https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-04/Brief%20on%20DA%20and%20private%20health%20sector%20issues%20v2.pdf

The private health sector in India from the lens of Dalits and Adivasis

Executive Summary

Health outcomes have remained grossly unequal with India's Dalits and Adivasis living shorter lives of poorer quality. Private infrastructure now accounts for nearly 62% of all of India's health infrastructure making it critical to examine the extent to which it is responsive to these communities. Only 4% of Adivasi and 15% of Dalits utilize private facilities. According to the 75th round of NSSO for inpatient care out of pocket expenditure in private facilities is 524% higher than in public facilities. This is unaffordable given that 45.9% of the Adivasi and 26.6% of the Dalit populations are in the lowest wealth quintile. Treatment is often rendered unsustainable and there is a clear impact on the quality and cost of healthcare with patients subjected to unnecessary and dangerous treatments. The high costs of healthcare were expected to be addressed through the introduction of health insurance. However, only 1.6% and 4% of private hospital admissions under PMJAY were from Dalits and Adivasis compared to their projected eligible population share of 19.7% and 15.4% respectively. Furthermore, private hospitals tend to have an urban bias with nearly 67% of private hospitals registered under PMJAY located in big cities while rural areas with Adivasi and Dalit populations continue to suffer from severe infrastructure gaps. Dalits and Adivasis face discrimination in the private healthcare system including disparity in care, denial of entry into private clinics and longer waiting times. There is a relatively low representation of Dalits and Adivasis in the leadership of the medical profession. There is also limited space for social accountability in the private sector, especially for marginalized communities. Existing regulatory mechanisms for the private healthcare sector are weak and key provisions are not implemented. The paper makes recommendations for ensuring equity and accountability in the private health sector and addressing the specific concerns of SC and ST communities.

Introduction

Dalits and Adivasis together constitute 25.2% of India's population[1]. Both communities have faced systemic discrimination and have been denied access to basic services. Persistent structural[2] and deep-rooted poverty and deprivation among Dalits and Adivasis manifest in all aspects of their lives. Historically, Dalits, the former "Untouchable[3]" castes, could not cross the line dividing their part of the village from that occupied by higher castes.

Health outcomes have remained grossly unequal[4] with India's Dalits and Adivasis living shorter lives of poorer quality. Thus, a Dalit woman lives[5], on average fifteen years less than the upper caste Hindu woman. About 65% of ST women suffered from anaemia[6] compared to 47.6% of non-ST women. They miss out on access to healthcare. While 15% of higher caste women did not receive prenatal[7] care, such care was not received by 26% of Dalit women. Only about 61% of ST mothers received the tetanus vaccination[8], compared to 81% of non-

[1] https://censusindia.gov.in/census_and_you/scheduled_castes_and_sceduled_tribes.aspx
[2] https://southasia.web.ox.ac.uk/sites/default/files/southasia/documents/media/oxford_university_csasp_-_work_in_progress_paper_5_social_discrimination_in_india_a_case_for_economic_citizenship.pdf
[3] https://www.hrw.org/reports/2001/globalcaste/caste0801-03.htm#P141_18954
[4] http://www.ncdhr.org.in/wp-content/uploads/2018/12/293284207ADRF-report-for-web.pdf
[5] https://theprint.in/health/rich-outlive-poor-by-7-5-years-upper-caste-women-live-15-years-more-than-dalits-oxfam-report/699835/
[6] https://scroll.in/pulse/902787/new-report-highlights-the-neglect-of-the-health-of-indias-tribal-communities
[7] https://gcap.global/wp-content/uploads/2018/11/Dalit-Shadow-Report-2017.pdf
[8] http://nhm.gov.in/nhm_components/tribal_report/Executive_Summary.pdf

SC/ST women. They also face direct discrimination in the healthcare system. One study[9] found that 94% of Dalit children surveyed faced discrimination in the form of touch (whether they were touched sympathetically when accessing healthcare), dispensing of medicines (91%) and the conduct of pathological tests (87%); 81% of Dalit children were not given as much time as other children.

