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Caste, Gender, and Access to School Health Services in Rural India

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ABSTRACT

This paper examines how caste and gender shape access to school health services in rural India, and whether existing programmes are designed to address these social determinants. Drawing on government surveys, national education reports, and academic literature, it analyses how flagship initiatives, including the Mid-Day Meal Scheme (now PM POSHAN), the Rashtriya Bal Swasthya Karyakram, and the School Health Programme under Ayushman Bharat, function on the ground. Rather than accepting programme reach at face value, the paper interrogates the social barriers that condition access, including caste-based discrimination, patriarchal norms that restrict girls' mobility and autonomy, the stigma surrounding certain health needs, and the expectation in many rural households that children, particularly girls, prioritise domestic responsibilities over schooling and health. It further accounts for the institutional and infrastructural gaps that compound these exclusions. The paper argues that health policy which fails to account for caste and gender is unlikely to reach those who need it most, and calls for a grounded approach to school health programme design that takes seriously the social realities of rural India.

Keywords: School health, Caste, Gender, Rural India, Educational equity, Policy analysis, Substantive inclusion.

I. INTRODUCTION

School health policy in India is built around a simple premise: that where a child is born should not determine the quality of health services that child receives. In rural India, however, the evidence suggests otherwise. The Rashtriya Bal Swasthya Karyakram (RBSK), the Mid-Day Meal Scheme, and the School Health Programme under Ayushman Bharat collectively represent a substantial institutional commitment to children's health. Yet the distance between what these programmes promise and what children in rural areas actually receive remains considerable.

This paper argues that caste and gender are two of the most significant, and most consistently overlooked, determinants of that distance. In rural India, where caste hierarchies and patriarchal norms retain a strong grip on everyday life, school health programmes designed as universal interventions frequently fail to reach the children who need them most. The paper draws on

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government surveys, national education reports, and existing academic literature to examine how this occurs, not as an accident of implementation, but as a structural outcome of policies designed without adequate attention to social realities.

The analysis proceeds in five parts. It begins with an overview of India's school health policy landscape, then examines caste and gender separately as determinants of health access, before bringing them together to consider how they compound one another. It then considers institutional and infrastructural barriers, before concluding with a discussion of what substantive inclusion in school health would actually require.

II. SCHOOL HEALTH IN INDIA: THE POLICY LANDSCAPE

India's approach to school health has evolved considerably over the past two decades. The Mid-Day Meal Scheme, formally renamed the PM POSHAN Scheme in 2021, is among the oldest and most expansive, providing cooked meals to children in government and government-aided schools with the dual aim of improving nutrition and boosting school attendance.¹ The RBSK, launched under the National Health Mission, extended this framework by introducing systematic health screenings for children from birth to eighteen years, targeting thirty health conditions spanning defects at birth, deficiencies, diseases, and developmental delays including disabilities.² More recently, the School Health Programme under Ayushman Bharat has sought to integrate health and wellness into the school environment more broadly, training Health and Wellness Ambassadors among senior students and deploying Health and Wellness Coaches in schools.³

These programmes are ambitious in design. Ambition at the policy level, however, does not automatically translate into equitable outcomes on the ground. Several evaluations have noted significant gaps in programme reach, particularly in rural areas where infrastructure is weaker, health-worker density is lower, and social barriers to access are stronger.⁴ What these evaluations have been slower to address is the role that caste and gender play in determining who, within rural areas, is further left behind.

¹ Ministry of Education, Government of India, PM POSHAN SCHEME: PROGRAMME OVERVIEW (2022).

² Ministry of Health and Family Welfare, Government of India, RASHTRIYA BAL SWASTHYA KARYAKRAM: OPERATIONAL GUIDELINES (2013).

³ Ministry of Health and Family Welfare, Government of India, SCHOOL HEALTH PROGRAMME UNDER AYUSHMAN BHARAT (2018).

⁴ Amol R. Dongre, Pradeep R. Deshmukh & Bharat Bhise, *Factors Associated with Stunting Among Children in Rural India*, 37 INDIAN J. CMTY. MED. 87 (2012).

