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Indian Women's Self-Help Organizations And Health Disparities: The Impact Of Caste And Class

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Abstract

The creation of Self-Help Groups (SHGs) has been seen as a crucial tactic in combating the worrying levels of poverty and marginalisation that have followed global progress since the United Nations Millennium Declaration of 2000. SHGs are small, voluntary groups of individuals from a similar socioeconomic background that were formed with the intention of resolving common social and economic issues by supporting one another. It has been expected that such grassroots unity will foster communal empowerment and guard against economic exclusion. This presumption is primarily based on the global, neo-liberal agenda, which calls on the State to stop providing for social needs. In India, SHGs are frequently used, particularly to end the social marginalisation of impoverished women and increase their access to healthcare. With an emphasis on its implementation in the Indian State of Maharashtra, this article examines the potential and constraints of SHGs in enhancing women's health. By examining the vital roles of caste and class in access to health care, it critically evaluates the extent to which SHGs may be involved in achieving improved health for women and children. The article's conclusion is that international policy circles' solutions like SHGs fail to recognise local structural contexts like caste and class, leading to the development of instrumental zed strategies that are unlikely to result in the equitable delivery of health services to the underprivileged and marginalised.

KEYWORDS- Caste, Class, Equity, Health, Self-help organisations.

Introduction

After the United Nations' Millennium Declaration was ratified by 189 countries in 2000, there was a commitment to realising it. The great majority of the world's poor people will be better off economically and socially thanks to the ten main goals known as the Millennium Development Goals by the year 2015 (United Nations 2006). The creation of Self-Help Groups (SHGs) was one of the methods for achieving these objectives, particularly in rural areas with high levels of poverty (IFAD 2006). Self-Help Groups (SHGs) are informal, small groups of people from similar socioeconomic backgrounds that get together to solve difficulties by helping one another and themselves. These organisations go by many names depending on where they are. Depending on the area, words like Bachat gat, Sangha, Samooh, Mandal, and Samiti are used to describe these groups in India. With the exception of specially defined activities concentrating on women's empowerment, health, and educational achievement, SHGs in India are typically focused on the needs and interests of women, with the majority of their activities focussed on financial savings and credit operations.

Self-help organisations and female health

According to a common belief in the development literature, women's increased involvement in credit and savings activities—or economic attainment—will empower them by enabling them to access and use better health services and facilities and by improving the health, nutritional status, and educational standing of their families—especially that of their children (Zeller et al. 1997:25–8). The improvement of women's welfare, particularly in connection to their health, is one of the key effects projected to come from this empowerment. The fundamental philosophy of women's engagement in microfinance initiatives has therefore been extremely beneficial, both for their personal socioeconomic well-being and that of their families. But as several studies have demonstrated (Malhotra and Mather 1997; Kishor 1995, 2000; Hashemi et al 1996; Beegle et al 1998), just because women may be empowered in one area does not mean that they will automatically be powerful in other areas. Structural disparities are a major cause of the limitations on treatments like SHGs, while there are other contributing reasons as well.

SHGs, caste, and class disparities in health

One of the most serious inequalities in India is the inequality between men and women. This is represented not just in educational possibilities but also in terms of the fundamental human right to survive and the prerequisites for it, such as good nutrition and physical health. The lopsided sex-ratio that exists in India (925 women for every 1,000 males) (Census of India 2011), which has gotten worse over time, amply illustrates this inequality. Unsurprisingly, women are more susceptible to sickness and have a higher death rate when they lack access to basic healthcare and proper nutrition. . Women are also more likely to suffer from malnutrition and anaemia, which can cause complications during pregnancy and delivery and are the main causes of the high maternal death rate. The lower literacy rate (64.80%) for females. (Census of India 2011) exacerbates the issue and creates a significant roadblock for women to achieve improved health outcomes.

As a result, gender inequality is one of the biggest structural obstacles that attempts to enhance women's health in India must overcome. Class and caste are equally important. Hindu social strata are organised according to the caste system. It has a diverse structure made up of distinct and separate castes. The caste system is a traditional, inherited form of social stratification in India that uses a variety of endogamous, hierarchical groupings to designate different social divisions. The caste system is primarily a Hindu institution, but it is also commonly used by Muslims, Sikhs, and Christians in India. It is a significant institutionalised source of structural inequality as a result. The Indian system of class and caste is one of the major contributors to the widespread poverty and social marginalisation of women, along with the impacts of gender inequality.

