Surviving Inequality: An Intersectional Analysis of Nutritional Depletion, Occupational Hazards, and Reproductive Injustice among Dalit Women

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Abstract
This article examines the multi-dimensional health inequities that Dalit women in India experience, employing the Social Determinants of Health (SDH) framework to unpack the caste-gap in morbidity and mortality. Rooted in the concept of 'biological weathering,' this review examines how structural violence and ritualised exclusion are converted into physiological breakdown, yielding a staggering 14.6-year survival gap relative to dominant-caste women. Through the integration of longitudinal data from the National Family Health Survey (NFHS-5) and institutional documents, this research reveals a triple burden of caste, gender, and class that is expressed through chronic energy deficiency, severe anaemia (56.7%), and high rates of under-five mortality (56.4 per 1,000 live births). This review emphasises the 'Paradox of Institutional Delivery,' suggesting that improved hospital access is compromised by institutionalised obstetric violence and a clinical gaze that otherizes marginalised bodies. Additionally, the caste-nutrition nexus and occupational pathologies related to dangerous labour, such as manual scavenging and landless agricultural labour, accelerate cellular ageing. The article concludes that the public health structure in India needs to shift from a caste-blind strategy to a caste-sensitive framework. This needs to be achieved by bringing together anti-discriminatory healthcare practices, land rights-based nutritional security, and trauma-informed mental health services to fill the biological divide created by social inequality.
Keywords: Dalit Women's Health, Health Inequity, Social Determinants of Health, Biological Weathering, Intersectional Vulnerability and Caste-Based Discrimination, etc.

INTRODUCTION

The discourse on global health equity has increasingly shifted towards a paradigm that recognises the social as the primary determinant of the biological, acknowledging that structural inequities are not merely peripheral to health but are instead the primary determinants of health (Farmer, 2004). In the Indian subcontinent, the most pervasive and enduring structural determinant of health inequity is the caste system that determines

access to social capital, environmental security, and health care resources (Nayar, 2007). Although the contemporary public health literature often employs the rubric of poverty as a convenient shorthand for marginalisation, such a perspective is insufficient to capture the distinct, intersectional experiences of vulnerability that are particular to Dalit women. For this population, health outcomes are instead determined by the triple burden of caste-based patriarchal oppression, systemic economic deprivation, and the ritualised exclusion that has historically been designated as untouchability (Rege, 1998; Sabharwal, 2017). This article argues instead that the Dalit female body is a biological register of graded inequality wherein the concomitant forces of gender and caste-based oppression cohere as chronic morbidity and premature mortality (Ambedkar, 1936; Thorat & Neuman, 2012).

The most horrifying evidence of the connection between social status and biological survival can be located in the statistics on life expectancy. Although there has been a general increase in life expectancy in India, the difference between life expectancy for Dalit women and dominant-caste women is a gap of human rights proportions (United Nations [UN], 2018). Based on the data compiled by the Indian Institute of Dalit Studies, the average life expectancy of a Dalit woman in India is 39.5 years, as opposed to 54.1 years for women of Upper Caste groups (Thorat & Neuman, 2012). This represents a 14.6-year survival disadvantage that is the result of genetic factors or lifestyle choices but is the biological outcome of the weathering process, whereby the cumulative effect of lifelong social exclusion and environmental toxins, nutritional deprivation, and the psychosocial trauma of caste-based degradation. (Geronimus, 1992). The health of the Dalit mother is compromised even before she reaches the delivery room. According to the National Family Health Survey (NFHS-5), only 48.2% of SC women had four or more antenatal care visits, compared to 62.4% of women belonging to the general caste group (IIPS, 2021). The absence of care is further emphasised by the "Caste-Nutrition Nexus," where food insecurity and the stigma associated with traditional foods result in Chronic Energy Deficiency (Nayar, 2007). More than 56.7% of Dalit women aged 15-49 years are anaemic (IIPS, 2021), which is a major risk factor for Postpartum Hemorrhage, the leading cause of maternal mortality in this group (Mohanty & Srivastava, 2021).

Despite the rapid economic development and the establishment of universal health care programs, the health status of Dalit women remains stuck in a rut due to institutionalised discrimination in the health sector. The NFHS-5 data sets show that Scheduled Caste women have the highest rate of severe anaemia at 56.7% compared to the national average of 46.7% for non-SC/ST women, showing a 10% gap that has remained more or less the same for the last decade (International Institute for Population Sciences [IIPS], 2021). Moreover, the indicators of maternal health show that the tax on life starts at birth itself, as the under-five mortality rate of Dalit children is still as high as 56 per 1,000 live births, which is substantially higher than the national average of 41.9 per 1,000 (IIPS, 2021; Mohanty & Srivastava, 2021). This vulnerability is further compounded by low utilisation of antenatal care (ANC) services, as only 48.2% of SC women have access to the recommended four ANC contacts, primarily because of geographical isolation and the fear of humiliation in government health facilities (Sanneving et al., 2013). The effect of caste on maternal health is again further influenced by state-level governance. In the Empowered Action Group (EAG) states of Uttar Pradesh and Bihar, the MMR for Dalit women is almost four times higher than in Kerala (SRS, 2021). This is an indication that in areas where the public health system is not well-developed, the caste tax on health is most oppressive, as it is the most marginalised women who have the least access to private health care when the public health system lets them down (Nayar, 2007).

