



RESEARCH ARTICLE

Social Inequalities and Health Disparities among Scheduled Castes and Scheduled Tribes: A Gender and Income Perspective in Maharashtra

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Abstract

Health disparities among Scheduled Castes (SC) and Scheduled Tribes (ST) in India continue to reflect deep-rooted social inequalities shaped by caste, gender, and economic disadvantage. This paper examines social inequalities and health disparities among SC and ST populations in Maharashtra, with a specific focus on gender and income as intersecting determinants of health outcomes. Maharashtra, despite being one of India's economically advanced states, exhibits significant intra-state inequalities, particularly in tribal and socially marginalized regions.

Using an intersectional framework, the study draws upon secondary data from national health surveys, government reports, and existing literature to analyse variations in health indicators such as nutritional status, maternal and child health, morbidity patterns, and access to healthcare services. The findings indicate that SC and ST communities experience disproportionately poorer health outcomes compared to the general population, with women from low-income households facing the highest levels of vulnerability. Gender-based discrimination, low household income, occupational insecurity, geographic isolation (especially in tribal districts), and limited access to quality healthcare services collectively exacerbate health risks.

The paper highlights notable disparities between SC and ST populations across rural, tribal, and urban settings in Maharashtra, emphasizing how income constraints and gender norms restrict healthcare utilization and health-seeking behaviour. The study underscores the need for equity-oriented public health policies, strengthened primary healthcare systems, and targeted interventions addressing the specific needs of SC and ST women and economically marginalized households. By situating health outcomes within broader social structures, this research contributes to a deeper understanding of caste- and gender-based health inequalities and offers insights for inclusive and socially just health planning in Maharashtra.

Keywords: Scheduled Castes (SC); Scheduled Tribes (ST); Health Disparities; Social Inequalities; Gender Inequality; Income Inequality; Social Determinants of Health;

Introduction

Health inequalities indicate about proper negligence and differences in health outcomes between caste class gender groups this comes from unparallel social arrangements

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rather than biological variation (World Health Organization, 2010).

In India, caste, class, and economic status represents powerful weapons of social stratification which leads to access of resources, explosive to risk and it is close to healthcare services. (Marmot & Wilkinson, 2006). As a part history, Scheduled caste and Scheduled Tribe are most vulnerable group in society, they suffer from many diseases. Despite having many policy interventions, still this group continue to experience many diseases. (Government of India, 2021).

The Caste system has been structured by Indian Society for centuries. It produces the pattern of exclusion and disadvantages. (Desai & Dubey, 2012). SC and ST populations have historically faced to access to education, land, empowerment which has converted into huge poverty and poor living standard. (Thorat & Newman, 2010). These

structural disadvantages operate main causes of ill health by also having limited opportunities for healthy and good quality of life with time to time of getting medical care (Link & Phelan, 1995).

Gender based discrimination is also one big challenge and it also having caste-based disadvantages. Since India has history of Women who always faces discrimination in all aspect such as caste, class, education, decision making healthcare (Kabeer, 2005). SC and ST women face a double burden from both side such as caste and gender. As India is patriarchy society, it main results about maternal mobility, and also impact on reproductive health problems (IIPS and ICF, 2021) there are evidence from studies observed that women from marginalized social groups are mainly having less to access to antenatal care, institutional delivery and postnatal services as compared another social advantaged group. (Baru et al., 2010).

Income inequality is one of the critical components which shapes to health disparities. Those households include low socio-economic condition, they restrict to secure nutritional food, safe housing, clean water and healthcare services. (Sen, 1999). SC and ST community are always

known as a lowest wealth household which is making them vulnerable to poor health services. (Deshpande, 2011). Low income interacts with caste and gender to produce large disadvantages across the life course. (Marmot, 2015).

Maharashtra is developed state in India. But even it indicates as contradictory context. It is one of the most industrialized and economically advance state. It also displays wide intra-state health disparities in various district of Maharashtra. (Government of Maharashtra, 2022).

Tribal district like Gadchiroli, Nandurbar and Palghar consistency having record and report of poorer maternal health and child health indicator than the other state average (IIPS & ICF, 2021). Urban SC population residing in informal settlements and living in poor slums areas. They also experience several health issues due to poorer sanitation, insecure livelihood, and unsafe health and hygiene in slum areas. (Patel et al., 2014).

This study investigates social inequalities and health disparities among SC and ST population in Maharashtra through a gender and income perspective. This study helps to apply an intersectional and social determinant of health framework; it can be generating a proof that can be useful equal health care planning and inclusion health care policy.

