SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF DALIT WOMEN IN TAMIL NADU

A Study Report
July 2021

RUWSEC

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Dr. P. Balasubramanian

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CommonHealth and RUWSEC Team

LIST OF ACRONYMS AND ABBREVIATIONS

BMI	Body Mass index
BPL	Below Poverty Line
C- Section	Caesarean Section
CommonHealth	Coalition for Reproductive Health and Safe Abortion
Cu-T	Copper-T
HCP	Healthcare Provider
HSC	Health Sub-Centre
ICDS	Integrated Child Development Scheme
IDI	In-Depth Interview
IIPS	International Institute for Population Sciences
IUD	Intrauterine Device
KII	Key Informant Interview
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
PCOD	Polycystic Ovarian Disease
PHC	Primary Health Centre
RUWSEC	Rural Women's Social Education Centre
SAHAJ	Society for Health Alternatives and Justice
SC	Scheduled Caste
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights

1. INTRODUCTION

1.1 Background

The health and well-being of women are predominantly determined by their social status, power, and privilege in access to resources and healthcare services. Studies in India have shown that women's autonomy, decision-making power, socio-economic status, poverty, and gender-based violence against women are strongly correlated with their health, especially reproductive health (Bloom, Wypij, and Das Gupta 2001; Das Gupta 1987; Sundari Ravindran 1995; Yadav et al 2019).

It has been well established that in India, there are marked inequities in access to resources to enjoy good health and in access to and utilisation of sexual and reproductive health (SRH) services by women from economically weaker and socially deprived sections (Dilip 2002; Duggal 2008; Kavitha and Audinarayana 1997; Krishnamoorthy 2004; Ramachandran and Ravishankar 2004; Sivakami and Kulkarni 2003; Sundari Ravindran, Balasubramanian, and Mini 2014). Due to their poor socio-economic conditions, Dalit women, who are on the lower rungs in the caste hierarchy, often tend to postpone seeking healthcare and visit healthcare facilities only when experiencing severe health problems. According to the National Family Health Survey (International Institute for Population Sciences [IIPS] and International Classification of Functioning [ICF] 2017), 70.4 per cent of Dalit women in India reported that they had problems in accessing healthcare services. Discrimination against Dalit women by healthcare facilities and healthcare providers has been reported by many studies from India (Chidambaram 2018; Subramaniam 2018).

Dalit women in India experience discrimination at many levels and face multiple deprivations and violations of human rights all through their lives, starting from their childhood. Dalit girls have limited opportunities to get education, and only a few of them complete their school education. Consequently, their economic empowerment and autonomy are constrained. Dalit women score worse than Dalit men and non-Dalit women in the human development index (Sabharwal and Sonalkar 2015). The multiple axes of disadvantages based on caste, class, and gender act together to deny Dalit women their sexual and reproductive rights (SRRs).

Only a very few studies in India have examined the multiple deprivations of Dalit women based on caste, class, gender, and educational level and how they affect their sexual and reproductive health and rights (SRHR). Fewer still look at how the multiple layers of disadvantages result in marginalised Dalit women being denied their rights to bodily integrity, autonomy, choice of sexual partners, and reproductive choices and decisions as well as control over their sexuality within marriage.

Against this backdrop, CommonHealth – a network advocating for reproductive rights and safe abortion in India – conducted a qualitative research study in collaboration with eight partners from different states to document the reproductive life histories of women and young people from marginalised sections of the population. Of the eight partners, Rural Women's Social Education Centre (RUWSEC) carried out a study on the SRHR issues of Dalit women in Tami Nadu.

1.2 Objectives and Methodology

The main aim of the research study described in this report is to document the SRHR issues of low-income Dalit women in Tamil Nadu and to understand how women's life circumstances, gendered realities, and interactions with the healthcare system influence their SRHR.

The specific objectives of the study are:

1) *To document Dalit women's experiences of SRHR at the household, community, and health system levels.*

2) *To examine the ways in which Dalit women's life circumstances as member of a marginalised population group and their gendered realities influence the protection or violation of their SRHR.*

3) *To document the enablers and barriers of Dalit women in access to sexual and reproductive health care services and also, to understand the health providers' perspectives and challenges in provision of SRH services to them.*

1.2.1 Conceptual Framework

The study tries to capture more than the salient sexual and reproductive events such as sexual debut, pregnancy, childbirth, abortion in women's lives. The aim is to understand the circumstances within which these events occurred and what transpired between two consecutive events, which may have influenced the event itself. The SRHR areas of focus in the study are *menarche, sexual initiation, and sexual lives including within marriage, contraceptive use, pregnancy and postnatal experiences, and sexual and reproductive morbidities.* We sought to examine how women's life circumstances and gendered realities as well as their interactions with health systems impacted their choices and decisions along their sexual and reproductive pathways and their enjoyment of SRRs.

Figure 1 attempts to capture some key concepts that are central to this study. This conceptual framework was developed for examining the results of all the studies carried out under this project, which took place in different settings within India and among different marginalised population groups. It, therefore, includes the setting of government policies relating to women's health and the larger sociocultural context. In our study, the main axes of analysis have been how various social determinants like age, gender, class, caste, social status, and related vulnerabilities determine or influence women's health and how women adapt, negotiate, and resist to get what they need, particularly in terms of reproductive health choices. However, the influences of the larger context of the study districts and states were also included in the analysis whenever they were associated with changes in gender roles and access to and control over resources.