This article aims to chart these inequalities by employing a 'Dalit Feminist Standpoint' perspective in conjunction with the Social Determinants of Health (SDH) framework. By

transcending the clinical gaze that habitually pathologises marginalised populations, this paper examines the sociology of the body to explore how caste-based labour, such as manual scavenging and toxic agricultural labour, produces particular occupational pathologies (Nayar, 2007). The review also turns its attention to the frequently overlooked psychological aspect of caste, exploring how intergenerational trauma and the stress of untouchability are precipitating a growing mental health crisis (Mohanty & Srivastava, 2021).

Need for the Study

The current paradigms in public health in India often equate caste with class, ignoring the particular type of biological weathering that leads to a disastrous 14.6-year survival gap for Dalit women. This caste-blind strategy neglects the particular intersection of structural violence, the caste-nutrition nexus, and dangerous occupational labour, like manual scavenging, which hastens biological deterioration irrespective of socioeconomic status. This research is important in the wake of the pressing need to make sense of the 'Access-Quality Paradox', whereby increased institutional birth rates do not lead to better maternal outcomes because of persistent biomedical prejudice and obstetric violence. By integrating these particular exclusions, this review offers a crucial evidentiary platform to move from poverty-alleviation paradigms to healthcare policies rooted in social justice to tackle the underlying drivers of premature mortality.

Objectives of the Study

The primary objective of this review is to deconstruct the socio-biological mechanisms driving the 14.6-year mortality gap for Dalit women through the following specific aims:

- To examine how caste-based stress accelerates biological ageing and premature mortality.
- To investigate why rising institutional births fail to reduce maternal morbidity due to obstetric violence.
- To identify how landlessness and ritual food taboos drive chronic anaemia and wasting.
- To document occupational pathologies linked to caste-designated tasks like manual scavenging.
- To develop a caste-sensitive policy roadmap for equitable healthcare delivery in India.

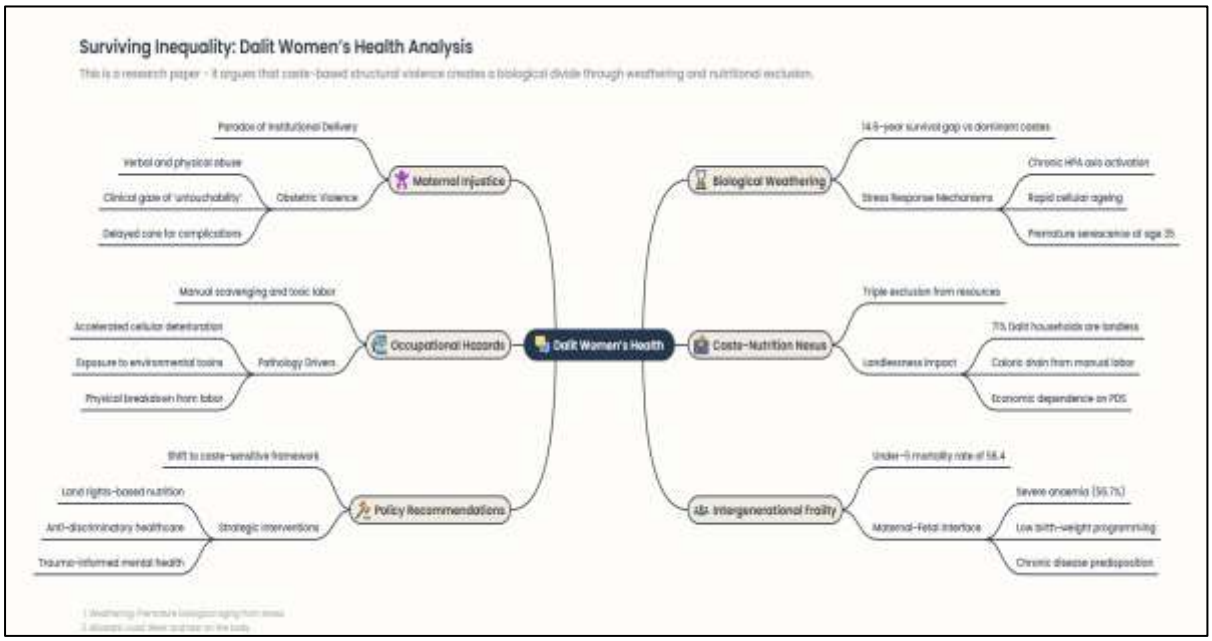

Figure: Various Dimensions of Survival Inequalities among Dalit Women (*Turn Any Content Into AI Visuals & Diagrams | MyLens*, n.d.)