Much of the focus while looking at the health outcomes for these communities has rightly been on the performance of the public health system. However, private infrastructure[10] now accounts for nearly 62% of all of India's health infrastructure. India has a total of 43,486 private hospitals,[11] 1.18 million beds, 59,264 ICUs, and 29,631 ventilators. 55% of all in-patient hospitalizations[12] in India are in private hospitals. It is critical to examine the extent to which this large private healthcare system is able to deliver good quality healthcare to India's marginalized communities.

This brief provides an overview of the issues pertaining to the private health sector as they impact Dalits and Adivasis who are among the most vulnerable communities in India. This brief will provide an overview of the existing evidence related to the challenges faced by these communities while availing health services in the private health sector and the consequences of the profit-driven health model on Dalits and Adivasis. This document is meant for Dalit and Adivasi rights activists who want to work on private health sector issues and health activists who are advocating for the regulation of the private healthcare sector.

The Evidence

Dalits and Adivasis: Excluded from the formal private healthcare system or left to the vagrancies of unqualified private practitioners

Few Dalits and Adivasis use the formal healthcare system. Only 4% of Adivasi and 16% of Dalits utilize Outpatient (OPD) private facilities whereas 4% and 15% of patients use private facility in-patient[13] (IPD) facilities respectively.

However, private practitioners still play a critical role. In India, only 37% of the population in the rural areas has access to health care services within a 5-km radius and only 68% of the population have access to a basic outpatient[14] health facility. Therefore, a large share of Dalits and Adivasis, particularly women, consult private medical practitioners in their locality, many of these may be quacks. Thus, one study of Dalits in Rajasthan found this proportion to be

[9] Acharya, S.S. (2010). Access to Health Care and Patterns of Discrimination: Study of Dalit Children in Selected Villages of Gujarat and Rajasthan. New Delhi: IIDS & UNICEF, p.16 Accessed from https://idsn.org/wp-content/uploads/user_folder/pdf/New_files/India/IIDS_-_Access_to_Health_Care_and_Patterns_of_Discrimination.pdf

[10] https://www.institutmontaigne.org/en/blog/private-healthcare-india-boons-and-banes#:~:text=India%20has%20a%20total%20of,all%20of%20India's%20health%20infrastructure.

[11] https://cddep.org/wp-content/uploads/2020/04/State-wise-estimates-of-current-beds-and-ventilators_24Apr2020.pdf

[12] https://indianexpress.com/article/business/private-hospitals-account-for-55-of-in-patient-cases-public-hospitals-42-6134065/

[13] https://www.researchgate.net/publication/336441256_Utilization_of_health_care_services_in_public_and_private_healthcare_in_India_Causes_and_determinants

[14] Kasthuri A. Challenges to healthcare in India - the five A's. Indian J Community Med. 2018;43(3):141–3

74%[15] and another in Bihar[16] at 84%. Even in an urban settlement like Delhi[17], 48.9% of Dalits/Adivasis sought help from unqualified practitioners for episodic illnesses. However, when it comes to chronic illnesses or hospitalization, the role of private hospitals becomes more prominent. Thus, in a Delhi study[18], private hospitals account for 30.8% of hospitalizations and 42.6% of sites of treatment of chronic illnesses. Incidents of refusal or denial of health care on the basis of casteism and discrimination in government hospitals against Dalits and Adivasi patients forces them to rely on unregulated private hospitals resulting in financial exploitation and even more grave abuse of their rights.

Financial Exploitation of the poor and marginalized communities

Private healthcare is expensive. The average expenditure incurred for private hospital hospitalization is six times[19] more than government hospitals (Rs. 4,452 compared to Rs. 31,845). According to the 75th round of NSSO[20] for OPD care, Out of Pocket Expenditure (OOPE) in private facilities was 114% higher than in public facilities; and for In Patient care, OOPE in private facilities is 524% higher than in public facilities. For Dalit patients, the average medical expenditure per hospitalization[21] is Rs.11,315 and it is Rs. 18,380 in rural and urban areas respectively. For Tribal patients, it is higher- Rs. 14,857 and Rs. 19,492 in rural and urban areas respectively.

This is unaffordable for Dalits and Adivasis who are disproportionately likely to be poor. As per the National Family Health Survey 2015-16 (NFHS-4) data, 45.9% of the Adivasi population and 26.6% of the Dalit population are in the lowest wealth[22] bracket. Five out of six multidimensional[23] poor people in India belong to either scheduled tribes or castes. 83.55% of SCs households have their highest-earning members' income at less than Rs. 5,000 (SECC 2011)[24]. This place very real constraints on the capacity of marginalized community households to pay for healthcare out of pocket.