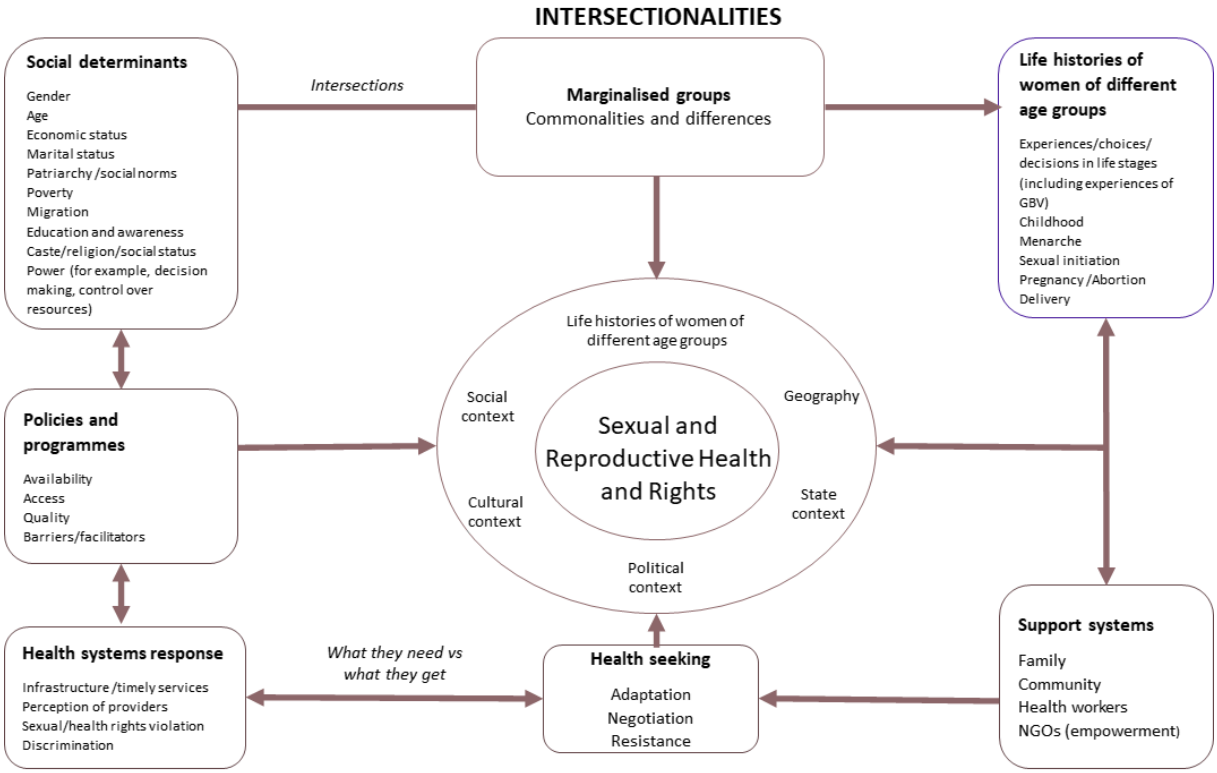

Figure 1 Conceptual framework

1.2.2 Study area

The study sample was drawn from the villages of Kancheepuram district[1] in north-east Tamil Nadu. Tamil Nadu is an Indian state with relatively good indicators of socio-economic development. The regional political parties that ruled the state for the last five decades have introduced innovative schemes to promote social justice and women's well-being. As a result of these initiatives, female literacy in the state has been rising over the years and many rural women have moved away from farm work to work in factories. Women's age of marriage has increased and the population of the state below poverty line (BPL) is low as compared with the national average.

Dalits accounted for 23.7 per cent of Kancheepuram district's population, slightly higher as compared to the state's average of 20 per cent (Census of India 2011). The district has witnessed rapid industrialisation and urbanisation during the last two decades. Kancheepuram district has a good health infrastructure. Eighty-four per cent of the villages in the district had a primary health centre (PHC) within a radius of 10 km. Nearly all PHCs are functioning on a 24X7 basis and have at least one lady medical officer. About 68 per cent of the villages had a health sub-centre (HSC) within a three-kilometre distance. Seventy-two per cent of the sub-centres had auxiliary nurse midwives (Government of India n.d.). As per the NFHS-4 survey of Kancheepuram district (IIPS and ICF 2017), almost all the deliveries were institutional and about two-third of the deliveries took place in government health facilities. The current contraceptive prevalence of Kancheepuram was high (62 per cent) as compared with the state average (53.3 per cent) (IIPS and ICF 2017).

1 On 29 November 2019, the district was bifurcated, and a new district named Chengalpattu was carved out of Kancheepuram. Our study villages fall within the newly formed Chengalpattu district, but data for this district are not available yet.

Dalit movements in Tamil Nadu have a long history, and the Kancheepuram district has witnessed the grassroots mobilisation of Dalits since the late 1970s. The National Adult Education Programme was implemented in Thirukazhukundram and Thirupporur taluks of the district during 1978–80 and worked exclusively in Dalit hamlets. Many Dalit women and men who were literacy teachers in this programme went on to take leadership in mobilising the community in many ways, and some of them are core members of the Dalit movement at present. There are several grassroots organisations in the district advocating for Dalit human rights and organising for restoring Panchami land[2] to Dalits, its rightful owners.

1.2.3 Methods and tools

The field study in the form of an in-depth interview (IDI) was carried out to document the lived realities of women. In total, we proposed to conduct 12 IDI with Dalit women: six each from Paraiyars and "non-Paraiyars" sub-caste category. But due to COVID-19 and time constraints, we were able to complete 11 case histories. To get the perspective of men on Dalit women's reproductive health status, short interviews with two men were also done. We also interviewed seven front line health workers. The IDI guidelines tools were translated into the local language (Tamil) and used.

1.2.4 Study sample

The Dalit women respondents were selected from among unmarried women and young and older married women based on their willingness to share their life stories. A list of women who were willing to participate in the study was put together by several community health workers of the RUWSEC. The field investigators team of six approached each respondent and briefed them about the study and asked for their consent. In all, 11 of 27 women and seven of 12 providers consented and could manage the time to participate in the study.

1.2.5 Data collection

Data was collected by six community health workers of the RUWSEC who had 7–25 years of experience in conducting in-depth interviews and focus group discussions. As workers drawn from the local communities who provided basic SRH information and services, the field investigation team was also familiar with local realities. So that respondents would not fear a breach of confidentiality, none of the field investigators carried out interviews in their villages of residence. Each participant was interviewed for more than one round and the duration of the interview ranged between three and eight hours. Almost all the participants except two providers were interviewed at their residences.

2 Panchami land is the assigned land that was distributed to Dalits in Tamil Nadu during the British rule in 1892. It is also called Depressed Class (DC) land. It can neither be sold nor reclassified, but over the years, it was occupied by non-Dalits and illegally transferred to others.

1.2.6 Analysis

Once the interview was completed, the researchers then transcribed it into Tamil. The handwritten copies of individual transcripts run from 70 to 200 pages. Using the standard coding framework developed by the CommonHealth team, a thematic coding of each transcript was done after multiple readings of the transcripts by two researchers. The first level of coding contained main life events according to the interview tool (background, childhood, education, work and employment, puberty, romantic relationships, marriage, first sexual experience, healthcare related to SRH, etc.). The second level of coding identified gender-based discrimination and violation of SRRs, with sub-codes indicating domains such as availability or denial of life opportunities (schooling, higher education, paid employment), SRHR details, sexual and reproductive decision-making, experience of gender-based violence, enjoyment or denial of the right to sexual and reproductive healthcare and resistance and resilience. The preliminary report was shared with the RUWSEC's staff and community health workers to validate the results and get their inputs for refining interpretations.

