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Research Article

Poverty, Social Exclusion and Health: A Case-Study on the Koutruk Community of Manipur

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ABSTRACT

Social exclusion is the process through which individuals or groups are wholly or partially excluded from the society in which they live. Social exclusion is the driving force of health inequalities. It may directly influence health by affecting the health system and indirectly by affecting economic and other social inequalities that influence health. This qualitative study explored the experiences of social exclusion among members of a remote and marginalised community of Manipur, India (Koutruk). Furthermore, this study aimed at understanding various factors responsible for social exclusion, especially in the health-care service sector and how these factors adversely affect their health. Seven key community members and two medical officers from adjacent primary health-care centres were selected purposively and were asked to participate in the semi-structured interview. Data generated from the interviews were qualitatively analysed using a thematic approach. This study clearly demonstrated that the Koutruk community has been experiencing social exclusion in various dimensions such as education, employment and health-care services. Furthermore, the prevalence of high poverty in the community can be considered the cause as well as product of social exclusion. The health status of the community was found to be very poor. High infant and maternal mortality rates, as well as various diseases were found in the community. Multiple factors were found to be responsible for exclusion of this community in the health sector. Major factors include physical isolation due to poor transportation and communication as well as cultural differences, high poverty and unemployment, traditional beliefs and attitudes about health and wellness, lack of awareness due to illiteracy and lack of support from governmental and non-governmental agencies, prejudice and discrimination by the dominant majority ethnic group and so on. Finally, policy implications of this research are also addressed.

Keywords: Social Exclusion, Poverty, Health

OVERVIEW OF THIS STUDY

Social exclusion is very rampant in developing countries like India. Despite economic growth, rising inequality and poverty in India have been a concern among academics and policy makers. The impact of social exclusion and poverty on community health has been recognised as a vital area especially in the context of developing countries. People living in poverty and social exclusion often have the greatest need for good healthcare, education, jobs, housing and transport. However, populations experiencing multidimensional social exclusion are at heightened risk of being deprived of their right to these basic facilities of life. In India, caste, religious minorities and tribal ethnicity remain strong markers of disadvantage and social exclusion.

This study intended to determine how social exclusion mediates community health through qualitative research. Focusing on social exclusion of the community, this

research aimed to provide how social exclusion mediates the experience of poverty, unemployment and health service utilisation, to produce differential health outcomes for a community. Thus, this study attempted to explore the experiences of social exclusion among the Koutruk community in various dimensions, specifically in health status and health service utilisation. In addition, this study investigated various factors responsible for social exclusion and poverty. Furthermore, the impact of social exclusion and poverty on health was also examined.

POVERTY, ETHNICITY AND SOCIAL EXCLUSION

Social exclusion has been conceptualised in many ways. Social exclusion is the process through which individuals or groups are wholly or partially excluded from the society in which they live (De Haan and Maxwell 1998). It provides a broader view of deprivation and disadvantage than does poverty and inequality (UNICEF 2006). Hence, it is possible to be excluded without being poor. Social exclusion is a multidimensional concept with three principle dimensions: economic, social and political (Bhalla and Lapeyre 1997). The United Nations Economic Commission for Africa (UNECA), 2008, has reported that the economic dimension of social exclusion is a direct product of poverty: the excluded consist of unemployed people deprived of regular income and excluded from the labour market and others who are deprived of access to assets such as land or credit. The social dimension of exclusion involves the loss of an individual's links to mainstream society in terms of restricted access to infrastructure, services and amenities, social services (education and health), social security and protection, as well as community and family support. The political dimension of exclusion refers to the deprivation of political and human rights partially or wholly to certain categories of the population, such as women, ethnic and religious minorities or migrants. Thus, social exclusion is a complex and multi-dimensional process. It refers not only to the financially poor but also to social groups whose ethnicity, culture and identity carry the least amount of recognition, influence and power in society. It involves socioeconomic exclusion, demographic disadvantage, denial of accessibility and so on. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.