Self-Help Groups have been established in India in an effort to remove gender inequality and the ensuing poverty and marginalisation of women, or at the very least, significantly decrease it. SHGs are projected to contribute to the advancement of the UN's "Millennium Development Goals" in poor nations by ensuring equal health access that transcends caste and class distinctions. Self-Help Groups are anticipated to be crucial in enhancing the provision of healthcare in low- and middle-income countries and to help to bettering population health outcomes despite decreased government spending on healthcare (see, for instance, Nayar et al. 2004). Such a strategy is significantly influenced by the global neo-liberal agenda, which restricts the State's ability to provide resources for social and economic development that are broadly linked with the Such a development in India has had extremely negative societal repercussions, including a decline in the living conditions of the poor and an increase in the privatisation of healthcare (Nayar et al. 2004).improvement of society as a whole. This view asserts that "the State is frequently characterised as inefficient and considered ill equipped to manage social sectors such as health." This inefficiency defence is used to support both the need for funding and the execution of health programmes (Nayar et al. 2004). Neo-liberalism's ideals and tenets have had a significant impact on governments in developing nations, usually leading to their retreat from welfare and health-related initiatives.

In this context, there has been a great deal of scholarly opposition to the implementation of SHGs as a key approach for eradicating poverty and enhancing women's access to better health care and resources. SHGs can be utilised as a method for local level health interventions and development, but they cannot be implemented as a strategy to offer equal health access, according to contributors to this criticism. This point of view contends that the economic gains produced by SHGs may not always empower the women who take part in them. Additionally, without a sufficient level of living, which includes the public supply of effective health infrastructure, services, and facilities, women cannot get health care. They contend that access to healthcare is more influenced by political and socioeconomic factors. It is simply not viable to provide women and children with fair access to healthcare without addressing these developmental difficulties and confronting the social systems of class and caste.

Study objectives and techniques

The research described in this article looked at the connections between SHGs and women's access to healthcare. It looked at the role caste and class played in improving women's health and ensuring fair access to healthcare in order to understand the extent and limitations of SHGs. As a result, the study looked at 200 women who were SHG members in the Gadchiroli district of the State of Maharashtra in order to examine the extent to which SHGs may be involved in achieving improved health outcomes using field surveys, interviews, focus groups, and select case studies. Both qualitative and quantitative techniques were utilised to gather and analyse the data.

Region of study and sampling

Maharashtra was chosen for the study due of the low status of the local women. These are ladies. The study's conclusions are supported by a number of trustworthy measures that contrast the social and economic standing of women in Maharashtra with the national average. These indicators include things like the low proportion of working women, how little media women are exposed to, the high maternal death rate, how low literacy rates are, how often child marriage is, and how common anaemia is. Only 0.469, or much less than the national index of 0.629 in 2021, characterises gender disparity in Maharashtra (Indian Planning Commission, 2021). This shows that gender disparities are far worse in Maharashtra than they are for the entire nation.

Due to the presence of a disproportionately greater number of SHGs than the other 36 districts in the State of Maharashtra, the Gadchiroli district was selected (UNICEF, no date). In addition to SHGs backed by the government, Gadchiroli also has a well-established network of NGO-supported ones. In Gadchiroli, there are also clusters of "blocks," which are the main construction-related units. A block is made up of many Gramme Panchayats, or village councils, and is made up of a collection of villages. A "bacaht gat" of Mukhaiyas chosen from the village councils oversees the governance of each block. The Bacaht gat is responsible for the village's basic healthcare, education, animal care, and agricultural growth. For each block, the government chooses a development officer.

Korchi and Bhamragad were chosen as the study's two blocks. These were picked because to the prominence of SHGs and the levels of infrastructure, health, and education services. These latter factors were utilised as selection criteria since they are thought to directly relate to the empowerment and wellness of women. In order to operationalize these requirements, literacy levels were taken as a measure of infrastructure availability and rates of home electricity usage were taken as a measure of educational attainment. The primary measure for health was the proportion of families reporting a source of drinking water outside of their premises and having no latrines. With the aid of the NGO Integrated Development Foundation, additional family and community members were located and enlisted.