1.2.7 Ethical issues

The study protocol was reviewed and approved by the SAHAJ institutional ethics committee. Written informed consent was obtained from all the participants and the whole discussion was audio recorded. The field data collection was completed in March 2020. Both transcripts and audio files were stored safely without any personal identities and a soft copy of the files was also protected with a password lock.

1.2.8 Limitations of the study

This is a qualitative study done with a small sample of respondents in a limited geographical area. We tried to interview doctors in the public sector, but we did not get government permission to interview them. Therefore, the views of only frontline health workers were captured and included in the report. While this limits the generalisability of the results to non-marginalised populations, it provides rich insights into the multiple layers of deprivation that influence Dalit women's ability to access SRHR.

2. FINDINGS FROM THE FIELD STUDY

2.1 Demographic and socio-economic characteristics of the respondents

Six of the 11 respondents were women below 30 years old, four were between 31 and 49 years old and one was 54 years old. One of the women had a physical disability. Ten of them were married, of whom six were currently living with their husbands. Four women had no children, four had one or two living children, and two had three or four children. The only unmarried woman in the sample reported during the key informant interview (KII) that she was set to be married soon.

Seven of the 11 respondents were Hindus and four were Christians. All women belonged to Dalit castes. Six respondents belonged to the Paraiyar[3] sub-caste and five others belonged to further marginalised Dalit sub-castes: Arunthathiyar[4] and Vettiyan.[5]

All the respondents were from BPL households. All but one woman had a formal education and nine of the 10 women had completed 10–12 years of schooling. All except one, the unmarried woman, were engaged in remunerative employment as casual workers in factories in the sub-district but only one had a salaried job in the garment industry.

As students, most of the respondents got free educational materials, free textbooks, school uniforms, and midday meals. All respondents possessed the Chief Minister's Comprehensive Health Insurance Scheme card[6] that would allow household members to avail cash-free secondary and tertiary healthcare. Three respondents out of 11 had received the state government's financial support to construct a house and two had received bank loans through a self-help group to buy cattle.

Five of the seven healthcare providers interviewed were nurses and two others were Anganwadi (Integrated Child Development Scheme) workers. Three out of five nurses who participated in the study were working in the private sector. Among the nurses, those working in the public sector had more than 15 years of experience and the others had five-to-seven years of working experience.

3 The name "Paraiyar" is said to be derived from Tamil word for drum, which indicates their traditional occupation as musicians as well as settled cultivators and agricultural labourers. There comprise the majority in terms of Dalit population in Tamil Nadu.

4 "Arunthathiyar" is the lowest of the three main Dalit sub-castes in the state. They are traditionally landless and work with leather. The community is also known by the names "Chakkiliyars" and "Maadari". In the study area, there are only a small number of households who belong to this sub-caste.

5 "Vetiyan" is also minority in terms of population, and in every village, there are only a very few households that belong to this sub-caste. Traditionally, its members play drums during death rituals, prepare for the burial of dead bodies, and were in charge of burial grounds.

6 Chief Minister's Comprehensive Health Insurance Scheme is a Tamil Nadu state government flagship programme. In collaboration with a public-sector insurance company, the scheme provides quality in-patient healthcare to eligible persons through empanelled government and private hospitals and reduces the financial hardship for the enrolled families. The scheme provides coverage up to Rs 5 lakh per family per year for meeting all expenses relating to hospitalisation of the beneficiary. All BPL families in the state are provided a family card to avail the scheme.

3. GENDER, SOCIAL VULNERABILITIES, AND SRHR

3.1 Growing up poor, Dalit, and female

Almost all participants mentioned that their parents were poor, landless wage labourers in farming and non-farming sectors. About half of the respondents reported suffering from constant ill-health during their childhood. Most of the respondents reported being underweight, suffering from anaemia, and having irregular menstrual cycles in their adolescence. Possibly these could be due to family poverty and resulted poor nutritional status in their young age.

Caste-related problems and discrimination in schools and communities were mentioned by a few participants. Discrimination based on sub-caste was also reported. For instance, a twenty four years old disabled woman from the Vettiyan caste group said:

> My [fellow] villagers said we are the lowest among Dalit sub-castes. Both Naickers [non-Dalit] and Paraiyars [Dalit] would speak ill of us and mock us. At many instances, they would giggle at us, saying, "You are a Vettiyan." I experienced … inhumane behaviour. They also don't drink water from our houses. (TNDW05)

All but one – the oldest respondent – had been enrolled in school and had high-school education. Respondents described school life and friendships in childhood and adolescence as the happiest and most memorable part of their lives. Poverty meant that some of them had to stop schooling before or just after completing Grades 10 or 12 to start working at nearby factories. Higher education or vocational training were beyond their means.

None of the women remembered being treated any differently for being a girl in their childhood. However, once they attained puberty, their parents imposed various restrictions on the way they dressed, their mobility, and their relationship with the opposite sex. The most important advice was to be careful with boys and not to bring dishonour or shame to the family.

Most of the participants (eight out of 11) reported having experienced love and romantic relationships in their adolescent years but tried to maintain secrecy around it. As described in a later section, gossip in the community of a girl being "in love" with a boy often had far-reaching consequences. Family members reacted by immediately arranging the girl's marriage with another man, even taking them out of school in some instances, for the sake of family honour.

Once married, the woman is expected to obey and comply with the wishes of her husband and his family, even when faced with abuse and violence.

3.2 Gender, sexual, and reproductive rights

This section explores how gender-role socialisation and gender-based inequalities result in the denial of SRRs to Dalit women all through their reproductive lives. A detailed description of SRR violation at different life stages of the women are presented below under various heads.

