictions to going outside have added a burden on the household chores of family members. Increase in mental health issues due to fear such as stress, depression Increase in cases of domestic violence from a spouse Increase of problem of alcoholism among care seekers spouses.

(Source- Adapted from the empirical evidence and media)

Barrier 6.1.3: Covid led Lowdown, curfew, and restrictions

Sphere	Forms /Output	Outcome Access to Hospital	Impact	
			Maternal Health	General lives
Public conveyance to cover the distance between home and hospital	Lack of Transport	Restricted Access to Hospital	Unattended maternal needs at ante, peri, and post-natal. Low access to the hospital for maternal needs Access is limited only for delivery and emergency	Increase of morbidities

Source-Researcher

Barrier 6.1.4: Covid associated fear of contracting diseases

Sphere	Forms/Output	Outcome Access to Hospital	Impact	
			Maternal Health	General lives
Home	Lack of proper information/ awareness on Covid.	Restricted access to the hospital due to fear and uncertainties in the stepping of the house.	Unattended maternal health needs at ante, peri, and postnatal.	Increase in mental health issues. Women shared about experiences of negative emotions inflated by isolation causing Stress, anger, and confusion.

(Source- Adapted from the empirical evidence and media)

Barrier 6.1.5: Covid associated uncertainty and reverse migration

Sphere	Forms/ Output	Outcome Access to Hospital	Impact	
			Maternal Health	General lives
Home/Work	Lack of proper information on lockdown and about relaxations	Access to the hospital was not a priority for the urban poor given the loss of income.	Felt Maternal health needs take a backseat when survival challenges come to the forefront Lack of self-care given priority to meeting the financial needs of family	Loss of livelihood is the main cause to drive the urban poor back to the village Reverse migration has acted as a deterrent: Covid times has revealed disturbing news about reverse migration of the urban poor to their native villages due to loss of livelihood and news clippings of pregnant women returning barefoot to their village have been evident due to lockdown and lack of connecting means of transport to return. Loss of Social Capital/Networks due to reverse migration Respondent 1 shared "*When there is no work, we cannot stay here. Going back to the village is urgent and we don't have a choice".* *Here access to the hospital for seeking care for maternal health needs takes a backseat while going back to the village in whatever condition becomes a priority and need of the hour given the survival need challenges.* Unavailability of coping mechanisms

(Source- Adapted from the empirical evidence and media)

6.9 The scale of deprivation:

Being a heterogeneous group, each lived experience among the Urban poor women informs about the heightened vulnerability on the account of Covid 19. Deprivation is linked to a vulnerability against determinants of social exclusion. Context-specific vulnerability on the account of structural, social, and individual causes barriers and shapes the chances of access to the hospital. The vulnerability is further heightened with the ongoing pandemic barriers leading to adverse impacts on maternal health among the urban poor. The following key factors play a significant role in the upwards or downwards movement of care seekers on the scale of deprivation in access to the government hospital.

(i) **Access to a digital platform and digital literacy:** In times of pandemic, when isolation at home has become a norm to prevent further spread of the infection, digital literacy becomes important as it is a link for an individual to connect with society from a digital platform. In the case of the urban poor women who are unable to manage for basic two meals of the day, the digital platform is a faraway reality. Poverty and irregular and meagre resources do not allow an urban poor woman to afford a mobile phone of her own. Many respondents shared the phone number of their husbands or landlord to connect. In such a scenario, the government's initiative and messaging information on Covid 19, registration for vaccination, and guidelines for pregnant women do not hold relevance for the urban poor who are offline and away from the digital world. The digital divide between the population groups further marginalizes and socially excludes urban poor individual women from access to information as shared by the government and its services.

(ii) **Overloaded with Care work/ Housework:** Another factor that triggers the scale of vulnerability is the additional burden of the household chores when family members (husband and children) left for work and school respectively in normal times are under lockdown causing the addition to household chores and no support on child care responsibilities. Due to additional responsibilities in a pandemic, care seekers often ignore their felt need for antenatal and post-natal check-ups and approach the hospital at the last minute. Some urban poor women, who have comorbidities such as diabetes and blood pressure, either tend to ignore the health issues or miss the workday to visit the hospital.

(iii) **Loss of Livelihoods:** Pandemic-associated lockdown and fear of contracting infection has resulted in livelihood challenges. Care seekers working as domestic

workers shared about the loss of work as employers feared contracting infection from them. One care seeker shared that they think we come from a poor background so we are super spreaders." Another care seeker stated, "we have to work with a mask but they (employer's family) do not wear a mask". Here the question arises on who causes the spread of infection, is always transmitted from the poor to the rich or can go vice versa too

(iv) **Reverse Migration**: Here maternal health needs took a backseat and survival challenges in Delhi became primary. Reverse migration occurred on the account of lockdown and resultant loss of livelihood. Due to multiple work responsibilities at home and reverse migration, many care seekers are informed about frequent entry and exit from the work they do. The exit from work can be due to termination from the employer of not turning up for work on time or missing the workdays in a row for two days or more, not informing the employer about missing or getting late for work in advance or over the phone. This is the major dilemma of care seekers who fear the loss of work if there is a delay in the queue or if the doctor asks them to come back again tomorrow.

(v) **Domestic Violence/ Lack of partner support:** Some care seekers are informed about the lack of coping mechanisms in dealing with household, and domestic work as support from husbands is minimum, none or negative. In terms of negative, here it refers to domestic violence and the problem of alcoholism that causes the care seekers' inability to work at all levels, increases depression, stress, and other mental health issues, and finally results in alienation from work, social exclusion, and lack of self-worth. Here the context of taking care of felt maternal health takes a real back seat.

(vi) **Comorbidity and pre-existing morbidities:** On the scale of vulnerability, pre-existing co-morbidities cause an additional layer of vulnerability among urban poor women. Pre-existing medical conditions along with pregnancy-associated medical conditions such as diabetes and blood pressure added additional stresses.

(vii) **Social Identity:** Living on the margins of the city, the urban poor face a paradoxical situation of living in a developed capital city yet lacking the basic ecosystem for their own survival. With the death of basic amenities such as drinking water, sanitation, hygiene and space, and ventilation in the room, the lives of the urban poor women never remain in the strict spheres of public and private as portions of houses fall in the public domain and for some public roads, underneath the flyover

or metro stations is their private sphere. Thus, there is a very thin line to demarcate the two spheres and often seen as intersecting during the different time periods in a day.

(viii) **Social Capital** is an important factor assisting easy access to the hospital for the urban poor. Social Capital is determined by the tenure of stay in Delhi. Care seekers who have stayed in Delhi for more than six months to one year are more aware of the travel routes, transportation, and hospital facilities around. Besides, they also have better social connections. Care seekers shared that, with social connections with the hospital personnel both inside and surrounding areas who are connected with anyone in the hospital, it becomes easy for them to access the hospital compared to those, who have no social capital.

Urban poor women who are residing in Delhi for a longer period (more than a year) or having those with social networks and connections have greater chances of access to the hospital and meeting the doctor. "Hum *jaante hai kisi ko yahan par isliye humara number aage ho gaya nahi toh pata nahi*". Respondent is able to get away from the queue as she has social contacts with known persons in the facility. This facilitates greater chances of access to a doctor in a timely manner compared to others who are new to the facility and they keep on waiting thinking their chance would come. With a delay in meeting the doctor, many care seekers return. It is the alignment of delays caused at the hospital and time poverty that hinders access to the hospital, especially for antenatal, post-natal, and meeting maternal health needs

6.10 Outcomes of the barriers

Pandemic has impacted care seekers in all spheres of life. The Covid 19 pandemic has a heightened risk of social exclusion in maternal health. Preexisting determinants at structural, social, and daily living levels play out to cause barriers in access to the hospital and their resultant social exclusion. This expression of social exclusion has found further escalation in various forms with the onset of the pandemic. Measures to combat the further spread of the pandemic inform on necessary steps such as frequent hand washing, wearing a mask covering the mouth and nose, and physical distancing. With the new normal norms under Covid 19, care seekers bear the brunt of being labeled and stigmatized as "super spreaders" as they are poor. Respondent X is a domestic worker "*kaam karne jaate hai par unhe lagta hai ki hum corona phela denge*" [we go for work, but they feel that we will spread it.] Care seeker shared that she

is poor and lives in a jhuggi where there is no proper sanitation, but she is wearing a mask and maintaining physical distance and washing hands, yet her employers do not trust her words. The care seeker fears further getting labeled as unclean and losing her job from other houses too. Here, it is important to understand how labeling and stigma play an important role. Being poor is not associated with cleanliness. The measures under pandemic handling and further prevention inform about hand washing, mask-wearing, and physical distance that urban poor women follow. But still being labeled as corona carriers is on the account of their social and economic status is a further act of social exclusion against them. Similarly, care seekers' access to hospitals shows expressions of social exclusion.

***Maternal Health**:* Expression of social exclusion in the hospital: Due to Covid only facility in the government hospital, care seekers were diverted to alternate hospitals. Given the risk of infection and increase in distance to an alternate facility, many care seekers were compelled to access private hospitals. Care Seekers are informed about incurring loans to pay the hospital fee.

***Mental Health**:* In the times of pandemic, urban poor women with maternal health needs shared about mental health issues faced on the account of domestic violence from the husband, loss of livelihood, limited resources to handle pregnancy and virus inability to meet basic two meals, denial of admission to the hospital due to Covid only facility resulting in an increase in unattended morbidities and mental health issues such as depression, stress.

Overall Health: Urban poor women with ailments are at heightened risk: Covid 19 lockdown and restrictions has adversely impacted the pregnant women with comorbidities such as diabetics and blood pressure. Provider Y "*Due to restrictions on movement, overall health has been impacted which otherwise remained under control with physical movement during the day".*

***Relative in nature**:* Barriers to access to maternal health care are relative in nature. It gets shaped by coming in contact with the various determinants of social exclusion that exist on a structural, social, and individual basis.

