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SOCIAL EXCLUSION OF DALIT - A SOCIOLOGICAL STUDY (WITH SPECIAL REFERENCE TO TUMAKURU)

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ABSTRACT

Even today the Indian society is following the same varna system were the society is categorized in to four namely the Brahmans, kshtriya, vaishya, and the shudra and the practice of the varna system is still in existence which has a practice of discriminating the shudras. . Today in contemporary Indian society the shudras are known as the dalits which is a Marathi word means as “broken men” and presently there are 180 million Dalits categorized and classified as scheduled castes in the Indian constitution. How ever more than 180 million Dalits are subjected to social, economical, political and cultural exclusion deeply imbedded in social practices. Dalits are social and physically separate they most live in outside areas of the village in rural areas and in specified areas in cities. They are denied basic human rights not allowed to own property rights and to use public and common property such as the wells, tanks and temples.

Traditionally, India's caste system assigns individuals a certain hierarchical status and profession, according to Hindu beliefs, there are four principal castes (divided into many sub-castes) and the people who fall outside the caste system is the Dalits. As members of the lowest rank of Indian society, Dalits face discrimination at almost every level, from access to education, availing

facilities, to restrictions on where they can live and what jobs they can have. The discrimination against the Dalits is especially significant because of the number of people affected.

In spite of this the practice of social exclusion and discrimination has been practiced in one or the other form the practice still exists in a newer forms and strategies. the exclusion is based on caste untouchability such as the excluded member of a community do not have the right to entry a public places like temples, schools, hospitals, housings, etc.restrictionon entry of various educational institution, unequal treatment in teaching. The untouchables are made to practice some identifiable cultural practices separate from the society such that they have their separate gods, marriage system, the crimination system and different food culture from the other people of the society.

social exclusion is the inability to participate in aspects of social life considered important. These are economic, cultural and political.“Hardcore” social exclusion occurs when there is mutual feedback, rather than offsetting, relationships between the inabilities to participate in these three dimensions of social life.

Key Words - Indian society, Varna system, Social exclusion and discrimination, Human rights,

Untouchables, Caste system, Discrimination, Hierarchical status.

I. INTRODUCTION:-

These practices forced people to perform according to the principles of the Varna system. The causes for exclusion can vary from country to country in different times; reflecting deferent situation such geographically, historically and politically but the results will be the same in the form of lack of people development and the country. As a result of social exclusion, its impacts on the livelihood of the people such as increase in rate of poverty, health, and others.Those individuals and groups who violated the caste prescriptions were punished in different ways and those who conformed themselves with the existing normative system were rewarded. So far as the caste occupation of non-twice born is concerned, it got less prestige and status in the hierarchy of occupation.

The exclusion is practiced world wide mostly on the identity of gender, caste, religion, ethnicity, color, race, nationality, and others. Social exclusion is a process which involves denial of rights and opportunities which the majority enjoy, resulting in the inability of individuals from excluded groups to participate in the basic political, economic and social functioning of the society, there by causing high human poverty and deprivation among them Social Exclusion is lack of access to resources and consequent inability to utilize them.

Most of these occupations were manual which required relatively less amount of technical knowledge. Since population from this caste category was very large, large number of people entered in the caste occupation. Social exclusion is a term used to describe a situation in which a person (or a group of people), resident in a society is excluded from the key activities of the society, and is prevented from participation by factors beyond his or her control. Poverty is associated with. Most form so social exclusion Most often, social exclusion can happen when a person is faced with problems like poor health, unemployment, inadequate housing, crime or discrimination. The process of overcoming such deprivation is referred to as social inclusion. Health, poverty and social exclusion are strongly interrelated concepts that are best addressed through an integrated approach to improve quality of life and the promotion of social inclusion.

As put forward by the European Commission, the objective of fighting poverty and social exclusion should be mainstreamed into sectoral policies, such as health policy, at

national and community level. However, the collaboration between the public health sector and the social sector is not as beneficial as it can be in many Member States. Improved access to health services and the use of health promotion strategies and methodologies will positively contribute to the social inclusion process.