3.2.1 Lack of information on SRH

Almost all women who participated in the study mentioned that they did not have any SRH information before they attained menarche or got married. Most of the respondents (10 out of 11) did not have any prior knowledge about menstruation before they attained menarche. Majority of the participants tried to hide it from their family members, believing that something abnormal happened to them. A respondent who had three elder sisters reported:

I attained menarche at the age of 12 years. I thought I had got hurt and was bleeding because of it as when I was young, all girls in my village used to go to a big well. I used to climb the well and keep jump into it. There were stones and rocks [embedded] in the well's sidewalls. As there was blood on my skirt, I thought I might have sustained an internal injury while jumping into the well... When I told my mother, she smiled and told me to remain silent and that it is happy news. (TNDW11)

Information on female sexuality was hard to come by, and what the women learnt was to fear sex and to avoid interactions with the opposite sex so that nothing "dishonourable" (premarital sex) would occur. Poor knowledge about conception and contraception was also reported by all women. It appears that poor knowledge about conception is one of the important factors for unwed pregnancies among women. Three women were pregnant before marriage, but none of them knew that sexual intercourse could lead to conception. A 34 year old women whose husband was already married but she did not know when she loved him, but she knew it only a day before her marriage and she was helpless

At that age, I did not know anything about sex or conception. I did not even know that the absence of menstruation is a symptom of conception. Only after six months did we [she and her partner] go to the hospital for my fever. They took blood tests, and I asked him why. He pacified me that it was for fever, but later, the doctor told me that I was pregnant. If I knew all these matters [about how pregnancy happens and how contraception can prevent it] at that time, I could have avoided conceiving. (-TNDW04)

3.2.2 Strict control over women's sexuality and early/forced marriages

Social norms prohibit sexual relationships outside marriage, and interactions between adolescent girls and adolescent boys or men are sought to be controlled. Girls are expected to be virgins at the time of marriage. However,

there are many more opportunities for boys and girls to interact in present times, at schools and at workplaces. But girls and women have to be very careful that their "name" is not "tarnished". At instances where the community starts gossiping about the girl having an "affair" – usually no more than flirtation, not involving sexual interaction – the girl or woman pays a punitive price. A young woman of 22 years old who got married at the age of 17 and divorced within three years said

I wanted to become a teacher, but I was unable to go for higher studies. My father told me that we were constructing a house and he could not support my higher education. In reality, it was because I loved a boy in my village. On hearing about it, my parents arranged my marriage with another boy, and I was forced to marry the person of their choice. After marriage, I joined a company for work and lost interest in studies. -TNDW03)

When and whom to marry is an important aspect of women's SRRs. Although the legal age at marriage of girls in India is 18 years, about half of the married respondents (five out of 10) in the study got married when they were below the legal age, which makes them more vulnerable to SRH risks and rights violations.

It is reported in the interviews that in most instances of arranged marriages, a woman's consent is rarely asked for. In four out of five arranged marriages of women in this study, their consent was not taken. In three of these instances, the marriage was forced. As mentioned earlier, the reason was that the young women had been discovered by their parents to be "friendly" with a boy.

About half of the respondents had gone through "love" marriages. Three of the five "love" marriages may also be considered as "forced" because the women were forced to marry after becoming pregnant before marriage. All three had married in haste so that they would not be unwed mothers, a state considered to be worse than death in the Tamil culture. A 34-year-old woman who was living alone with her daughter and working in a factory reported:

He was already married, and I did not know about it at all during my relationship with him. He had completely hidden that information from me. I knew it only after I conceived. As I was pregnant, I could not do anything, and my family members arranged for marriage with him. (TNDW04)

3.2.3 Intimate-partner violence

Being poor and unemployed, almost all participants had faced one or the other form of control by their husbands over their autonomy and mobility. Irrespective of whether they had an arranged or a "love" marriage, women reported encountering all types of violence: physical, psychological, and sexual. Psychological violence permeates many women's lives. Insufficient dowry, "suspicion" (of the wife's fidelity) on the part of the husband, and the husband's alcoholism are the main underlying reasons for psychological violence.

All participants experienced physical violence by their intimate partners at some point in their lives. For two respondents, it was a one-time event and for the rest, it was a regular occurrence. Four married women had encountered extreme forms of physical violence. A 40-year-old woman with two adolescent children said:

One day, he asked me to get more money from my natal family. I said no and asked if it was for his extra-marital relationships. He was drunk and closed the front door and beat me severely, took the tube-light bulb and injured my face and eyes; he kicked me heavily in the stomach. I collapsed. I shouted for help and my son broke the door and saved me. After that incident, I was hospitalised for months, and I am still suffering from many health problems. (TNDW09)

Non-consensual sex was also a common experience for all women. Women who had engaged in sex before marriage with a person they were attracted to said that they did not have consensual sex and did not know much about what was happening. All the married women except one had faced non-consensual sex within their marriages. Most of the respondents said it was a routine aspect of their lives. It seems that many married men think "after all, she is my wife" and there is no need to ask her consent for sex.

We have only one room in the house. I have told him many times that there are children at home and looking at us being together may have a negative impact on their lives. He never listens to my words and argues with me, saying "Women will say such things, but men cannot control their desires. When they get an erection, they need to have a sexual relationship." He also says that the wife should agree to it when a husband asks. He is married to me, and it is his right as a husband who has tied my "thali" [symbol of marriage]. (TNDW12)

The narratives of the women depict that violence is used as a weapon by men to reinforce patriarchal values and gender norms. It is observed that women with disabilities and ones who are marginalised in other ways are facing extreme forms of gender-based violence. While exploring the causes of these extreme forms of violence, gendered power relations, social norms, suspicion, and alcoholism are found to be significant. Men's extra-marital sexual relations and excessive sexual desire also seem to be an important factor for intimate-partner violence

3.2.4 Sexual harassment

Sexual violence outside the home is also reported by a few participants. Two participants faced it before marriage and the other two women encountered it after marriage. It is also found that survivors of domestic violence are more susceptible to sexual harassment by men in the community. This is a very sad part of their lives.

Whenever my husband quarrelled with me in a drunken state, he would to say, "You are a sick person and not suitable for sex. That is why I have been avoiding you and search for other women." On overhearing it, a man in my village one day asked me, "It seems that you have not have penetrative sex with your husband and that is why your body is very weak. Can we have it now?" I got very angry and shouted at him .... Because of my husband's irresponsible talk, this fellow approached me. (TNDW09)

3.2.5 Reproductive rights

Women's freedom and autonomy in decision-making about whether, when, and how many children to have is a part of their reproductive rights and key to their reproductive health. Most women in the study were deprived of these rights. All the participants who had one or more children (five out of 10)[7] tried to limit their family size, but their husbands and in-laws controlled those decisions.

