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Is Proper Access to Healthcare Still a Myth for the Marginalized Sections?

A Study of the Residents of Dakshin Dhupjhora, Dooars, West Bengal

Ahana Bhattacharya

B.A. Sociology, Student, Department of Sociology, Sister Nivedita University, Kolkata, West Bengal, India

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Abstract— *In India, the right to health is a fundamental human right for the citizens. Yet, the accessibility of healthcare facilities comes with certain barriers, especially for the marginalized sections of the society. Marginalized communities are those systematically excluded from full participation in society, often due to factors like race, ethnicity, gender, socio-economic status, disability or geographical location, leading to limited access to healthcare. This paper focuses on the access to healthcare facilities of the population of Dakshin Dhupjhora, Dooars, West Bengal, mainly comprising tribals and Rajbanshi ethnic groups. It makes an attempt to examine how the socio-economic, geographical and institutional challenges hinder equitable healthcare access for these populations. It explores the impact of poverty, caste-based discrimination, inadequate infrastructure, urban-rural divide and inefficiencies of governmental policies on health outcomes on these marginalized and vulnerable communities. Focusing on this geographical area, with the help of both primary and secondary data, the study highlights the struggles of tribal and ethnic communities, predominantly working in the tea estates, in accessing the public health services. This study underscores the health imperatives for the rural and marginalized population of Dooars, which are essential to realize the constitutional right to health and reduce inequities among these vulnerable communities.*

Keywords— ***Dooars, Health, Human rights, Institutional barriers, Marginalized sections, Tribal ethnic groups***

I. INTRODUCTION

Health is not merely a component of human life but a holistic state of physical, mental and social well-being. The Constitution of India, through its Directive Principles of State Policy, recognizes the right to health as a fundamental human right that is intrinsically linked to the right to life under Article 21. Over the years, the judiciary has reiterated the obligation of the State to ensure accessible, affordable and developed healthcare facilities for all the citizens. However, despite various legal considerations and initiatives relating to public health, the reality remains starkly different when one tries to examine the situation of the marginalized communities in different states of India. Therefore, this paper focuses on the various issues of access to healthcare among the marginalized sections residing in *Dooars*, West Bengal, particularly, in the *Dakshin Dhupjhora* region.

In a socio-political context, marginalization can be understood as a form of exclusion of certain groups of the society from their complete participation in economic, social and political spheres. Such exclusion is often rooted in factors like caste, ethnicity, gender, geographical isolation and poverty (Silver, 1994). These factors and conditions create structural vulnerability[1], leading to certain individuals and communities, to an even more disadvantageous position in terms of access to basic

[1]*Structural vulnerability: It refers to the heightened risk and negative consequences individuals and groups face due to systemic societal structures and inequalities, particularly those that marginalize certain populations.*

services, including healthcare. In the Indian context, the Dalits and the tribal communities and various ethnic groups face discriminations. The consequences of such marginalization are most visible in their food, education and health outcomes.

Dakshin Dhupjhora of *Dooars*, where the fieldwork for the study was conducted, consists of different tribal and ethnic communities, like the *Santhals, Oraons, Mundas* and the *Rajbanshis*. The majority of this population, since the colonial period, have been employed in nearby tea plantations, which form the socio-economic backbone of this region. Others either have forest-based livelihoods or are engaged in agricultural activities. However, they continue to be economically and socially marginalized. Hence, this location serves as a critical site to investigate the impact of socio-economic marginalization, especially in terms of access to healthcare facilities. It also makes an attempt to identify the structural and infrastructural barriers that continue to limit the reach and efficacy of public health services. Despite the efforts of the government to expand healthcare coverage through schemes such as the National Health Mission (NHM)[2], Ayushman Bharat[3]and various tribal welfare programs, often failed to effectively translate on the ground reality.

Therefore, this paper includes data, both from primary sources, obtained from fieldwork and secondary sources, in order to understand and provide a brief analysis on the barriers and vulnerabilities that hinder the healthcare access of the marginalized communities of *Dakshin Dhupjhora* village in *Dooars.* By referring to the socio-economic realities of the tribal and ethnic communities in North Bengal, this study aims to contribute to the discourse on health equity and justice in India. It advocates for a more inclusive approach to healthcare, one that recognizes the intersecting vulnerabilities of marginalized groups and addresses the structural determinants of health. The findings are not only relevant for policymakers and health practitioners in West Bengal, but also hold implications for broader efforts to make healthcare truly universal and equitable across India.

