

Research Article

Development, Marginalization and Health in India- Implications of Covid-19

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ABSTRACT

Development, marginalization and health are interrelated and inter-influencing phenomena. Among Indian population the effects of growing socio-economic inequality and its effect on health status are concerns. The rural population, women, children, aged, STs, SCs, Muslims, and urban poor are mostly excluded from many fruits of development, and are more prone to long-term effects of Covid-19 or any other disease. There are both internal and external factors playing its roles in deciding the fates of these marginalized groups, especially their health status. In order to address the health needs of these groups, public policy should focus on both improvements of socio-economic conditions on the one hand, and health policy and programmes targeted to them, on the other hand. For sustainable and equitable development, social justice and social security are prerequisites, which are presently under threat. Therefore, the challenge of social and health inclusion is of deeper concern.

Keywords: Covid-19, Development, Health status, Marginalized groups

INTRODUCTION

Although development is needed for all throughout human history, the process is also leading to marginalization of groups or communities. Usually, most of the macro level developments are at the cost of the micro level marginalization, e.g., in the construction of a dam for generating electricity, the local people get displaced from their own habitats, loss their livelihoods and are partially or never get rehabilitated. Health implications of imbalanced or partial development are multiple. One the one hand, it is

leading to better life conditions of people at macro level and on the other, the displaced or marginalized suffer a lot both physically as well as emotionally. The process of marginalization is affecting both the physical and mental health of the local people, and in course of time leading to their underdevelopment. In addition, development as such has positive and negative health implications. Positive implications are better economy leading to better health status, better health care, better environment, etc. At the same time, negative implications are found in the form of new lifestyles and related diseases like obesity, overweight, diabetes, etc. The development in health care technology is also leading to marginalization. Some are able to utilize the modern high cost services, while others are denied of such technology.

Socio-economic inequality is harmful to the health of any society, especially when the society is diverse, multicultural, overpopulated and undergoing quick but disproportionate economic development. Caste, class, gender, age and ethnic inequalities infuse through the whole array of our society. The socio-cultural determinants of such weaker or marginalized groups or communities' health are playing a major role in the perseverance and intensification of health inequalities. This paper attempts to review the effects of growing socio-economic inequality in Indian population and its effect on the health status. A look into the traditional marginalized groups in India (like women, children, aged, minorities, scheduled castes and tribes, OBCs, etc.) gives us a clear picture of poor health status of such sections of our society. Therefore, it is strongly recommended to plan and practice for sustainable and equitable development including health development for all.

The Covid-19 has its uneven implications on Indian society. On the one hand, the incidences and deaths due to Covid-19 are found to be more among the rich or well off section of population and in the developed nations, while on the other hand, the brunt of lockdown and other restrictions are more on the poorer section of population. Nearly half of the global cases (48%) and deaths (55%) due to Covid-19 as on 11 October 2020 continue to be reported in the Region of the Americas with the United States of America, Brazil and Argentina accounting for the greatest numbers of new cases and deaths in the region; while the Western Pacific region shows lowest cases (2%) and deaths (1%). The highest number of cases and deaths are reported from the United States of America with 75,83,748 cases and 2,12,229 deaths, while in India 70,53,806 cases and 1,08,334 deaths are reported on 11 October 2020 (<https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201012-weekly-epi-update-9.pdf>). Further, globally, the highest percentage of cases has been reported in the 25-39 age group, with approximately 50% of cases in the 25-64 age group, but the percentage of deaths increases with age, and approximately 75% of deaths are in

those aged 65 years and above (<https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201005-weekly-epi-update-8.pdf>).

Development and Health Implications

Studies across the globe have authenticated the close relationships between race, ethnicity, social class and health through time and across space. A few selected studies were reviewed to have a better glimpse on the issue. One of the prominent studies showed that the growing field of health inequalities research has given rise to many questions and debates about definitions of concepts, analytical strategies, interpretation of findings, and explanatory models, which suggested for glossary for health inequalities must go further than simply defining terms and concepts - it must also acknowledge and discuss controversies in the field (Kawachi *et al.*, 2002). An IMF study showed that the recent past has witnessed a global transformation in human health that has led to people living longer, healthier, more productive lives, having profound consequences for population size and structure, including better health boosting the rates of economic growth worldwide, which was pointed out by economic historians and demographers that the rising incomes (and resulting improvements in sanitation and food availability) as the major cause of declines in 19th century mortality rates (IMF, 2004). A WHO report noticed that the global context affects how societies prosper through its impact on international relations and domestic norms and policies; which in turn shape the way society, both at national and local level, organizes its affairs, giving rise to forms of social position and hierarchy, whereby populations are organized according to income, education, occupation, gender, race/ethnicity and other factors; the position in the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill health and the consequences of ill health (WHO, 2015). The social determinants of health are the collective set of conditions in which people are born, grow up, live and work, which include housing, education, financial security, and the build environment as well as the health system; these conditions in turn are shaped by a powerful over-riding set of forces - economic, social policies and politics (RCN, 2012).

In a study it was found that there was no direct link to ill health from income inequality per se; but the raw correlations that existed in (some of the) data were most likely the result of factors other than income inequality, some of which were intimately linked to broader notions of inequality or unfairness (Deaton, 2003). In Britain, during 1980s and 1990s, deaths from suicide, AIDS, violence, and cirrhosis among young men had increased, which suggested the psychosocial effects of relative deprivation; and the international data also confirmed that death rates from accidents, violence, and alcohol related causes were closely related to wider income inequalities (Wilkinson, 1997).