Social exclusion focuses primarily on relational issues: inadequate social participation, lack of social integration and lack of power (Room 1995). Silver (1994) claimed that social exclusion threatens the society as a whole with loss of collective values and destruction of the social fabric. The Social Exclusion Knowledge Network (SEKN) (2008) defines social exclusion as a dynamic, multidimensional process driven by unequal power relationships interacting across four main dimensions "economic, political, social and cultural" and at different levels including individual, household, group, community, country and global levels. Sen (2000) argues that social exclusion's emphasis on relational features in the deprivation of capability is of particular value, as this highlights the relationship between poverty and inequalities in societies.

Caste-based discrimination is rampant in India and a major cause of social exclusion. According to a report (2008-2009) of the Indian Institute of Dalit Studies, "despite legal provisions, over the years, there has been increasing number of caste-based atrocities. The nature of such atrocities has also undergone changes. Many cases of atrocities are under-reported or unreported, especially in rural areas. Even the cases are officially registered; many of them are not charge sheeted under penal codes". This study also exemplifies caste-based exclusion and its impact on various dimensions of community life.

SOCIAL EXCLUSION AND HEALTH

The vital role of the society and community on health has been clearly recognised. Effective health promotion of socially excluded groups and communities is an important issue that needs serious attention. All the three indicators of the human development index of United Nations Development Programme (UNDP) (life expectancy, literacy and income) are adversely affected by social exclusion. Social exclusion is the driving force of health inequalities. It may directly influence health

by affecting the health system and indirectly by affecting economic and other social inequalities that influence health (WHO 2010). These inequalities may further contribute to social exclusion. People experiencing social exclusion and discrimination may not get equal access to healthcare and treatment due to prejudice and biases of health-care providers, language barriers and cultural disparity (Nelson 2002). Furthermore, the stress associated with social exclusion and discrimination may have a profound psychological impact, which may adversely affect mental and physical health.

The social exclusion framework can help us explain why some population groups are at a higher risk of poverty and health inequities (WHO 2010). Certain characteristics of some population makes them more vulnerable to poverty such as living in a rural area, being unemployed, low level of education and so on or belonging to certain social groups such as refugees and internally displaced persons, ethnic minorities, as well as disabled and institutionalised people (Alam *et al*. 2005). These vulnerable groups encounter adverse living conditions and ill health, which may further contribute to health inequities, poverty and social exclusion. A recent report by the UNDP, 2010, indicates that inequalities in access to healthcare have widened, with less access for the poor, elderly and minorities and between urban and rural areas. A major reason for the rising inequality appears to have stemmed from significant growth in private expenditure, informal payments and in fees for medicines and services, absence of community-based and tailored services, as well as attitudes and discrimination in the health sector (UNDP 2010).

People living in poverty and social exclusion often have the at most need for good healthcare, education, jobs, housing and transport. Unfortunately, such populations are at heightened risk of being deprived of their right to heath, education and other basic facilities. Health for all by the year 2000 programme of WHO suggests that we should ensure that ethnic minorities also have equal access to health services, regardless of their standing in society. Equal access to healthcare is considered a fundamental human right. However, many individuals groups, and communities do not have access to this basic human right.

In the Indian context, castes and tribes can be considered a proxy for poverty and socioeconomic status (Nayar 2007). Scheduled castes and tribes are the major disadvantaged and marginalised groups in India. Nayar (2007) reported a considerable difference in the prevalence of anaemia, diarrhoea, infant mortality rate, utilisation of maternal healthcare and childhood vaccination among different caste groups in India from the data of National Family Health Survey II (1998-1999). This survey clearly indicated a considerable higher percentage of women and children with anaemia among scheduled tribes and castes (more prominent among scheduled tribe population). Similarly, infant and child mortality rates were found to be much higher among scheduled castes, tribes and other backward castes. Furthermore, it was found that a higher proportion of scheduled castes and tribes were not availing any treatment for diseases such as diarrhoea and maternal health-care services and childhood vaccination. Therefore, it was evident that caste-based marginalisation has an adverse impact on health status and health services.