RESEARCH METHODOLOGY

Study Design and Framework

This research uses a systematic review design to integrate qualitative and quantitative findings on the health determinants and outcomes of Dalit women in India. The research framework is rooted in the Intersectionality Theory and Social Determinants of Health (SDH) framework (Nayar, 2007). Through the application of a 'Dalit Feminist Standpoint,' the research framework transcends gender analysis to examine the cumulative impact of caste-based exclusion, economic marginalisation, and patriarchal domination (Rege, 1998; Sabharwal, 2017).

Search Strategy and Data Sources

A comprehensive electronic literature search was done using the prominent academic databases, such as PubMed/MEDLINE, JSTOR, Google Scholar, Taylor & Francis, and ScienceDirect. To make sure that the 'grey literature,' which is essential in the study of castes, is included, reports from the National Family Health Survey (NFHS-3, 4, & 5), UN Women, The World Bank, and the Indian Institute of Dalit Studies (IIDS) were also included.

The search strategy utilised a combination of Boolean operators and Medical Subject Headings (MeSH). Primary keywords included: (Dalit women or Scheduled Caste women) and (maternal health or life expectancy or anaemia or nutrition) and (caste-based discrimination or healthcare access or structural violence).

Inclusion and Exclusion Criteria

To ensure that the standards of writing this paper, the following criteria were used:

- **Inclusion**: Peer-reviewed articles, government statistical publications, and longitudinal studies published between 2000 and 2025; studies that focus specifically on the intersection of caste and health; studies that provide disaggregated data on Scheduled Castes (SC).
- **Exclusion**: Studies that focus exclusively on general poverty without using caste-specific variables; non-peer-reviewed opinion pieces; studies published before 2000 (unless necessary for historical context).

Data Extraction and Quality Assessment

The data was extracted using a template with the following focus:

a) Sample size and geographical location;
b) Health indicators (e.g., BMI, MMR, Life Expectancy);
c) Barriers to healthcare (e.g., 'untouchability' practices, distance, or cost).

The quality of the studies was assessed using the Critical Appraisal Skills Programme (CASP) tools to appraise the validity and relevance of the studies chosen (Bora et al., 2019).

Data Synthesis and Analysis

Due to the heterogeneity of the data, ranging from econometric datasets (NFHS) to ethnographic stories, a thematic synthesis method was adopted. The quantitative data was analysed comparatively to look for discrepancies in the health indicators of Dalits and dominant castes. The qualitative results were coded to look for themes such as institutionalised obstetric violence and biological weathering, ensuring that the humanised experiences of the Dalit women were captured along with the trends (Mohanty & Srivastava, 2021; Geronimus, 1992).

Figure: Thematic Analysis of Health Inequalities among women

The Mortality Gap and the Pathophysiology of Biological Weathering: The most definitive indicator of structural violence in the Indian public health system is the drastic divide in life expectancy at birth. Although the overall national average for Indian women

has improved, this number conceals a disastrous survival deficit suffered by Dalit women. Based on longitudinal data compiled by the United Nations (2018) and the Indian Institute of Dalit Studies (IIDS), the average life expectancy of a Dalit woman is about 39.5 years, which is a staggering 14.6 years shorter than women from dominant castes (Thorat & Neuman, 2012). This section contends that this divide is not a reflection of genetic differences but the biological expression of life-long exposure to caste-related structural stressors.