***Impacts quality of life**:* Without proper access to health care services in the Covid times, many respondents shared about unattended morbidities adversely impacting the overall well-being and maternal health. An increase in morbidities also amounts to an increase in disease burden in the country.

Ignorance of felt need to approach the hospital: Preventive restrictions such as quarantine, physical distancing, home isolation, and remote consultations with healthcare professionals associated with Covid 19 have aggravated concerns over the felt maternal health needs of the pregnant women reducing their chances to access hospitals. This poses unintended risks to both mother and child, as preventive measures of providing care and support at prenatal, intrapartum, and postnatal remain diminished during the pandemic.

Low Institutional deliveries, increase in unattended morbidities impacting overall health and quality of life: Fear and uncertainties of infection led to the inability to step out and compelled to be at home. Many pregnant women are fearful of stepping out of the owing risk of contracting Covid 19 causing home birth. Owing to fear and uncertainties around the pandemic, there is low access to the hospital for maternal needs. Access is limited only to emergencies causing an increase in deliveries at home. Limited access to the hospital with inadequate antenatal visits and post-natal care has the potential to cause an adverse effect on maternal mental health.

6.11 Provisioning

6.11.1 Government Hospital:

Overwhelmed Health Care System: At the government hospital, reduced staff capacity, change of hospital into Covid only facility has further shattered the experience of the urban poor in accessing care. Due to being a Covid facility, the respondents were denied access and diverted to other non-covid hospitals thus causing confusion, frustration, and a helpless pathway to their maternal and child health. From the perspective of the provider's provisioning, with more and more health care workers turning positive for the infection, the staff are sent under quarantine and sometimes the hospitals are sealed. Due to this, a majority of the care seekers were informed about their inability to visit the hospitals for antenatal care. For some of the care seekers, they were forced to travel to the hospital located at a distant location, thus risking their lives from coronavirus infection, while others had no option but to birth at home.

Response Mechanisms: Response to pandemics has to be on an immediate basis and requires a robust health care system to safeguard people from contracting a deadly infection and for disease control. However, the onset of the pandemic has reflected on the pre-existing deficiencies in the Health Care System. Some of them have been mentioned below:

Lack of preparedness of the health care services: The health care services, the hospitals, doctors, nurses, administration, frontline workers who serve as the lifeline in the era of a pandemic are falling prey to the spread of infection. Being a new infection, there exists a lack of preparedness among the health care system and the providers in addressing this health emergency. On an often basis, many doctors, nurses, and frontline workers have stated about working without protective gear such as masks, sanitizers, PPEs, basic equipment, and supplies which is similar to going to the war without any arms to self-defend. Providers have shared about risking their own lives for saving the patients.

Fire Fighting Mode versus Preventive/Precautionary Response: Pre-existing deficiencies in the health care system such as infrastructure. Manpower and resources have caused government response to be in a fire fighting mode than in a preventive manner.

Medical staff at risk: Globally around 70 percent of health workers are women, inclusive of care institutions. Being on the frontline to fight against COVID 19, they face a double burden of working longer shifts and additional work at home.

In the context of India, the Accredited Social Health Activists ASHA workers, who serve as a link between the health services and the community are actively fighting the battle against Covid 19 as the frontline female community health worker. Their role constitutes going door to door to provide services to the people. However, are poorly paid, ill-prepared and vulnerable to attacks and social stigma (BBC 2020). In the words of Ms. Alka Nalawade, a community health worker in the western state of Maharashtra during the first wave of Covid 19 (2020) "The value of our life is just 30 rupees [less than $1], accordingly to the government. The government is paying us 1,000 rupees ($13; £10) a month for corona-related work," she adds. "That is 30 rupees daily for putting our lives in danger. Their role in the fight against Covid-19 is not that different - they visit the homes they have been assigned, educate families about isolation, and monitor people for symptoms of the virus. But the risk is far greater than anything they have faced before as they don't have masks or sanitizer, India is facing a severe shortage of personal protective equipment (PPE)**,** and even doctors and nurses are unprotected".

Referring to the context of Italy, the women health workers remain overworked during pandemics yet underpaid. The International Labour Organisation (ILO 2021) states that, for a,

around 100 million female workers in health and care institutions around the world, it remains a challenge to balance out work and family. With the Covid 19 pandemic, the [amount] of unpaid care work has heavily increased due to the closure of schools, childcare, and other care facilities. As a result, single female health workers are also at risk of infecting their dependents at home. (ILO 2021).

Manpower: The resilience of health systems, as well as the countries' emergency preparedness and response, have been put to a challenge and it calls for further strengthening of the Health System as well as the manpower (ILO 2020). The health care workers form the basis of the health system. However, with the second wave of the Covid 19 virus in India and also the different waves of Covid 19 across the globe, the world has witnessed a loss of many health care providers who in order to save the lives of the care seekers have either risked or lost their lives in the battle against Covid 19.

6.11.2 Practise among the Urban Poor Women from Provider's Perspective:

- Being migrants, they are a floating population between cities and rural areas, therefore they are always on move, access to a hospital is generally in case of emergency and at the time of delivery.
- For other maternal health needs and ailments- practice is to approach a nearby chemist or unqualified practitioner.
- On an often basis, there is late Identification of Pregnancy: Many care seekers are informed about not being able to identify their pregnancy in the initial weeks or months. Care seekers shared that upon missing the menstrual cycle for months and when the changes occurred due to the development of the fetus they had to approach health care services. The reasons for delays were shared as ignorance about pregnancy being a first-time pregnancy experience, time poverty, and inability to give time for self-care.
- Anaemia and poor intake of nutrition, IFA, and calcium supplement: Maternal health of the urban poor women is not limited to access to the hospital but also to the other components crucial to health such as nutrition, IFA, and calcium supplements. Urban poor care seekers shared about their inability to arrange for basic two meals of the day. Respondent 1 is five months pregnant domestic worker; she works in the morning and evening in seven houses and gets a total of seven thousand per month. In this amount, she needs to pay four thousand for the room rent and is left with three thousand to run her family. Her family consists of a husband and a minor child. Her husband is an

alcoholic, she remains worried as he often snatched her money from the purse to buy liquor and incurred battering and other forms of domestic violence. Under such circumstances, the respondent is stressed and worried about the five-year-old minor. She is thinking about how to arrange two meals for him as all her money is lost, she has no thoughts about her own nutritional intake or consuming IFA and calcium tablets. The next day, she borrows money from one of her employers and when her employer asks why she could not move her hand, she replies that her hand got injured when doing work at home. She does not reveal the domestic violence suffered by her husband.

- High susceptibility to Covid 19 infection and other communicable diseases due to poor sanitation, no proper garbage disposal system, and lack of drinking water in the urban slums.
- There exists an avoidance behaviour towards the access hospital due to indicated risk of Covid. Many care seekers are not willing to enter the hospital premises for fear of contracting the infection. Provider 1 "Due to Covid 19 fear, patients don't show up much at the government hospital as before. Instead, they prefer going to the private hospital".
- Further to this, care seekers tend to hold negligence over the safety norms and preventive measures as on an often basis, they are without a mask that brings risk to others. "*Bina Mask kea a jaate hai, mask bag mein rakh kea aate hai."*
- There exists a lack of adequate staff for meeting the maternal health needs of the care seekers. One provider mentions that "Nowadays C Section is being handled by a single person."
- Lack of Transport facility: Major challenge was transporting in the first three months. Care users were unable to access hospitals due to lockdown. Now (as of 02 Nov 20) things have improved.
- Lack of self-disclosure and Stigma attached: Care Users are hiding symptoms of Covid. During an examination, they come to know of temperature and then they are referred to Covid testing and fever clinic.
- Lack of Monitoring: Health Care providers cannot keep track of care users returning to their homes in the villages. "We ask them to refer to the nearest government hospital".
- Provider 'P1' "*Due to fear patients are approaching private clinics even when they are unable to afford them. There is fear, the stigma of Covid in government hospitals. No one wants to go there unless urgent owing to corona. In government hospitals, there*

are corona wards. If a patient is covid positive then private is not dealing with them, they go to the government hospital. Due to this no patient today wants to go to a government hospital".

- Provider 'P2' "*Delay or no salary, lack of PPE kits, proper infrastructure to the staff is another factor hindering the provisioning of services and care to the patients. Our tolerance is put to test*."
- Provider 'P3' "*Over Covid testing in the government hospital is a factor that is making the patients complaint. Every time they go, they have to be tested. Why this is happening is an issue."*

Table 6.2: Covid 19- Barriers in Care and Impact on Maternal Health- Care Seekers' Perspectives

Barrier 6.2.1Covid associated changes in the Hospital

Sphere	Form	Output	Impact on Maternal health	Care seekers perspective
Hospital	Denial or diversion of maternal health care services in governme nt hospitals, Hospital	Lack of proper access to maternal health care needs Non-availability of services given government hospital turning as Covid facility No access to Covid only hospitals Unavailability of Maternal Health Care Provider, Beds, Infrastructure Unavailability of doctor, drugs, beds Unavailability of Health care personnel Crowding of higher-level hospitals and poor quality of lower-level facilities	Maternal health needs remain limited in a governm ent hospital.	**Fear:** There exists fear in visiting government hospitals due to the presence of Corona wards. Fear of contracting the disease restricts users to access government hospitals in the first place. Secondly, there are no proper referrals. Third, due to the usage of rude language there exists difficulties in accessing government ambulance services. **Uncertainties**: There exist uncertainties over hunting for the doctor among the care users. There is confusion about alternate hospitals due to the diversion of care users to other non-covid hospitals **Shift towards private hospital**: Due to fear of Covid wards and government hospitals turning into Covid only facilities, this compelled care seekers to shift towards the private clinic. Turning public hospitals into Covid centers pushes non-Covid cases into the private sector and the majority then drop out **Vicious debt trap:** Increase in a debt trap due to access to a private hospital. Care User incurred debts and liabilities to access private care. This is over and above, loss or fear of losing the jobs in the household chores, construction sites adding to time poverty.