BACKGROUND OF THE SAMPLE: KOUTRUK COMMUNITY

The Koutruk community is a small community residing in a remote area of the Imphal west district, Manipur, India. All inhabitants of this community belong to the Loi or scheduled caste (considered lower caste in India). The total area of the village is 24427 hectares. The total population of Koutruk is 495 as per the statistical abstract, Manipur 2009. The scheduled caste population of Manipur is spread in various parts of the Manipur state predominantly residing in villages. Such communities are generally considered inferior by the mainstream majority ethnic group known as Meitei. The ancient people of Manipur had no caste system as such. However, the mass acceptance of Hinduism by the people of Manipur in the eighteenth century led to the concomitant formation of the caste system as per Hinduism. Loi people are considered scheduled or lower caste and experience social exclusion and discrimination in various dimensions.

The Koutruk community is a backward, under-privileged and ethnic minority community. An initial field visit to this community clearly indicated the high prevalence of social exclusion and poverty in this community. Singh (2001) reported that the Koutruk community has not witnessed any modernisation and development primarily due to lack of transportation and communication facilities in and around the community. Furthermore, the community has been preserving their age-old traditions, customs and practices inside the village. The Koutruk community is a prototype of multidimensional exclusion where poverty, deprivation, inequality and cultural belief systems influence exclusion in various dimensions such as economic, social and political. Therefore, this community was found to be suitable for studying the phenomenon of social exclusion and its multiple dimensions. The specific focus of this study was to understand the impact of exclusion in health of the community people and to understand the causes and mitigation policies.

RESEARCH OBJECTIVES

The primary objectives of this research can be summarised as follows:

(1) To understand the experience of various dimensions of social exclusion among Koutruk community members.

(2) To explore the determinant of social exclusion in health-care services.

(3) To understand the consequence of social exclusion on health-care services.

QUALITATIVE INQUIRY

Qualitative research is "a form of systematic empirical inquiry into meaning" (Shank 2002: 5). It involves a systematic inquiry as it is planned, ordered and follows agreed-upon rules. Qualitative research is also grounded in empirical inquiry as it is based on the world of experience. Inquiry into "meaning" means by this type of inquiry, a researcher tries to understand how the participants make sense of their subjective experience. Denzin and Lincoln (2000: 3) claim that qualitative research involves an *interpretive and naturalistic* approach: "This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them".

This study was based on qualitative research as it was found to be more suitable for the present research problem. The advantages of doing qualitative research include:

(1) Provides opportunities for in-depth examination of phenomena and subjective experiences of participants.

(2) Sensitive to contextual factors.

(3) More flexible as they allow greater spontaneity and adaptation of the interaction between the researcher and study participants.

(4) Helps us to understand a given research problem or topic from the perspectives of the local population it involves.

(5) Effective in obtaining culturally specific information about the values, opinions, behaviours and social contexts of particular populations.

(6) Effective in identifying intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity and religion, whose role in the research issue may not be readily apparent.

Qualitative research methods are suitable for exploratory research and primarily use open-ended questions, which give participants the opportunity to respond in their own words, rather than forcing them to choose from fixed responses, as quantitative methods do. Open-ended questions have the ability to evoke rich responses unanticipated by the researcher and that are meaningful and culturally salient to the participant. In short, qualitative research seeks out answers for its research questions by analysing unstructured information using tools and techniques like interview transcripts, open-ended survey responses, emails, notes, feedback forms, photos and videos and so on. It does not just rely on statistics or numbers, which are the domain of quantitative researchers. It is used to gain insights into people's inner subjective life composed of attitudes,

value systems, concerns, motivations, aspirations, cultural beliefs and so on.

This study sought to explore the subjective experiences of social exclusion and belief systems of a culturally distinct community. Therefore, this study adopted a qualitative method because of its flexibility and suitability for exploring subjective experiences.

METHOD

Participants

Participants were seven key members from the Koutruk community who were living for the last 50 years in that area and had enough knowledge about their community. They were selected purposively. Furthermore, two medical officers (both males of average age 51 years) from adjacent primary health-care centres were interviewed. Participants included five males (average age=60 years) and two females (average age=61 years). Five participants had high school level, one higher secondary level and one primary level education.