I delivered a girl in the government hospital. When I was in the hospital, they asked me to have female sterilisation operation but my husband did not agree to it. He strictly told me that if I had the operation, I should go and stay with my mother and need not come back to him. (TNDW07)

Men's involvement in taking contraceptive measures is very low. None of the respondents reported that their husbands took any initiatives to use contraceptives to space or limit births. Consequently, they encountered unwanted pregnancies and abortions. More details on these are presented in the next section.

Again, it is apparent from the study that the health system is also contributing to the violation of women's reproductive rights. The target-free approach in contraception was introduced in Tamil Nadu in the year 1998, but even now it seems that there are indirect targets in the public sector for specific methods. There is strong pressure for married women to use Copper-T (Cu-T).[8] Some of the women who participated in the study, mostly the frontline health workers, reported that Cu-T is inserted immediately after childbirth without women's knowledge and consent in the government facilities quite commonly. A nurse working in the public sector said:

In our PHC, we put Cu-T after delivery. Only when we update the information in the online portal will she get Rs 2,000.[9] This is only for Cu-T but not Chaya, Anthara, or any other contraceptive device. (TNPRO1)

7 Of the ten married women, one got divorced within a few months of marriage and four do not have children.

8 Copper-T is a contraceptive, intrauterine device used for birth control.

9 Tamil Nadu has a maternity benefit scheme (conditional cash transfer) of cash incentive of Rs 18,000 for poor women. It is given in six instalments: three before delivery, two after delivery and the last when the child gets vaccinated. The Rs 2,000 referred to here is the final instalment of the maternity benefit scheme.

3.3 Gender, sexual, and reproductive health

This section discusses the SRH status of Dalit women and their interactions with the health system. Due to poverty and poor nutritional status in their childhood period, the general health status of the Dalit women was poor. Unequal gender relations within marriage and the denial of SRRs at many levels accentuate their frailty and contribute to poor SRH status.

3.3.1 Pregnancy

The results show that pregnancy was a difficult experience for many women. As mentioned earlier, three women had become pregnant before marriage. Two of them were not even aware of their conception because, at a young age, they had anaemia and an irregular menstrual cycle, so they did not find it suspicious that they had missed their menstrual cycles.

Even when the pregnancy was desired and planned, the women often did not have the support they needed and sought. A young woman who worked at a company reported:

> I had suffered a lot during pregnancies. I used to spend long hours in the van commuting for work and the nature of my job involves sitting the whole day. On night shifts, I returned home after midnight and my legs would be swollen. On day shifts, I had to be ready at 6 a.m. Even though I woke up early, my mother-in-law would scold me for not doing household work. (TNDW08)

3.3.2 Miscarriages, stillbirth, and abortion

Intimate-partner violence appears to have increased the risk of frequent pregnancies, miscarriages, abortions, stillbirths, and other gynaecological problems. This is seen in the case of the woman living with a disability, who experienced extreme physical violence by her husband and sister-in-law. Consequently, she had a miscarriage and stillbirth.

> My brother-in-law's wife took one of my gold ornaments and pawned it. When I asked her to return it, she beat me very badly. She pulled my hair and hit me in the abdomen. I was eight-months pregnant. Following the incident, I had a stillbirth. Once again, in my fourth pregnancy, my husband kicked me severely in my abdomen as I had not cooked food on time and that pregnancy ended in a miscarriage. (TNDW05)

Due to non-consensual sex, sexual violence, and husbands not permitting the women to use contraceptives, few other women encountered unwanted pregnancies and repeated abortions. A 32-year-old woman with three children, who had had two abortions, said:

My husband's blood group was O+ and mine was B-, and the doctor asked me to get sterilised after having one child.[10] But he [her husband] did not allow me to go for it, saying that we will have as many children as possible. Then I had two more children and two abortions. Only then was I able to get sterilised. (TNDW12)

3.3.3 Delivery complications

A few women experienced delivery complications that led to forceps delivery and C- sections. Four participants also reported that they experienced postpartum depression and stress due to their husbands' extra-marital relations. The following narrative exhibits the mental agony of a woman who had had a love marriage:

I was under severe stress during the first pregnancy [premarital conception] as he had completely hidden his first marriage from me and got me pregnant. Immediately after delivery, when they showed me my baby, I was shocked to see her. Her face and mouth were not normal [cleft palate]. I fainted and developed severe depression. (TNDW04)

The study suggests that although a preference for sons had not been an issue among the Dalit community in the area for the past three or four decades, it is now emerging. Three respondents reported that their husbands and/or in-laws had a strong preference for sons.

Immediately after delivery, I asked the doctor whether the baby was a boy or a girl. They said it was a boy baby, and then I could relax. My husband and mother-in-law had told me directly that if it was a girl, they would leave me and go home. (TNDW07)

3.3.4 Gynaecological morbidities

None of the respondents aged 25 years or less reported any gynaecological morbidities. However, four out of five participants aged over 25 years had gynaecological problems. Menstrual problems and polycystic ovarian disease (PCOD) were reported.

One respondent had uterine cancer and another one had tumours in her breast. Of these, one was also childless. Both women had lived with many years of intimate-partner violence. One of them had suffered three miscarriages and had been raped by her husband soon after she had undergone dilation and curettage.

I can surely say that it was because of his excessive and forceful sex and continued miscarriages that I had uterine cancer and hysterectomy. I have no words to express my pain and miseries. (TNDW11)

10 When a woman has a negative blood group and husband a positive blood group, the second baby may have complications because of the mis-match in the parents' blood groups and hence the doctor suggested...

As a result of poor menstrual hygiene and not taking any treatment for gynaecological illness (especially PCOD), childlessness is an emerging issue in rural areas. A frontline health worker said:

> In every village, we can see five-to-six childless couples. (TNPRO5)

In the study, there were four childless respondents and in all the cases women are blamed for it. A 35-year-old woman described the societal pressure that she had to face due to childlessness:

> A few of his [her husband's] relatives say That if one buys a cow, one will get milk from it, but nothing beneficial has come from him marrying me. I have also overheard the talks of some other people that, he [my husband] has built a large house in the village but there is not even one successor to it. A few have advised us that instead of building a concrete house, we should have spent one or two lakhs and got a test-tube baby. (TNDW10)

3.3.5 Interactions with the healthcare system

This sub-section examines how the healthcare system is contributing to improving or worsening Dalit women's reproductive health and rights. The state has good public health infrastructural facilities, and it is the main source of poor Dalit women's maternal healthcare needs (antenatal care, delivery care, and contraceptive services). However, there are problems in access to abortion and other gynaecological services by poor women.