Interviews with 200 SHG participants were conducted. They were all Tribe, reflecting the district's high tribe population. The ladies were from a variety of castes, including Gond Madia ,Kolam, Pradhan, and others. While there were little disparities in their lifestyles, there was a clear caste-based division in the sample as a whole. This involves a separation of women from what are known as the "Scheduled Castes" (SCs) and the

"Tribes" (ST). Of the 200 ladies, 55% are from the ST and 45% are from the SC. Socially speaking, STs are in a better situation than SCs. They earn more money and have better levels of education. Despite being made up of castes that are officially acknowledged as having historically been excluded, they nonetheless have a greater standing than the SCs. STs are eligible for 27% of the job reservations in government employment, although making up approximately half of India's population. The STs are classified as "socially and educationally backward" in the Indian Constitution.

Development On the other side, the Indian Constitution grants special status to the SCs, a group of groups. These groups were regarded as "outcasts" and kept out of many aspects of Tribe culture on the Indian subcontinent for a very long time. They still face significant social disadvantage and prejudice since they were historically limited to the lowest-paying jobs with no chance for advancement.

A few family members, neighbours, and other members of the community, including field level authorities actively working with the SHGs, were also questioned in addition to the 200 women. This gave the chance to learn about some of the opinions and experiences of other members of the community on the effectiveness of SHGs for empowering women and gaining access to healthcare.

Tools and methods for gathering data

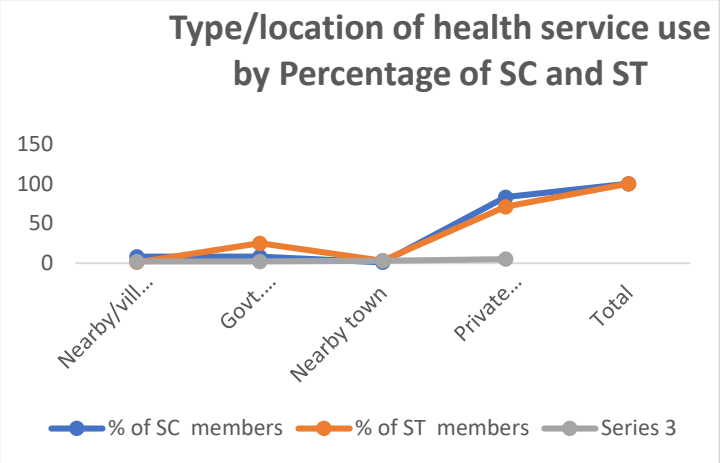
Both qualitative and quantitative survey methodologies were employed for the objectives of data gathering due to the complex and multi-dimensional character of the topics covered in the study. According to Figure 1, participants might be divided into three groups. The methods used to collect data from each of these categories are depicted in Figure 1 and range widely.

Results

The results are based on a field survey, interviews, case studies, and focus groups that looked at a variety of topics, including: women's perceptions of their health, their health-related practises and beliefs, disease patterns and prevalence, their access to health services and their role in facilitating that of their family, knowledge about family planning, use and type of family planning methods used, discussion on health issues within the family, and The research was done by visiting and making field observations at several public and private health institutions, including a sub-centre, a primary health centre, community health centres, and private clinics. Table 1 summarises and presents the quantitative data in tabular format.

Table 1: Type/location of health service use by Percentage of SC and ST group members

	% of SC members	% of ST members
Nearby/village	8	1
Govt. hospital/dis	8	25
Nearby town	1	3
Private doctor	83	71
Total	100	100



According to Table 1, women from the Scheduled Castes are more likely to utilise "private doctors" than women from the Tribes. These physicians are typically "quacks" or unlicensed professionals who take advantage of the women's ignorance and lack of education by demanding exorbitant rates. The majority of women from the SC who employ these practitioners' services obtain loans from SHGs or payday lenders to pay them. Comparatively, ST members rely more on government-run clinics and pharmacies that don't charge a lot of money.

Table 2: Reported change in health knowledge by percentage of SC and ST members

Health knowledge category	% reporting an increase		% reporting an decrease		% reporting no change	
	SC	ST	SC	ST	SC	ST
Health and hygiene	35	70	0	1	60	29
Vaccination	39	68	0	2	51	30
Contraceptives	36	65	0	2	69	33
Care of during pregnancy	28	54	0	6	78	40
Care of self-post childbirth	38	61	0	4	73	35
Care of infant	24	70	5	2	71	28
Awareness of personal health care/needs	36	70	0	2	64	28
Awareness about existing health services	49	72	0	5	56	23