Source- Researcher

Barrier 6.2.2: Stigma post-Covid

Sphere	Form	Output	Impact on Maternal health	Care seekers perspective
Home	Increase of self-isolation	Care seekers tend to hide disclosure on Covid due to the stigma attached to causing infection to others. Also, due to fear of losing daily wage or informal job if the employer gets to know. Among the social groups and contacts, disclosure means getting avoided by others for an indefinite time.	Lack of Interpersonal relations of care seekers within the society and with providers at the hospital.	There is a stigma attached to the infection. One who gets it is excluded by the family, neighbors, providers,and employers for many days.

Source: Researcher

Barrier 6.2.3: Covid associated Social Distancing

Sphere	Form	Output	Impact on Maternal health	Care seekers perspective
Hospital	Increase of social exclusion in maternal health	Restricted access to hospital given lack of information on changing social distancing norms. Social exclusion in hospitals owing to lack of quality care.	Reduction of care users accessing government hospitals.	Increase in social isolation. Increase in social exclusion given lack of social capital/ no community support, unlike rural areas. Social Exclusion in maternal health with an increase in unmet maternal health needs. Growth of Social Exclusion due to machine-like treatment and their lack of individual attention Low consumption of IFA tablets due to multiple responsibilities due to low level of self-care given pandemic, time poverty, and social exclusion at the hospital.

Source-Researcher

Barrier 6.2.4: Access to Health Care: Covid associated hoarding of medicines or increase in the cost of test

	Sphere	Form	Output	Impact on Maternal health	Care seekers perspective
Medical Market	Inability to afford Covid tests, routine tests, and medications owing to shortage	Lack of proper availability and affordability to the medical care	Unavailability of medicines	Increase in maternal morbidity and chances of mortality	Lack of medicines adds to their reluctance to access health services owing to time poverty.

Source-Researcher

Barrier 6.2.5: Access to Health

	Sphere	Form	Output	Impact on Maternal health	Care seekers perspective
Hospital	Limited or nil and negative interaction with health care personnel	Interpersonal relationship: Provider user interaction: Violence against care service providers; irrational behaviour towards infected persons/apathy towards the prospective user	An increase in unattended felt maternal health issues	Reluctance to access health services Increase in maternal morbidities Among the care providers: Increase in cases of Covid 19 among the health care provider Reshuffle or Denial of access to services	

(Source- Field data and media report)

Discussion

The interplay of the social forces causes the exclusionary processes. An exclusion from normal activities and relationships could be in various forms and in various spheres such as social, economic, cultural, or political. Forms of exclusion may involve denial or lack of rights, opportunities, resources, and participation, as enjoyed by the mainstream population. Social exclusion impacts the quality of life of the individual. The exclusion of the socially excluded individual from mainstream society negatively impacts societal equity and cohesion, as a whole.

The ongoing Covid 19 pandemic and loss of livelihood have tremendously worsened the health and well-beg of the urban poor. The discourse on social exclusion needs to focus on new spheres and forms of social exclusion that play a key role in determining the prevalence and extent of the exclusionary processes in the overall access to the hospital. Social Identity of an urban poor shapes chances of having social connections. Being a heterogeneous group from different caste, regions, and states. Sharing similar identities in terms of language, region, religion, and caste helps in building social connections.

Acceptance over the feeling of social exclusion: Social exclusion is subjective in nature. It is based on lived experiences, and perceptions that are unique to the heterogeneous group of urban poor women. Access to hospitals and the lived experience of discrimination, apathy, and ignorance from the different providers amounts to experiences of social exclusion. Many times, such experiences are interpreted as difficulties on the part of providers to address all patients, shortages, and deficiencies in the hospital as a system. The acceptance of being socially excluded on the account of social factors such as caste and poverty get camouflaged as deficiencies in the health system instead. Given the mobile nature of the migrant population, many urban poor women seeking maternal health care shared about frequent entry, relocation, and resettlement in Delhi based on the needs of the informal economy. This has further escalated due to the pandemic and associated reverse migration causing uncertainties over leaving and coming back to Delhi. It also holds ambiguities over their entry and exit from the informal sector.

6.12 Vaccine started in Delhi for pregnant women

WHO recommends the vaccination if the benefit of vaccination overweighs potential risks such as those at high risk of exposure to Covid 19 and those with co-morbidities? Pregnant women are at an increased risk of several illnesses if they get infected as compared to non-pregnant women. An official order issued by the Delhi government in July 2021 stated that *"Pregnant and lactating women will now be able to get vaccinated against the coronavirus disease (Covid-19) at the clinics where they go for their ante-natal and post-natal check-ups"*.

6.13 Suggestions: Policy dimension

- In terms of the policy framework, this pandemic necessitates the need of thinking fresh from the mid 80's neo-liberal idea favouring the market forces and informing on the minimum role of the State. In terms of the health sector and health care services, a huge proportion of the health care is provided by the private sector which is dominated by out-of-pocket expenditure, while the share of public services is very less comparatively. The out-of-pocket expenditure levy is a major burden on the poor, who gets further into the vicious circle of poverty backed by indebtedness causing higher health inequities and further poverty stratification in society. Provisioning through the private sector has led to stratification and an increase in inequities therefore, the right to health for all citizens should not be taking a back seat anymore.
- Managing the virus and public information: As per Covid 19 India Outbreak Report during its first wave in 2019-2020, the media reports highlighted that, India would peak in the month of May with around more than 2 lakh cases as the worst-case scenario and with around 70 thousand cases by 16 May. Such projections on Covid 19 peak and daily case count, mortality, and bed occupancy have become a daily news bulletin. Hospitals on one hand were already overburdened with the pandemic-affected caseload. They were also struggling to cope with the dynamic nature of the virus and the inflow of relevant information. On the other hand, care users are also confused about the actions on their part in order to seek health care at the hospital. Thus, simplistic SOPs were required for quick implementations on the ground. The year 2021 marked the beginning of vaccination for Covid 19 in a phased manner. Besides, March 2021 has seen a surge in cases once again.
- Role of Government: Today, governments around the world are working on ways to keep the economies running so life could come to track. The disease is also perceived as a virus, which is going to stay and be with us, so we have to live along with it. As Covid 19 has shaken us individually, like sectors, societies, nationally or internationally. It is important here to analyze how this pandemic is being viewed by the countries. Is it a medical emergency, a public health issue, a socio-economic or a sociological issue? The complexity of this disease is that it has impacted us all and has an impact on all the sectors with which an individual comes in contact or has a relationship. Today, the discourse has moved from health is wealth to health

and wealth. Therefore, is it a question of life or livelihood or both? Different countries are evolving their ways of easing or extending the lockdowns to set their priorities and define the fate of their countries.

- In terms of the handling and management of this disease, governments across the world are working out ways of mitigating the ill effects such as morbidity and mortality by introducing and implementing partial or complete lockdowns and curfews. At the same time, the governments are trying to test how to keep the economies running, so that life also comes to track gradually. In terms of handling a pandemic, which is a global public health emergency, the world has witnessed the tackling and containment of the disease is not happening at any global level. But it is being directed at the country levels, basically the heads of the government delegating the roles and responsibilities to the state as well at the district levels. In India, the government is providing national and state-wise information on the number of cases, causalities, and recoveries. At the same time, the government through its various schemes is supporting the poor in terms of provisioning of ration/food, distribution of masks, and sanitizers.
- Unlike the other disasters such as earthquakes where the system provides for mock drills etc, this outbreak came as a surprise cumulative package of fear and panic around the world, from global to the local and individual levels. The public health emergency trickles down at the societal level. On the societal/ community level, the governments across the globe have been in action with strategies of partial or full lockdown and curfew and informing the citizens to follow the same. However, some countries experience civil disobedience on this aspect as lockdown is perceived to be a hindrance to social justice and basic freedom when individual responsibility for life is insured in one's own way of taking enough vitamins to boost immunity and being individually responsible in case some of the negative consequences.
- One thing, at present, are witnessing during the given lockdown is our transition from routine lives into a time period that was never thought, imagined, or planned. The Individual under the lockdown situation is under the immense burden of quickly learning the new rules of this disease management and on the spot effectively implementing them to safeguard the life of him/herself and the immediate family members around. However, as the disease is perceived to be here to stay and so are we, the Individual is again at the receiving end of receiving the

brunt of this disease and its management. However, to prepare for the same, the people also require adequate information on how to prepare once the given lockdown period is over as the government asks for responsible individual behaviour which is enforced by the law.

- In the year 2021, the Government of India has initiated Covid 19 vaccination for pregnant women. In the context of the urban poor women having felt maternal health needs to avail vaccination requires comprehensive door-to-door support. Care seekers shared about not having information on vaccines, the reluctance of husband-fearing side effects, and the inability to take any decision in this regard. To address the vaccine concerns, comprehensive door-to-door support from the health workers in the requirement of the hour to assist pregnant women to avail of the vaccination.

Conclusion

Given the above information from WHO, the fight against the pandemic, which is a global public health emergency has been reduced to Individual risk factors informing the quick adaptation and implementation with a new Behavioural Change Approach at the Individual level rather than addressing the social patterns and structures that shape the chances of being healthy at the population level. At the Individual level, the terms such as "handwashing", "personal hygiene", "use of mask", "self-quarantine" and "social distancing" have become the buzz words an individual-oriented fight against COVID 19. Instead, it is proposed that attention to also focus on improving the health care system. Health System strengthening must focus on improving the capacity of the government hospital to become inclusive. Besides provisioning of infrastructure, manpower, bed allotment, and dispensing of medicines, the strengthening of the health system should focus on "*keeping the urban poor care seekers at first especially the women with maternal health needs*" at the government hospital. With such care seekers at the centre, hospitals should make inclusive policies in addressing health needs. With the participation of care seekers, through a help desk or booth for care seekers' assistance at the hospital, daily experiences of social exclusion faced at the hospital could get addressed and more inclusive measures could come into action to ensure a dignified visit of the urban poor care seekers. The last chapter summarises the discussions in the above chapters.