1) Access to maternal healthcare services: Almost all women who had children (five out of six) used public-sector delivery-care services. It seems that many women choose public facilities for delivery because of the high cost of delivery care in the private sector and to avail the maternity benefit schemes. A healthcare provider said:

> For a regular delivery, Rs 30,000 is charged in the private sector, and the woman is asked to stay in the hospital for two to four days. For C-section, Rs 70,000 is charged, and the women are asked to stay in the hospital and observed from one week to 10 days. (TNPRO6)

Women also mostly used public health facilities for contraceptive services. All four participants who used contraception had accessed them through government hospital.

Disrespect and abuse during child delivery were reported not only by women who had used the government health facility but also users of private facilities. One woman, who delivered her child in a private hospital, said:

> The birth was difficult as the vaginal canal did not open to make way for the baby. During the delivery, the healthcare providers abused me very badly, both verbally and physically. They shouted at me, "Did you have sex with your husband after becoming pregnant?" They beat me. (TNDW09)

Some women seeking contraceptive services in government facilities experienced denial or delays. A respondent who had a bad experience using the public facility for delivery care reported that she was asked to come for repeated visits for her sterilisation without being given any interim contraceptive options. This resulted in an unwanted third pregnancy.

Coercion to use Cu-T is commonly reported by women. Majority of the married women and the frontline health workers who participated in the study reported that in the government facilities, Cu-T is inserted immediately after childbirth, with or without women's consent. A woman shared:

> My sister-in-law had delivered a girl in the government hospital. At that time, without informing her, the staff had inserted a Cu-T. When her child was four years old, she started to wonder why she did not conceive again, and she started to get pains in the upper abdomen. She then went to the government hospital for a check-up and there they asked her to get a scan done. After seeing the scan report, the doctor informed her that there was a Cu-T in her uterus, and it was then removed. (TNDW12)

2) Abortion services: Abortion services were not available at PHCs or nearby secondary hospitals and was provided only in the government medical college hospital. This information emerged from interviews with healthcare providers. A nurse who worked at a PHC said:

> I do not know whether abortion services are available in the nearby taluk [sub-district] hospital but at Government Chengalpattu Medical College and Hospital, they do it for both married and unmarried people. (TNPRO2)

Stigma and discrimination in accessing abortion services are commonly reported. The limited availability of safe abortion services at public facilities forces many women to seek them at private hospitals and spend heavily. Some participants also reported that in recent times, self-medication through pills for abortion is happening in the region. A local non-governmental organisation (NGO) clinic also provided medical abortion services to villages in its vicinity.

> I decided to abort my third pregnancy, so I went all alone and had the abortion in RUWSEC hospital. It was through medicines, and I did not stay there. The cost was not much but I don't remember it exactly as it was done four–five years ago. (TNDW07)

3) Other gynaecological services: For other gynaecological problems including breast tumour, uterine/cervical cancer, infertility, and PCOD, our respondents had to use only private hospitals. Of the four women without children, two had not sought any treatment, while two participants had sought treatment from many private facilities, ranging from small clinics to big corporate hospitals. Both had incurred heavy out-of-pocket expenditure for it.

> I had visited many places and, say, seven-to-eight private doctors. In the first round, we spent Rs 3–3.5 lakh, and if we combined all expenses, it would come to around Rs 5 lakh. (TNDW10)

The non-availability of infertility treatment services in public health facilities is of great concern. Both in the interviews with women and HCPs, it is reported that infertility treatment services are not even available in government hospitals.

The woman with cervical cancer has social and economic support from her natal family, and also owned some assets given to her at the time of her marriage. She sought treatment, including chemotherapy, from private corporate hospitals in Chennai. Luckily her husband was a central government staff and hence her medical charges were met out by the government which came around rupees 6.3 lakhs. As she was unable to walk, they took a private taxi to visit the hospital for chemotherapy. The travel expense alone for her was about one lakh rupees.

3.4 Resistance and resilience

This section examines how Dalit women are resisting and coping with their lives' miseries and various forms of domestic violence. It is evident that Dalit women started challenging the sociocultural norms that affect their lives. A few overcame the situation and others are challenging, rebelling, and living with the situation. There were reports of women challenging myths around menstruation, caste discrimination, dowry, and domestic violence. An 18-year-old unmarried girl said:

My mother used to tell me that during menses, I should not go near the puja room, where they kept the gods' photos at home. I told my mother that there are many goddesses in the puja room, and they too are women. I asked her to not restrict my entry into the puja room during menstruation. She still tells me about superstitions and belief systems, but I do not bother. (TNDW01)

Women rebelled against, fought, and challenged men when they faced sexual and physical violence from their husbands. The study participants disapproved of intimate-partner violence that they faced. They repeatedly used the word "torture" when they spoke about their husbands' physical, sexual, or even psychological violence. Women have also started to define what is acceptable and what should be resisted. A 54-year-old woman who had been associated with the RUWSEC for a long time reported that it has been a great source of inspiration for her and has promoted her self-confidence and leadership skills. These have helped her to overcome difficulties in her personal life and serve society.

I had faced extreme distress as I had no child and my husband forced me to agree to his second marriage. I finally gave my consent for it. He kept torturing me even after his second marriage. Then I told him I that as I had arranged for his second marriage, he did not have any right to torture me again and had to leave me alone. Then he and his second wife started to lead a separate family life. After that, I thought that as there is no husband for me, why should I wear this Thali Kayaru [a symbol of marriage]? So, I removed it. Once, my fellow villagers asked me why I did so. I replied, "There is supposed to be a respect for that thread, and after losing the respect, I did not want to wear that plain thread in my neck. So, I removed it." (TNDW11)

Despite all these miseries and intolerable violence, some Dalit women continue to live with their husbands for their children's future. None of the victims of domestic violence either reported it to the police or sought any external help for dealing with the violence. The two women – one who had an external and internal physical injury and the other who had attempted self-immolation – had not revealed the truth behind their injuries to the healthcare providers when they asked for details. Both tried to protect their husbands by saying that it was an accident. It is also observed that the prevailing patriarchal and societal norms prohibit women to seek support services. A private-sector nurse said:

Recently, I was counselling a woman who had experienced sexual and physical violence. I asked her if she could give her parents' or relatives' phone number or if we should make a police complaint on her behalf. The lady said, "No Sister, even if I suffer a lot, I don't want to punish or shame him." (TNPRO5)

This was a situation where social norms controlled women to neither report their issues nor seek any support services. Some women were able to come out of their abusive relationships when they faced extreme forms of violence. They decided to either live in permanent separation or get divorced. A young respondent said that her husband was very suspicious and violent, so she decided to leave him and got a divorce.