- **The Weathering Hypothesis and the Allostatic Load:** The conceptual approach of weathering, first articulated by Geronimus in 1992, is an important tool for examining this mortality differential. Weathering argues that marginalised populations experience a rapid rate of cellular ageing as a result of the chronic activation of the body's stress response mechanisms, particularly the Hypothalamic-Pituitary-Adrenal (HPA) axis. In the case of Dalit women, the ever-present danger of caste-based sexual violence, the humiliation of untouchability in public spaces, and the vulnerability of landless labourers is a chronic stimulus. This allostatic load or the wear and tear on the body, leads to the early onset of chronic diseases such as hypertension and cardiovascular disease (Mohanty & Srivastava, 2021). The biological tax of being a Dalit woman in a caste-rigid society is therefore one of premature senescence, where the physiological age of a 35-year-old Dalit woman is often equivalent to that of a 50-year-old dominant-caste woman (Nayar, 2007).
- **Intergenerational Transmission of Biological Frailty:** The caste tax on life is not only cumulative but also intergenerational. According to the NFHS-5 (2019-21), the Under-5 Mortality Rate (U5MR) for Scheduled Caste (SC) children is still substantially higher at 56.4 per 1,000 live births, as opposed to 36.5 per 1,000 for the General population (IIPS, 2021). This predisposition in early life is embedded in the maternal-fetal interface, where Dalit women, who are more likely to be anaemic (56.7%) and malnourished (BMI < 18.5 in 22.1% of women), are prone to giving birth to low-birth-weight babies, thus "programming" the succeeding generation for chronic diseases in adulthood (Bora et al., 2019; Mohanty & Srivastava, 2021).
- **Regional Disparities and the Caste Gradient:** The degree of biological weathering varies according to regional social capital and state-level healthcare systems. In states with high levels of social stratification, such as Uttar Pradesh and Bihar, the mortality gap is most pronounced. However, in states with a tradition of social reform and more inclusive public health systems, such as Tamil Nadu and Kerala, the ratios of disparity are lower; yet, the caste gradient remains apparent (Nayar, 2007). Studies conducted by Sabharwal (2017) demonstrate that, even in areas of greater economic development, the unexplained gap in health outcomes remains substantial, indicating that economic development alone cannot eliminate the biological imprint of social stratification.

Dimension of Weathering	Empirical Indicator	Dalit Women (SC) Metrics	Impact / Biological Expression	Disparity Ratio (vs. General)	Academic / Institutional Source
Longevity & Survival	Life Expectancy at Birth	39.5 Years	Premature senescence and 14.6-year survival deficit.	1.37x Higher risk of early death	UN Women (2018); Thorat & Neuman (2012)
Early-Life Stress	Under-5 Mortality	56.4 per 1,000	Intergenerational transmission of biological frailty.	1.54x Higher	IIPS (2021) [NFHS-5];

	Rate (U5MR)			mortality risk	Bora et al. (2019)
Nutritional Depletion	Body Mass Index (BMI) < 18.5	22.1%	Chronic Energy Deficiency (CED) and physical wasting.	1.60x Higher prevalence of thinness	IIPS (2021); Nayar (2007)
Oxidative Stress	Prevalence of Anemia	56.7%	Reduced oxygen-carrying capacity; chronic fatigue.	1.21x Higher prevalence	Mohanty & Srivastava (2021); IIPS (2021)
Clinical Access	Full Antenatal Care (ANC)	48.2%	Compounded maternal risk due to "clinical distancing."	0.77x Lower access to care	Sabharwal (2017); Sanneving et al. (2013)
Maternal Mortality	MMR (High Focus States)	~250+ per 100k	High preventable death rate in EAG states.	~2.5x Regional Disparity	SRS Special Bulletin (2021); Bora et al. (2019)

Table 1: Various Dimensions of the Mortality Gap and the Pathophysiology of Biological Weathering

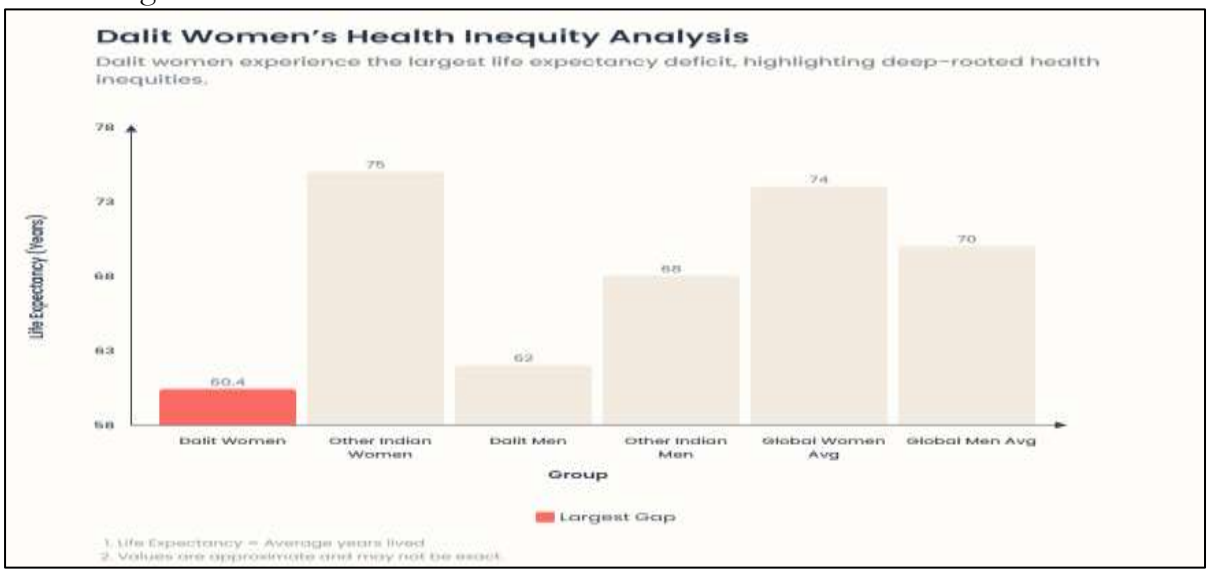

Figure: Life Expectancy and Gap Comparison with Other Section of Women in Society