II. OBJECTIVES

1.To identify and analyze the socio-economic, geographical and institutional barriers that hinder healthcare access for the tribals and *Rajbanshi* ethnic communities in *Dakshin Dhupjhora, Dooars*, West Bengal.

2.To examine the role of poverty and caste-based discrimination in shaping the healthcare experiences and health outcomes of marginalized populations in the region.

3.To evaluate the effectiveness of existing governmental health policies and infrastructure in addressing the health needs of tea garden workers and ethnic minorities in *Dakshin Dhupjhora.*

III. RESEARCH METHODOLOGY

The study has made use of both primary and secondary sources of data. Qualitative approach has been used for this study. The data collection has been done using convenience sampling, with a detailed study of the existing literature. Face-to-face interviews, with the help of an interview guide, have been conducted among 10 individuals residing in the regions of *Dakshin Dhupjhora*, following the ethical considerations. The field visit was quite informative and crucial for the study, including the interactions with the residents and an overall observation. The interaction with the respondents became much clear within 1-2days. The secondary sources of data include journals, books, articles and government reports related to this research topic.

IV. LITERATURE REVIEW

Review of the existing literature plays a crucial role in the research design of a particular study. According to Earl Babbie (2020), reviewing the designs of previous studies can give you a head start in planning your own study. The literature review will have to be laid out in a logical manner, what has already been learned on a topic by past researchers, then leading up to loopholes in the knowledge of the topic, which you propose to remedy or the review of the literature may point to inconsistencies or disagreements among existing findings. In this paper, the review of literature has been divided into-(i) Empirical review, including the review of governmental policy, the article socio-economic barrier and the aspect of caste-based discrimination; (ii) Theoretical review, including the Political Economy Approach to Health of Vicente Navarro.

[2] *The National Health Mission (NHM): It was launched by the Government of India in 2013. It aims to provide accessible, affordable and accountable healthcare for all, with a focus on rural and urban populations. It is a flagship program of the Government of India, seeking to strengthen the public health system and ensure universal access to healthcare.*

[3]*Ayushman Bharat: Ayushman Bharat Pradhan Mantri Jan Arogya Yojana was launched in 2018. It aims to provide health coverage and financial protection for those lacking access to healthcare among the identified deprived households.*

Empirical Review

The National Health Policy, NHP (2017) acts as a guiding document for the healthcare system of India. It focuses on preventive measures for proper care, investments on public health and improving healthcare infrastructure. It also adapts to modern challenges in financial aspects and advancements in medical technology. The NHP provides significant emphasis on addressing the healthcare needs of the marginalized and vulnerable sections of the entire population, including the poor, tribal communities, urban slum dwellers, women, children and persons with disabilities. The government initiated certain policies to ensure financial protection in medical care, which includes reducing excess expenditure on availing healthcare facilities, introducing and expanding government financed health insurance to cover secondary and tertiary care[4], providing certain essential drugs, diagnostics and other emergency services free of cost in all public hospitals, for the people of the marginalized sections. It focuses on the increase in public health investment, especially for the development of the districts with poor healthcare systems and providing resources to the rural areas. This includes the Jalpaiguri district, which is considered as one of the most backward districts of West Bengal[5]. The policy also includes improving Health and Wellness Centers in rural areas and expanding mobile medical units for the weaker populations. In case of the tribals, as a part of the marginalized sections, it includes expanding healthcare infrastructure and including documentation and validation of tribal medicines as a part of the medical facilities, providing focus on micronutrient deficiencies among tribal children through enhanced Anganwadi services in these areas. There is a lack in healthcare facilities like diagnosis of osteoporosis, cardiovascular diseases, cancer and others in local healthcare centers in these rural areas, which needs to be improved. It also focuses on ensuring barrier-free access to public hospitals and health centers and providing specialized training for healthcare workers to manage disability care. It is essential to conduct regular surveys on healthcare access, disease burden and social determinants of health among the marginalized sections, in order to make necessary improvements in the working of the healthcare system in the under-developed districts.

Studies (State Government Report, 2004)[6] have shown certain shortcomings that contribute to the gap of accessibility to healthcare of the marginalized sections. First, geographical isolation and poor transport infrastructure, making it difficult for the residents to access healthcare facilities. Many villages lack well-equipped primary healthcare centers, which leads to referral in the nearby government hospital or other healthcare centers that involves long travel distances, longer time and financial costs that are difficult to afford by this section of the population.

Second, socio-economic deprivation compounds the problem. Job insecurity and dependency on informal labour markets such as tea gardens leave little room for health expenditures. Majority of the population refer to unqualified health practitioners and traditional cures due to affordability and accessibility issues. Nutritional deficiencies, poor sanitation and lack of health literacy, especially in maternal and child healthcare further aggravate their health conditions.