III. CASTE AS A DETERMINANT OF HEALTH ACCESS

Caste remains one of the most powerful organising principles of rural Indian society. Despite constitutional protections and decades of affirmative-action policy, Dalit and Adivasi communities continue to face systematic exclusion from public services, and health is no exception. As Thorat and Lee have documented, caste-based discrimination operates not only in labour markets and housing but also in the delivery of public services, including health and education.⁵

Within school settings, caste shapes access in ways that are both overt and subtle. Studies have noted that in some rural schools, Dalit children are made to sit separately, serve themselves last during midday meals, or are assigned cleaning duties that other children are not.⁶ These practices are not merely matters of social dignity; they have direct consequences for health-programme access. A child who is systematically marginalised within the school environment is less likely to present for health screenings, less likely to report health concerns to teachers or health workers, and less likely to receive follow-up care.

Borooah's analysis of caste and poverty in India demonstrates that Scheduled Caste and Scheduled Tribe households face compounding disadvantages that render them structurally less able to access and benefit from public health interventions.⁷ In the context of school health, this means that even where programmes are physically present in a school, caste-based exclusion can effectively render them inaccessible to the children who need them most.

Data from the National Family Health Survey (NFHS-5) reinforce this picture. Nutritional outcomes, anaemia prevalence, and access to preventive health services all show significant disparities along caste lines in rural areas, with Scheduled Caste and Scheduled Tribe children consistently faring worse than their upper-caste peers.⁸ These are not gaps that school health programmes, as currently designed, are adequately equipped to close.

IV. GENDER AS A DETERMINANT OF HEALTH ACCESS

If caste operates as a structural barrier to school health access, gender operates as an equally powerful one, and in rural India it does so through a distinct set of mechanisms. Patriarchal

⁵ Sukhadeo Thorat & Joel Lee, *Caste Discrimination and Food Security Programmes*, 40 ECON. & POL. WKLY. 4198 (2005).

⁶ Ghanshyam Shah et al., *Untouchability in Rural India* (2006).

⁷ Vani K. Borooah, *Caste, Inequality and Poverty in India*, 9 REV. DEV. ECON. 399 (2005).

⁸ International Institute for Population Sciences, *National Family Health Survey (NFHS-5), 2019-21: India Report* (2022).

norms governing girls' mobility, autonomy, and bodily agency shape their relationship with school health services in ways that are rarely captured in programme evaluations.

The most immediate manifestation of this is school attendance itself. Girls in rural India continue to drop out of school at higher rates than boys, particularly at the secondary level, where domestic responsibilities, early marriage, and concerns about safety and distance to school all play a role.⁹ A school health programme can only reach children who are in school, and so the gender gap in attendance is simultaneously a gender gap in health-programme access.

Even among girls who are in school, access to health services is mediated by gender norms in important ways. Menstrual health is perhaps the most documented example. Despite the introduction of various state-level menstrual hygiene schemes, studies have consistently found that girls in rural schools face significant barriers to menstrual health management, including inadequate sanitation infrastructure, social stigma, and a lack of trained female health workers to whom they can speak confidentially.¹⁰

Nivedita Menon's work on gender and the body in India is instructive here. She argues that patriarchal control over women's bodies is not simply a cultural residue but is actively reproduced through institutional structures, including schools.¹¹ In this light, the failure of school health programmes to address girls' health needs adequately is not an oversight but a reflection of the gendered assumptions built into programme design.

Beyond menstrual health, gender norms shape girls' access to nutrition programmes, mental health support, and general health screenings. In households where girls are expected to eat last and least, the nutritional gains of the Mid-Day Meal Scheme are partially offset by what happens outside school hours. And in communities where girls' health concerns are considered secondary to their domestic and reproductive roles, the health-seeking behaviour on which programmes depend is structurally discouraged.

V. WHERE CASTE AND GENDER MEET: COMPOUNDING EXCLUSIONS

Considered separately, caste and gender each produce significant barriers to school health access in rural India. Considered together, they produce something more than the sum of their parts. Uma Chakravarti's concept of Brahmanical patriarchy is instructive here. She argues that caste and gender in India are not parallel systems of oppression but deeply intertwined ones, in

⁹ Deon Filmer & Lant Pritchett, *The Effect of Household Wealth on Educational Attainment*, 36 DEMOGRAPHY 367 (1999).

¹⁰ Marni Sommer et al., *Menstrual Hygiene Management in Schools: Midway Progress Update*, 34 WATERLINES 267 (2015).