He put a lot of restrictions on me when we went to any family event. I met lots of relatives and I wanted to chat with everyone, but I was not supposed to do so. I was not to talk to anyone and instead only be with him. I was not allowed to meet or talk to anyone. He kept on framing rules for me, and I did not like it at all. Even if I tried a new hairstyle, he would ask me why I was doing that or why I wore a salwar [Indian pants, considered "fashionable" in rural settings]. I was not supposed to do anything I liked. He did not even talk affectionately with me. Above all, he suspected my fidelity. So, I left him. (TNDW03)

Some women carried on with their lives hoping that their situation would change one day, that their husbands would change their behaviour and they would lead a happy life with their children and family. In many cases, women's natal family provided both psychological and financial support when the women encountered domestic violence. A woman who was in distress after she lost her son and her husband became more violent and an alcoholic expressed how she was recovering from that state.

After my son died in an accident, my husband became a drug addict. He quarrels with me regularly. There is no peace in my family. After the incident, I was in severe depression, and I did not speak to anyone for few months. Gradually, I started to go out. Last year, there was a woman's day meeting at the RUWSEC. Someone invited me saying they will provide food and travel expenses and prizes for those who win competitions. I enjoyed participating in various competitions and cultural shows. I won many prizes. I will not forget that event for the rest of my life. On that day, my husband returned home very late, say, around 10:30 p.m. I showed him all the prizes I won; he was happy and appreciated my talents. (TNDW08)

4. SUMMARY AND DISCUSSION

This qualitative study aimed to document the reproductive health histories of Dalit women in Tamil Nadu brings out how poverty, gender inequality, sexual norms, and domestic violence intersect and impact women's SRHR. The results of the study provide rich insights into the vulnerabilities of Dalit women that they experience in their life stages and how it affects their SRHR.

India has signed several international agreements and treaties to promote gender equality and protect the SRH rights of poor and marginalised women. The Sustainable Development Goals (2015) also stress the importance of promoting gender equality, health, and well-being of poor women. Following these global agreements, both central and state governments of India have come up with social welfare and health policies and programmes to promote the SRH of women and young people, especially those from poor and marginalised groups. There are several progressive Indian laws such as the Prohibition of Child Marriage Act , The Dowry Prevention Act, The Protection of women from Domestic Violence Act and the Medical Termination of Pregnancy Act, which are diluted at various stages of implementation. The field study findings indicate that these laws are not very helpful for poor Dalit women in protecting their SRR because of the strong gender and social norms that prevail.

Dalit movements in Tamil Nadu have a long history and, starting from the year 1991, there have been many progressive movements and organisations that emerged to promote and protect human rights. These developments have significantly contributed to increasing awareness among the Dalit groups about Dalit human rights and land rights. But there is a long way to go towards protecting and promoting the SRR of rural poor Dalit women.

4.1 Key findings from the study and reflections

Findings from our field study are similar to previous studies from Tamil Nadu in terms of nutritional status and low level of knowledge on reproductive health issues. Many studies indicate that low body mass index (BMI) and nutritional anaemia are very common among Dalit girls and women as compared to women from other castes (Bharathiraja and Hemalatha 2017; IIPS and ICF 2017; Jaiswal and Valarmathi 2015). Awareness about SRH among Dalit women is also very low. Even college-going Scheduled Caste (SC) girls were found to have poor knowledge about menarche and reproductive health. There were also many restrictions and taboos on menstruation (Ravishankar 2017).

The field study documenting the lived realities of Dalit women in rural Tamil Nadu provides a deep understanding of the facilitating factors and barriers in attaining SRH rights. The results also illustrate how the socio-economic forces like lack of male employment, presence of female employment, and consumerism impact Dalit women's SRHR. In a short interview with two men in the area and from our interactions with the RUWSEC's women community health workers, we found that women find employment in the factories relatively easily but the men do not. The job men find are casual or temporary, and so men get frustrated, probably because they cannot live up

to the gender norm of the male breadwinner. When the women go out for work, they have a chance to interact and develop friendships with men. They would talk over the phone with their male friends, but this made their husbands "suspicious". This contributed to increased instances of domestic violence in the family.

Decades of affirmative action combined with Dalit movements have resulted in improved education and better social status for the Dalit community in the region and enabled them to leverage opportunities provided by economic liberalisation. One offshoot of this is the consumerism among Dalit households that showcases their upward social mobility. Dalit parents spend beyond their means for their children's education, puberty ceremonies, dowry, and wedding expenses. Dowry among Dalit households in this district was unheard of even until the mid-1980s but is compulsory in the present times. Second, during the interaction with Dalit women leaders in the community that mobilisation of women into self-help groups has made access to loans for purchase of consumer goods easier for women. Many are unable to repay the loans with interest and borrow from private money-lending enterprises to repay them. This leads to chronic household indebtedness among many Dalit households, causing anxiety and contributing to cut-back on essentials, including food and healthcare.

The study brings out how gender discrimination has restricted women's participation in both public and private worlds and limited their economic independence. Once girls attained menarche, men in the households – fathers, uncles, and brothers – control their mobility and freedom. Young women are allowed to study and work but within the parameters dictated by the men in their households.

Social norms censure interactions between adolescent boys and girls and punish women who have sexual relationships or get pregnant before marriage. At the same time, many young girls now travel to nearby towns for higher secondary education, and work at factories post schooling, giving them opportunities to interact with men without the supervision and control of parents and relatives. But gender and sexual norms at the community level are highly skewed towards upholding patriarchal control over women's sexuality and reproduction. There are many instances of the community labelling all relationships between young men and women as "love". Once the young woman's family knows of her relationship, they force her into an arranged marriage with another man. Young people in love rarely get a chance to spend time together and get to know each other. These relationships are often secret encounters with varying degrees of physical intimacy. Young women get into these relationships without any information about their bodies, sexual relationships, or conception and contraception. Consequently, a few get pregnant and when they are unable to terminate it, getting married to the man is the only option to save the family honour, even in situations where the man is already married.