Third, social discrimination and cultural alienation often create barriers to inclusive healthcare. Women and the elderly individuals in particular, face higher levels of neglect in terms of access to reproductive and geriatric care. Therefore, we can point out that all these factors are linked with each other.

The institutional framework suffers from chronic issues such as staff shortages, irregular supply of medicines, lack of accountability and others. Moreover, the absence of participatory governance and lack of community engagement in health planning have led to a top-down approach that fails to address ground realities. Health indicators from government surveys often do not reflect the lived experiences of these marginalized populations, as many fall outside the purview of data collection due to migratory reasons or others.

The article, 'Inequities in Access to Health Services in India: Caste, Class and Religion' written by Rama Baru, Arnab Acharya, Sanghamitra Acharya, A.K. Shiva Kumar and K. Nagaraj (2010), examines the persistent disparities in the aspect of health outcomes and access to healthcare facilities in India, despite having an economic growth after the economic reforms of the 1990s. The article focused on

[4]*Secondary healthcare: it is a type of healthcare that provides specialized consultations from medical specialists like cardiologists, dermatologists, etc.*
Tertiary healthcare: it is considered to be the highest level of specialized medical care, involving advanced diagnostic and treatment procedures.

[5]*This has been observed through the Jalpaiguri District Human Development Report, 2020. https://journal-innovations.com/assets/uploads/doc/e5eae-74-86.23128.pdf, Accessed on: 20th March, 2025.*

[6] *West Bengal Human Development Report, 2004. https://hdr.undp.org/system/files/documents/indiawestbengal2004en.pdf , Accessed on: 27th April, 2025.*

the historical trends and the socio-economic inequities based on caste, class and gender, resulting in disparities in healthcare. For instance, in many districts of West Bengal, there is an evident disparity that the Scheduled Castes and Scheduled Tribes are experiencing poorer health outcomes and reduced access to healthcare services. Differences in the availability, utilization with lack of adequate infrastructure and medical professionals in these areas. Although, this article did not mention the travel time and distance in order to receive medical assistance, as there is not sufficient local healthcare centers or hospitals in the rural areas. The article emphasizes on addressing these inequities in order to achieve a stable and developed healthcare system for the marginalized groups in India.

The article, 'The Minimum Core Approach to the Right to Health: Progress and Remaining Challenges' by A. Müller (2017) gives an idea of the evolution, current status and the existing challenges of implementing the minimum core concept within the framework of the right to health. This concept was introduced by the Committee on Economic, Social and Cultural Rights (CESCR)[7] in General Comment No. 14 (2000), which aims to ensure that all individuals have access to essential health goods and services as a part of the fundamental human rights.The author has also outlined the primary objectives of the minimum core approach including universal guarantee, accountability framework and international cooperation. It also highlights certain challenges which leads varied interpretations in the understanding of the Right to Health. This outlines the problem of resource constraints in some states in India, for which they struggle to meet the fundamental obligations, in terms of health. It also highlighted the fact that the universal standards may not fit or account to every section in cultural and economic contexts.

Theoretical Review

There are various theoretical approaches to health, based on several aspects of the society, that has been put forward by several sociologists. One of the theoretical approaches that relates to this study is the 'Political Economy Approach of Vicente Navarro (Nagla, 2018). Vicente Navarro talks about this approach to health, which is mainly derived from the Marxist perspective. It describes the structural inequalities embedded in capitalist societies, which emphasizes that health disparities are deeply rooted in social, economic and political power relations. He argued that health is not merely a matter of biological well-being or individual behavior, but is significantly determined by the distribution of power, wealth and resources in the society. He highlighted that the economic interests of the elite class that shapes the health system in ways that often disadvantage the working class and the marginalized communities. Navarro asserts that class is a central determinant of health and he argues that the health disparities are fundamentally rooted in class divisions. Unlike functionalist theorists, who considers the state as a neutral arbitrator[8] Navarro views the state as a tool used by the dominant classes to maintain power. Therefore, he highlighted that the health policies, in this view, are shaped not by general public interest but by the struggles of power relations between the social classes.