Chapter Seven

SUMMARY AND CONCLUSION

Our country has made advances on the economic front yet advances to fight against caste, class, and gender-based violence remain challenging.

Social Exclusion as a concept serves to be an important tool to help make advances in analyzing the interplay of social forces that move beyond the poverty context and explores the exclusionary processes.

The expression of Social Exclusion is manifested in different forms and spheres of the social system. In a hospital setting, the expression of social exclusion can be extracted through the perspectives of the providers and through the lived experiences of the care seekers, who experience different forms of social exclusion within the different spheres of the hospital. Understanding the exclusionary processes in a hospital setting involves asking the urban poor women about their lived experiences at the different spheres and forms of the hospital as well as the providers' perspectives. The study informs on the mindscape of social attitude in the hospital setting impacting the urban poor women. The present chapter attempts to give an overview of the discourse on Social Exclusion in Maternal and Child Health in the context of the Urban Poor Women in Delhi. An attempt has been made to examine their access to the facilities in a government hospital in Delhi. This chapter opens with a summary of the thesis followed by the findings and the conclusion. Health is a social concept determined by the interplay of socioeconomic forces existing in society. Being a social concept, Health is dynamic in nature getting shaped and impacted by the axis of social factors around the exclusionary processes acting in society. In return, the health of an individual determines the chances of existence and survival in society. Thus, being social concept health is impacted by society and in turn, impacts society.

7.1 About Social Exclusion:

The term Social Exclusion is an umbrella term; thus, the definition remains contested and conceptualization is varied. The nature of Social Exclusion is complex given its dynamic and relational characteristics. Due to no universal definition or measuring model, the concept has

evolved as an umbrella concept accommodating a scope for various definitions, meanings, and interpretations. At a global level, no two countries share the same determinants of social exclusion as they are context-specific, similarly, variations exist within a country at state and regional levels. Given the varied interpretation of its definition, existence, and processes, there is no one measuring model that fits at all. Due to this reason, countries from time to time have come up with their own country-specific measuring models on social exclusion.

Conceptualizing of social exclusion has been done from different lenses such as the background of poverty and deprivation, capability approach, basic rights and human development framework, welfare approach, participatory framework, voice and knowledge dimension, 'discrimination' perspective, relational approach, and the WHO's formed Commission on social determinants of health's knowledge network on Social Exclusion.

The exclusionary processes are embedded in our social systems at family, household, community, state, national and global levels. The Social Exclusion Knowledge Networks (SEKN) model assumes that these processes and their impact on health inequalities operate in the context of pre-determined biological determinants. The multiple characteristics of Social Exclusion explain its existence as "state" or "process" or both; being dynamic, context-specific and relation in nature; operating at multi-levels (Individual/Group/Community) and multilayers and dimensions; agents; having both subjective and objective dimensions; existence in active and passive forms. Furthermore, the notion of Social Exclusion has various proximal terminologies that have often been used interchangeably with social exclusion. These proximal terminologies are Discrimination, extreme poverty, disadvantage, vulnerability, deprivation, marginalization, etc. In contrast, related terms such as Social Inclusion, Social Integration, Social Cohesion, Social Justice, and Human Rights inform the positive side of efforts against social exclusion.

Major analytical models for measuring social exclusion can be classified under the Social Gradient approach; SEKN Model; Vertical and Horizontal Model of Inequality and Disadvantage Model. In the Indian context, social exclusion has been measured from Health Outcome Indicators as well as from the Identity-based perception indicators experienced at different spheres, in different forms, and providers' perceptive.

Lastly, Measuring Social Exclusion becomes imperative to understand the extent of social exclusion, especially in health and more specifically in maternal and child health as it has an

impact on the lives of the vulnerable in a population group. The qualitative measures provide better insight into the concept. On the other hand, the quantitative approach fails to provide [detail] on the experiences of the exclusionary forces on the people most severely affected, It thus raises questions about the usefulness and coherence of the concept itself (Levitas 2006, 154).

7.2 Social Exclusion in Maternal Health

Maternal health is a crucial period in a woman's life. In the case of Delhi, the urban poor, form the lower category of individuals in the social gradient, having a poor socio-economic status that negatively impacts their health.

During pregnancy, access to the hospital is not merely the physical distance from the house to the hospital but includes the background factors in the individual lives of the urban poor care seekers that enable or restrict them from using the hospital services in a government-run facility.

The study has focussed on understanding experiences of social exclusion in maternal and child health faced by women in Delhi. It is done by examining the perception of women accessing health care services. Based on their social identity, their perceptions have been analysed to examine the presence and extent of social exclusion in maternal and child health based on social identity.

Maternal health needs are crucial in having an impact on the overall health and well-being of both mother and the child. Distress on the account of social exclusion manifested in the general lives adversely impacts health and access to health care services. The interplay of the structural, social, and individual determinants of exclusion shapes the lived experiences of urban poor women. These are primarily the background factors that explain the pre-existence of social exclusion and vulnerability among the urban poor women before she reaches any health care facility to access care for their maternal and child health needs. Despite, having a significant role in nation-building and development, the urban poor women's own significant felt health need (maternal health) remains an ignored reality, faced by challenging experiences of the exclusionary processes with an interplay of social forces acting as barriers, that play out at different spheres and in different forms in her life. The analysis of the lived experiences of the care users belonging to the voiceless set of the urban poor confirms the presence of exclusionary processes in our society and the need to raise voices and propose policy

suggestions for the reversal of such processes in order to sow the seeds of social cohesion and inclusiveness in all the spheres of an urban poor women's life.

The intersectionality of the determinants of exclusion at the domain level (structural, social, and daily living conditions) as well as at the inter-domain level reflects the multiple factors causing social exclusion of the urban poor women in maternal health and the deepening of social inequalities and health inequities. The study informs about the pre-existing inequalities causing social exclusion among the marginalized urban poor care seeker in all the spheres of their lives. These inequalities exist not only between the rich and poor but also among the poor and those with additional vulnerabilities, thus informing the heterogeneous nature of the urban poor care seekers.

An urban poor care seeker who has experience of living in Delhi for some time, having an informal job, ability to earn ever a meagre amount, having a mobile phone with digitally sound knowledge of apps for transportation, awareness of routes to the hospital, bus numbers, having previous birthing experience shared of being able to access the hospital in comparison to the urban poor care seeker facing limitations on such parameters who often face barriers and social exclusion in access to the hospital. Further, those care seekers who are able to establish any social connections within the hospital are able to access care, jump the queues, meet doctors without any hassles. This is unlike a new migrant urban poor woman who is new to Delhi who has faced an accident of birth by being born in a lower caste, facing accident of life in terms of disadvantages attached by being a lower caste from a poor family, having low or no social connections, income, and awareness about how to access the hospital with uncertainties on being actually able to meet the doctor.

In the sphere of the hospital**,** care seekers shared about the presence of low-quality services and lack of individual attention towards their felt needs. Due to the general apathy and avoidance behaviour of the provider, care seekers often feel ignored, face general negligence, and lack adequate support and empathy from the provider. However, due to poverty and low socioeconomic status, many urban poor women with maternal health with antenatal and post-natal felt needs are unable to get quality service at the government hospital and on the other hand, they are unable to afford care at the private hospital. Having no option left, they often find themselves to be compelled to be a part of overcrowded queues and long waiting hours from early in the morning at the government hospital. Long waiting hours outside the Out Patient Department (OPD) often make the care seekers either return home without having

access to care or refrain from coming in the first place as coming early in the morning means not being able to conduct household chores and missing the daily wage at work. As an alternative, some care seekers shared about incurring debts and loans to access the private hospital as access becomes challenging at the government hospital, which adversely impacts their spheres of life- health, household, child care, and work.

Sphere of Allotment of Bed at the hospital informs about the infrastructural gaps in the existing health system that negatively impacts the utilization of care. Shortage of beds, sharing of beds, or being on the floor are the provisioning gaps that require immediate attention. Further to this, barriers in this sphere exist in the form of giving preferential treatment to some in bed allotment over them makes the care seekers existence as socially excluded, feeling discriminated against when someone with better means and social capital gets their means to the end unlike them struggling for acceptance, inclusion, and equality in provisioning.

While analysis of the sphere of dispensing medicines highlighted the lack of information among the care seekers in terms of dispensing of medicines. Often the care seekers rely on the patients, visitors, and cleaning staff of the hospital to find directions for dispensing medicines. Poor availability of services at the government hospital compels the care seekers to switch to anti-natal and post-natal care at private clinics. Many respondents shared their experiences about incurring debts for quality care at private clinics and resorting to government hospitals only for delivery or complication. At the government hospital, care seekers shared experiences about feeling isolated due to perceived low dignity. Due to a lack of individual approach or personal touch, they feel alienated from having a proper provider and care seeker's experience. Also, at times, care seekers shared about their helpless situation when without consent family planning measures opted on their behalf.