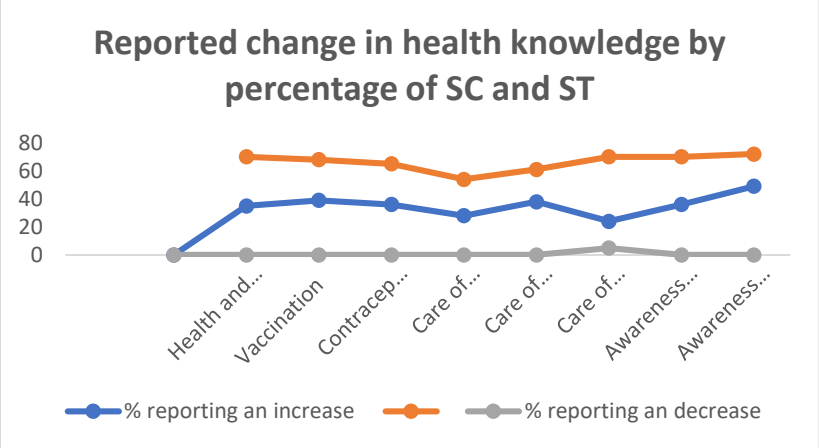


Table 2 shows that, as a result of their involvement in SHGs, members of the ST much more frequently than SC women saw an increase in their health awareness across all categories. This was particularly apparent when it came to baby care, pregnancy, delivery, and contraception. In contrast, women from the SC reported a two- to three-times greater rate of no change in their health knowledge than their ST counterparts as a result of their involvement in SHGs.

The trend is similar in Table 3. The benefits of joining SHGs in terms of healthy habits and practises, according to the participants, were substantially stronger for women from the ST. The latter claimed to have utilised antenatal, postnatal, and primary health centre services much more. On the other hand, despite participating in SHGs, women from the SC reported a much greater rate of maintaining their usage of these services.

It should come as no surprise that women from the ST were around three times as likely as SC women to declare a complete improvement in their health and the health of their families as a result of their membership in SHGs. Almost all of the ST women who participate in SHGs have improved their health or the health of their families.

Table 3: Reported change in health behaviour and practices by percentage of SC and ST members

Health behaviour/practice category	% reporting increase		% reporting increase		% reporting an no change	
	SC	ST	SC	ST	SC	ST
Visit to PHC	16	38	25	12	59	50
Visit to private doctor/nursing home	48	64	4	16	48	20
Ante-natal care during pregnancy	20	60	4	04	76	36
Post-natal care	28	68	2	03	70	29

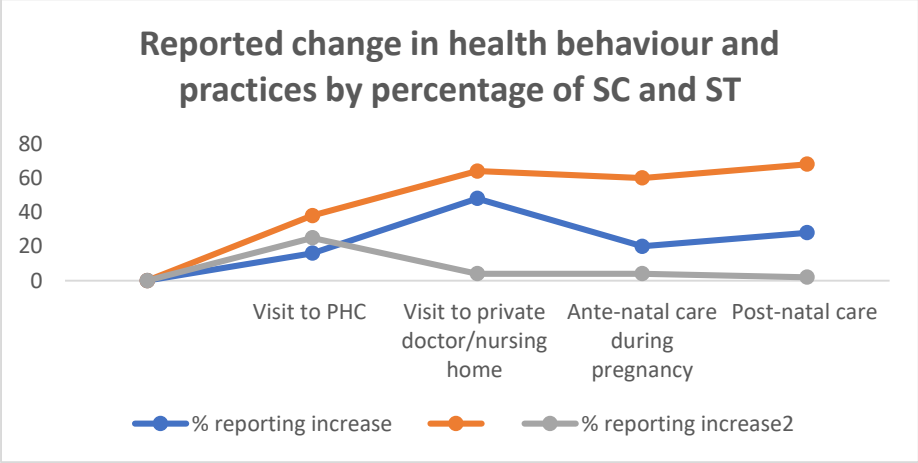


Table 4: Reported improvement in health by percentage of SC and ST members

category of health improvement	% reporting full improvement		% reporting part improvement		% reporting an no change	
	SC	ST	SC	ST	SC	ST
Improvement in personal health	14	38	20	28	66	34
Improvement in family health	10	45	21	30	69	25