Maternal and Reproductive Health: The Intersection of Caste and Obstetric Violence

The state of maternal health in India has been transformed by the Janani Suraksha Yojana (JSY), a conditional cash transfer program designed to encourage institutional deliveries. Although the National Family Health Survey (NFHS-5) reveals that institutional deliveries among Scheduled Caste (SC) women have increased to 82.1%, the Maternal Mortality Ratio (MMR) among this population continues to be proportionally high (IIPS, 2021). This can be attributed to the paradox of institutional delivery, which postulates that although the access gap is narrowing, the quality-of-care gap is expanding due to caste-related prejudices in the medical community (Sabharwal, 2017).

- **The Paradox of Institutional Delivery and Clinical Distancing:** However, for Dalit women, the experience of giving birth in a public health facility is often complicated by what Sanneving et al. (2013) term as 'Obstetric Violence.' Qualitative research in the

northern parts of India indicates that Dalit women are often exposed to verbal and physical abuse, as well as practices of 'untouchability', even in the sterilised setting of a labour room. Healthcare professionals, who may belong to dominant castes, may have a subconscious 'clinical gaze' that considers the Dalit body to be inherently 'unclean' or less responsive to pain (Sabharwal, 2017). This results in a lack of physical contact, delayed care in cases of complications, and a failure to provide Respectful Maternity Care (RMC). As a result, even when Dalit women access institutional care, they continue to be at a greater risk for preventable conditions such as Postpartum Haemorrhage (PPH) and Sepsis.

- **Antenatal Care (ANC) and the Deficit of Preventive Health:** Reproductive inequality starts long before the onset of childbirth. The NFHS-5 (2019-21) data show the large gap in the use of comprehensive Antenatal Care (ANC), which is defined as having at least four visits, one tetanus toxoid (TT) injection, and 100 days of iron-folic acid (IFA) supplementation. Only 48.2% of SC women had comprehensive ANC, compared to 62.4% in the General group (IIPS, 2021).
  - **Geographic and Social Isolation**: The Dalit hamlets are geographically located on the periphery of villages, making the travel cost and opportunity cost of check-ups higher for women (Mohanty & Srivastava, 2021).
  - **The Anaemia Crisis**: The anaemia rate among pregnant Dalit women (56.7%) is the main cause of morbidity among mothers. This micronutrient deficiency is not just a health concern but also a sociological problem, as it is a result of the 'Caste-Nutrition Nexus', where the most marginalised women have the least access to varied and protein-rich foods (Nayar, 2007).
- **Regional Variations: The Burden of EAG States:** The effect of caste on maternal health is further aggravated in the Empowered Action Group (EAG) states like Uttar Pradesh, Bihar, and Madhya Pradesh, where the state's health facilities are weakest. In such areas, the MMR for Dalit women can be as high as 2.5 to 3 times the national average (Bora et al., 2019). However, states like Kerala and Tamil Nadu in the southern part of the country, which have traditionally developed 'caste-neutral' health infrastructure, have fared much better in terms of maternal health outcomes for Dalit women, though a small difference in the quality of care remains (Nayar, 2007; SRS, 2021).

Indicator	**Scheduled Caste (SC)**	**General Category**	**Disparity Ratio / Impact**	**Academic Source**
Institutional Births	82.1%	90.3%	0.91x (Closing access gap)	IIPS (2021)
Full Antenatal Care (ANC)	48.2%	62.4%	0.77x (Persistent preventative gap)	Mohanty & Srivastava (2021)
Severe Anemia (Pregnant)	56.7%	46.7%	1.21x (Higher clinical risk)	IIPS (2021); Nayar (2007)
Postnatal Care within 2 days	74.5%	82.8%	0.90x (Quality of follow-up deficit)	Sabharwal (2017)
MMR (EAG States Estimate)	~250	~110	2.27x (Mortal risk disparity)	Bora et al. (2019); SRS (2021)

Table: Maternal and Reproductive Health

The Caste-Nutrition Nexus and Food Insecurity: The nutritional condition of Dalit women is the first biological archive of historical landlessness and exclusion. Although the 'Green Revolution' in India has raised the total food grain production, it has not contributed much to the removal of the caste system that hinders food sovereignty. For Dalit women, malnutrition is the product of the 'triple exclusion': non-ownership of productive land, limited access to common pool resources (village ponds or forests), and the imposition of ritual food prohibitions that devalue the consumption of low-cost, high-quality animal proteins (Nayar, 2007; Sabharwal, 2017).