Perceptions gathered from among the care seekers inform us that there exists a dilemma as Social Exclusion is often camouflaged as normal: Forms of Social Exclusion are experienced as perceived as "Normal" and "Used to" treatment. *Kyunki paisa nahi hai, isliye Sarkari mein aaye hai, ab yahan aisa hi hota hai. Agar Paisa hota toh nijee mein hee dikhate".* "*Private toh hamesha badiya hi hota hai, par paisa nahi hai toh kya kare, yahan government hospital mein aana padta hai, majboori hai". (Respondent 1 shared that coming to a government hospital is out of compulsion owing to financial problems, else they prefer private hospitals).*

Corruption and bribe are rendered as a reason for preferential treatment to "some" who are rich and powerful. Some care seekers perceive that, although there are long queues the people who

are better dressed or have social connections within the hospital system or have some higher connections get preferred treatment. *"Sometimes people do not join any queue and they are able to meet the doctor quickly while we keep waiting in the queue*". Some care seekers believe that the 'preferred few' have the means, so they are able to influence the system and get access to care fast. In this scenario, power relations among the care seekers also come to light, where those with better means, having not faced accident of birth (horizontal discrimination) or of life (Vertical discrimination) or having better social capital are able to get quick treatment than the urban poor. Besides, the heterogeneous interplay of power relations within the care seekers. There exist power relations between the provider and a care seeker that play an important in determining the extent of social exclusion in health at the level of a government hospital. Providers hold the power with authority, knowledge, and higher social status. On the other hand, the care seeker is powerless, at the receiving end, lacks knowledge, and belongs to a lower caste and poor socioeconomic status. The evident social inequality impacts the interaction between the provider and care seeker causing unequal power relations, and the manifestation of various forms of social exclusion among the care seekers.

7.3 Coping Mechanisms to counter Social Exclusion

The urban poor care users shared about hiding their social identity as the levels possible for social acceptance by the mainstream population in Delhi. They shared about using pseudo names and Delhi-based surnames at work that helps their easy acceptance in mainstream society. Care seekers shared that if the house owners come to know their lower caste social identity, then, there are high chances of job loss. Care users shared that access to the hospital becomes less challenging for people with similar social identities unlike them. Care seekers shared how similar identities built on social capital within the hospital spheres assisted "some" to approach the doctor directly without having to join any queue. Furthermore, those urban poor women who have migrated to Delhi for a long period of time around a year or so, and who are aware of Delhi and its whereabouts are much more able to make their access easier than the newly arrived migrant women in the hospital. In addition, the culture of silence among the women makes them internalize the experience of social exclusion at the hospital as the very essence of their womanhood and life in the patriarchal society.

7.4 Impact of Social Exclusion on Care User's Access to Hospital:

Access to health care Institutions is adversely impacted by perceived experiences of Social Exclusion. This may lead to the following extent of Social Exclusion in accessing government hospitals: (1) Complete or extreme Exclusion: Poverty and lack of affordability would reduce their chances of complete exclusion from accessing government hospitals since private hospitals are beyond their reach given the affordability issues. Return to the parental home in the village appears as a culturally safe option. (2) Partial Exclusion: Accessing the government hospital is just before the delivery, complications, or an emergency, otherwise they prefer going to a private hospital. (3) Unfavourable Inclusion: Fear of unfavourable inclusion in terms of coercive family planning measures.

7.4.1 Provider's Perspective

There exists differential expression on the nature of the urban poor women population. Largely, they are believed to be a homogenous group suffering from poverty, having hygiene issues, and ignorant behaviour. Whereas, very few providers accepted them to be heterogeneous individuals requiring individual attention. Further, the notion of purity and pollution still exists in a concealed manner, whereby no such action is directly visible but undertaken after having given excuses. For example, One provider shared that *"yeh log naha ke nahin aate, hum inhe bolte hai naha kar agle din aaoo"*. "These people come without taking bath and we tell them to bathe and come on the next day". Here the notion of purity and pollution is very much evident but in an indirect way. Care seeker is judged from a distance that she has not taken bath and therefore needs to come on the next day. This form of refusal to touch informs the notion of purity and pollution. Moreover, rude and arrogant behaviour is justified by the provider owing to overcrowding, excess workload, care seeker's ignorance, and lack of proper infrastructural facilities at the hospital showing how social exclusion against the care user is camouflaged as mere management and infrastructural gaps in the hospital. Further, the power relations between the provider and care seekers along with systemic failure get reduced to patient blaming attitude. Insensitivity towards the patients is justified- "Only those who have time come here". This seldom informs the concerns of the voiceless urban poor who refrain from asking questions given the existing power relations between the two.

Strength: The lens of social exclusion informs on a broader perspective on identifying the socially disadvantaged by incorporating the variables that classify our society such as caste, class, gender, religion, age, etc, and as well, informs on an interplay between the variables. The

traditionally socially disadvantaged social groups have a higher probability to live in poverty and adverse conditions.

Weakness: Contextualizing forms and spheres of social exclusion in the hospital setting is bound influenced by the larger social forces in the society. The study has focused on contextualizing determinants of social exclusion and forms in the personal spheres of the life of urban poor women by capturing their lived experiences. The study has focused on select social forces of caste/class and gender, however, there are other factors broad and individual factors that, need to be considered while analyzing the extent of social exclusion.

Trends: With the emergence of Covid 19 and its ever-changing variants and its intensity, the new world order is dominated by the implementation of lockdown to control the spread of the virus. In this given scenario, basic access to health is a challenge due to restrictions, lack of transport, fear of infection, etc. The challenges surrounding the access to maternal health for the urban poor women have grown manifold, as lockdown has a direct impact on their lives and livelihoods, where access to the hospital is not a priority but only accessed in case of very urgent need. Given, such a situation, it would be interesting to know how policies could address exclusion-free hospital access, care, and utilization in this already overwhelming and challenging pandemic world.

7.5 Major Findings

1. Poverty and social exclusion are driving forces of health inequities Exclusion of an Individual from the mainstream society be it economic, social, cultural, or political has an overarching effect on the health and well-being of the individual leading to Health Inequality. This indirectly affects the economic and other social inequalities that influence health. These inequalities contribute to social exclusion processes, creating a vicious circle.
2. Social determinants of exclusion (Structural and Intermediate) operate along the social forces intersecting caste, class, and gender. This continuum results in inclusion/exclusion.
3. Intersectionality of Social Forces: The interplay of caste, class, and gender is embedded in our society where the health system is a subpart. Therefore, these social factors are dominant in the health care system as well. The interplay of social forces is evident through the exclusionary processes, that are embedded in our society, where social exclusion is both a process and a state. Terms of facing Social Exclusion within the

framework of maternal and child health and in the different spheres and forms, it has an impact on the overall health and wellbeing of the individual.

4. Urban poverty has a distinctive gender dimension. Despite being the major contributors to building the economies, the urban poor women remain at a disadvantage in terms of access to basic living conditions and health. Urban poor women are heterogeneous individuals, whose identities get defined by caste, class, and gender. Among the urban poor women, Dalit women face acute marginalization as a result of multiple and intersecting inequalities in terms of caste and gender. They are the most vulnerable given the intersection of their multiple identities defined by caste, class, and gender. The unique exclusionary pattern defined by the intersection of social forces makes the urban poor women become subject to exclusion both in the public and private spheres. In the private sphere, they are subject to domestic violence and in the hospital, they experience conservative attitudes based on caste and gender. The lived experience of the urban poor women with accounts of lack of care, dignity, and acceptance from the care provider reinforces the existing exclusionary processes.
5. Government Hospital: There is a rare explicit expression of exclusion shared by the providers who majorly belong to middle and upper class, male and female providers. Access and Utilization of Health Care are impacted by exclusionary processes operating in different spheres and in different forms. Social exclusion faced at the level of a government hospital has been analyzed in terms of spheres- access to the hospital, allotment of beds, and dispensing of medicine. In the hospital setting, exclusionary processes are embedded deep. Role and exclusionary processes operating due to gaps in power relation, knowledge, and authority is reflected through attitudes and lived experiences and perceptions. Poverty and caste operate to exclude the care users from proper access and utilization of health care. Power Relations between the provider and patient influence the access and utilization of services. This results in health inequities in the social exclusion of patients. In the government hospital, exclusionary processes have been embedded and acts of exclusion are camouflaged as normal.
6. Urban women did not openly attribute caste or flaws in the public health delivery system as exclusionary factors in access to maternal and child health. But, their inability to classify the “Some” Preferred people.
7. Chances of Caste-based discrimination and resulting in social exclusion could get camouflaged in the general problems of health care.

8. Issues of poor access and adverse health outcomes of Dalits would be side-lined as sheer supply-side problems. It hence allows the perpetuation of caste practices by practitioners in the health services without being adequately noticed.
9. There is a rare explicit expression of exclusion shared by the providers who majorly belong to middle and upper class, male and female providers. Given the inherently stratified society with structural inequalities – Subconscious prejudice or implicit bias has an impact on the way patients are dealt. Thus, there exist multiple layers and levels of social exclusion and can be analyzed through spheres, forms, and perspectives in any contextual setting.

7.6 Conclusion

Social Exclusion in access to health services affects members of all socioeconomic levels. The inaccessibility or delay in care services adds to further unattended morbidity and increased chances of mortality. Therefore, policymakers need to address the exclusionary processes bound by power relations operating at different spheres of the social system shaping differential access to the common services, opportunities, rights, and choices for "preferred some" over the "powerless others". Thus, the focus should be to challenge the interplay of social forces that cause exclusionary processes than merely focusing on the groups and individuals who are excluded.

(a) Inclusion through the implementation of Human Rights: The inclusion aspect informs about ensuring proper access to health care services as a human right for those who are outside the mainstream society.

(b) Inclusion through Participation: The voices of the Urban Poor women are presently muted given the exclusionary process; therefore, the policy level recommendation is to make it visible by making it heard. This is possible through participation and representation of the urban poor women in the policy discourses so that their voices get recognized and help in policymaking.

(c) Respecting the Individuality: The Urban Poor Women are not homogenous but heterogeneous in nature, policy-making dimensions should look into adopting the gradient approach as adopted by the Commission on Social Determinants of Health to identify and be able to serve the poorest among the urban poor. Besides this, the context of social exclusion in society or in the hospital setting needs to be situation-specific,

therefore, needs to be contextualized through the analyses based on forms, spheres, and perspectives approach.