Costs of healthcare have been one of the major reasons for poverty in India. The percentage of patients experiencing catastrophic health expenditure[25]across India between 2014 and 2018 was 10% and 25% for public and private providers respectively. Average Out of Pocket treatment expenditure for hospitalized[26] patient in the lowest wealth quintile from rural areas is Rs. 19,964 as compare to Rs. 11,994 for patients from the highest wealth quintile.

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[15] https://www.jstor.org/stable/pdf/26188719.pdf

[16] https://www.academia.edu/215494/Health_Inequity_and_Women_s_Self_Help_Groups_in_India_The_Role_of_Caste_and_Class

[17] https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12792

[18] https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12792

[19] https://timesofindia.indiatimes.com/city/bengaluru/hospitalisation-is-6-times-more-expensive-in-private-sector-study/articleshow/73052991.cms

[20] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06777-7

[21] https://www.mospi.gov.in/sites/default/files/publication_reports/NSS%20Report%20no.%20586%20Health%20in%20India.pdf

[22] https://www.indiaspend.com/scheduled-tribes-are-indias-poorest-people-18413/

[23] https://ophi.org.uk/wp-content/uploads/UNDP_OPHI_GMPI_2021_Report_Unmasking.pdf

[24] https://secc.gov.in/getSCHhdSummaryNationalReport.htm

[25] http://www.healthfinancejournal.com/index.php/johcf/article/view/135

[26] https://www.mospi.gov.in/sites/default/files/publication_reports/NSS%20Report%20no.%20586%20Health%20in%20India.pdf

Dalits and Adivasis face the worst brunt of this trend. Mothers using private health centers for institutional delivery, especially those having a caesarean delivery, reported higher distress financing compared to mothers using public health centers (27.8% vs. 23.4%).

For Adivasi communities, catastrophic health expenditure is much higher during hospitalization[27] in private hospital (31.5%) than in government hospital (4.4%). Every year the extent of distress financing is higher among new mothers belonging to Dalits and Adivasis compared to those belonging to upper castes[28] as they struggled to meet the costs of institutional delivery. These expenses together contribute to financial unsustainability of treatment in the private sector. While the majority of Adivasi (64%) were dependent on private clinic/hospitals for the first visit to seek treatment[29] for acute illnesses, this number reduced to 51% for the second consultation.

Sadly, the COVID 19 pandemic has exacerbated the cost of medical care hitting the poor, especially the marginalized communities within them, hardest. The average cost[30] of COVID-19 treatment was INR 1,12,179 in government and Rs 2,97,577 in private hospitals. Before the pandemic, the cost for the treatment of all symptoms similar to COVID 19 was Rs. 4,622 in government hospitals and Rs. 28,932 in private hospitals.

Profits leading to unethical treatment of marginalized communities

Unregulated commercialization of provisioning, medical technology, medical and paramedical education has a negative impact on the quality and cost of healthcare, particularly for the poor and marginalized communities. Few efforts have been made to standardize the quality of care, introduce price capping for procedures or to regulate clinical establishments.[31] For a hefty commission[32], private doctors prescribe more tests than necessary, to be done at preferred in-house or outside labs or prescribe expensive medicines or vaccines when cheaper, quality substitutes are easily available[33]. Many of these medicines[34] and vaccines are available only at an in-house pharmacy, or recommended chemist shops outside. In a study in Maharashtra[35] of 261 small private hospitals visited, 146 provided maternity services yet 137 did not have a qualified midwife, and though most claimed they provided emergency care, including caesarean section, only three had a blood bank and eight had an ambulance.