There is no doubt that 'material' factors, such as exposure to low income and to health risks in the natural environment, are part of the explanation. Financial disadvantage may affect health through various mechanisms, among which psychosocial stress and subsequent risk-taking behaviours such as smoking, excessive alcohol consumption, or reduced access to health-promoting facilities and products such as fruit and vegetables, sports, preventive health care services, etc. Occupational health risks, take for example, exposure to chemicals, accident risks, or physically strenuous work as well as health risks related to housing, for instance, crowding, dampness, or accident risks are other examples of 'material' factors to attribute health inequalities. The second group of specific determinants which contribute to the explanation ofhealth inequalities are psychosocial factors. Those who are in a low socio-economic position experience averagely more psychosocial distress, which can be brought about due to negative life events such as loss of beloved ones, financial difficulties and so on, or 'effort-reward imbalance' ,in other words, high levels of effort without appropriate material and immaterial rewards.

II. REVIEW OF LITERATURE

Patwardhan (1973: 203) has shown in her case study of the "Harijans" of Maharashtra that urbanization leads to greater occupational mobility for the Scheduled Castes. Whenever a group of people continues with their traditional occupation in an urban area, it does so because it finds it financially more rewarding. There is a relative absence of ritual compulsions to do the hereditary work in cities. However, she has observed that not all castes performing menial jobs discard their traditional occupations in cities.

B.N. Srivastava (1997) to trace the origin of scavengers in India, their social and economic status, caste organizations, cultural heritage and territorial distribution. One of the important findings of the study is that although a large number of sweepers, mostly from northern India, have abandoned Hindu religion and converted to other religions, no significant change has come about in their occupation or social status.

III. OBJECTIVE OF THE STUDY :-

1. To know understand the difficulties faced by these workers.
2. To know the various steps undertaken by municipality
3. To know the government policies implement of municipality workers

IV. METHODOLOGY OF THE STUDY:-

The data is drawn by adopting the Primary data, is collected through the simple random sampling method. Is collected through the simple random sampling method. In the universe of 100 sample size. Observation techniques and also from various different news papers, research reports, journals, and websites and research papers and also through informal Interview method.

TUMAKURU DISTRICT PROFILE

Tumakuru is the headquaters town of the district and the district is also called by the same name.Popular tradition has it that tumakuru once formed part of territory, whose capital was Kridapura, now a small village known as kaidala, three miles to the south of tumakuru , and that it was presented byone of its rulers to a herald or tom-tom beater."Tumuke" is the small drum or "Tabret",which is used for tom-tomming, and the town might have been called Tumuke-Ooru" to indicate that it belonged to ibeater of "Tumuke".But the original name of the place according to the 10th century was "Tummeguru",which means, that the place of the "Tumme orTumbe ",a common fragrant herb found abundantly in the area.It is said that present town was build by Kante Arasu,a member of the mysuru royal family, and because the area was the same name with the addition of ooru for the town and called it Tumme-ooru or Tumbe-ooru ,in course of time came to be pronounced Tumakuru (or Tumakuru in its anglicised form) as it is now known.

Location

Tumakuru belongs to group of districts called the maidan (plains) district and is situtated in the east-central part of the Mysuru State and to the South and the South-east chitradurga district . It is bounded on the north by the Ananthapur district of Andrhra Pradesh, on the east by Kolar and Benguluru rural districts, on the south by Mandya district and on the west by the districts of Chithradurga, Chikkamagalur and Hassan. One Unique feature of this district is that

one of the taluks, i.e. Pavagada, is not at all connected with it at any point. The taluk is surrounded on all sides by Ananthpur district of Andhra Pradesh and is connected with Karnataka at one point by a narrow strip of land on the north-west, and that too, not with the Tumkuru district to which it belongs, but with another district of Karnataka i.e. chitradurga. This is because of the fact that this taluk once formed part of the Chitradurga district and was separated from it and attached to Tumkuru district in 1886.

In 2011, Tumkur had population of 2,678,980 of which male and female were 1,350,594 and 1,328,386 respectively. In 2001 census, Tumkur had a population of 2,584,711 of which males were 1,313,801 and remaining 1,270,910 were females. Tumkur District population constituted 4.38 percent of total population.

Tumkur District Population Growth Rate

There was an increase of 3.65 percent in the population compared to population as per 2001. In the previous census of India 2001, Tumkur District recorded increase of 12.10 percent to its population compared to 1991.

Tumkur District Density 2011

The initial provisional data released by census India 2011, shows that the density of Tumkur district for 2011 is 253 people per sq. km. In 2001, Tumkur district density was at 244 people per sq. km.