¹¹ Nivedita Menon, *Seeing Like a Feminist* (2012).

which the control of women's sexuality and mobility is central to the reproduction of caste hierarchy.¹² For Dalit and Adivasi girls in rural areas, this means that the disadvantages of caste and gender do not simply add up; they interact and amplify one another in ways that produce a distinct and particularly acute form of exclusion.

NFHS-5 data illustrate this clearly. Dalit and Adivasi girls in rural areas show the worst outcomes across almost every health indicator, including nutritional status, anaemia, access to healthcare, and school attendance, compared not only to upper-caste boys but also to Dalit boys and upper-caste girls.¹³ This is not a coincidence. It reflects the intersection of caste-based exclusion and gender-based marginalisation operating simultaneously on the same children.

School health programmes, as currently designed, are ill-equipped to address this intersection. Their universal framing, which treats all children as equally positioned to access services, obscures the ways in which social hierarchies determine who actually benefits. A health screening available to all children in a school is not equally accessible to all if some children are discouraged from participating by caste-based discrimination, if some girls are absent because of domestic responsibilities, or if the health workers conducting the screening carry the same social biases that produce these exclusions in the first place.

VI. INSTITUTIONAL AND INFRASTRUCTURAL BARRIERS

Social barriers rarely exist on their own. In rural India, they sit alongside, and are often worsened by, the everyday realities of poorly equipped schools and overstretched institutions. UDISE+ data consistently show that a substantial proportion of rural schools lack functional toilets, safe drinking water, and basic medical facilities.¹⁴ The absence of separate toilets for girls is particularly significant; it is one of the most consistently cited reasons for girls' school dropout, and its implications for health-programme access are direct.

At the institutional level, the effectiveness of school health programmes depends heavily on the attitudes and capacities of frontline workers, including teachers, ASHA workers, Anganwadi workers, and school health teams. Studies have found that these workers often carry the same caste and gender biases as the communities they serve, shaping who they prioritise, whom they refer for follow-up care, and whose health concerns they take seriously.¹⁵ Training and

¹² Uma Chakravarti, *Conceptualising Brahmanical Patriarchy in Early India: Gender, Caste, Class and State*, 28 ECON. & POL. WKLY. 579 (1993).

¹³ International Institute for Population Sciences, *supra* note 8.

¹⁴ Ministry of Education, Government of India, *Unified District Information System for Education Plus (UDISE+) Report 2021-22* (2022).

¹⁵ Devaki Nambiar et al., *Health Provider Bias and Marginalised Populations in India*, 11 BMC HEALTH SERVS. RSCH. 1 (2011).

sensitisation programmes exist on paper, but their reach and effectiveness in rural areas remain limited.

VII. DISCUSSION: FROM FORMAL ACCESS TO SUBSTANTIVE INCLUSION

What the evidence collectively suggests is that formal access to school health services and substantive access are two very different things. Formal access, the presence of a programme and the availability of a service, is a necessary but insufficient condition for health equity. Substantive access requires that children are actually able to use those services, that the services are designed with their specific needs in mind, and that the social and institutional environment in which services are delivered does not reproduce the very exclusions the programmes are meant to address.

For rural India, moving toward substantive inclusion in school health would require at least three things. First, disaggregated data collection: programme evaluations need to track outcomes by caste and gender, not merely by geography or school type, in order to make existing inequalities visible. Second, community-informed programme design: school health initiatives need to be developed in genuine consultation with marginalised communities so that social barriers are identified and addressed from the outset. Third, accountability mechanisms: there need to be meaningful ways for communities to flag discrimination and exclusion in programme delivery, and for those concerns to be acted upon.

None of this is straightforward. But the alternative, continuing to design school health programmes as if all children stood in equal relation to them, is to guarantee that the children who need these programmes most will continue to benefit from them least.

VIII. CONCLUSION

India's school health programmes represent a genuine commitment to children's health and wellbeing. But commitment at the policy level is not enough if programme design does not reckon with the social realities of the communities it serves. In rural India, caste and gender are not background variables; they are active determinants of who gains access to health services, on what terms, and with what consequences. Until school health policy takes these determinants seriously, the gap between formal access and substantive inclusion will persist, and the children at the sharpest end of that gap will remain invisible to the programmes designed to help them.

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