The result is negative experiences for Dalits and Adivasis. The Government of India has been receiving many complaints[36] regarding malpractice in clinical establishments, particularly large multi-specialty hospitals and corporate establishments. One particularly egregious

[27] Hooda SK. Growth of Formal and Informal Private Healthcare Providers in India: Structural Changes and Implications. J Health Care Finance. 2017;44(2):FALL
[28] https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1001-7
[29] https://www.oecd.org/els/health-systems/48723982.pdf
[30] https://www.downtoearth.org.in/news/governance/myth-of-coverage-household-burden-of-covid-19-treatment-was-several-times-higher-than-government-spending-81096
[31] http://www.indiaenvironmentportal.org.in/files/Inequities%20in%20access%20to%20health%20services.pdf
[32] https://thediplomat.com/2016/08/dealing-wth-the-growing-threat-of-medical-malpractice-in-india/
[33] https://www.firstpost.com/india/medical-council-of-india-largely-responsible-for-corruption-in-health-care-reveals-committee-2755450.html
[34] https://www.linkedin.com/pulse/how-private-hospitals-cheating-patients-corporates-ritesh-kumar-singh/
[35] https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2811%2937560-X
[36] https://gh.bmj.com/content/bmjgh/5/2/e002026.full.pdf

example is how the profit-making agenda of private hospitals has put Adivasi women in danger. Before 1997,[37] only 43% of hysterectomies were performed in private hospitals; by the end of 2016 this increased to 74%. A major racket[38] involving the removal of the uterus of nearly 2,200 women belonging to the Adivasi Lambani and Dalit communities emerged, with young women targeted.

Private hospitals and pharmaceutical manufacturers also have a strong nexus[39]which leads to unethical and unhuman medical practices on poor people. Poor rural Adivasis were recruited for drug trials by many pharmaceutical[40] companies. Between 2007-2012 as many as 25,000 girls in Andhra Pradesh and Gujarat were recruited by private hospitals for cervical cancer vaccine clinical[41] trials; several Adivasi girls and boys allegedly died within week or months following vaccination.

Health insurance fails to benefit Dalits and Adivasis

The high costs of healthcare were expected to be addressed through the introduction of health insurance. The Ayushman Bharat– Pradhan Mantri Jan Aarogya Yojana[42] was launched in 2018 and became the Union government's flagship scheme to make healthcare accessible to the poor and marginalised. However, it covers less than 30% of hospital charges[43] leaving a heavy financial burden on the poor. In another estimate in Chhattisgarh[44], 95.1% of insured private sector users still incurred costs during hospitalization. Dalits and Adivasis were specifically inadequately covered. Only 4% of private hospital admissions under PMJAY[45] was from Dalits; the figure was even lower at 1.6% from among Adivasis. This contrasts to a projected eligible 19.7% Dalit and 15.4% Adivasi population respectively. Besides, most health insurance schemes only cover hospitalization expenses, not OPD expenses which include most costs.

Social Exclusion of Dalits and Adivasis in private hospitals

Both Dalits and Adivasis face discrimination in the private healthcare system. Dalits face explicit discrimination in access to health care in terms of disparity in care provisioning.[46] One study[47] found that Dalits were denied entry into private health centres or clinics in 21.3% of villages. There were significant differences between Brahmins and other castes in terms of waiting time in the private sector[48]. Oxfam India's survey[49] across seven states revealed that

[37] https://www.thehindubusinessline.com/news/science/here-is-why-hysterectomy-cases-in-india-are-rising/article30017810.ece
[38] https://timesofindia.indiatimes.com/city/bengaluru/hysterectomy-scam-doctors-cheat-lambani-dalit-women/articleshow/57008799.cms
[39] https://www.downtoearth.org.in/blog/health/where-are-the-doctors-bodies-when-common-man-suffers-due-to-poor-treatment--60293
[40] https://www.ijlmh.com/wp-content/uploads/Right-to-Health-pertaining-to-Scheduled-Tribes-An-Exposition.pdf
[41] https://economictimes.indiatimes.com/articleshow/41280050.cms
[42] https://scroll.in/article/1001457/why-india-should-make-access-to-healthcare-a-fundamental-right
[43] https://www.epw.in/engage/article/ayushman-bharat-and-false-promise-universal
[44] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0187904
[45] https://www.newsclick.in/Failing-to-Serve-the-Marginalised-Private-Health-Sector-Burdens-Public-Systems-Instead
[46] https://idsn.org/wp-content/uploads/user_folder/pdf/New_files/India/IIDS_-_Access_to_Health_Care_and_Patterns_of_Discrimination.pdf
[47] https://us.sagepub.com/en-us/nam/untouchability-in-rural-india/book230642
[48] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6188850/
[49] https://scroll.in/article/1001457/why-india-should-make-access-to-healthcare-a-fundamental-right

over 50% of Dalits and Adivasis in private hospitals faced difficulties in accessing non-COVID-19 medical facilities compared to 18.2% in the general category.