For making government hospitals more inclusive, it is important to measure the aspects of the exclusionary processes by breaking them down into spheres, forms, and providers' perspectives. Examining the aspects of the exclusionary processes in each sphere through different forms and the provider's response or perspective on the same provides a deeper sense of the exclusionary processes. For policy-making, each sphere could be analysed through forms so that quality care becomes available, accessible, and utilized by the care users. Empathy and inclusiveness should be made key messages in the spheres of the hospital, helpline numbers to be made operational to respond to the distress faced by the care users in access to the hospital as well as in the utilization of the services. Empathy and inclusiveness should be a part of routine provider training so that the exclusionary processes start rolling in a reverse way. For improvement in the health system, all core dimensions- political, economic, social, and cultural needs to align in ending health inequities. More resource allocation on making use of media as a tool in bringing inclusiveness in health care services by increasing its visibility through the good practice of provider and end-user relations emphasizing the role of empathy, dignity, and inclusiveness in combating any form of social exclusion.

The plight of urban poor women largely highlights the flaws in the health system or corruption in various spheres of the hospital as the probable cause for their inferior treatment and preferred treatment for 'some'. Also, the common lived experience of women in the government hospitals seems to be general concerns over low quality, poor infrastructural and logistics and does not clearly or openly inform on dynamic caste and class interplay. This mindset sustains the dominance of social forces of caste, class, and gender in determining the lived experiences of the care users. Being conscious of the interplay of social forces operating at the hospital level to sustain the exclusionary processes could help the care users to become realize the existence of social exclusion and the need to counter it.

A health care provider is an expert in the area with his knowledge and position enjoys a superior role in the power relations that exists between a provider and user, where a user is a recipient having no knowledge, money. This presence of power relations between the two sustains the exclusionary processes. With no power in hand, the urban poor belonging to the lower caste suffer greater harm with the power play in this setting. The care user faces exclusion in each sphere of the hospital setting and in different forms based on the situation. The attitude and

perspective of the provider towards the care user happen to sometimes be based on their identity. "*Yeh log to naha ke nahi aate*" such verbatim are common, where some of the providers have generalized a fixed attitude towards the urban poor women based on their physical appearance and thus, getting easy grounds to avoid touching them and informing them to come on the next day. The mere assumption of turning the care users on the account of not being clean and to take bath and come informs about the perpetuation of caste-based discrimination based on the notion of purity and pollution. Therefore, there is an urgent need to reverse the exclusion-centric attitudes.

7.7 Suggestions

The purpose of the study is to identify and make recommendations for reversing the exclusionary processes for making inclusive policy changes in maternal and child health. There is a need to deliberate discourses on the urgency of hearing the felt issues of the poorest of the urban poor women. This informs of both larger level as well as participants centric approach to be administered for bringing positive changes. The following recommendations can be made based on the study:

1. **Shift from Health for all to Health in All**: Health in all policies is an approach to public policies to achieve improvement in the population health and health equity. The approach takes into account the health implications of the decisions making, it [builds on partnerships and collaborations], avoids damaging health impacts, and [drives measures] to contribute to socio-economic development and sustainable action across the sectors (WHO 2014).
2. To tackle Social Exclusion in Maternal Health of the Urban Poor Women when they access the hospital is not the call only of the health System but requires collaboration with other sectors: Urban Planning, Housing, Women and Child Development, Transport, Labour, and Environment, Social Justice and Empowerment. Inter-sectoral cooperation and collaboration among Government, NGOs, local organizations, private sectors, and civil society must be in place to improve their quality of life through poverty reduction; improvement of housing conditions, safe water supply, environmental sanitation, road and transportation, food supplies, health education, and health care services.
3. **Improve the Social Determinants of health and those contributing to Exclusion**: conditions of daily life – the circumstances in which people are born,

grow, live, work, and age- The inequities in how society is organized mean that the freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies. This inequity is seen in the conditions of early childhood and schooling, the nature of employment and working conditions, the physical form of the built environment, and the quality of the natural environment in which people reside. Depending on the nature of these environments, different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more or less vulnerable to poor health. Social stratification likewise determines differential access to and utilization of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival (WHO 2008).

4. **Right-Based Approach:** Availability, accessibility, affordability, and utilization of healthcare is a human right. Given the Social Stratification and operating exclusionary processes, it is important to look into the health of the most vulnerable.
5. **Holistic Framework:** There is a need to move towards a holistic framework by considering the embodiment of social and biological factors.
6. **Usage of the term Social Exclusion:** Usage of Social Exclusion in policy discourse provides a broader lens to understand the interplay of unequal power relations along with the social forces operating in the society. Social Exclusion has pathway linkages with the health system therefore it is important to strengthen health systems. There is a need to have a synthesis of evidence on social exclusion in health, which can help the policymakers to find what works for them by learning from other experiences.
7. **Importance of Social determinants of Exclusion**: have a detrimental impact on the health, daily lives, and overall well-being of the urban poor women, whereby the aspect of maternal health is only one aspect. The focus should be on improving the overall health and well-being of the women by improving addressing to the social determinants of exclusion, which refers to the structural as well as daily living conditions, where the social forces such as caste, class, and gender play a vital role in further widening of the exclusionary processes.
8. **Equity**: Make equity an explicit priority in the ongoing planning, monitoring, and evaluation to reverse the exclusionary processes.

9. **Intersectionality**: Emphasis on intersectionality to understand the impact of caste, class, and gender on the exclusionary processes at the hospital and on the general lives of the women. Need for Intersecting policy framework
10. **Socially Inclusive Right-based framework for policymaking:** Social Inclusion for Urban Poor should be the prime focus for any policy-level intervention. There is a need to contextualize the discourse on social exclusion in health "hearing the silent voices" through the following:
    - Profiling of Urban Poor Women through gradient approach as they are heterogeneous in nature.
    - Improving the daily living condition of the urban poor is key for overall health and well-being.
    - Making the spheres, forms, and providers' perspectives at the government hospitals more inclusive.
    - Make equity an explicit priority in the ongoing planning, monitoring, and evaluation to reverse the exclusionary processes.
    - Usage of Social Exclusion in policy discourse provides a wider lens to understand the causes and consequences of power relationships that are unequal in nature.
    - Emphasis on inter-sectionalist to understand the impact of caste, class, gender on the exclusionary processes at the hospital and on the general lives of the women**.**
11. **Inclusive and Care User Friendly**
    - Manpower: Strengthening of Human resource capacity in the hospital to manage overcrowding and provide proper quality care to the care users.
    - Infrastructure: Proper reception facility with clear visibility of other department locations. Toilet needs to be clean, with staff dedicated to maintaining its hygiene
    - Management: Provide differentiation of role of core and support staff, so end care user doesn't suffer. Strengthening of referral systems at all levels.
    - In house mandatory training for all staff informing Patients' right to access and utilize an inclusive, dignified, and quality treatment. sensitizing the providers to be conscious of the invisible or the camouflaged reality, where the practice of exclusion appears to be normal instead of an abnormal or not normal scenario.

- Display messages and posters within the hospital informing that "this Hospital respects inclusiveness of its patients", so they feel welcomed and have trust that they will be attended to on time and with quality.
- Monitoring: Need to hold routine monitoring of the hospital spheres, so exclusionary processes could be reversed. State/UTs should set indicators, objectives, and outcomes of inclusiveness for monitoring the performance of the hospitals and determining their ranking. Further, Getting cross stratified data on the lines of caste, class, gender and other variables in line with the contextual realities of each place. The data would help in monitoring the progress and setbacks in reducing social inequalities in health. Finally, a proper and timely evaluation should be an integral part of the approach.
- **Strengthening Health System:** Given the socio-economic inequalities and its resultant health inequities, strengthening of the health system is core. In order to cater to the maternal health needs of the urban poor in Delhi, it is important that the health system gets prepared to address the needs. Health System is the backbone of running health services. Health Systems Strengthening Public provisioning of Universal health Coverage remains a dream with the present budget 2021, which declines to a mere 2.21 percent (Priya 2021). This causes an overburdening Out of Pocket Expenditure.

12. **Universal health coverage:** The World Health Assembly in 2005 defined Universal health coverage (UHC), "*as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access"*. While the integral outcome of UHC is to achieve equitable access and financing, health inequities persist and widen. Thus, there is a need to focus attention on the design, monitoring, and evaluation of the UHC to incorporate the health coverage of the disadvantaged population (Balagopal 2018).
13. **Perceiving Maternal health as a Priority:** from the provider as well as care seeker's perspective. Strengthening of self-care among the urban poor women, including health promotion and disease prevention. The urban poor women must be empowered through the strengthening of social support systems or social networks or social capital. This requires the active participation of the urban poor women in health development and service delivery at the community level. A focus on health

education, digital literacy, and community organization could strengthen a healthy self-care approach among urban poor women.