Another study from gender perspective found that in men, social class based on employment relations, was the most important influence on mortality while in women, social class based on individual employment relations and conditions showed only a weak gradient; and the large differences in risk of mortality in women were found when social position was measured according to the general social advantage in the household (Sacker *et al.*, 2000). The results of another study showed that income on the one hand and qualification and occupational position on the other were largely independent; and the mortality related effects of income dominated those of the other socio-economic status indicators (Geyer *et al.*, 2000). In the context of aboriginal people's health, it was considered that life stages, socio-political contexts and social determinants, each affecting the other in temporally and contextually dynamic and integrated ways; which reflected that the aboriginal contexts and social determinants not only had a direct impact on health but also interacted with one another to create vulnerabilities and capacities for health (Reading *et al.*, 2009).

In the context of poor developing countries, it was mentioned that such countries tend to be unhealthy and unhealthy countries tend to be poor; the poorest countries are in the tropics, an area rife with tropical diseases, which may hold back development; bad government or geographic disadvantages might also impede both productivity and disease control; and more particularly, poor health in childhood might depress the formation of human capital (Hoyt, 2010). A report acknowledged that in some of the poorest countries, carefully designed programmes have brought health benefits to the most vulnerable people and suggested that although public health has traditionally focused on improving the health of the majority, policies and programmes could be reoriented to better meet the needs of poor and vulnerable groups (PRB, 2004). Imrana Qadeer (2007) opined that even the most efficient of public health systems could not achieve the best possible results unless they were supported by the welfare inputs like food availability and nutritional status of populations, drinking water supply, housing, transport, education, employment and gender equality; which were the most critical inputs in Third World countries without which health systems played a very minor role in preventing diseases.

In India, the Dalits, Adivasis, Muslims and especially women from such groups were physically, socially and economically excluded from rest of the society. It was considered that certain groups in the society often encounter discriminatory treatment and need special attention to avoid potential exploitation, which was disadvantaged as compared to others mainly on account of their reduced access to medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing, sanitation, etc. (Chatterjee and Sheoran, 2007). It was pointed out

that despite progress in improving access to health care in India, inequalities by socioeconomic status, geography and gender continued to persist, which was amalgamated by high out-of-pocket expenditures, with the rising financial burden of health care falling overwhelming on private households, which account for more than three-quarter of health spending (Balarajan *et al.*, 2011). A study found that the SC and ST were poor on both health outcome and also in accessing healthcare services. It revealed that social groups having poor socio economic development level were poorly performing on reporting of morbidity/illness as well as on curative care behaviour; availability of government healthcare facility and providers mattered more for ST than any other social group and poor utilization of government health facilities was still a major concern in rural India (Raushan and Mutharayappa, 2014). Another study showed that poor health and inequality in urban India reduced human capital attainment and productivity, increased social fragmentation, and threatened sustainable development; while health services were particularly expensive in urban areas and their quality was extremely variable, including large numbers of informal and untrained healthcare providers as well as highly trained specialists, but preventive and primary care delivered by a qualified general practitioner was not sufficiently available, and the lack of access to quality and appropriate services contributed to poor health across the life course; further the poor health in early life as evidenced by stunting was associated with chronic disease in later life, leading to a double burden of communicable and chronic disease, and threatening households with constant risk of catastrophic expenditure (Nolan *et al.*, 2014). Thomas (2013) pointed out that in India, gender differences relating to health and population indicators could be observed in sex ratios at birth, infant and child mortality by sex, and low ages at marriage for women; and at the household level, disempowerment of women resulted in less access to education, employment, and income, and power and freedom of movement. It also shows that the sex-selection phenomenon, in compare to earlier decades, was found to be more among the educated and wealthy families, which was causing violence against women into a bigger issue. The results of another study in Indian context showed that between 1992–93 and 2005–06, the prevalence of childhood under-nutrition declined across household wealth quintiles and educational level of mothers, although the pace of decline was much higher among the better-off socioeconomic groups than among the least-affluent groups; and also opined that poor economic conditions contributed to health inequalities in older population followed by illiteracy and rural place of residence, while the socioeconomic inequality was critical for health inequality in younger old population than oldest old population (Goli, 2012). Even the Intergovernmental Panel on Climate Change (IPCC) clearly acknowledged that some groups were especially vulnerable to climate change, and stated - *'Impacts of climate change are like to be felt most acutely*

not only by the poor, but also by certain segments of the population, such as the elderly, the very young, the powerless, indigenous peoples, and recent immigrants, particularly if they are linguistically isolated, i.e. those most dependent on public support. Impacts will also differ according to gender' (IPCC 2007).

The Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) of the United Nations confirm the relationships between health and development. The eight MDGs have been modified as 17 SDGs, even without achieving completely the MDGs. The newly created SDGs and particularly the goals like - End poverty in all its forms everywhere; End hunger, achieve food security and improved nutrition and promote sustainable agriculture; Ensure healthy lives and promote well-being for all at all ages; Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; Achieve gender equality and empower all women and girls; Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all; Reduce income inequality within and among countries; Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels; etc. are quite relevant for nations like ours. Without achieving these goals we cannot think of an equitable and sustainable India.