This is at least partly given the relatively low representation of Dalits and Adivasis in the leadership of the medical profession. STs and SCs constituted only 8.7% and 18.8% of health professionals (except nursing) in 2011-12. SCs and STs were particularly underrepresented in the nursing profession which employed 1.9% SCs, 10.7% STs and 70.4% General[50] caste.

Absence of private hospitals in remote and hilly rural areas of India

The majority[51] of private providers lack interest in working in remote Adivasi-dominated areas. Private hospitals tend to have an urban[52] bias with nearly 67% of private hospitals registered under PMJAY located in big cities. In contrast, it is rural areas with Adivasi and Dalit populations which suffer from severe infrastructure gaps. Thus, across 10 states with sizable Adivasi population, the percentage deficit of healthcare providers in Adivasi areas is found to be 64% ANMs at Sub Centres and Primary Health Centre, 33% Allopathic doctors at PHC, and 84% specialists at CHC which depict the huge deficiency of specialist doctors and thus quality[53] healthcare.

Weak measures for social accountability ensure that voices of marginalized communities remain unheard

Mechanisms for ensuring accountability from private hospitals have been weak for everyone. A recent research[54] into compliance in private hospitals in Maharashtra found that only 15 of 161 private hospitals had a designated person to look into the grievances of patients. In 130 of 161 hospitals, complaints had to be registered with the hospital owner and no independent mechanism for handling grievances was prescribed. Only 75% of hospitals[55] were registered under the Bombay Nursing Home Registration Act, but most lacked mechanisms for transparency. Weak mechanisms for the voice of patients[56] to be heard and absence of social accountability mechanisms in the private healthcare sector makes it even harder for Dalits and Adivasis to receive redress.

The legal and policy framework

Several provisions exist for the protection of the human rights of Dalits and Adivasis in India. Thus, the Constitution's Article 14[57] confers equal rights and opportunities to all and Article 15 prohibits discrimination on the grounds of caste, religion, race, sex or place of birth. The right against exploitation (Articles 23 and 24) prohibits caste-based discrimination. The Fifth

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50 https://www.researchgate.net/publication/321126333_Health_for_not_All_Mapping_the_discriminated_and_detached_terrains_of_health_services_in_rural_India

51 https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/IndigenousWomenNetworkIndia.pdf

52 https://pmjay.gov.in/sites/default/files/2020-11/Policy_Brief_9_Private_PM-JAY_201123_WB_NHA_R.pdf

53 https://journals.lww.com/jfmpc/Fulltext/2020/09090/Examining_tribal_health_inequalities_around_three.51.aspx

54 https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2811%2937560-X

55 https://indianexpress.com/article/india/maharashtra-health-dept-pulls-up-6700-nursing-homes-for-not-conforming-to-rules-791-are-in-pune-alone-4818299/

56 https://thewire.in/health/covid-19-crisis-delhi-oxygen-dhli-hospital

57 https://indiankanoon.org/doc/367586/

and Sixth Schedules under Article 244 of the Indian Constitution[58] provide for self-governance in specified Adivasi majority areas.

The United Nations Declaration[59] on the Rights of tribal populations refers specifically to the right to health (articles 21, 23, 24 and 29), with particular attention to the needs of tribal elders, women, youth, children and persons with disabilities. More specifically, Article 24[60] of the UNDRIP specifically talks about the rights of Adivasi people to health; right to access health care and social services without discrimination, and the right to use traditional medicines and health practices that they find suitable. It is therefore the duty and responsibility of the government to deliver this right to the Adivasi peoples.

While the Constitution of India does not expressly guarantee[61] a fundamental right to health, it could be inferred from its Article 21- the right to life and the Directive Principles of State Policy in Part IV of the Indian Constitution. Article 39 (E) directs the State to secure the health of workers, Article 42 directs the State to just and humane conditions of work and maternity relief and Article 47 casts a duty on the State to raise the nutrition levels and standard of living of people and to improve public health.

