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Research Paper

Dalit Women's Work and Reproductive Health in Uttar Pradesh

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***ABSTRACT**: In India, caste, class, and gender are indistinguishably interconnected thus shape each other. Women are always considered as second gender/sex in the society based on cultural constructions of social norms. However, the classification of 'woman' is conceived as uneven, based on their being oppressed by the fact of their womanhood; which is biology/sex hiding the social norms. Thus, relative to men, women have limited access to education, employment and more importantly autonomy in the existing social order. Secondly, when stigmatised caste tag is attached to women they become doubly oppressed. There are various ways through which Dalit women had been oppressed by the upper strata (Brahmanical view) of the people in Indian society. These inequalities led to the vulnerable conditions of the women in their socio-economic development. Though, in the last few decades, overall development in India has served to enhance the opportunities in terms of accessing education and employment for women. Despite all these opportunities the current picture is quite different in reality. As several studies argue that the bulk of Dalit women in India still suffers from impoverishment, such as poor reproductive health, malnourished, etc. This study attempts to explore the factors behind women's economic dependency on men even when they earn, and specifically its impact on their reproductive health in the context of Uttar Pradesh. This paper is based on the primary study conducted in Central Uttar Pradesh.*

***KEYWORDS**: Dalit Women, Reproductive Health, Gender, and Economic Vulnerability.*

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I. INTRODUCTION

In India, the caste system is so strong that even today people believe in the old and worn-out classification of society on the basis of the four Varna system. Though, there are laws and atrocity acts, which provide constitutional safeguards to people but still they are subordinated and discriminated against it because laws and acts cannot change the mentality of the people. The status of women in India has been subject to many great challenges. In that Dalit[1] women have to make as two ways struggle, one in the house and the other out of the house. In line with this, it is necessary to write about caste and gender.

Schedule Caste women in India suffer from caste and work-based discrimination, practices of 'untouchability', and violence arising out of the caste system. Historically, Dalits have been excluded from social, economic, cultural, civil, and political rights. Egregious denial of rights and violation have been primarily customary restrictions imposed on them under stratified social hierarchy based on their birth in particular polluted '*jatis*' or castes. Dalits are therefore, amongst the most socially and economically disadvantaged community given their social exclusion, lack of access to land ownership, lack of significant political participation, and lack of atrocity-free employment (Thorat 2009: 1). Over half of the Dalit workforce, working as landless agricultural labourers relied on the dominant castes in their localities for their daily basic

[1] *Dalit:* The word 'Dalit' comes from the Sanskrit root *dal*-means "broken, ground-down, downtrodden, or oppressed. However, in Dalit Panther movement in Maharashtra, the Dalits used the term Dalit to denote assertion."

amenities. Within the Dalit community, Dalit women are more vulnerably placed given caste and gender subordination (Irudayam et. al. 2011: 17, Chakravarty, 2003: 8).

Sheshadri (2015) writes in this context that the health issues cannot be seen in isolation from the social context (ibid: 8). So, caste and gender differences too affect medical conditions of the people as well as affect the provisioning of health care services. However, public health scholarships have continued their focus to class structure and subsumed caste and gender within the class. Against this backdrop, caste scholars brought new dimensions on health. For instance, Ramaiah (2015) emphasizes that although as citizens of India, Dalits got access to constitutional rights, including economic rights, as guaranteed in the Indian Constitution, but still, they continue to constitute the majority proportion of those with poor health indicators (ibid: 70). Drawing from his statement, further he explains that studies reveal about an individual's poorer health status, including higher morbidity, lower life expectancy, and higher rates of infant mortality was linked to her race, ethnicity, and caste, and in certain cases nationality. Studies also reveal that any kind of discrimination rooted in society, including caste, or racial origin affects the health of people in at least three distinct ways: (a) health status, (b) access to health care, and (c) inequality of health services (Ramaih 2015: 70). Similarly, according to Menon and Contractor (2002) in the context of Dalits and health they have argued that inequalities in health status is the most grave and inadmissible of all inequalities as it has direct impact on individual's right to life (ibid: 4). If caste inequality and division of labour based on caste, has debilitating effects on Dalits as whole, in such a scenario then Dalit women are far more vulnerable because they face multiple interlocking forms of violence. As phrased by Rege (1998), the category 'women' is conceived as collectively, based on their being oppressed by the fact of their womanhood. However, it is argued that the category called 'women' cannot exist- it is fictitious because there are several differences (race, class, etc.) that construct women differently (ibid: 40).The caste and gender matrix in Indian society is to be taken under consideration while talking about women oppression because merely pluralising the term patriarchy is not enough. The category "woman" is being differently reconstituted within regionally diverse patriarchal relations cross-hatched by graded caste inequalities (Rege et. al. 2013: 36).