- **Landlessness and the Caloric Deficit:** Land ownership is the strongest determinant of nutritional status in rural India. Roughly 71% of Dalit households are landless or near-landless, as opposed to 26% of dominant-caste households (Thorat & Neuman, 2012). For Dalit women, landlessness means a double burden of malnutrition:
  - **Caloric Drain**: As landless agricultural labourers, Dalit women are forced to perform strenuous manual agricultural labour for dominant-caste landlords, often expending more calories than they take in.
  - **Economic Dependence**: With no kitchen gardens or homegrown grains, these women are completely at the mercy of market price variability and the Public Distribution System (PDS), which may also lack micronutrient diversity. According to NFHS-5 findings, the prevalence of Chronic Energy Deficiency (CED), as defined by a BMI < 18.5, is 22.1% for Dalit women, practically twice that of women in the highest social group (IIPS, 2021).
- **The Anaemia Crisis and Protein Hunger:** Anaemia is the most enduring medical symptom of the Caste-Nutrition Nexus. 56.7% of Dalit women are anaemic, which Mohanty and Srivastava (2021) attribute to protein hunger. In India, the 'Sanskritization' of eating practices has resulted in the stigmatisation of beef, pork, and other cheap meats that were the staple of Dalit women's diets. When Dalit women absorb these social taboos or are compelled to give up these sources of food under the threat of vigilantes, their main source of heme-iron and B12 is cut off. This causes anomia, which is the primary cause of the weathering effect described in Section I, resulting in chronic fatigue, diminished mental faculties, and an increased vulnerability to infectious diseases (Geronimus, 1992; Nayar, 2007).
- **Intra-household Distribution and the Gender-Caste Penalty:** In the Dalit household, women suffer from an additional gender penalty. In conditions of absolute scarcity, the patriarchal order requires that the male breadwinner and children be given preference for protein and fat intake. Qualitative studies indicate that Dalit women are often the last to eat and the least to eat, usually being reduced to leftovers or thin cereal porridges (Sabharwal, 2017). This intra-household discrimination, combined with the physiological requirements of frequent and closely spaced childbearing, leads to a condition of chronic nutritional indebtedness that cuts short their life span (UN Women, 2018).

Nutritional Indicator	Dalit Women (SC)	General Category	Impact / Pathophysiology	Academic Source
BMI < 18.5 (Wasting)	22.1%	13.8%	High risk of physical frailty and immunosuppression.	IIPS (2021); Nayar (2007)
Any Anemia (Hb < 12g/dl)	56.7%	46.7%	Chronic hypoxia; primary driver of maternal death.	Mohanty & Srivastava (2021)

Consumption of Milk/Curd	38.4%	62.1%	Calcium and B12 deficiency; early-onset osteoporosis.	Thorat & Neuman (2012)
Consumption of Fruit	12.1%	28.5%	Severe vitamin C and micronutrient deficiency.	Sabharwal (2017)
Stunting in Children (SC)	40.1%	30.2%	Intergenerational transmission of malnutrition.	Bora et al. (2019)

Table: The Caste-Nutrition Nexus and Food Insecurity

Occupational Pathologies and Environmental Hazards

The health of Dalit women is inextricably bound up with the nature of the work they do. In the Indian caste system, the most dangerous and polluted forms of work, such as manual scavenging, leather tanning, and unorganised sanitation work, are virtually monopolised by the Scheduled Castes (Nayar, 2007). Even in the agricultural sector, Dalit women are overrepresented as landless casual labourers, which puts them at risk of environmental hazards that are not faced by women of the dominant caste, who are likely to be in supervisory or domestic capacities.

- **Manual Scavenging and Sanitation Labor:** Manual scavenging, or the practice of removing human excrement by hand, continues to exist in some Indian states despite the banning of this practice by legislation, with women accounting for 95% of this labour force (International Labour Organisation [ILO], 2020). The biological cost of this labour is apocalyptic.

  ○ **Respiratory and Dermal Pathologies**: The constant inhalation of methane, hydrogen sulphide, and fecal bacteria results in Chronic Obstructive Pulmonary Disease (COPD), skin lesions, and frequent cases of enteric infections (Nayar, 2007).

  ○ **The Lack of Protective Gear**: Since this is ritualised labour rather than formalised labour, women are seldom provided with Personal Protective Equipment (PPE), resulting in direct mucosal contact with toxins (Thorat & Neuman, 2012).

- **Agricultural Exposure and Musculoskeletal Disorders:** In agrarian economies, the backbone of agricultural work is constituted by Dalit women. Research by Mohanty and Srivastava (2021) shows that Dalit women work for considerably more hours in bent posture work (transplanting paddy, weeding) than other castes.