Existing regulatory mechanisms for the private healthcare sector are weak. These include the Clinical Establishment Act[62] and the Patients' Rights charter which place obligations on private hospitals. A review of the extent of implementation[63] of CEA 2010 shows that all five crucial aspects of regulation of clinical establishments are yet to be implemented. The National Council for Clinical Establishments approved an updated PRC in August 2021.[64] This provides a consolidation of various rights which enables the assurance of protection and promotion of Human Rights of patients and works as a guidance document for the Union and State governments to formulate concrete mechanisms so that patient rights are given adequate protection. The latter includes an explicit clause on non-discrimination against marginalized communities.[65]

Conclusion and Recommendations

India's current substantial reliance on the private healthcare sector is a reason for grave concern for India's Dalits and Adivasis. Due to extremely weak and ineffective mechanisms for accountability and regulation, the private healthcare sector's quest for profit maximization often results in unwarranted treatments, exorbitant healthcare bills and a commercialised approach towards patients, especially those from marginalized communities.

[58] https://www.thecitizen.in/index.php/en/newsdetail/index/4/20000/how-about-implementing-the-constitution-in-adivasi-and-tribal-areas
[59] https://nhsrcindia.org/practice-areas/kmd/tribal-health
[60] https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/IndigenousWomenNetworkIndia.pdf
[61] https://www.orfonline.org/expert-speak/declaring-the-right-to-health-a-fundamental-right/
[62] http://www.clinicalestablishments.gov.in/
[63] https://www.oxfamindia.org/knowledgehub/workingpaper/analysing-regulation-private-healthcare-india
[64] https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1797699
[65] http://clinicalestablishments.gov.in/WriteReadData/8431.pdf

A. Recommendations for ensuring equity, accountability and regulation of the private health sector in India for all its citizens, including those historically marginalized:

- Strengthen the public health system and ensure that union and state budgetary allocations in health for SCs, STs and other marginalized communities are proportionate to their population and include a concrete gendered focus. The government must monitor spending under these heads via a special monitoring cell.
- Notify a right to health that makes it obligatory for the government to ensure equal access to timely, acceptable, and affordable and gender sensitive healthcare of appropriate quality to all its citizens, address the underlying determinants of health and regulate privately provided healthcare in India.
- The MOHFW must ensure that all states and UTs to adopt and implement the CEA and the Patient's Rights Charter as soon as possible. The extent of implementation of the CEA should be monitored.
- The MOHFW must ensure that all States and UTs mandatorily display the Charter in all private and public hospitals.
- Regulate private hospitals to address financial exploitation and unethical treatment of Dalits and Adivasis, particularly women. The Union and state governments should declare the standard price list and standard treatment protocol for private hospitals to control unethical and malpractices. Strong steps must be taken to stop unnecessary practices affecting women like caesarean sections and hysterectomy.

B. Recommendations for addressing the specific challenges faced by Dalits and Adivasis

- The government should strengthen the grievance redress mechanisms for marginalized communities which is easy to access, prompt and people friendly. This would entail establishing functional helplines in tribal and other local languages and streamlining mechanisms for informing complainants about the status of complaints and provide for auto escalation of the same if unresolved in time. Private hospitals should have a separate help desk for tribal patients.
- The Union, state and district government should include the representatives of groups/NGOs working on Dalit Rights in the regulatory bodies and committees under the CEA at the district and state level.
- The government should amend the existing Human Resource policy and increase the appointment of medical and para-medical staff from the Dalit and Adivasi communities.
- The Union, state and local governments should develop training modules and conduct regular training programs for sensitization of doctors and medical staff on the issues of Dalit and Adivasis to minimize discrimination and social exclusion, especially with a gender lens.
- The government should provide basic training on disease prevention and treatment to tribal spiritual and cultural healers given the faith bestowed on them by the tribal community.
- Promote additional research on the impact of the private healthcare system on the rights of Dalits and Adivasis.

Authors: Nitin Jadhav and Anjela Taneja
Inputs from: Vandana Prasad (PHRN), Ravi Duggal, Amitabha Sarkar (Independent researchers), Pankaj Anand, and Anushree Jairath (Oxfam India).