This is evidenced by the fact that in comparison to higher caste women; human development outcomes are lower inferior for Dalit women. In 2001, it was brought to light that a lower proportion of Dalit women - 41 percent in rural areas were literate as compared to 58 percent non-Dalit women. While nationally (across rural India) about 40.5 percent of all women were underweight, the incidence of under-nutrition was eight percent higher for Dalit women. Moreover, Dalit mothers and their children had relatively poor access to public health services as compared to other social groups (Booroah et. al. 2012: 5). Dalit women face triple burdens of economic marginalization, caste discrimination, and gender subordination. However, this is not to mean that they do not exercise agency (Rao 2014). Their particular location within the caste hierarchy and their subject-position, including age, life cycle, work, and educational status, their personalities and quality of relationships, mutually intersect to shape their agency.

II. METHODOLOGY AND RESEARCH SETTINGS

The study primarily draws from an anti-caste feminist perspective to understand the subjectivity of Dalit women in relation to reproductive health. It holds the qualitative research design and is used to understand the reproductive health experiences of women in the Barabanki district. This research is descriptive and explanatory in nature as it tends to analyse and explain the role economic activity and its impact on reproductive health of Dalit women in relation to caste, class, gender and public health. The information has been collected through both primary and secondary methods of data collection. Primary sources are (a) Interview, (b) Observation. The secondary sources included various journals, Census of India reports, Yearly socio-economic reports of the district, books, and scholarly articles regarding reproductive health services, etc.

This study was conducted in a village named- Dharampur, located in the midst of Kundanganj block of Barabanki district in Uttar Pradesh (UP). Kundanganj block is situated between the Lucknow-Sultanpur highway in the southeast direction of the Barabanki district. This study covered 35 married women belonging to Dalit and Brahmin caste. The Dharampur village is basically a mixed-caste village dominated by Brahmin's. The ANMs and *Dais* were also interviewed in this study. The deliveries at hospital were observed at the nearby CHCs.

The maternal mortality ratio (MMR) for Barabaki district is 364/1, 00,000 live births(NHM Barabanki Report 2016-17) whereas for the state it is 201/1, 00,000 (SRS Report 2018). The high rate of MMR in the district as compared to the state level necessitated conducting research in the Barabanki district. The skewed sex ratio in Barabanki shows the sign of persistence of gender inequality.

III. WOMEN'S ECONOMIC DEPENDENCY ON MEN AND ITS IMPACT ON THEIR HEALTH

Rural women are mostly economically dependent on men for their livelihood especially in developing countries. Economic dependency is the degree to which a person is being controlled by others in fulfilling his or her needs. It is more prevalent in India that females are more dependent in their adolescence and adulthood, which is also their reproductive age that is (15-49). Economic disability is the main thing which concedes the schedule caste in the state the economic oppression of the Dalit women which has made them to live below the poverty line. They live with the disappearance of their means of earning and livelihood. The Dalit women employed mainly in unorganised sector and work as a labourers' in agriculture, construction work, and landless labourers', factory work and other household and marginal works, as a daily wages worker.