Generally marriages are arranged by parents and family elders, with or without the consent of the women concerned. They are meant to take place strictly within sub-castes, and marriages even across various Dalit sub-castes are frowned upon or even stopped through the threat of social sanctions against the families concerned

At the family level, male–female relationships are rarely cordial and affectionate. There is a lot of violence, control, anger, and disappointment. Violence within the family is about gender power dynamics. The power structure within the family normalises intimate-partner violence. When women are very poor and not employed in paid occupations, men control women's mobility and decision-making, including in all matters related to sexuality and reproduction

Women bear the burden of men's struggle to retain power and privilege by suffering violence and lack of respect and dignity. The study findings are similar to the findings in IIPS and IICF (2017): that almost in all Dalit women's lives physical and sexual violence is a regular event. A qualitative study done among Dalit couples in the region by the RUWSEC in the year 2002 also reported that non-consensual sex was the main underlying factor for unwanted pregnancies and abortions. It seems that there is not much of a change over the years in the prevalence of sexual violence, despite significant improvements in the education and employment of Dalit women in this area. The study also shows that sexual violence underlies the risk of frequent pregnancies, miscarriage, abortion, stillbirth, and other gynaecological illnesses.

Men do not take any initiative to use contraception to prevent pregnancies and often restrict women from using contraception. For many women, getting men's consent for sterilisation is only possible after a few unwanted pregnancies and abortions.

Poverty and powerlessness combine with poor SRH knowledge and intimate-partner violence to contribute to chequered reproductive histories and morbidities. Dalit women with multiple socio-economic deprivations, such as belonging to the lowest sub-caste, not working outside the home, disability, and no natal family support, could act as key factors factor for domestic violence and have poor SRH outcomes than the others.

Dalit women seek healthcare amidst these challenging circumstances. Unfortunately, poor quality of care, denial of essential reproductive health services in the public sector, and unaffordability of services in the private sector worsen their reproductive health and well-being. Disrespect and abuse in health facilities is a common experience for the women in this study. Some Dalit women and most frontline health workers who participated in the study reported that Cu-T is inserted immediately after childbirth, irrespective of women's consent. An ethnographic study done in 1995 among Dalit women in Chennai reported that as a part of target-oriented family planning policy, intrauterine device (IUD) insertion was done routinely in the maternity wards of government hospitals. There were instances of IUD insertion without women's consent, and this affects their social, psychological, and physical well-being (Van Hollen 1998).

While the study suggests that women's SRHR remain much the same as a few decades ago, what seems to have changed is women's willingness to accept the violation of their rights as their destiny. Against all odds, women now resist unfair gender norms and gender-based violence and make strategic decisions about whether to remain in violent relationships or walk out of them. They show grit and resilience in difficult situations and weather the impossible odds stacked against them.

4.2 Recommendations

Based on the above-mentioned findings, we put forward certain recommendations for civil society organisations and the government for ensuring the SRHR of Dalit women in Tamil Nadu.

4.2.1 Civil society organisations

- Adolescent girls and boys should be educated on gender and SRHR matters and linked to available healthcare services. It could be done

through community- and institution-based awareness generation activities and through mass and social media.

- Newly married couples' workshops and gender and SRH workshops for young married men are also very important to prevent domestic violence and to promote gender equalitarian relationships in the family.
- Mass awareness on the rights of poor rural Dalit women should be generated and access to the support services when they face any violence should be provided. A mechanism also needs to be set up to document the Dalit women's rights violations at the local level, and there should be a forum to address them or bring them to the district/ state human rights committees and commissions.
- Broader discussion with women's rights groups and regional political parties need to take place for them to integrate Dalit women's rights in their agendas.
- Community-level support could be formed to provide first-level care for women affected by gender-based violence and they should be referred to appropriate centres for further support.
- Education of women on coping strategies, resistance, and resilience should take place to make concrete decisions about their lives.

4.2.2 Government

- Public health facilities are the main source of SRH services for poor Dalit women and, hence, the government should make efforts to provide the required SRH services without any delay, denial, discrimination, stigma, or coercion. Abortion services at the PHC level and other SRH services, including screening and treatment for childlessness and reproductive cancers, should also be provided at the government hospitals.
- It is also important to sensitise healthcare providers on key SRH issues of Dalit women and enable them to provide women-centred counselling and guidance for those who access the services. The provision of temporary contraceptives, including emergency contraceptive pills, at the public facilities and safe abortion services at the primary-care level for unmarried and married women should be made available without any delay, stigma, or discrimination
- The existing support systems like shelter homes, district domestic violence protection officers, women's police, and one-stop centre services should be widely popularised and better coordination between government departments should be developed so that the victims of intimate-partner violence can access and avail these services. It is also imperative to strictly implement existing laws (Dowry Act and Protection of Women from Domestic Violence Act) related to the SRHR of women.

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About Us

CommonHealth, also known as the Coalition for Reproductive Health and Safe Abortion constituted in 2006, is a multi-state coalition of organisations and individuals working to advocate for increased access to sexual and reproductive healthcare and services to improve the health conditions of women and marginalised communities. CommonHealth has been actively engaged in evidence building through research for different SRH issues and used this to advocate for improved and rights-based SRH services.

Rural Women's Social Education Centre (RUWSEC) is a grassroots Dalit women's rights organisation based in Tamil Nadu. It was established in 1981 and its focus has been on enabling women to gain greater control over their bodies and their lives and achieving well-being through the promotion of gender equality and SRRs. The RUWSEC's overall approach has been to motivate, educate, and organise women from poor and marginalised communities to stand up for their rights and become agents of social change.

SAHAJ on behalf of CommonHealth
SAHAJ, 1 Shri Hari Apartments,
13 Anandnagar Society,
Behind Express Hotel, Alkapuri,
Vadodara, Gujarat, India 390007
Tel : 91-265-2342539
Email : sahaj_sm2006@yahoo.co.in
Website : www.sahaj.org.in

Contact: Swati Shinde [Coordinator CommonHealth]
Email : cmnhsa@gmail.com;
coordinator@commonhealth.in
CommonHealth website: http://www.commonhealth.in

RURAL WOMEN'S SOCIAL EDUCATION CENTRE (RUWSEC)
61, Karumarapakkam Village,
Veerapuram (Post), Thirukazhukundram
(Via), Chengalpattu District,
Tamil Nadu – 603109
Phone: 91 44 29542751
Email : ruwsec.tn@gmail.com
Website : www. ruwsec.org

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