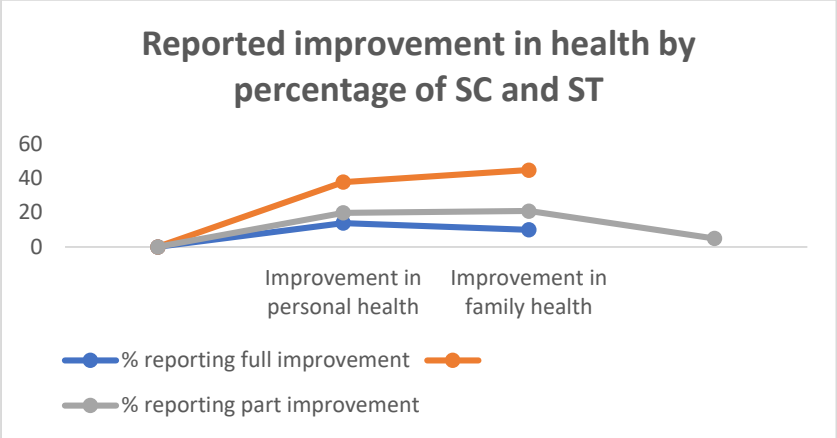
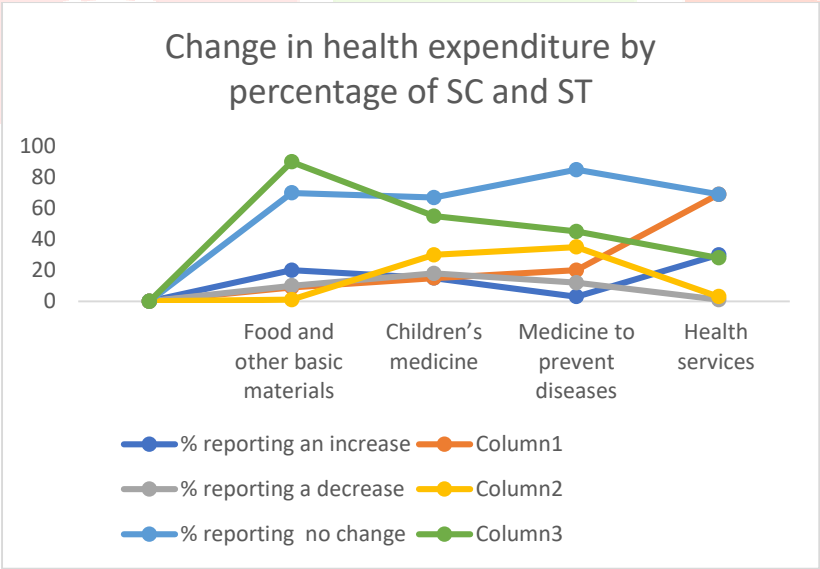


Table 5: Change in health expenditure by percentage of SC and ST members

category of health expenditure	% reporting an increase		% reporting a decrease		% reporting no change	
	SC	ST	SC	ST	SC	ST
Food and other basic materials	20	09	10	01	70	90
Children's medicine	15	15	18	30	67	55
Medicine to prevent diseases	03	20	12	35	85	45
Health services	30	69	01	03	69	28



According to Table 5, the most notable distinction between ST and SC women in terms of health expenditures is that the vast majority of SC women reported no change in spending on food and other necessities, children's prescriptions, and preventative drugs. Approximately 20% of SC women reported a drop in medical spending while taking part in SHGs, compared to almost a third of ST women. Additionally, more than 85% of ST women reported rising health service costs. Compared to their ST counterparts (39%), the proportion of SC women reporting increased spending on health services was much lower. Nevertheless, among SC women, this spending category showed the fastest rate of change.

Discussion

Since women from the Scheduled Castes are in a lower socioeconomic position than women from the Scheduled caste, it was thought that they would primarily benefit from the establishment of SHGs in Gadchiroli. Despite this inequality, ST and SC women participated in SHGs at about the same rates. However, as shown by the findings of this study, ST women notably benefited more from SHG involvement in terms of general health, as indicated by the improvements the women reported. As seen by the statement that follows, this had led to some animosity among SC women.

Sab fayada to sc Jaat le rahe hain, humlog ko koi fayada nahi mil raha. Na ghar hai na kamai. Fayda usiko pahunch raha hai jiske pas paisa or pahchan hai'. (All benefits are taken by the SC caste; we are not getting any. We have neither house nor job. Benefits of the programme are reaching people who have money and connections).