DATA SOURCES AND METHODS

A look into health and development related aspects of the marginalized groups in India [e.g. women, children, Scheduled Castes (Dalits), Scheduled Tribes (Adivasis), Other Backward Classes, minorities, rural people, urban slums, etc.] gives us a clear picture of the overall poor status of such sections of our society. This paper is exclusively based on survey of relevant literature, including SRS Bulletin, Census of India, NFHS-3 & 4, NSSO 2010, India Human Development Report 2011, India Exclusion Report 2013-14, Accidental Deaths & Suicides in India 2015, etc. For our current analysis of health status in Indian society, the indicators analyzed are – TFR, sex ratio and literacy rate; nutritional status of children; child mortality; age-specific and cause-specific death rate; suicides among farmers and agricultural labourers; contraception, health services received by pregnant women and institutional delivery; labour force participation, unemployment and landless population; urban household characteristics; and poverty; by social and religious background.

Development and Health in Indian Context

In Indian context, we find all the thrust areas of SDGs yet need to be achieved, though we are progressing to certain extent. Unless a balance is maintained in achieving these

goals, development will remain as usually lopsided and inequality will remain to prevail to large extent. The complex social structure and social relationships in Indian society make many individuals, groups and communities excluded from receiving the fruits of development, which further inhibits the development as non-sustainable. Even in areas having economic boosts due to green revolution, though standard of life has changed, incidences of suicides by peasants has alarmed the social and political concerns.

India, on the one hand is heading for continuing economic development, while on the other hand is still experiencing major health burdens, due to both communicable and non-communicable diseases. Many studies highlighted the existing widespread inequalities in health and health care. For example, a study (WNTA, 2007) showed that – i) India accounted for more than 20% of global maternal and child deaths, and the highest maternal death toll in the world estimated at 138,000 in 2000; ii) United Nations calculations showed that India's spending on public health provision, as a share of GDP was the 18th lowest in the world; iii) Nearly 67% of the population in India did not have access to essential medicines; iv) IMR was 67.6 in 1998-99 and has come down to 57 in 2005-06 and Kerala headed the progress made so far with an IMR of 15/1000 births, while Uttar Pradesh had the worst IMR in the country of 73/1000 births; v) 79% of the children between the age of 6-35 months, and more than 50% of women, were anaemic, and 40% of the maternal deaths during pregnancy and child-birth were related to anaemia and under-nutrition; vi) There were 585 rural hospitals compared to 985 urban hospitals in the country and out of the 6,39,729 doctors registered in India, only 67,576 were in the public sector; and vii) The ratio of hospital beds to population in rural areas was almost fifteen times lower than that for urban areas. Though changing, the current situation is more or less similar. Therefore, it is imperative to make an analysis of India's health status in the context of sustainable and equitable development.

A. TFR, Sex Ratio and Literacy Rate

A look into the Total Fertility Rate (TFR), sex ratio and literacy rate by social and religious groups shows that the TFR during 2005-06 was highest among the STs (3.12), followed by Muslims (3.09) and SCs (2.92), while it was lowest among the Sikhs (1.96) (GOI 2011a). The sex ratio in 2001 was ironically lowest among the Sikhs (770), followed by Hindus (901) and best among Christians (963) (Census 2001). The literacy rate in 2011 was highest among the Christians (80.3%); while it was lowest among the STs (59%), followed by Muslims (59.1%) (Census, 2011b). The drop-outs from schools, especially from primary to upper primary level during 2012-13 shows that it was highest among the Muslims (58.9%), followed by Adivasis (58.5%)

and Dalits (54.4%), which was mainly due to their poor socio-economic and marginalized status (BFC, 2014).

B. Nutritional Status of Children

Table 1 shows that the proportions of stunted, wasted and underweight children were much higher in rural areas, among illiterate mothers and among the lowest household wealth group. Among social groups, proportion of stunted children was higher among the STs and SCs (54%); while wasted and underweight children were higher among the STs (28% & 55%). Among the religious communities, proportions of stunted and wasted children were highest among the Buddhists (56.1% & 21%), while underweight were highest among the Hindus (43.2%) followed by Muslims (41.8%). It is interesting to observe that the proportions of stunted, wasted and underweight children were lowest among the Sikhs (29.8%, 11% & 22%). Further, a look into the environmental factors shows that the proportions of stunted, wasted and underweight children were higher among the households not having improved source of drinking water, improved toilet facility and practicing unsafe disposal of children's stools.

C. Child Mortality (IMR and U5MR)

The child mortality in India by background characteristics (Table 2) shows that the infant mortality rate (IMR) and under 5 mortality rate (U5MR) were much higher in rural areas, among illiterate mothers, among STs and SCs, among households having low standard of living and among mothers of less than 20 years of age. The IMR and U5MR were also higher in households having unsafe drinking water, not improved or no sanitation, and using high polluting fuel for cooking. It can be noted that the IMR has decreased from 64.3 and 44.1 in 1999-2005 to 43 and 26 in 2014 in rural and urban areas respectively. Table 2 shows that the IMR was highest for mothers of less than 20 years age (81.2), followed by mothers of more than 35 years age (74.3), for mothers had no education (71) and households had low standard of living (70.2). The IMR was lowest for the mothers who had 12 or more years of education (26.6). Similarly, the U5MR was as high as 100.3 among STs, 99.6 for mothers of less than 20 years age, 99 for mothers of more than 35 years age, 98.6 among households of low standard of living and 96 for mothers who had no education. It was lowest also for the mothers who had 12 or more years of education (29.8).