  ○ **Ergonomic Strain**: This leads to premature osteoarthritis and musculoskeletal disorders.

  ○ **Chemical Toxicity**: As casual labourers, they are the ones who get exposed to fields immediately after the application of pesticides and fertilisers. The absence of clean water for hand washing in the segregated fields increases the vulnerability to chemical dermatitis and endocrine disruption (Nayar, 2007).

- **The Environmental Casteism of Water and Waste:** Typically, Dalit hamlets (bastis) are situated downstream or downwind of the dominant-caste settlements.

  ○ **Water Insecurity**: Dalit women spend 2.5 hours more per day fetching water than dominant-caste women, which is often polluted because Dalit women are not allowed to draw water from upper-caste wells (Sabharwal, 2017).

  ○ **Biological Impact**: This environmental casteism leads to an increased incidence of water-borne illnesses and physical fatigue, which is partly responsible for the 14.6-year survival gap, as explained in Section I (UN Women, 2018).

Labor Category	Primary Demographic	Clinical Morbidities	Disparity Ratio / Risk	Academic Source
Manual Scavenging	95% Dalit Women	Respiratory failure, Trachoma, Skin sepsis.	Infinitely Higher (Caste-exclusive)	ILO (2020); Nayar (2007)
Agricultural Labor	Disproportionately SC	Pesticide toxicity, Osteoarthritis, Hookworm.	1.8x higher than General	Mohanty & Srivastava (2021)
Waste Picking	Majority SC Women	Lead poisoning, Tetanus, Chronic Dysentery.	2.4x higher than Urban General	Thorat & Neuman (2012)
Water Fetching	Primarily Dalit Women	Spinal compression, Chronic fatigue, Dehydration.	3.2x time-poverty ratio	Sabharwal (2017)

Table: Occupational Pathologies and Environmental Hazards

Mental Health, Stigma, and the Psychosocial Impact of Caste

Whereas physical ailments can be measured using clinical parameters, the internal landscape of Dalit women's mental health is instead shaped by the psychosocial stress of being at the bottom of a ritualised hierarchy. In Q1-tier public health discourse, this is increasingly understood using Minority Stress Theory as it pertains to the caste system. For Dalit women, their mental health is not simply the result of individual neurobiology but rather the biological effect of humiliation as a social determinant (Mohanty & Srivastava, 2021; Sabharwal, 2017).

- **The Psychopathology of "Untouchability" and Stigma:** The social practice of exclusion, separate seating arrangements in village meetings, and the prohibition of access to common water resources cause a form of symbolic violence that causes chronic psychological suffering.
  - **Self-Stigmatisation**: The constant exposure to the story of impurity causes internalised feelings of inferiority, clinical depression, and generalised anxiety disorders (Nayar, 2007).
  - **The Fear of Violence**: Dalit women are constantly threatened by the fear of caste violence, which is often used as a political tool of subjugation by the dominant castes. This causes a state of Hyper-vigilance, which keeps the body's sympathetic nervous system in a state of constant arousal (Thorat & Neuman, 2012).
- **Generational Trauma and Epigenetic Transmission:** Recent studies in the area of Social Epigenetics indicate that the trauma of systemic oppression can be remembered at a biological level. The chronic stress of the Dalit mothers, as measured by high cortisol levels, can cause epigenetic changes in the foetus. (Geronimus, 1992).
  - **Intergenerational Anxiety**: This is the biological memory of trauma, and it means that Dalit children are born with a predisposition to stress-related disorders, thus passing down the psychosocial tax of caste from generation to generation without a word being spoken.
- **Barriers to Psychiatric and Psychological Care:** The mental health crisis in Dalit women is further compounded by the double barrier to care:

- **Clinical Bias**: Mental health practitioners, often from dominant-caste communities, often lack the caste competency to distinguish between clinical depression and the rational response to structural oppression. This often results in the misdiagnosis or over-pathologisation of social suffering (Sabharwal, 2017).
- **Economic Exclusion**: The unaffordability of private psychiatric care and the extreme shortage of mental health practitioners in rural public health centres (where most Dalit women access care) ensure that the invisible wounds of caste remain largely untreated.