Conceptual and Theoretical Framework

The Present study mainly focuses on social determinant of Health (SDH) framework. Which mainly points that health is structure by the social economic and political condition in where people live (World Health Organization, 2010). As per this framework, structural determinant such as socio-economic background caste and gender which directly impact psycho-social factor, health related behaviour and

access of health care services. (Solar & Irwin, 2010).

These aspect of fundamental causes of disease provides further insight into continuous health inequalities. Link and Phelan (1995) states that social factors such as poverty and social exclusion are highly connected with health outcomes even specific risk factor change. This Context is mainly connected to caste-based inequalities in India, where discrimination and exclusion continue to structure health outcomes despite improvements in medical technology and service availability.

This study mainly highlights about intersectional approach. This Intersectionality approach developed by Kimberlé Crenshaw, how multiple systems of oppression comes together to produce unique forms of disparities and disadvantages (Crenshaw, 1991).

As per perspectives of India, caste gender and class creates differential platform to health risk and unequal access to healthcare services. (Kapilashrami & Huncovsky, 2018).

An intersectional lens moves beyond single-axis analyses and enables a more nuanced understanding of health inequalities among SC and ST women from low-income households.

By integrating the SDH framework, the concept of fundamental causes, and intersectionality theory, this study conceptualizes health disparities as the product of interlocking social, economic, and structural forces. This integrated framework guides the selection of variables, interpretation of findings, and formulation of policy recommendations

Review of Literature

A substantial body of literature documents persistent caste-based disparities in health outcomes in India. Analysis of National Family Health Survey data consistently shows higher prevalence of undernutrition, anemia, infant mortality, and maternal mortality among SC and ST populations compared to other social groups (IIPS & ICF, 2021). These disparities remain significant even after controlling for socioeconomic variables, suggesting that caste operates as an independent determinant of health (Desai & Dubey, 2012).

According to large number of research, across India there are still caste-based discrimination and differences in access to health care services and health's outcomes. As compared to other socio-economic categories, SC and ST people have large amount of prevalence of undernutrition, anemia, infant mortality and maternal mortality (IIPS, and ICF, 2021). Even after adjusting for socioeconomic factors, these differences are still considerable indicating that caste is separate factor in determining health (Desai & Dubey, 2012).

A number of research emphasize how material deprivation influences the health outcomes of SC and ST communities. Marginalized social groups are more likely to experience food insecurity, poor housing, poor sanitation,

and contaminated drinking water, which increases their vulnerability to malnutrition and infectious diseases (Patel et al., 2014).

Because SC and ST workers are over-represented in low-wage, dangerous, and informal occupations, occupational patterns also increase health risks (Thorat & Newman, 2010).

There are noticeable gender differences in the SC and ST communities. Compared to men, women are more likely to suffer from dietary deficiencies and use healthcare services less frequently (Baru et al., 2010). Women's mobility and decision-making abilities are restricted by patriarchal standards, which makes it more difficult for them to seek prompt medical attention (Kabeer, 2005). For SC and ST women, health risks are further increased by early marriage and many pregnancies (IIPS & ICF, 2021).

One of the main factors influencing health inequalities is income inequality. According to Marmot (2015), health is a social gradient, with worse health outcomes being linked to each step down the socioeconomic ladder. In India, illness and death rates are much greater for those in the lowest wealth quintiles than for those in the wealthiest quintiles (Deshpande, 2011). While it does not entirely account for observed discrepancies, economic deprivation mediators a large portion of the caste-health association (Desai & Dubey, 2012).

Tribal districts in Maharashtra have serious health disadvantages, according to region-specific studies. Low use of mother and child health services is caused by a lack of skilled workers, a shortage of healthcare facilities, and challenging terrain (Government of Maharashtra, 2022). According to studies on urban poverty, SC people residing in slums have a high frequency of malnutrition and infectious diseases (Patel et al., 2014).

Materials and Methods

Research Design

The current study uses a descriptive and analytical research approach to investigate health disparities and social injustices among Maharashtra's Scheduled Tribes (ST) and Scheduled Castes (SC) from the perspectives of income and gender. Because it enables thorough examination of extensive population-level trends and makes cross-social comparisons easier, a secondary data-based approach was used (Bryman, 2016).

Data Sources

These secondary data included in the study came from a number of reliable sources. The National Family Health Survey (NFHS-5), which offers state- and nationally representative data on healthcare use, nutrition, and population health, serves as the main source (IIPS & ICF, 2021). Additional information was gathered from published peer-reviewed research articles, reports from the Maharashtra Public Health Department of the Government, and the Census of India.