D. Age-specific and Cause-specific Death Rate

A look into the distribution of age-specific deaths in India (Table 3) shows that higher deaths were in the age groups 70+ years (32.1%), followed by 55-69 years (25.5%) and 0-4 years (11.8%) age groups. Among females in compare to males the death

Table 1: Nutritional status of children by Background Characteristics, 2005-6

Characteristics	Stunted (%)	Wasted (%)	Underweight (%)
Residence			
Urban	40	17	33
Rural	51	21	46
Mother's education			
No education	57	23	52
8-9 years complete	41	18	35
12 or more years complete	22	13	18
Household wealth			
Lowest	60	25	57
Middle	49	19	41
Highest	25	13	20
Social Groups			
ST	54	28	55
SC	54	21	48
OBC	49	20	43
Others	41	16	34
Religious communities			
Hindus	48.0	20.3	43.2
Muslims	50.3	18.4	41.8
Christians	39.0	15.5	29.7
Sikhs	29.8	11.0	22.0
Jains	31.2	15.8	24.0
Buddhists	56.1	21.0	39.2
Others	58.5	33.6	62.7
Drinking Water			
Improved source	49	19	42
Not improved source	49	23	48
Toilet facility			
Improved	34	14	28
Not improved	53	22	48
Disposal of Children's Stools			
Safe disposal	36	15	29
Unsafe disposal	51	21	46

Source: GoI, 2009, *NFHS-3 (2005-6) - Nutrition in India*, Ministry of Health & Family Welfare, New Delhi.

Table 2: Child Mortality by Background Characteristics, (1999-2005)

Background	IMR	U5MR
Residence		
Rural	64.3	84.0
Urban	44.1	55.0
Mother's education		
No education	71.0	96.0
8-9 years complete	44.3	49.6
12 or more years complete	26.6	29.8
Social group		
S C	65.4	87.5
ST	67.4	100.3
Muslims	56.0	74.4
Others	56.1	68.7
Standard of living		
Low	70.2	98.6
Medium	62.5	79.8
High	41.6	48.3
Mother's age		
>20 years	81.2	99.6
25-34 years	48.0	67.6
35 + years	74.3	99.0
Source of Drinking Water		
Safe (tap/hand pump/tube-well/bore-well)	57.3	74.4
Unsafe (all others)	66.4	86.2
Sanitation		
Improved	42.9	52.1
Not improved or none	66.9	88.5
Fuel for cooking		
Low-polluting	33.1	38.9
High polluting	64.7	85.5

Source: NIMS, ICMR and UNICEF, 2012, *Infant and Child Mortality in India: Levels, Trends and Determinants*, National Institute of Medical Sciences, New Delhi: Indian Council of Medical Research and UNICEF Country Office.

rate was higher for the age groups 0-4 years (13.3%), 5-14 years (2%), 15-29 years (6.7%) and 70+ years (40.4%). On the other hand, among males the death rate was higher in the age groups 30-34 years (3%), 35-44 years (7.9%), 45-54 years (11.5%) and 55-69 years (25.5%). It is interesting to note that higher death rates among females

Table 3: Deaths (%) by age, gender and Residence in India, 2010-2013

Age Group	Person	Male	Female	Rural	Urban
0-4	11.8	11.8	13.3	13.4	9.0
5-14	1.7	1.7	2.0	2.0	1.4
15-29	6.5	6.5	6.7	6.6	6.6
30-34	3.0	3.0	2.0	2.5	2.8
35-44	7.9	7.9	4.8	6.4	7.1
45-54	11.5	11.5	6.9	9.0	11.3
55-69	25.5	25.5	23.9	24.5	26.0
70+	32.1	32.1	40.4	35.7	35.8

Source: CGHR, 2015. Causes of Death Statistics: 2010-2013. A Joint Report of the Registrar General of India and the Centre for Global Health Research

in the early ages are probably due to lower socio-cultural status and discrimination of girls in our society; while higher death rate among aged 70+ is probably due to old age natural deaths, as the proportion of elderly female population is more than the males.

Further, the death rate differentials in rural and urban India (Table 4) shows that it was higher in rural areas for the age groups 0-4 years (13.4%) and 5-14 years (2%); while it was higher in urban areas for the all other age groups, except for 15-29 years (6.6%).

Table 4: Proportion of Top 10 Causes of Death in India (all ages), 2010-2013

Major Cause Group	Total	Male	Female	Rural	Urban
Cardiovascular diseases	23.3	25.1	20.8	21.5	29.2
Ill-defined/ All other symptoms, signs and abnormal clinical and laboratory findings	12.4	10.0	15.4	12.7	11.3
Respiratory diseases	7.6	7.8	7.5	8.1	7.0
Malignant and other Neoplasms	6.1	5.8	6.6	6.0	6.2
Perinatal conditions	5.6	5.5	5.8	5.9	5.7
Diarrhoeal diseases	5.1	4.2	6.3	5.5	4.1
Digestive diseases	4.9	6.0	3.5	4.9	4.1
Unintentional injuries: other than Motor Vehicle Accidents	4.7	4.8	4.6	4.7	3.8
Respiratory infections	3.9	3.7	4.2	4.1	3.5
Tuberculosis	3.7	4.5	2.8	3.9	3.3
All Other Remaining Causes	22.6	22.7	22.4	22.7	21.8

Source: CGHR, 2015. Causes of Death Statistics: 2010-2013. A Joint Report of the Registrar General of India and the Centre for Global Health Research.