14. **Focus on Social Determinants of Health**
    - Social Determinants are instrumental in helping people be healthy. It rather varies from medical care that steps in to help only when people are sick.
    - Rather than focusing on individual determinants it focuses attention on social patterns and structures that improve people's chances to be healthy. For example, access to basic amenities such as safe water, sanitation, shelter, and proper health care provisioning.
    - Introduced in the 1970s, the term "Determinant of Health" offers a critique of the Individual approach to health expenditure in public health research and policy. Instead, it focused work on social policies and social determinants.
    - Equally important is health education to fight the stigma and xenophobia involved with labeling the patients as "Others" and causing social exclusion from the mainstream society.
15. **Human Rights Approach** Guaranteeing human rights – Due to the deep health inequalities born from the economic and social inequalities, there is inadequate provisioning of the health care services along with the practice of social exclusion against the poor. This requires a Human Rights approach to Fight Stigma Xenophobia and Social Exclusion against the Urban poor women
16. **Setting the priorities correct: Government to strike a balance between Covid and non-Covid Health priorities**: In a major discourse on the response to the disease vis-à-vis the community is to know whether the increase in the number of cases is on the account of a lack of adequate facilities in the health care services which are unable to meet the needs of the patients. Or is it the lack of basic facilities in the communities such as living conditions, proper space, ventilation, and sanitation that is hindering the chances of measures of social distancing.
17. **Policy level challenges:** Despite India's rapid advances on the economic front. Much work is yet to be done on ending the vulnerability of the urban poor women, who happen to be at the intersection of caste, class, and gender. Addressing access to maternal health among the urban poor women at the government hospital is complex given the social inequalities and health inequities in the system operated by the already embedded exclusionary processes. Thus, greater inclusion is

expected at the policy level to address the accounts of social exclusion existing in the different spheres and forms of any setting in the lives of the urban poor women and in particular in the hospital setting

In recent times, with the Covid 19 pandemic and changing nature of the variants and strain information, there is an overwhelming burden on the health system from the all levels (global, regional, national or local). Therefore, when acute health challenges with urgent needs draw the attention of the policymakers then it might become challenging to hope for policy-level changes for the excluded when the mainstream is in danger. Therefore, it would be interesting to see how policymakers would resolve this dilemma of urgency as an immediate issue of Covid 19 or urgent subtle issue based on historical yet ever-changing dynamics of caste, class, and gender, where the consequences of Covid 19 and its phases would be drastically challenging, as we are seeing now.

Emerging areas: Health problems have now become globalized, especially with the pandemic, yet the solutions offered need to be context-specific. With the global emergence of the pandemic, it is important to focus on the social determinants of health as well as the social determinants of exclusion, to get a holistic understanding of the health issue in order to address it. This is one of the emerging areas to study how social determinants of health and exclusion could be studied simultaneously and how far it assists in bridging the health inequalities and inequities. It is important that the discourse on Social Exclusion takes into account the emerging and significant threats that require action if they are to be taken effectively. These include the aspects related to the growth of infectious diseases that have caused a substantial way in which the issue of accessibility of health services is studied and analyzed. Given the pandemic situation with the emergence of Covid 19, the context of access to Health care from the global to local level needs to follow an inclusive framework Health problems become globalized. The ongoing pandemic has brought out into the light, the existing cracks in the system. Before analyzing the presence or extent of social exclusion in maternal and child health in a government hospital, it has become mandatory to ascertain whether a particular hospital is a Covid facility or not and whether maternal and child health is open to access or not. Pre-Pandemic determinants of social exclusion in maternal and child health inform the role of structural, social, and daily living determinants. Whereas in the ongoing pandemic

the determinants have reduced access to hospitals during the lockdown, a surge in Covid cases, lack of transport, government hospitals turning into Covid 19 only hospitals would confuse the care seekers' access to health through the hospital.

Challenges to revisit in the near future: Achieving social inclusion and social cohesion in policy for many countries. The term social exclusion has been differently defined and no one definition persists. In order to implement work on inclusion in health, the countries have adopted their own frameworks by not focussing so much into the different ideological but on making the health care services to be exclusion free.

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Annexure I

Interview Schedule

Social Exclusion in Maternal and Child Health Services: A study of a government hospital in Delhi

(To be administered to mother (of <=2 years child)

Identification-
District
Respondent-

Age

Sex

Education

Caste/sub caste

Native/migrant

Work Status (Self/ Parents)

HEALTH CARE RESOURCES AND SERVICE ACCESS

A: Ante Natal Period

1. Could you share the total distance from your home to the centre/hospital?

(1) Less than 500 meters, (2) in between 500 meters to 1 kilometer,

(3) Between 1 and 2 kilometers, (4) more than 2 kilometers

2. What is the means of transport used to visit the centre/hospital?

(1) By foot, (2) By Rickshaw

(3) By Bus, (4) By other means of public transport (specify)

3. When did you last approach the health centre/ Hospital?

(1) Within last week, (2) within last month,

(3) Within last six month, (4) other (specify)

4.What facilities are available at the health centre/ Hospital?

Doctor	Yes	No
Nurse/Midwife	Yes	No
ANMs	Yes	No
Lab technicians	Yes	No
Gynecologists	Yes	No
Pediatricians	Yes	No
Pharmacists	Yes	No
All medicines prescribed	Yes	No
Lady Health Worker	Yes	No
Referral Transport facility	Yes	No
Multi Purpose Worker (male and female)	Yes	No
ANMs	Yes	No
Vaccination	Yes	No
Iron Folic acid supplement	Yes	No
Contraceptives	Yes	No

5. Did you face any of the below-mentioned issues while accessing the centre/hospital?

Unavailability of doctors	Yes	No
Unavailability of specialists	Yes	No
Unavailability of necessary medicines	Yes	No
Unavailability of diagnostic services	Yes	No
Negligence from doctor	Yes	No
Negligence from other staff	Yes	No
Provider(s) demand money for rendering the service(s)(bribe)	Yes	No
Delay in delivery of services	Yes	No

6.. Is there any waiting area within the health centre/ hospital premises?

(1) Yes, (2) No

7 Is this waiting area common for all in the health centre/ hospital premises?

(1) Yes, (2) No

8. Does the waiting area have proper seating arrangements?

(1) Yes, (2) No

9. Do you use the seats/bench available along with the different caste people, without any hesitation?

(1) Yes, (2) No

10. Is your caste recognized by the doctor/other care providers?
(1) Yes, (2) No
11. Does your caste have any role in getting proper services?
(1) Yes, (2) No
12. If yes (Q No.18), please give reason(s)
13. Is there any wait for you when a dominant caste care seeker approaches?
(1) Yes, (2) No
14. For consulting the doctor which below provision is there?
Coupon (1) Yes, (2) No
Queue (1) Yes, (2) No
15. Even after your turn comes, do you have to wait as the dominant caste is given preference by the doctor?
(1) Yes, (2) No
16. If the doctor is aware of your social identity, then are you allowed to sit in the chair in front of the doctor?
(1)Yes, (2) No
17. Does the doctor enquire in-depth about your illness/problem?
(1) Yes (2) No

18. Does your social identity affect the way in which the doctor talks to you?
(1)Yes, (2) No
19. Does your social identity affect the way in which the doctor touches you during diagnosis/ interaction?
(1) Yes, (2) No
20. During interaction with you, does the doctor use the necessary apparatus (stethoscope, thermometer other body examination tools)?
(1) Yes, (2) No
21. If the doctor did not use the apparatus (Q24), do you think, it is because you are Dalit?
(1) Yes, (2) No
22. If yes (Q No.25), please give reasons
23. Are you able to gain enough time to discuss your problem with the doctor?
(1) Yes (2) No
24. Do you feel any limitations or hesitation while speaking to the doctor about your problems?
(1) Yes (2) No
25. If yes (Q No. 31), please give reasons

26. Does the doctor give preference to a dominant caste persons before you?
(1) Yes (2) No
27. If yes (Q No.30), please give reasons
28. During the interaction, are you able to get the same attention as compared to dominant caste care seeker?
(1) Yes (2) No
29. If yes (Q No. 35), please give reasons

30. Are you allowed, by the Lab Technician to enter his/her room?
(1) Yes, (2) No
31. Are you allowed, by the Lab Technician to sit in the chair made available for the patient in front of him?

(1) Yes, (2) No

32. Do they use the required machines/tools during different tests?

(1) Yes, (2) No

33. Are they sympathetic towards you during the test?

(1) Yes, (2) No

34. At the pharmacy or medicine dispensing unit of the hospital,, does a dominant caste person given medicines before despite your turn in the queue?

(1) Yes, (2) No

35. At the pharmacy or medicine dispensing unit of the hospital, whether medicines are placed respectfully in your hands or before you on the counter to collect?

(1) Yes, (2) No

If the response is No, the (Q.36 & 37)

36. Whether the medicines are left on the floor or window for collection

(1) Yes, (2) No

37. Is it the same way, that medicines are dispensed to someone from the dominant caste also?

(1) Yes, (2) No

37. Are you allowed to take facilities made available for a public purpose such as water from the cooler/taps within the hospital premises?

(1) Yes, (2) No

38. Are you allowed/is it acceptable to interact with the other caste people within the premises?

(1) Yes, (2) No

PREGNANCY & ANTENATAL CARE

Now I am going to ask you about your experience during last pregnancy and child birth

39. Did you receive any antenatal care for this pregnancy?

(1) Yes, (2) No

40. Were you able to get the bed allotment on time?

(1) Yes, (2) No

41. Did you face any difficulty in getting a bed allotment?

(1) Yes, (2) No

42. Do you think Caste has a role to play when beds are assigned to care seekers?

(1) Yes, (2) No

43. Have you witnessed anyone getting preferred treatment from the doctor and above all the waiting patients?

(1) Yes, (2) No

43. Have you received any assistance for any of the following (Under JSY):

(1) For choosing institutional delivery	Yes	No
(2) On the birth of the girl child	Yes	No
(3) For cesarean delivery	Yes	No

(4) Transport Assistance for travel to a health centre for delivery Yes No

44. Did anyone come along with you to the facility besides a family member?
(1) Yes, (2) No

45. If yes, who?

(1) Husband
(2) Relative
(2) Neighbour
(3) Friend
(5) ASHA
(6) Other (specify)

46. When the health worker is providing you information, do they-
(1) Talk in a respectful manner
(2) Provide all information, you have asked
(3) Listen and respond to your queries
(4) Does not show any interest/ignores it

47. Do they provide medicines and other supplements?
(1) Yes, (2) No

48. If yes, what all?
(1) IFA Tablets
(2) ORS packets
(3) Contraceptives
(4) Pamphlets on pregnancy and child care
(5) Any other

49. How many times during this pregnancy did you receive ante-natal care?

No. of times _____ Don't know

50. During this pregnancy, did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?
(1) Yes, (2) No

51. If yes, where did you receive this service from?
(1) From ANM
(2) At Health Centre
(3) At Private Clinic
(4) Any other (specify)