Data collection

A semi-structured interview schedule was devised for data collection. Questions were initially asked in an open-ended and non-directive manner, and further specific probing was used wherever necessary (see Appendix for interview questions). All interviews were conducted in the Koutruk community, Manipur, India. The interviews took place either at home (mostly) or outside depending on the respondent's preference. Each interview was audio taped and necessary notes were taken side by side. The average time for each interview was around 150 minutes. Initially some time was spent for building trust and rapport before each interview.

Data analysis

Data were analysed using thematic analysis. Thematic analysis is one of the most widely used qualitative data-analysis processes, which involves searching through data to identify any recurrent patterns and themes. It is a process-oriented approach involving systematic technique of identifying and coding themes (Boyatzis 1998). Boyatzis (1998: 4) defines a theme as a "pattern found in information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon". According to Braun and Clarke (2006: 79), "thematic analysis is a qualitative analytic method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes the data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic". They further added that thematic analysis is common to all forms of qualitative data analysis and does not require any detailed pre-existing theoretical knowledge or approaches as in grounded theory, discourse analysis, narrative analysis and so on.

The analysis processes of the data included the following six steps (Braun and Clarke 2006).

(1) *Familiarising with data:* Data analysis starts with the transcribing data, reading and re-reading the data, noting down initial ideas.

(2) *Generating initial codes:* It involves coding interesting features of the data in a systematic manner across the entire data set and then collating data relevant to each code.

(3) *Searching for themes*: This phase involves re-focusing the analysis at the broader level of themes, rather than codes. This step requires sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. It starts with analysing codes and then combining different codes to produce initial themes. The relationship between codes, between themes and between different levels of themes is then explored. Some initial code becomes themes and others become sub-themes and so on.

(4) *Reviewing of themes:* Once a set of themes is identified, refinement or reviewing these themes may be necessary. During this phase, analysis is done to check whether all themes identified are really themes with enough data and possibility of combining some themes with each other or the possibility of breaking down a theme into separate themes.

(5) *Defining and naming the theme*: In this phase, further analysis is done to refine the specifics of each theme and generating clear definitions and names for each theme. Here, the focus of analysis is on identifying the essence of each theme and overall themes and to determine aspects of the data that captures each theme.

(6) *Report each theme:* This phase involves the final analysis and write-up of the report. Final analysis and write-up of the report should provide a concise, coherent, logical, non-repetitive and interesting account of the story the data tell within and across themes. Furthermore, the write-up should provide sufficient evidence of data to demonstrate the validity of a theme.

To sum up, thematic analysis involves searching across the data set to repeated patterns of meaning and constructs the final form of theme. Finally, its description is written and illustrated with a few quotations from the original text.

RESULTS

Overview

Three master themes emerged out of the data analysis of the participants. They are:

(1) Experiences of social exclusion.

(2) Determinants of social exclusion in health-care services.

(3) Consequences of social exclusion on health-care services.

Results showed that the people of the Koutruk community have been experiencing social exclusion in various dimensions such as education, employment and health-care services. Major factors that were found to be responsible for exclusion in health-care services include spatial disadvantage, lack of awareness, attitude and beliefs, poverty and ethnic discrimination by various social institutions. The major impact of exclusion on the health of the Koutruk community included high mortality rates and prevalence of diseases, low life expectancy and so on.

These master themes and their sub-ordinates are detailed in the next sections. Each theme has been illustrated with verbatim extracts from the interview transcripts.

Experiences of social exclusion

This research clearly showed that the Koutruk community has been experiencing various dimensions of social exclusion. Following are the details of some of these dimensions:

(a) Education

Low education and literacy rate was evident in the Koutruk community. One can easily pinpoint the number of graduates from this community. A survey of the community revealed the following details:

- Till now seven members have graduated so far from the community.
- One person is pursuing a Master's degree for the first time in this community.
- Ten members have passed intermediate till now.

Literacy, as defined in Census operations, is the ability to read and write with understanding in any language. A person who can merely read but cannot write is not classified as literate. Any formal education or minimum educational standard is not necessary to be considered literate. As per this definition, the literacy level of this community was found to be quite low.