The current trend shows that majority of deaths in India were due to non-communicable diseases (49.2%); followed by communicable, maternal, perinatal and nutritional conditions (27.7%); and injuries (10.7%); while the symptoms, signs and ill-defined conditions were responsible for 12.4% deaths (CGHR, 2013). It is further found that the proportion of death for males in compare to females were more due to non-communicable diseases (51.8%) and injuries (12.4%); while for females in compare to males were more due to communicable and related diseases (30.4%) and symptoms, signs and ill-defined conditions (15.4%). It is also interesting to note that the proportion of deaths due to non-communicable diseases were higher in urban areas (57%), although the proportion of deaths due to all other causes were higher in rural areas (CGHR, 2013).

A look into the deaths due to top ten specific causes by gender and residence (Table 4) shows that the highest proportion of deaths was due to cardiovascular diseases. In fact, the cardiovascular diseases were higher among males (25.1%) than females (20.8%) and also in urban areas (29.2%) than in rural (21.5%), which are non-communicable diseases and are usually related to lifestyles, although in earlier times communicable diseases were the major causes of mortality and morbidity in countries like India. Of the other selected diseases, ill-defined/ all other symptoms, signs and abnormal clinical and laboratory findings; malignant & other neoplasms; perinatal conditions; diarrhoeal diseases and respiratory infections were found to be causing more deaths among females. It is also found that except the cardiovascular diseases, the proportion of deaths due to all other diseases was more in rural areas.

Further, the medically certified deaths in 2014 shows that the top eight causes were Diseases of the Circulatory System (31.6%); Symptom, Signs and Abnormal Clinical Findings (13.2%); Certain Infectious and Parasitic Diseases (11.9%); Diseases of the Respiratory System (7.8%); Certain Conditions Originating in the Perinatal Period (7.2%); Injury, Poisoning and Certain Other Consequences of External Causes (7.1%); Neoplasms (5.4%); and Diseases of the Digestive System (4.4%), while all other causes led to 11.5% of deaths (MHA 2014). It is interesting to note that the deaths due to diseases of the circulatory system (32.1%); symptom, signs and abnormal clinical findings (13.4%); certain conditions originating in the perinatal period (7.3%); and neoplasms (6.3%) were more among females. The above facts and discussions confirm the variations on deaths based on age, gender, residence and cause. Secondly, it is confirmed that the majority of deaths were due to non-communicable diseases.

E. Suicides among Farmers and Agricultural labourers

A look into the reported incidences of suicides in India may also give insight into the relationships between development and mental health implications. The NCRB data

shows that the suicide rate has decreased from 11.2 in 2011 to 10.6 in 2015, but still it is a concern. It varied across states and sectors. The proportion of suicides was highest in Maharashtra (12.7%), followed by Tamil Nadu (11.8%), West Bengal (10.9%), Karnataka (8.1%) and Madhya Pradesh (7.7%); while the suicide rate i.e. the number of suicides per one lakh population was highest in Puducherry (43.2) followed by Sikkim (37.5), A & N Islands (28.9), Telangana and Chhattisgarh (27.7 each) and Dadar & Nagar Haveli (25.4). The suicide victims by profession shows that highest proportion of suicides was among the daily wage earners (17.8%), followed by house wife (16.7%), self-employed persons (9.1%), unemployed persons (8.2%), professionals/salaried persons (7.9%), students (6.7%) and others (24.2%). It was observed that 69.5% of the suicide victims were married, 70.0% of suicide victims were having income of less than Rs. 1 lakh, and the suicide rate in cities (12.2) was higher as compared to all-India suicide rate (10.6) (NCRB, 2016).

The suicide in farming sector is of great concern for our country, as majority of our population are still directly or indirectly involved in the sector. It is found that though suicide rate at national level has decreased, but it has increased in farming sector from 8.7% in 2013 to 9.4% in 2015 (NCRB 2016). A total of 12,602 persons - 8,007 farmers/cultivators and 4,595 agricultural labourers, have committed suicide during 2015, and the majority of such suicides were reported from Maharashtra (4,291) followed by Karnataka (1,569), Telangana (1,400), Madhya Pradesh (1,290), Chhattisgarh (954), Andhra Pradesh (916) and Tamil Nadu (606), which together accounted for 87.5% of total such suicides in the country. It may be noted that Telangana (34.7%), followed by Maharashtra (24.7%) and Andhra Pradesh (10.9%) accounted for maximum female farmers/cultivators' suicides. It may also be noted that Bihar, Goa, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Mizoram, Nagaland, Uttarakhand and West Bengal along with all 7 UTs have report no incident of farmers/ cultivators suicides; while Goa, Manipur and West Bengal and all UTs (except Puducherry) have reported no incident of agricultural labourers' suicides during 2015. Further, the Land holding status of farmers/cultivators who committed suicide revealed that 45.2% and 27.4% of total such victims were 'Small Farmers/Cultivators' and 'Marginal Farmers/Cultivators' respectively, which accounted for 72.6% of total farmers/cultivators' suicides (NCRB 2016). It is required to be mentioned here that West Bengal having third highest suicides in 2015, did not reported a single case of suicide either by farmers/cultivators or by agricultural labourers.