52. During this pregnancy, were you given any iron tablets?
(1) Yes, (2) No (3) Don't know

53. If yes, where did you receive this service from?

(1) From ANM
(2) At Health Centre
(3) At Private Clinic
(4) Any other (specify)

54. If no, (62), did you buy it?
(1) Yes, (2) No

55. If yes, from where?
(1) Pharmacist
(2) Other shop
(3) Any other place/person (specify)

56. Were you able to get the bed allocated at the hospital on time?
(i) Yes, (2) No
57. Who assisted with the delivery?
(1) Dai
(4) Nurse
(5) Doctor
(6) Any other (specify)
(7) No one
58. Did the provider during the delivery was sympathetic towards you?
(1) Yes, (2) No
59. Why do you say so? Give reasons

Did not speak respectfully	(1) Yes,	(2) No
Ignored requests	(1) Yes,	(2) No
Used foul language	(1) Yes,	(2) No
Not attended immediately despite the need	(1) Yes,	(2) No
Was not touched, verbally told to move my body	(1) Yes,	(2) No

60. Did you receive any assistance for transportation to go to hospital/facility (referral transport)?
(1) Yes, (2) No
61. If yes, how much? Rs._____
62. Where (facility) did you go? Name
63. If you gave birth to child at home, why did you make that choice?
(1) Unavailability of institutional services at the locality
(2) Financial constraints
(3) Unavailability of transport facility at that time
(4) It was an emergency delivery
(5) Uncomfortable with hospitals (Interviewer must probe why and should record it)
(6) More comfortable with Dias
(7) Doctors do not give enough attention
(8) Had previous bad experience of discrimination at hospitals
Any other (specify)
64. In two months after the child was born, did any healthcare provider or TBA come to check on his/her health?
(1) Yes, (2) No (3) Don't know
65. How long after the birth of child the first check up/ visit by the health worker was done?

Hours ____; Days _____; Weeks months

66. Describe your experience of visit to the facility for this purpose (Probe the discrimination)

67. Has the child ever been vaccinated?

(1) Yes, (2) No

68. If yes, do you have a vaccination card for the child?

(1) Yes, (2) No

69. Did you face any problem in getting the card?

(1) Yes, (2) No

70. If yes, please describe the problem that you faced

71. Has the child received the following vaccines? { (1) Yes, (2) No, (3) Don't know}

BCG	Polio 0	Polio 1	Polio 2	Polio 3	DPT 1	DPT 2	DPT 3	Measles

CONSEQUENCES OF DISCRIMINATION

(ONLY FOR DALIT RESPONDENTS)

72. What do you do when you/your child do not receive the expected services from health centres?

(1) Do not visit that provider/facility again
(2) Visit Health centres/hospital in other where providers are sympathetic to you
(3) Do not seek services/treatments from anywhere
(4) Approach private care providers

(Ask below questions if the mother/child did not seek treatment/services from anywhere)

73. Why did not you seek treatment outside health centres?

(1) Cost associated with services
(2) Fear of loss of work days
(3) Unavailability of other facilities
(4) Experienced similar/worst practices in other places
(5) Any other (specify)

74. Are there any casualties occurred due to not taking treatment?

(1) Yes (2) No

75. If yes, please specify (Interviewer must record if the respondent is willing to narrate the incident)

(Ask below questions if the respondent sought treatment from private care provider)

76. Have you faced similar forms of discrimination in private hospitals?

(1) Yes (2) No

77. If yes, please specify

78. Could you please tell us the expenditure incurred for the following services in the private care centre when you visited last?

(1) Registration
(2) Consultation
(3) Medicines
(4) Diagnosis
(5) Delivery (including Caesarian, if there and hospital charges)
(6) Food
(7) Transport

79. Number of days lost of work by you or family member for treatment at private hospital?

(1) Your loss of days of work_____days
(2) Family members' loss of days of work_____days

SUGGESTIONS

80. To enable inclusive services, what modifications are suggested for the providers and health centre/hospital?

Household schedule for mothers (for cross checking)

Experience	Respondents' s response
• Visit to the health care centre • Visit by the health worker • Home • Health Centre/Hospital **Providers who discriminated-** • Doctor/Specialist • Lab technician • Pharmacist • Nurse • ASHA • Others **Spheres of Social Exclusion** • Visit to the facility • Diagnosis • Bed allotment • Dispensing of medicine • Any other **Providers' Perspective** • Overworked provider • Existence of historical notion of purity and pollution **Coping mechanisms among the care users** • Culture of Silence • Hiding of Social Identity **Background exclusionary factors** • Interplay of social forces of caste, class and gender	

Annexure II

Questionnaire For Exit Interview on Social Exclusion in Maternal and Child Health Services: A study of a government hospital in Delhi

Greetings. I understand that you have just visited the Health Centre/hospital. If you permit, may I please talk to you regarding your visit? Thank you.

Identification-

Locality - District-

Respondent- Age- Caste/sub caste

Educational Level completed- Religion-

Work Status Self- Spouse-

Reason for visit to the Facility

1. Why did you come to the health centre/hospital?
(Details of the illness/service being sought)

2. Who are the providers you talked to/visited in the Centre/hospital? Did you have to wait for the service to be delivered? If yes, where do you wait?

Providers visited	Wait (yes/No)
Registration Clerk	
Doctor	
Visiting Doctor	
Pharmacist	
Lab Technician	
ANM/ Nurse	
Others (specify)	

3. Was there any longer waiting time for you because someone else was given preference before you?

Providers	Yes /No	Reason(s)
Registration Clerk		
Doctor		
Visiting Doctor		
Pharmacist		
Lab Technician		
ANM/ Nurse		
Others (specify)		

You may share details below:

4. Were you able to get the adequate time to talk to the doctor/other provider to share your problem?

(i) Yes (ii) No

5. Do you think the providers listened to you with attention? Why do you think so?
(i) Yes (ii) No

(ii) Describe your experience when you visited them.

Provider
Doctor

Lab technician
Pharmacist
ASHA
Anganwadi worker

Sphere of Experience
Visit to/ by provider (diagnostic)
Allocation of bed
Dispensing of medicine
Pathological test
Seeking referral

Form of Experience
Duration of interaction with the care provider
Touch (without offending)

Speak gently
Use of demeaning words/ phrase
Wait to give chance to the dominant caste person(s)

Annexure III

Google Form

Questionnaire for Health Care Provider

To understand Provider's perspective on Social Exclusion in Maternal and Child Health in a Government Hospital in Delhi.

Urban Poor Women may constitute the minorities in terms of caste, class, gender, religion basis, who would be referred to as beneficiaries below.

Please answer to all the questions and specify, when other option is selected.

Thank you for your time and participation

* Required

Name

Your Designation *

Your answer

Department of work *

Your answer

In which State/UT is the hospital located? *

Your answer

What is the type of the Hospital (Government/ Private/ Charitable/ any other)? *

Your answer

Please further classify your hospital category?

Your answer

Whether your work is related to maternal and child health? *

Yes

Partially

No

If Partial, please specify below in Other:

Other:

Does the hospital provides maternal and child health care to the urban poor women (Beneficiary)? *

Yes

Partially

No

Not aware

If Partial, please specify:

Other:

Is the hospital fully equipped with the basic Infrastructure, heath care providers and medicines to assist the beneficiaries? *

Your answer

Do the health care providers have a welcoming gesture (proper tone/choice of words) towards the beneficiary seeking care? *

Yes
Partially
No

For no/partial, please elaborate reasons below in Other:

Other:

Average duration of waiting period in a queue for the beneficiary to access care? *

Less than 15 minutes
15 minutes to half an hour
Around an hour
More than one hour

If above one hour, please specify below in Other:

Other:

Average time allocated to each beneficiary during consultation? *

Less than 5 minutes
5 to 10 minutes
Around 15 minutes
More than 15 minutes

Other:

During diagnosis- is the beneficiary properly checked (touched) without any discrimination from the rest of the population group? *

Yes
Partially
No

For yes/partial, please elaborate reasons below:

Other:

During Treatment- Do the beneficiaries face a differential treatment owing to their profile? *

Yes
Partially
No
I am not sure

For yes/partial, please elaborate reasons below in Other:

Other:

Is there any differential treatment in dispensing of medicine to the beneficiary? *

Your answer

Is the beneficiary allotted bed without any discrimination? *

Yes
Partially
No
If Partially or No, please elaborate on the reason below in Other:
Other:

Do all beneficiary get proper access to a doctor? *
Yes
Partially
No
If partial or no, please elaborate on reasons below in Other:
Other:

At what stage do beneficiaries usually seek care at the hospital? *
Ante Natal
Peri Natal
Post Natal
All of the above
Other:

In your opinion, how is the interaction experience of beneficiaries at the spheres of hospital (Example- Reception/OPD/Lab/Chemist/Bed allotment) *
Satisfied
Partially Satisfied
Not Satisfied
Can't comment
Please elaborate below in Other:
Other:

Have you observed preferential treatment being provided to "some" over the beneficiaries while seeking care at the hospital? *
Yes
Occassionally
Most of the time
Never
Other:

Whom do you think constitute the "preferred some"? *

Your answer

Whom do you think constitutes the most excluded among the urban poor beneficiaries and why?

Your answer

What are the prominent factors causing exclusion among the beneficiaries in the hospital?

Your answer

Does the availability of the health care provider and quality of services differs when approached by an urban poor and when by a preferred individual? *
Yes
Partially
No
If yes/partially, please elaborate to explain how?
Other:

In what ways are the "preferred some" treated in a favourable manner? *
Your answer

Do you think beneficiaries face exclusion based on their profile from the health care providers in the hospital ? *

Your answer
How Covid 19 challenges have impacted the beneficiary's access to maternal and child health care? *
Your answer

In your opinion, has Covid 19 widened social exclusion among the beneficiaries seeking maternal and child health care in the hospital? If yes, then please support with any example *

Your answer
Any remarks:

Your answer
Submit
Clear form