All respondents rated a low literacy rate in this community. Participants reported that the major cause behind the low literacy rate is poor quality of primary education in government schools and most children do not even complete the primary level of education. On asking the reasons for such a low literacy rate, participants reported that the lack of attention and concern of teachers and other government officials for this community contribute to the low literacy rate. Furthermore, the option of sending children to private schools is not feasible for most of the members of this community because of the high poverty level.

(b) Employment

Unemployment, poverty and social isolation mutually reinforce each other and cause progressive social

exclusion. Prolonged poverty and unemployment cause decline in the standard of living, which further limits resources for seeking employment and to participate in social activities. The Koutruk community has been experiencing a high level of social isolation, poverty and unemployment for a long time. All respondents reported a high unemployment rate in the community. It was also evident that there is a lack of awareness about the opportunities and accessibility to employment. Most of the community members still follow the same old-fashioned traditional occupations such as piggery, distillation of liquor and cultivation. Survey in the community revealed that about 30 community members (out of 500 members) hold government jobs and most of them are grade IV employees and a few are in the defence forces.

(c) Health service sector

Impact of social exclusion on the health service sector was clearly evident in the Koutruk community. Being a minority community and lack of participation from the community members in political institutions, they cannot influence the political decisions that affect them. Participants reported that no one from the community is an active member of any political organisation and cannot influence political decisions that affect their community. One male respondent of age 70 years reported that

"The demand for a primary health sub-centre (PHSC) in Koutruk area was turned down and instead shifted to another nearby village, Kadang band even though Koutruk village was more deserving."

Furthermore, most of the respondents reported that they have experienced prejudice and discrimination while receiving health-care service. All participants reported that vaccination or immunisation programme is also not regularly conducted in their village.

Determinants of social exclusion in the health service sector

This study made an in-depth exploration of various factors responsible for social exclusion in the health service sector. Analysis of the data showed that the major determinants of exclusion in the health service sectors include geographical location, economic constraints on accessing healthcare, health beliefs and attitudes, lack of awareness and discrimination (institutional and ethnic). Detailed descriptions of each of these factors are as follows:

(a) Geographical location

The geographical location of the Koutruk community is one of the important factors responsible for physical isolation and social exclusion. Physical accessibility, i.e., people's ability to reach desired goods, services, activities and destinations is often an important factor in social inclusion. Health professionals from the nearest primary health centre and community health centre stated that the Koutruk community is identified as a hard-to-reach area. Development of transport and communication has not taken place. One male respondent of age 60 years stated that

"To get access to transport, we have to walk about 4 kms to the neighbouring village. Also, the condition of the road gets worst during the rainy season."

There is no primary health/community health centre in the area of the Koutruk community at the present time. The nearest primary health centre is around 8 km and community health centre is 12 kms away from the Koutruk community. Furthermore, reaching and seeking appointment with doctors is difficult for community members due to poor communication and transportation facilities. One female respondent of 60 years of age reported that

"We face a lot of difficulty in obtaining a timely appointment to seek health care service due to difficulty in accessibility to transportation."

(b) Economic constraints on accessing healthcare

One major determinant of social exclusion in health-care service is poverty. Owing to high poverty and unemployment, most of the community members are not able to bear the cost of medicine and other health-care services. Although many government hospitals provide subsidised services, they still have to visit private clinic and hospitals for many diagnostic tests and the costs

involved in such tests are quite high and not affordable for most community members. Therefore, most of the respondents reported that they have to rely on alternative traditional medicines available in their village.

(c) Health beliefs and attitudes

Another major barrier in seeking health-care services apart from physical isolation and poverty is the beliefs and attitude towards health. Koutruk community members are traditional and illiterate people who believe in traditional views of health and medicine. Most of them seek the services of traditional local healers (Maibi). This practice of seeking the services of traditional medicine and healers has been passed down from generation to generation. Furthermore, there are additional benefits of seeking local services such as low cost and easier to get access and interaction as compared with hospital doctors. Boiling of plant leaves from the nearby hill is a very common medicine used in the Koutruk community. One of the female respondents stated that

"We seek traditional local healers and medicine because it is cheap and accessible as compared to doctors."