Table 5 shows that among the farmers/cultivators, bankruptcy or indebtedness (38.7%) and farming related issues (19.5%) including failure of crop and inability to sell, were the major causes of suicides. On the other hand, among agricultural labourers the major

Table 5: Suicides Committed by Farmers/Cultivators and Agricultural Labourers by cause, 2015

Cause	Farmers/ Cultivators	Cause	Agricultural Labourers
Poverty	92	Poverty	178
Property Dispute	86	Property Dispute	93
Marriage Related Issues	157	Marriage Related Issues	90
Farming Related Issues (Failure of Crop and Inability to Sell)	1562	Death of Dear Person	28
Illness	842	Family Problems	1843
Drug Abuse/Alcoholic Addiction	330	Illness	872
Fall in Social Reputation	11	Drug Abuse/Alcoholic Addiction	312
Bankruptcy or Indebtedness	3097	Bankruptcy or Indebtedness	255
Causes Not Known	334	Causes Not Known	281
Other Causes	563	Other Causes	643
Total	8007	Total	4595

Note: a) ‘Farmers/Cultivators’ include persons whose profession is farming and who either cultivates his/her own land or who cultivate lease land with or without the assistance of agricultural labourers; b) ‘Agricultural Labourers’ are those persons who primarily work in farming sector (agriculture/horticulture) and whose main source of income is from agricultural labour activities; c) Family Problems excludes Marriage Related Issues.

Source: NCRB (2016). Accidental Deaths & Suicides in India 2015, National Crime Records Bureau, Ministry of Home Affairs, New Delhi: Government of India.

causes of suicides were family problems (40.1%) and illness (19.0%). These are serious concerns.

F. Contraception, Health Services received by Pregnant Women and Institutional Delivery by Social and Religious Background

The data on selected health indicators by social groups and religious communities in India (Table 6) shows that contraception prevalence was highest among the Sikhs (66.5%) and lowest among the Muslims (45.7%), followed by the STs (47.9%). Three or more ANM visits to pregnant women was again highest among the Sikhs (76%) and lowest among the STs (40.1%), followed by SCs and Muslims (45.7%). Similarly, the institutional delivery was lowest among the STs (17.7% in comparison to 38.7% among all social groups).

G. Labour Force Participation, Unemployment and Landless Population

The India Exclusion Report 2013-14 shows that the labour force participation rate during 2009-10 was worst among the women (23.3%), followed by Muslims (33.8%),

Table 6: Contraception, ANM visits and Institutional Delivery (%)

Characteristics	Prevalence of Contraception (2005-6)	Health Services Received by Pregnant Women (3 or more ANM visits)	Institutional Deliveries
Social Group			
Scheduled Castes	55.0	45.7	32.9
Scheduled Tribes	47.9	40.1	17.7
Other Backward Classes	54.2	49.9	37.7
Religious Communities			
Hindus	57.8	52.5	-
Muslims	45.7	45.7	-
Christians	57.7	67.7	-
Sikhs	66.5	76.0	-
All India/ All social group	61.9	63.5	38.7

Source: Government of India, 2011, India Human Development Report 2011 - *Towards Social Inclusion*, Institute of Applied Manpower Research, New Delhi; and *National Family Health Survey (NFHS) – 3 (2005-06)*.

Dalits (41.2%) and Adivasis (46%); the unemployment rate was again highest among the women (2.15%), followed by Muslims (2.07%); and the landless population was found to be highest among the Muslims (10.4%), followed by Adivasis (10.1%) and Dalits (8.6%) (BFC 2014).

H. Urban Housing Characteristics

A look into the housing characteristics in urban India reflects that the important variables like kitchen, latrine, bathroom, and tap water facility among Hindus were better than average, while among Dalits were worse followed by Muslims. It is observed that 67.52%, 54.27% and 48.45% households had separate kitchen; 62.35%, 54.12% and 31.44% had private latrine; 48.42%, 39.33% and 35.45% had separate bathroom; and 76.87%, 68.23% and 70.54% had tap water facility; among the Hindus, Muslims and Dalits respectively (<https://unu.edu/publications/articles/housing-inequality-amongst-disadvantaged-communities-in-indian-cities.html>).

Data on monthly consumption expenditure, occupation and employment (<https://unu.edu/publications/articles/housing-inequality-amongst-disadvantaged-communities-in-indian-cities.html>) also shows the variations across groups. The average monthly consumption expenditure per household was lowest among the Dalits, followed by the Muslims. It revealed that Dalits had average monthly consumption expenditure per household of Rs. 4438, Muslims had Rs. 4678 and that of the Hindus had Rs. 5480. A similar pattern is observed in occupation and employment. It is found that among

various occupations, 25%, 19% and 12% were professionals/managerial; 45%, 55% and 49% were sales/service workers; and 16%, 21% and 33% were elementary workers among the Hindus, Muslims and Dalits respectively. The employment nature shows that 38%, 50% and 28% were self employed; 39%, 24% and 39% were regular wage/salary earners; and 12%, 18% and 24% were casual labour among the Hindus, Muslims and Dalits respectively. It is also found that Dalits were highly concentrated in slums (23%), followed by the Muslims (19%), while only 11% of the Hindus (non-Dalit) were living in slums. The average household sizes were 4.33, 5.44 and 4.69 for the Hindus, Muslims and Dalits respectively.

I. Poverty by Social and Religious Groups

Poverty is a major concern in Indian context, especially for the marginalized communities, which has implications on their health status. The 2011-12 data (table 7) clearly shows that relating to social groups poverty was higher among the STs (43%), followed by SCs (29.4%) and the OBC (20.7%). Relating to religious groups poverty was higher among the Muslims (25.4%), followed by Hindus (21.9%) and Christians (16.4%). In fact, among all social and religious groups poverty was higher than national level among the STs, SCs and Muslims.