It was believed that joining the SHG especially in regards to bettering their own and their families' health. But as the study's findings demonstrate, ST women and their families benefited in terms of overall health far more. Better-off caste groups had access to and understanding of health care that was greater than that of the SC's disadvantaged groups. Their health improvement rates were noticeably faster. According to the findings, it is impossible to give poor people, especially women, access to better health facilities and improve their health outcomes without addressing the obstacles of caste and class-based discrimination. The prevalence of severe illness, which in turn had an influence on health care usage, was another indication of the class and caste-based disparity in health service use. Encounter really severe disease that made daily tasks more difficult and required care outside of the community at government facilities. The most vulnerable women's resources are further stretched by the everyday consequences of acute sickness. Except for where it comes at the expense of other already limiting access to health services, the programme would mostly benefit SC women.

Data from focus group talks indicate that SC women's reliance on moneylenders or Savkar in the case of illness has decreased as a result of their involvement in SHGs. However, their reliance continues. The SHGs' ability to save money is constrained, and they are unable to satisfy their members' credit demands. The SC ladies continue to contact the moneylender, usually asking for larger sums of money than previously. SC women who participated in focus groups said that many homes do not provide enough food for the family. The nutritional needs of many women and their families are not being met by their food intake. Women from the SC were more likely to live close to the needs and services of a government hospital. Additionally, they lack access to sanitary facilities and clean water to drink.

The distribution and calibre of local public healthcare in Maharashtra are unequal, and they only cater to the most fundamental requirements for health. In fact, Maharashtra is at the top in the nation for both inpatient and outpatient private health care delivery. This is true even if the majority of patients lack the financial resources to cover private vital expenses for things like basic nourishment. Hospitalisations frequently cause patients and their families to become impoverished. Since minor infections and diseases need to be treated and controlled to stop the spread of disease in the SC community, it is particularly difficult for poor women to find and afford licenced private practitioners. Members of the historically wealthier caste groups, such as those from ST homes, were able to access government health services, but this was not the case for the SC households, who were unwilling to use the government health system. Along with being less likely, SC families also seem to lack confidence in their ability to receive government health care. It is not clear why this is the case based on the data gathered. Clearly, additional research is needed.

Conclusion

In India, access to healthcare is significantly influenced by caste and class. The higher rise in benefits of programmes like SHGs to the better off is one of their most obvious outcomes, especially in the context of increased privatisation through health sector reform. Among poor women, this disparity is more pronounced and widespread. This pattern is illustrated by the case study below:

Bayja Devi, 46, has been a part of a SHG for the past four years and belongs to the Scheduled Caste community. Her spouse, four children, and in-laws make up her family. Health insurance costs are Bayja's main concern. Despite the fact that nobody in the family has a major chronic disease, she claims that someone is always unwell in the family. But due of the unsanitary circumstances, seasonal and other illnesses are widespread. She devotes half of her income to the medical needs of her family. Although she has major concerns about her own health, she seldom visits a doctor. She buys painkillers for herself every time she goes to the neighbourhood (unlicensed) doctor to get medication for her kids or in-laws. She has experienced back discomfort for the past two years, but because a certified doctor would require her to travel to the city, she has not sought their advice. She is unable to afford the associated fees. She claims that her children's health comes before her own. After enjoying her own life, she is now living for her family and children.

The results of this study demonstrate that castes were excluded by class-based injustices as a result of structural economic transformation. However, the interaction of caste and class continues to play a significant role in limiting women's access to better health. Because of how powerful this combo is, there are significant restrictions on how much SHGs may be utilised to improve women's health. The availability of women from the most disadvantaged groups to health care has grown more severely impacted by gender relations that are now in place and how they interact with money. For schooling and overall living standards, the author is thankful to Australian Aid. The ability of SHG initiatives to significantly impact women's health is severely hampered to the degree that they operate in a vacuum without addressing these contextual challenges. To do this, the entire community must take part in addressing the issue and educating males about gender parity. It is also obvious that local accessibility and decentralisation of public health services are urgently needed to improve the health of underprivileged and disadvantaged women.

The results refute the hypothesis that microcredit schemes for women's financial empowerment have a direct bearing on women's health. However, if SHGs offered practical healthcare services and facilities that were accessible to everyone, there may be unintended positive effects on health. It is impossible to advance women's economic and social status if fundamental public infrastructure and a supportive social, cultural, and economic environment are not provided. Indeed, development projects for women must take into account the unique social and economic environments in which they live as well as the requirements these environments create. Evidence that SHGs are indeed capable of eradicating poverty among women and improving their health is necessary to moderate the excitement of the Indian government, the international donor community, and the World Bank for SHGs. Because SHGs come from foreign policy circles that embrace instrumental zed methods without taking into account regional structural dynamics like caste and class, they are unlikely to be successful strategies for improving health equity among Indian women.

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