In addition, the Koutruk community still relies on traditional methods village Maibi for child delivery and very few deliveries have taken place in hospitals. Hence, the Koutruk community mostly relies on tradition medicines and methods because of their beliefs and poverty. However, such practices may not provide solutions for many diseases and may contribute to sufferings and death.

(d) Lack of awareness

Lack of awareness is another important determinant of exclusion from the health service sector. According to the medical officer of a primary health centre of a nearby village, lack of awareness about sanitation and hygiene is one of the big differences between the Koutruk community and other nearby communities. Doctors of nearby health centres have reported that they always witness very low attendance of Koutruk community members in various vaccination or immunisation programmes. It was evident from the reports of all respondents that health awareness is very low in the Koutruk community and very few steps were taken by authorities to sensitise people of this community to health awareness. Health awareness programmes become especially important for this community as the literacy rate is very low. One female respondent reported that

"Many times we don't know where to go and what to do when we face health related problems and especially during childbirth"

(e) Prejudice and Discrimination

Prejudice and discrimination is a powerful determinant of social exclusion. Groups that experience discrimination often lack equal access to healthcare and other facilities that may in turn contribute to poverty and poor health. As the Koutruk community belongs to scheduled castes, they often face prejudice and discrimination from the major ethnic group (Meitei). Meiteis even forbid inter-dining, intermarriage with Lois (SC) community. Participants also reported many other examples of discrimination and prejudices that they have faced. All most all participants reported that they do not get adequate access to subsidised goods and services provided by the government and public bodies. However, few said that they only get subsidised kerosene. Many said that they depend on cultivation but do not get subsidised materials for cultivation such as fertilisers, water pumps and so on. All respondents also reported that government authorities have not paid proper attention to the development of their community. Participants also reported that as a result of prejudice, they frequently become victims of violence especially in conflict between government armed forces and insurgency. Such prejudice and discrimination may adversely affect their larger social participation, confidence in social institutions and seeking of health-care services.

Effects of social exclusion on health

In our attempt to explore the potential effects of social exclusion on health, the following themes were found:

(a) Mortality rates (mothers, children)

According to health professionals of the nearest health centre, there is high infant mortality rate and poor

reproductive health among Koutruk community members as compared with other nearby communities and villages. Most of the child birth takes place in their respective homes using traditional methods instead of hospitals. Therefore, it is difficult to estimate the exact infant and maternal mortality rates of the Koutruk community as most of the cases are not registered. Furthermore, lack of proper nutrition especially during pregnancy is another major cause of high infant and mortality rates.

(b) Prevalence of disease

The prevalence of various diseases is very high in the Koutruk community primarily due to lack of awareness and sanitation in the community. Large numbers of piggeries contribute to poor hygiene in the community. Piggeries are very common in the community and are an important part of their livelihood. Most of these piggeries are built near houses and cause stagnant water which in turn increases the probability of mosquitoes laying their eggs and various diseases associated with them. Furthermore, pigs can harbour many parasites and diseases that can be transmitted to humans.

According to reports of health professionals of the nearest primary health centre, most common communicable disease prevalent in the Koutruk community are typhoid, fever, tuberculosis, water-borne disease like diarrhoea and dysentery. The most common respiratory infections are bronchitis and bronchial asthma. Non-communicable diseases like arthritis and gout are very common in the Koutruk community. Cardiovascular disease like arteriosclerosis and hypertension is also very common. Nephrolithiasis and ureterolithiasis are also very common. Percentages of the common diseases to the total diseases include: communicable diseases: 28%, nephrolithiasis and ureterolithiasis: 12%, water-borne disease: 17%, arthritis and gout: 8%, respiratory infections: 6%, cardiovascular disease: 4%, other diseases: 25%.