Table 7: Poverty by Social and Religious Groups, 2004-05 and 2011-12

Groups	Share in population	% population below the Tendulkar line		% point poverty reduction
		2004-05	2011-12	
Social groups				
Scheduled Tribes (ST)	8.9	60.0	43.0	17.0
Scheduled Castes (SC)	19.0	50.9	29.4	21.5
Other Backward Classes (OBC)	44.1	37.8	20.7	17.1
Forward Castes (FC)	28.0	23.0	12.5	10.5
Religious Groups				
Christian	2.2	24.5	16.4	8.1
Hindu	81.5	37.5	21.9	15.6
Muslim	13.6	43.6	25.4	18.2
Jain	0.3	4.6	3.3	1.4
Sikh	1.6	18.9	5.9	13.1
Total	100.0	37.7	22.0	15.7

Source: Panagariya, A & More, V. Poverty by Social, Religious & Economic Groups in India and Its Largest States: 1993-94 to 2011-12. Working Paper No. 2013-02, School of International and Public Affairs and Institute for Social and Economic Research and Policy, Columbia University.

Further, a look into the poverty reduction during the period 2004-05 to 2011-12, reveals that the reduction was highest among the SCs (21.5%), followed by the Muslims (18.2%), OBCs (17.1%) and STs (17%). The reduction was lowest among the Jains (1.4%), like the lowest poverty among them (3.3%). This certifies the poor socio-economic conditions of the marginalized communities in India, which has multifarious implications on their health status and health seeking behaviour.

Covid-19

There are only few studies on implications of Covid-19 on the basis of socio-economic status of people. One paper finds that counties with high median income have a high incidence of cases but reported lower deaths; income inequality is found to be associated with more deaths and more cases; the distributions of age, race, and health risk factors such as obesity and diabetes are found to be particularly significant factors in explaining the differences in mortality across counties; and counties with better access to health care as measured by the number of primary care physicians per capita have lower deaths (Mukherji, 2020).

A linear regression analysis in a study (Shahbazi and Khazaei, 2020) showed a direct significant correlation between the incidence and mortality rate of Covid-19 and human development index (HDI) at the global level - the concentration index was positive for incidence rate (0.62) and mortality rate (0.69) of Covid-19, indicating the higher concentration of the rates among groups with high HDI (Shahbazi and Khazaei, 2020). It suggests that the high incidence and mortality rates of Covid-19 in countries with high and very high HDI are remarkable and should be the top priority for interventions by global health policy-makers.

A global study (Stojkoski *et al.*, 2020) found that the sole determinant strongly related to the coronavirus cases is the mortality from non-natural causes - countries where the mortality from non-natural causes is high also show greater resistance to being infected by the virus; and further, the prevalence of catholic religion within the population is a strong determinant of the registered coronavirus deaths per million population, with countries in which the catholic religion is dominant also reporting more deaths.

In a study in England and Wales (Sá, 2020) found that local areas that have larger households, worse levels of self-reported health and a larger fraction of people using public transport have more Covid-19 infections per 100,000 people; while for mortality, household size and use of public transport are less important, but there is a clear relation with age, ethnicity and self-reported health, i.e., local areas with an older

population, a larger black or Asian population and worse levels of self-reported health have more Covid-19 deaths per 100,000 people.

A study (Finch and Finch, 2020) of 2,853 of the 3,007 counties in the United States demonstrated that in the very early stages of the Covid-19 pandemic, counties with higher overall poverty (as reflected in the poverty index) had larger numbers of confirmed cases than did relatively more affluent counties, though this trend has changed over time. Further, results for the number of deaths confirmed to be caused by Covid-19 demonstrated a pattern whereby the number of deaths was greater in areas of relatively greater poverty later in the pandemic, and a larger number of deaths was associated with a larger percent of county residents living in poverty, living in deep poverty, a higher incidence of low weight births, and with the county being designated as urban.

The correlation analysis in a study (Gangemi *et al.*, 2020) displayed significant relationships between Covid-19 incidence with several indicators, including the Gross Domestic Product per capita and the number of flights per capita, whereas mortality is mainly related to the main age of the population. Socio-economic indicators are important determinants of pandemic spread - people living in countries with higher economic status are likely to attend a larger number of social events and to spend more time in overcrowded places, possibly paving the way for an easier virus diffusion; the higher efficiency of national health systems that could affect the number of Covid-19 identified cases; and the aging of the population also makes countries at different risks for pandemic - with those with the older population featuring a higher amount of cases, on average and the higher occurrence of deaths related to the Covid-19 .

In a study in Indian context (Gopalan and Misra 2020) showed that during the Covid-19 pandemic, the economic downturn has greatly affected people from the lower socio-economic stratum (SES) - migrants got stuck abroad trying to cope with the exigencies will compromise to the adverse circumstances, by taking up low wage jobs, live in poor working conditions, restrict spending and thus, risk exposure to infections like the corona virus, while the scenario among the internal migrant workers (intra- and inter-state) in India was equally grim. It considered that the economic impact is likely to be more severe for India in the sense - increase in poverty i.e. pushing more people below poverty line; worsening of socio-economic inequalities, thus affecting health and nutrition indices; and compromise in health-related precautions like use of masks, social distancing, seeking medical advice in case of cough and fever, etc. Further, despite the lockdown, crowding has been observed in religious places, during travel e.g. 'herds' of migrants on buses, or even while purchasing liquor at the shops; and the more troubling aspect is the lack of proper provision of safety nets (e.g. food

safety) for those hit the hardest by lockdown; which also considered that Covid-19 has the potential to cause disruptions to health and health services in India in different ways.