Table 1: Underweight Children (%) by Social Group

Sr. No	Social Group	Percentage
1	SC	36
2	ST	38
3	Other	24

ST children show the highest prevalence of underweight, followed by SC children, indicating significant nutritional disadvantage (IIPS & ICF, 2021)

Table 2: Anemia among Women (15–49 years)

Sr. No	Social Group	Percentage
1	SC	58
2	ST	62
3	Other	45

ST children show the highest prevalence of underweight, followed by SC children, indicating significant nutritional disadvantage (IIPS & ICF, 2021).

Table 3: Institutional Delivery (%)

Sr. No	Social Group	Percentage
1	SC	79
2	ST	72
3	Other	90

Lower institutional delivery among ST women highlights access barrier

Table 4: Health Status by Income Group

Income Group	Poor Health (%)
Low	41
Middle	28
High	17

Poor health is concentrated among low-income households.

Table 5: Antenatal Care (4+ visits) (%)

Sr No	Social group	Percentage
1.	SC	51
2.	ST	46
3.	Other	67

Low Antenatal Care within SC and ST community

Study Area

Maharashtra was chosen because of its significant intra-state differences in health metrics, economic diversity, and sizable SC and ST population. It has been determined that tribal areas like Gadchiroli, Nandurbar, and Palghar are especially underprivileged in terms of health outcomes and infrastructure (Government of Maharashtra, 2022).

Table 6: Logistic Regression Predicting Anemia among Women (15–49 years)

Predictor Variable	β Coefficient	Odds Ratio (OR)	Std. Error	p-value
Scheduled Caste (ref: Others)	0.41	1.51	0.08	0.000
Scheduled Tribe (ref: Others)	0.56	1.75	0.09	0.000
Female (ref: Male)	0.63	1.88	0.07	0.000
Low Income (ref: High)	0.72	2.05	0.10	0.000
Rural Residence	0.28	1.32	0.06	0.001
Constant	-1.36	—	0.21	0.000

Interpretation of Table 6

Table 7: Logistic Regression Predicting Institutional Delivery

Predictor Variable	β Coefficient	Odds Ratio (OR)	Std. Error	p-value
Scheduled Caste (ref: Others)	-0.38	0.68	0.09	0.000
Scheduled Tribe (ref: Others)	-0.61	0.54	0.10	0.000
Female Education (Primary+)	0.59	1.80	0.08	0.000
Low Income (ref: High)	-0.72	0.49	0.11	0.000
Rural Residence	-0.46	0.63	0.07	0.000
Constant	1.21	—	0.24	0.000

Variables and Measurement

Indicators of maternal health (antenatal care, institutional delivery), child health (immunization, infant mortality), morbidity patterns, nutritional status (underweight, anemia), and access to medical treatment are examples of dependent variables. Caste (SC, ST, others), gender (male, female), and income (wealth quintiles) are examples of independent variables.

Data Analysis

Patterns of inequality were examined using descriptive statistics like cross-tabulations and percentages. A comparative analysis was carried out between income, gender, and caste. The results were clearly presented using tables.

Observation/Results

The regression results show that caste, gender, and income significantly influence the likelihood of anemia among women. Belonging to Scheduled Caste increases the odds of anemia by 51%, while belonging to Scheduled Tribe increases the odds by 75% compared to women from other social groups. Being female is associated with 88% higher odds of anemia, indicating strong gendered nutritional disadvantage. Low-income women are more than twice as likely to be anaemic compared to women from high-income households. Rural residence also significantly increases anemia risk. These findings confirm that anemia is strongly shaped by intersecting social and economic disadvantages.

Scheduled Caste women have 32% lower odds and Scheduled Tribe women have 46% lower odds of

institutional delivery compared to women from other social groups. Low income reduces the likelihood of institutional delivery by 51%, while rural residence further decreases access. In contrast, women with at least primary education are 1.8 times more likely to have institutional delivery. These results demonstrate that socioeconomic disadvantage and geographic isolation remain major barriers to maternal healthcare utilization.

Multivariate regression analysis indicates that caste, gender, and income exert independent and statistically significant effects on health outcomes. Even after controlling for residence and education, SC and ST women remain at higher risk of anemia and lower utilization of institutional delivery services. Income emerges as one of the strongest predictors across models, highlighting the central role of economic deprivation in shaping health inequalities. The combined effects of caste, gender, and income reveal a pattern of intersectional disadvantage, where multiple forms of marginalization operate simultaneously to worsen health outcomes.

Policy Implications

- Strengthen primary healthcare infrastructure in tribal and rural areas.
- Expand nutrition supplementation and anemia control programs.
- Promote gender-sensitive healthcare services.
- Improve livelihood opportunities for SC and ST households.

Conclusion

Health disparities among SC and ST populations in

Maharashtra are deeply rooted in intersecting inequalities of caste, gender, and income. Addressing these disparities requires comprehensive, equity-oriented public health strategies that tackle social determinants of health and promote inclusive development.

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