DATA INTREPRETATION

CASTE OF THE RESPONDENTS

Table-01 - Caste of the respondent

Sl. No	Caste	Frequency	Percentage
1	General	12	12.00
2	Scheduled Caste	71	71.00
3	Scheduled Tribes	11	11.00
4	Other Backward Caste	06	6.00
	Total	100	100.00

Source: Primary Data

Table - 6 show that respondents and the majority of them out of total respondents, i.e., 100, 12.00 % of the respondents were General caste, 71.00 % of the respondents were Scheduled Caste, 11.% of the respondents were Scheduled Tribes, 06.00 % Other Backward Cast

Table-02- Age group of the respondents

Sl. No	Age	Frequency	Percentage
1	20-25	25	25.00
2	26-30	20	20.00
3	31-35	16	16.00
4	36-40	15	15.00
5	45 above	24	24.00
	Total	100	100.00

Source: Primary Data

The field work carried out starting from the age profile of the respondents with the above table shows that 25 % of the respondents are young aged (20-25 years) 20% of the respondents are between the age group of 26- 30 years, over 16% of the respondents are in between the age group of 31- 35 years, and 15 % of the respondents are in between the age group of the 36-40, 24 % of the respondents are in between the age group 45 & above years.

EDUCATIONAL QUALIFICATION OF THE RESPONDENTS

Table-03- Educational Qualification of the respondents

Sl. no	Educational	Frequency	Percentage
1	Illiterates	49	49.00
2	Primary	19	19.00
3	Middle school	11	11.00
4	High school	13	13.00
5	PUC	05	05.00
6	Degree/graduates	03	03.00
	Total	100	100.00

Source: Primary Data

The social discrimination faced by some of these workers is another major factor that influenced the outcome of this query. This highlights the lackof proper policies to encourage education in socially and financiallymarginalized communities in India and lack of support from the governmentfor any educational provisions.With the above table 3 it is clear that in the present study, out of totalrespondents, i.e., 100, 49.00% of the respondents are illiterates, 19.00% of therespondents passed primary level, 11% of the respondents were completed theirmiddle

school, 13.00% of the respondents were having theeducation up to high school, 5.00 % of the respondents are completed their PUC /equivalent,and the rest of 03.00 respondents completed their degree/graduates.

MARITAL STATUS OF THE RESPONDENTS

Table-04-Marital status of the respondents

Sl. No	Marital Status	Male	Female	Percentage
1	Married	37	15	52.00
2	Unmarried	14	06	20.00
3	Widow/ Widower	03	05	8.00
4	Divorced	03	02	5.00
5	Separated	12	03	15.00
	Total	69	31	100.00

Source: Primary Data

The marital status is one of the features of Indian society has a bigger variations, and the same if compared to the marginalized sections also. One can observe that the poorer are married very early and this not an exception among the pourakarmikas, table 4 Marital status of the respondents the marital status of respondents and themajority of them out of totalrespondents, i.e., 100, 52 % of the respondents were male and female married, where as 20 % of the respondents were unmarried, 8 % of the respondents wereWidow/Widower, 5% of the respondents were divorced and the rest of 15 % were separated.

FAMILY TYPE OF THE RESPONDENTS

Table-8 Family size of the respondents

Sl. No	Family Size	Frequency	Percentage
1	1 to 3	17	17.00
2	4 to 6	65	65.00
3	7 to 9	08	8.00
4	10 above	10	10.00
	Total	100	100.00

Source: Primary Data

The above table shows the family size of the 100 respondents. In the present 1 to 3 members who consist of 17.00 %, while 65.00 per cent respondents have 4-6 members in the family, 8.00 per cent have 7-9 members, and only 10 per cent of the respondents have morethan 10 members in the family.

9. MONTHLY SALARY OF THE RESPONDENTS:

Table- 9 Monthly Salary of the respondents

Sl. No	Monthly Income	Frequency	Percentage
1	4000 to 6000	29	29.00
2	7000 to 9000	45	45.00
3	10000 to 12000	15	15.00
4	Above 12000	11	11.00
	Total	100	100.00

Source: Primary Data

Table- 9 show the 100 respondents scavengers having monthly salary starting from Rs. 5000 to 7000 constituted 29.00% a large amount of the respondents i.e. 45.00% of the respondents earns monthly salary in the range of Rs 7000 to 9000. 15.00% earn 10,000 to 12,000, those earning above Rs. 12000 are 11.00%. Majority respondents are 45.00% of the respondents earns monthly salary in the range of Rs 7000 to 9000.