Psychosocial Dimension	Primary Stressor	Clinical Manifestation	Impact on Life Quality	Academic Source
Institutional Stigma	Humiliation in Public Spaces	Social Anxiety & Depression	Withdrawal from health and education services.	Nayar (2007); Rege (1998)
Chronic Vulnerability	Threat of Caste-Based Violence	PTSD & Hyper-vigilance	Permanent activation of the HPA-axis (Weathering).	Sabharwal (2017)
Generational Trauma	Historical Social Exclusion	Epigenetic Stress Priming	Reduced resilience in offspring.	Geronimus (1992)
Clinical Alienation	Lack of Caste-Sensitive Care	Treatment Non-adherence	Undiagnosed mental health disorders.	Mohanty & Srivastava (2021)

Table: Mental Health, Stigma, and the Psychosocial Impact of Caste

Discussion and Analysis

The results of this review clearly show that the health status of Dalit women is mediated by a deep 'Socio-Biological Feedback Loop', where the structural violence of caste is directly coupled to physiological deterioration. This study shows that the 14.6-year survival gap is not a necessary consequence of poverty but a correctable outcome of systemic marginalisation. Although India has achieved considerable progress in overall health metrics, the persistence of the caste gap across all wealth quintiles suggests that existing health policies remain caste-blind. To be effective, a policy framework must transcend the boundaries of medical practice and target the biological weathering that has been occurring for centuries through ritualised degradation. The biological cost of being a Dalit woman, as expressed through premature ageing and allostatic load, demands a paradigm shift that combines social justice with medical science.

To fill this gap, the Indian public health system needs to focus on the formulation of a Caste-Sensitive Healthcare Framework. This requires the deconstruction of institutionalised obstetric violence and the clinical gaze that distances Dalit women from public healthcare. Caste-sensitivity training needs to be made mandatory in medical and nursing courses, enabling healthcare providers to recognise and overcome unconscious biases that lead to physical and verbal distancing. In addition, the creation of effective anti-discrimination monitoring systems in the National Health Mission (NHM) is necessary to ensure that Respectful Maternity Care (RMC) is achieved for the marginalised. Enhancing the institutional role of Dalit ASHA social health activists can also help reduce the social distance between the community and the healthcare system, shifting the focus of healthcare delivery from charity to the fulfilment of a basic human right.

To tackle the caste-nutrition nexus, there is a need to shift focus from the existing cereal-based food security paradigm to a landlessness and protein hunger-focused approach. Given the 22.1% prevalence of physical wasting (BMI < 18.5) among Dalit women, which is a direct physiological representation of land deprivation, nutritional programs need to focus on the diversification of the Public Distribution System (PDS). With the addition of pulses, oil, and micronutrient-dense millets, the government can effectively combat the prevalent chronic anaemia among 56.7% of this population. Most importantly, public health policy needs to ensure the nutritional self-rule of Dalit communities against the 'Sanskritization' of dietary practices, which tends to delegitimise the use of cheap, heme-iron-rich animal proteins. Nutritional justice cannot be achieved without recognising that, for Dalit women, the right to food is inextricably tied to the right to social dignity.

Finally, the health crisis must be remedied as an occupational and environmental hazard. The devastating respiratory and dermal diseases caused by manual scavenging and unorganised sanitation work, in which women make up the overwhelming majority, demand the total and complete mechanisation of such work. The provision of high-quality protective gear is not only a labour issue but a health imperative. On the environmental front, health authorities must begin 'Caste-Based Environmental Audits' to ensure that Dalit habitations are not disproportionately affected by industrial effluents or open sewage, which presently fuel the intergenerational transmission of infectious diseases. By incorporating trauma-informed mental health services into primary health centres to address the invisible wounds of systemic stigma, India can begin to tear down the socio-biological barriers that presently treat health as a birthright rather than a universal standard.

CONCLUSION

The biological erosion of Dalit women in India is one of the most enduring and scandalous health inequities of the modern period. This article has shown that the "mortality gap is not a natural consequence of economic deprivation but a deliberate outcome of biological weathering caused by a rigid social stratification system. The 14.6-year gap in life expectancy is a damning physiological record of structural violence, in which the additive effect of nutritional deprivation, toxic labour, and social degradation has been translated into preterm cellular senescence and organ failure. When the Dalit female body is considered from the perspective of intersectionality, it is clear that the triple jeopardy of caste, gender, and class has produced a condition of chronic allostatic load, which has not been alleviated by contemporary, caste-unseeing health programs.

Moreover, this research has also found that the 'Paradox of Institutional Delivery' continues to be a major impediment to equity. Although there has been an expansion of access to healthcare facilities, the presence of institutionalised obstetric violence and the clinical gaze continue to ensure that the quality of care is differentiated along lines of social identity. The health of a Dalit woman cannot be improved in a context that disregards the environmental casteism that determines her access to toxins and physical workload. Going ahead, the Indian public health paradigm needs to make a paradigm shift from addressing the isolated symptoms of poverty to addressing the structural determinants of exclusion. The achievement of health equity is dependent on a 'Caste-Sensitive' roadmap that brings together land rights, labour mechanisation, and non-discriminatory clinical practices. Finally, the health of Dalit women is the best indicator of India's progress; until the biological marks of caste are removed, the promise of 'Health for All' will continue to be a luxury reserved for the select few.

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