(c) Addiction

High prevalence of alcoholic addiction among Koutruk community members is another major concern and cause of their poor health. Distillation of liquor take place in the community itself and alcoholic beverages form an indispensible part of their socio-religious activities. In the Koutruk community, rituals, ceremonies related to birth and death, mundane offerings and so on are accompanied with liquor, and thus have ritual significances. Alcoholism and food habits act as a major catalyst in the deterioration of this community's health. Thus, their beliefs, customs and habits could contribute to their poor health.

The poor health conditions of this community are direct and indirect outcomes of social exclusion. It was evident that high poverty, low literacy, lack of awareness, lack of concern and support from the concerned authorities, etc. all contribute to poor health outcomes and health service utilisation.

CONCLUSIONS

This study clearly revealed the phenomenon of social exclusion and its adverse impact on the life of the Koutruk community. Specific focus was given on the health status and health service utilisation of the community. The prevalence of high poverty in the community can be considered the cause and the product of social exclusion. The health status of the community was found to be very poor. High infant and maternal mortality rates, as well as various diseases were found in the community. Multiple factors were found to be responsible for exclusion of this community in the health sector. Major factors include physical isolation due to poor transportation and communication, as well as cultural differences, high poverty and unemployment, traditional beliefs and attitudes about health and wellness, lack of awareness due to illiteracy and lack of support from governmental and non-governmental agencies, prejudice and discrimination by the dominant majority ethnic group and so on.

The Koutruk community still relies on the traditional way of earning such as cultivation, piggeries, distillation of alcoholic beverages. However, these sources of income are insufficient to lead their life and as a consequence for raising the poverty level. Furthermore, spatial disadvantage of the Koutruk community (due to poor transportation and communication) is a major

roadblock for doing businesses. In addition, dominant ethnic communities consider scheduled caste people of Koutruk as inferior, which raises prejudice and discrimination against this community. Moreover, belief in the traditional views of health and wellness motivates them to seek local medicinal methods of healings provided by local healers. Illiteracy as well as lack of concern and support from governmental and non-governmental agencies are responsible for lack of awareness among the community members which in turn promotes further poverty, exclusion, poor sanitation and health. Hence, all these factors contribute to poverty and social exclusion, which in turn acts as a barrier for accessing adequate health-care services.

POLICY IMPLICATIONS

This case-study showed multidimensional social exclusion (social, political, economic and cultural) experienced by a community and how it is influencing their life. This research has made an analysis of how poor ethnic minority communities are experiencing deprivation and neglect from the mainstream society using a case-study on the Koutruk community of Manipur. Despite the rapid growth and development of India, extreme poor and ethnic minorities remained outside national and international interventions. Even NGOs have not given adequate attention to such communities. What is surprising is that the community in focus does not have access to the basic infrastructures such as schools, roads, transportation and communication, as well as primary health centres. Furthermore, various government policies for the poor such as subsidised products have not reached this community. Following are some of the guidelines for policy makers. These guidelines are not just for the Koutruk community, but also include people of many such communities in developing countries who are silently experiencing the pain of exclusion from the mainstream societies.

(a) Localised analysis of who are excluded and why and when policies should be developed. Furthermore, disaggregated information and monitoring system should be developed to track performance of policies.

(b) Governmental and non-governmental policies should be directed to improve the availability and access of primary health-care centres with subsidised medicine for poor communities as it was found that the high cost of medicine is a major barrier in seeking health-care services.

(c) Poor and excluded groups lack awareness of health issues and how best to seek treatment. They also lack awareness of the services available to them due to social and institutional barriers. Therefore, health staff training should be conducted to address inappropriate behaviours and to increase heath awareness among community members. Special emphasis should be given to sensitise people about maternity care.

(d) In addition to health-care service, education and employment have to be addressed to deal with the exclusion. Poorest members of the community should be identified and grants must be given to start income-generating activities with proper training and technical support. Lack of education breaks the backbone of future generations. Therefore, special focus should be given to the availability and access to schools. In addition, monitoring of teacher's attendance and performance is equally needed as many teachers of government schools do not even visit schools regularly. Moreover, scholarship can be provided to needy students to increase their motivation to study.

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