V. Inequalities in access to health and related services :-

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being, and is determined by the social, political and economic context of their lives, as well as by biology. Since time immemorial, the impact of Social exclusion has made the Dalits as vulnerable community in society; the process of social exclusion system has made the Dalits dependable on the others so called upper communities.

However, health and well-being elude the majority of women. [The major] barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and [among women]. In national and international forums, women have emphasized that to attain optimal health throughout the life cycle, equality, including the sharing of family responsibilities; development and peace are necessary conditions.

VI. Income and health :-

In this study of Tumakuru municipal corporation female Sweepers and construction workers. They receive very less money as their wages. Around Rs. 75 only, and finds it very difficult to lead their life since most of these female workers belongs to the age group of 25-45 yrs. They have their own family maintained with this very low income status. They ask for them self weekly around just Rs.5 or Rs.10 personally. Which would not be sufficient enough for the day from each houses they pass by. Since they collect dust and wastages from each houses they complaint about also suffering from allergy, cough , they are not provided with gloves and no

proper cleanliness of uniforms dress code maintained. These women's also works in private schools, Taluk office, shops,-etc. for their livelihood.

VII. Utility and role of health awareness camps :-

The role of health awareness camps has been conducted by taluk panchayat and municipality organization is very significant. They help them to attend the programme and get suitable awareness regarding cleanliness, providing them certain medical benefits like free treatment for minor health problems, from local health organizations and also counsel them regarding their working environment and other selected issues and also educate them regarding how to handle dry and wet dust items .when they collect from each houses and also make understand their work commitment.

VIII. Gender disparities and health related services :-

With the sample size of 100 women workers out of 36 members. These 100 sample selected female workers. Who have been undertaken for this study applying interview method. These women workers have experienced gender disparities throughout their working process while compared to their male counter parts.

They have expressed that male workers have been treated very differently in directing their work locating to very nearby areas, easily accessible, they have voice to question their discomforts selected to their work. But these female workers are not given appropriate chance to express their discomforts during their works.This has led to mental pressure and stress, physically also they find it very stressful and the health care suggested to them in many times has been neglected.

These 18 female workers are around age group of 25-45 all of these 18 female workers are from poor family background 15 members were married while 3 were unmarried. Married women's also faced the risk of family torture, non-cooperation from their husbands regarding their wok etc…

IX. Health counseling and suggestions:-

1. To educate and bring awareness them regarding their health and maintaining hygienic conditions during there working process.
2. To build up co-ordination and male and female workers and the concern authorities.
3. Role of medical institutions like PHC's and others should be very effective and committed towards these workers as a significant response.
4. Assistance from public homes and other areas for workers is very essential for these workers job commitments.
5. These women workers also should develop leadership qualities participate various other activities like sports, cultural.etc. would help them develop their life confidence for their future progress and improvements.

The present condition of pourakarmikas or dalits in Tumakuru has been discussed here with the help of data on socio-economic profile of pourkarmikas in Bangalore collected by researcher himself. In this chapter the caste, age, religion, marital status, type of family, educational status of the respondents, mother tongue of the respondents, income, awareness about rehabilitation programmes, etc. have been discussed. General caste, Muslims and Christians are also engaged in this work. This shows us how caste is still predominantly maintaining its characteristics even in urban and the traditional bond between occupation and caste. Both Muslims and Christian communities are immigrants they are doing this work from past 4-5 decades but General castes community joined the work recently. Majority of pourakarmikas came from Joint families. Lack of education of these communities is the main reason for adopting scavenging work. Due to lack of education and better health facilities people desire more children.

Conclusions.

The concept of social exclusion implies a focus on causes of poverty and inequality. An examination on causation and macro-micro linkages is central to the understanding of social inequalities in health. A commonality exists, alongside problems, when it comes to exploring the

links between social exclusion and health inequalities.The sole focus on a 'state' of social exclusion does not recognise the main causal links to inequalities in power across societies. Thus this approach cannot alone achieve the goals of greater equality and social cohesion.

Social exclusion and discrimination on Dalits is very much important problem in India, which can have the number of evil consequences on the establishment of welfare state. It is therefore very rigorous and honest efforts are necessary for its tackling.

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