V. DESCRIPTION OF THE FIELD AND THE PARTICIPANTS

The field study was conducted in *Dakshin Dhupjhora*, village of *Dooars* in North Bengal. The data has been collected from 10 participants, from 16th to 18th January, 2025, through convenience sampling. This village is under Matiali, Batabari-II Panchayat. The total rural population in this Panchayat is 1,02,418 (Census, 2011)[9]. The nearby hospitals from *Dakshin Dhupjhora* are in *Malbazar* and *Chalsa*. The accurate data on the number of hospitals has not been found from the secondary sources. While conducting the interviews, I came across how frequently the residents of this village face animal attacks. Animal attacks, especially from elephants and cheetahs, have been a part of their daily lives. Due to time constraint, the number of research participants is less, as I wanted to go in-depth in the study and relate with the issue of the accessibility to healthcare facilities.

Table 1.1: Ethnic Identity Community of the Participants

Ethnic Identity	No. of Participants
Oraon (Bhagat)	2
Rajbanshi	7

Source: Fieldwork, January, 2025

The majority of the participants belong to the *Rajbanshi* tribal community, with only a small number from the *Oraon (Bhagat)* group.

[7] *CESCR: The Committee on Economic, Social and Cultural Rights is a treaty body of the United States that monitors the implementation of the International Covenant on Economic, Social and Cultural Rights by ensuring the rights of food, education, health and housing.*

[8] *Neutral arbitrator: it refers to an impartial individual or organisation, selected to resolve disputes between parties, not controlled by or biased in favour of any party involved in the arbitration.*

[9] *https://villageinfo.in/west-bengal/jalpaiguri/matiali.html , Accessed on: 26th April, 2025*

Table 1.2: Sex Ratio of the Participants

Sex	No, of Participants
Male	3
Female	7

Source: Fieldwork, January, 2025

The research participants group mainly included women, due to a comparatively higher availability of females, at the time when the fieldwork was conducted.

Table 1.3: Religious Composition of the Participants

Religion	No. of Participants
Hindu	8
Muslim	2

Source: Fieldwork, January, 2025

The participant group mainly comprises of individuals from the Hindu Community and the other individuals from the Muslim Community. It is found that the Muslim households are located at a particular area of the village of *Dakshin Dhupjhora*, which showcases a kind of religious segregation. While conducting the interviews, they did not mention about religious discrimination, but there was some kind of inconsistency.

Table 1.4: Literacy level of the Respondents

Literacy Level	No. of Participants
Primary	1
Secondary (10th pass)	3
Higher Secondary (12th pass)	2
Tertiary Education	3
Illiterate	1

Source: Fieldwork, January, 2025

The education level varies widely, with a significant number having completed up to tertiary education. However, there is still a portion who are either at the primary level, secondary level or uneducated. In this sample group, one respondent in the primary level, studies in class 8 in a government-aided school and one respondent of 69 years old, who has not received proper education and is more interested in labour from the beginning, due to the socio-economic conditions.

Table 1.5: Marital Status of the Participants

Marital Status	No. of Participants
Married	9
Unmarried	1

Source: Fieldwork, January, 2025

This suggests that the sample is predominantly composed of married individuals. One of the participants is an adolescent, continuing her studies at the primary level.

Table 1.6: Occupation of the Participants

Occupation	No. of Participants
Self-Employed	4
Daily Waged Labour	2
Housewife	4

Source: Fieldwork, January, 2025

A balanced number of participants are either self-employed or housewives and a smaller proportion are daily waged labour, including both men and women.

VI. DISCUSSION OF THE FINDINGS

Vicente Navarro's (Nagla, 2018) political economy framework helps us understand that the healthcare crisis in Dakshin Dhupjhora and other parts of Dooars is not just a delivery issue but a structural, institutional, and class-based problem. The lived experiences of tribal and migrant communities demonstrate how healthcare inequity is produced and maintained through economic, social, and political exclusion. The economic marginalization limits their access to healthcare, both in terms of affordability and physical accessibility. Navarro criticizes the underfunding of public health systems and the commodification of health. In North Bengal, public healthcare infrastructure is inadequate, especially in the rural areas. Through this study, there are certain findings that have been underlined through thematic divisions, focusing on the issues in accessing healthcare facilities.

1. Inadequate Public Healthcare Infrastructure:

Despite policies aimed at rural development, the ground realities in Dakshin Dhupjhora reflect a severe shortage of qualified doctors and basic medical staff. Participants of the field study mentioned the lack of reliable medical care in nearby facilities, "এখানে কাছাকাছি যে নার্সিংহোম আছে সেখানে ভালো ডাক্তার নেই, তাই আমাদের চিকিৎসা বা টেস্ট করানোর জন্য চালসার হাসপাতালে যেতে হয়।" (The nearby nursing home in Dakshin Dhupjhora does not have

qualified and trained doctors, so we have to go to the hospital in Chalsa for treatment or any diagnosis.) (Source: Fieldwork, 16th January, 2025)