In a nationwide study (Imdad *et al.*, 2020), across India's districts, identified primary epicentres of Covid-19 as the international airports of Mumbai and Delhi and track the outbreak into India's hinterlands in separate time-steps that encapsulate the different lockdown stages implemented. It identified hotspots and significant clusters of Covid-19 cases, discerning temporal changes and highlighting areas where the pandemic may spread next - of prime concern are significant clusters in the country's west and north parts and rising numbers in the east as lockdown measures ease, migrant workers return home and the economy resumes. Socioeconomic susceptibility and vulnerability analyses showed regions that can report high fatalities due to ambient poor demographic and health-related factors - a high share of urban population and high population density (1500-2500 people/km²), particularly in slum areas, elevate the Covid-19 risk.

Another study (Ghosh 2020) considers that the most destructive effects of Covid-19 in India have not been the result of the disease, but the nature of the government response - the most stringent lockdown in the world destroyed the economy and forced millions into poverty and hunger, but did not control virus transmission. The resurgence of disease as restrictions were lifted and the continued economic distress point to ten major features of state response that ensured these unfortunate outcomes, which are – i) the unthinking adoption of containment strategies not suited to the Indian context; ii) excessive centralisation and top-down control, without coordination between central and state governments; iii) inadequate investment in and preparation of health systems, facilities and personnel; iv) misplaced timing and delayed responses in several critical areas; v) parsimony of the relief measures, despite inflated declarations about the official packages; vi) inadequate government spending to increase demand to counter the collapse in economic activity; vii) misplaced focus on measures to increase liquidity; viii) further privatisation of state assets and relaxation of regulations relating to land, labour and environment; ix) class, caste and gender biases of the policy responses; and x) suppression of democratic rights and crackdown on dissent during the lockdown.

CONCLUSION AND DISCUSSIONS

Some of the important findings are as follows:

1. The proportions of stunted, wasted and underweight children were much higher in rural areas, among illiterate mothers and among the lowest household wealth group. Among social groups, stunted children were higher among the STs and SCs; while wasted and underweight children were higher among the STs. Among

the religious communities, stunted and wasted children were highest among the Buddhists, while underweight was highest among the Hindus followed by Muslims. The proportions of stunted, wasted and underweight children were lowest among the Sikhs.

2. The IMR and U5MR were much higher in rural areas, among illiterate mothers, among STs and SCs, among households having low standard of living and among mothers of less than 20 years of age.
3. Higher deaths were in the age groups 70+ years, followed by 55-69 years and 0-4 years age groups. Among females death rate was higher for the age groups 0-4 years, 5-14 years, 15-29 years and 70+ years. The deaths due to top ten specific causes show that highest proportion of deaths was due to cardiovascular diseases, and were higher among males and in urban areas.
4. It is found that though the overall suicide rate has decreased, but it has increased in the farming sector during 2013-2015. Further, among the farmers/cultivators 72.6% of such victims were small and marginal farmers/cultivators.
5. The contraception prevalence was highest among the Sikhs and lowest among the Muslims, followed by the STs. Three or more ANM visits to pregnant women were again highest among the Sikhs and lowest among the STs, SCs and Muslims. Similarly, the institutional delivery was lowest among the STs.
6. The labour force participation rate was worst among the women, followed by Muslims, Dalits (SCs) and Adivasis (STs). Similarly, the unemployment rate was highest among the women, followed by Muslims. The landless population was found to be highest among the Muslims, followed by Adivasis and Dalits.
7. Data revealed the difficult position of the Dalits and Muslims in urban India in terms of access to housing and urban amenities, as well as socio-economic characteristics. The Dalits were highly concentrated in slums, followed by the Muslims. The average monthly consumption expenditure per household was also lowest among the Dalits, followed by the Muslims. A similar pattern was observed relating to occupation and employment.
8. Further, among all social and religious groups, poverty was found higher than national level among the STs, SCs and Muslims.
9. Data on Covid-19 shows that the incidences and deaths due to Covid-19 are found to be more among the rich or well off section of population, while the brunt of lockdown and other restrictions are more on the poorer section of population.

Therefore, it is clear that the rural population, women, STs (Adivasis), Muslims, SCs (Dalits) and urban poor were mostly excluded from many fruits of development, and are more prone to long-term effects of Covid-19 or any other disease. There are both internal and external factors playing its roles in deciding the fates of these marginalized groups, especially their health status. The poor plight of these groups is not only caused by a gap in socio-economic conditions but is also due to social exclusion and marginalization. Therefore, in order to address the health needs of these groups, public policy should focus on both improvements of socio-economic conditions on the one hand, and health policy and programmes targeted to them, on the other hand. In fact, our policies and programmes on health and socio-economic development should be inclusive in nature, based on national, regional and group or community needs. Further, for sustainable and equitable development, social justice and social security are prerequisites, which are presently under threat from the communal and inexperienced governance. Thus, the challenge of social and health inclusion is of deeper concern, for which all sections and sectors need to play its respective positive roles.

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