2. High Cost of Emergency Transport:

The unaffordability of ambulance services and time delays in reaching remote villages force residents to arrange private transport during medical emergencies, adding to the economic burden. "অ্যাম্বুলেন্স বুকিং করলে বেশি টাকা লাগে... তাই আমরা চেষ্টা করি নিজেদের মতো প্রাইভেট গাড়িতে পেশেন্টকে নিয়ে যেতে।" (Booking an ambulance is expensive and time-consuming for us, so we try to manage a private vehicle to take the patient for treatment.) (Source: Fieldwork, 16th January, 2025)

3. Urban-Centric Healthcare and Social Exclusion:

Healthcare remains largely urban-centric, often excluding marginalized groups like tribals and religious minorities in rural areas. According to Baru et al. (2010), caste, class, and religion play a crucial role in healthcare access in India. During the fieldwork, participants avoided discussing communal divisions but indicated subtle social segregations, "ওরা ওদের মতো থাকে, আমরা আমাদের মতো থাকি।" (They stay by themselves, and we stay by ourselves.) (Source: Fieldwork, 16th January, 2025). During the fieldwork, it was also seen that the settlements of the muslim and hindu residents were in two particular area of the village.

4. Poor Sanitation and Unsafe Living Conditions:

Health is also affected by poor housing, sanitation and lack of clean water, which is a major concern in Dakshin Dhupjhora. Several participants highlighted irregular water supply despite promised government pipelines. They mentioned, "সরকার থেকে আমাদের বাড়িতে জলের পাইপলাইন দেওয়া হয়েছে...কিছু কিছু বাড়িতে পাইপলাইন এখনো দেওয়া হয়েনি।" (The government has provided pipelines for water, but water doesn't come regularly, and some houses haven't received pipelines yet) (Source: Fieldwork, 17th January, 2025)

5. Educational Backwardness and Lack of Awareness:

Limited education and awareness restrict the ability of residents to make informed decisions about health. This compounds issues related to access, especially in navigating bureaucratic or urban-centered healthcare systems. As per Navarro's understanding, we can say that structural inequalities in education further reinforce health disparities. These are not individual failures but systemic exclusion.

VII. CONCLUSION

This research paper brings to light the multi-dimensional challenges faced by the tribal communities and the marginalized sections in general, in accessing equitable healthcare. Focusing on both primary data and detailed review of literature, this study situates the health conditions of these communities within the broader discourse on structural inequality, socio-economic deprivation and institutional neglect. Despite the constitutional guarantee of the Right to Health under Article 21 of the Indian Constitution and the other policy initiatives undertaken by the state and central governments, smooth accessibility remains elusive for many, particularly those residing in geographically and socially marginalized regions. It can also be highlighted that there is not enough literature focusing on the conditions of West Bengal.

The structural deficiencies in healthcare delivery in this region are particularly noteworthy. The lack of adequate healthcare infrastructure, including poorly equipped primary health centres, unavailability of qualified medical practitioners and logistical issues such as transportation and long travel time to tertiary care centres. As indicated in the interviews, that is the primary data, the cost and availability of ambulance services, combined with the geographical remoteness of the village, discourage individuals from availing necessary healthcare services. These challenges are compounded by an over-reliance on informal healthcare providers or traditional healing methods, which often lack scientific validation and may contribute to further health deterioration.

The theoretical lens provided by Vicente Navarro's Political Economy Approach to Health proves to be particularly relevant in interpreting the findings of this study. Navarro's argument that health disparities are not merely biomedical or behavioural in origin but are fundamentally rooted in economic and political inequalities is validated through the lived experiences of the people of Dakshin Dhupjhora. Furthermore, the study aligns with the concerns raised by scholars such as Rama Baru et al., who argue that caste, class and regional disparities continue to influence healthcare access in India, despite the economic growth and policy advancements of the country. The study's focus on a micro-region within a backward district adds empirical weight to the argument that macro-level economic progress does not necessarily translate into improved quality of life or access to basic services for all sections of the population.

One of the key implications of this research is the need for more community-based and participatory approaches in health planning and delivery. The top-down models currently in place, often fail to capture the nuanced needs of marginalized populations. In conclusion, this study has

attempted to contribute to the growing body of literature that emphasizes the importance of addressing social determinants of health, in order to achieve equity. The case of *Dakshin Dhupjhora* is emblematic of the larger challenges faced by marginalized communities across rural India. Addressing these challenges requires not just infrastructural investment, but a fundamental shift in the way health policies are conceptualized and implemented.

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