The major problem that affects Dalit women is role and opportunities for employment in this sector springs up from this helpless dependence caused by lack of adequate employment autonomous, limited skill, illiteracy, restricted mobility and lack of autonomous status. Thus, these inequalities lead to the vulnerable conditions of women in their socio-economic development. In the last few decades, development in India has served to enhance the opportunities in terms of accessing education and employment to women, but it is quite different in reality for Dalit women. The bulk of female population in India still suffer from impoverishment/ malnutrition. (Sethuraman and Duvvary 2007) writes, despite this reality, the field of gender and development and the field of nutrition are seldom connected. The former is based on human rights and social development models that follow a significant paradigm, whilst the latter is predominantly based on a bio medical model that follows a welfare paradigm- yet the two are complimentary, and both are needed for healthy human development (ibid: 51).

With regard to reproductive health in India, Indian women do work within an indescribable tight box in the sphere of reproductive and sexual health, and seldom allow taking decisions on such matters. It is their society, community, and family who take these decisions regarding reproductive health, not the women herself (Datta and Mishra 2000: 29). Here, until now through this paper we understood the situation of Dalit women's health in the Indian context as well within the sphere of Uttar Pradesh. Through these field insights it has been tried to explore the situation of Dalit women's health basically why it is poor?

Social and economic inequality is impediment to the health particularly on women's health which is basically prioritised as reproductive health by state. Dalit women experience triple forms of inequality such as caste inequality, gender inequality as well as economic inequality. This section mostly focuses on economic form of violence. In low income households as in the case of Dalits, women suffer a lot in terms of not taking rest during pregnancy. Taking rest is considered to be most helpful for women during pregnancy (as per the ANM during fieldwork).

'*Time has changed now but our statuses have not changed yet. For consulting doctors we need money. Without money there is no treatment, not even a simple pain killer we could get. In making these plates we cannot earn that much through which we can pay to private doctors for services. In this inflation we work during pregnancy also. If we do not work we could not be able to arrange our basic amenities and we do not take more rest after delivery?'*

[*Excerpts from an interview with a* Dalit *woman from Dharampur village who is landless.*]

'Yes! I work for earning. I am a ladies tailor. I have taken proper training from the stitching centre. I only worked in the early phase of pregnancy I used to stitch clothes but after the completion of fourth month I stopped working. I do not work for providing livelihood to my family I just do it for my time pass.'

[*Excerpts from an interview with a Brahmin woman Dharampur village who works independently for her time pass.*]

These insights indicated that although pregnant women are prescribed to take rest during pregnancy but their social and economic needs do not afford them to do so. However, this experience varies among different groups. For instance, women from Brahmin do not work during their pregnancy because they have ample resources to fulfil their need whereas for Dalit women it is totally reversed. They have to work during their pregnancy till it is bearable. For Brahmin women the picture is different as they have to work only in their household and the type of occupation they chose to do within their household. They do not have to work as labourers in fields like; harvesting, thrashing manually and sowing seeds etc. Although, Brahmin women are found more educated compared to Dalit, the former are not indulged in any kind of job which they achieve on the basis of their educational qualification outside home. In this connection, Jeffrey et. al. (1989) have discussed in the context of marginal farming households of Uttar Pradesh that the timing of marriage relates primarily to the sexual maturity of the partners, but the *bahu's* (daughter in laws) capacity to labour is also important. Certainly, once the daughter-in-law is living regularly in her mother in laws house expectations of her as a worker are a key feature of her life there (ibid: 57). Women in middle peasant class, then, have the greatest pressures of work, while others are rather less heavily laden.

In Uttar Pradesh, economic programmes targeted at women are rare and forms of out-work have little impact, because they are so badly paid. Yet this is not to say that such interventions have had no effect on women's activities. Rather the lack of attention to rural women has had consequences that were unplanned and largely unmonitored. For them, it cannot specify exactly how women's work has changed, but, basically, government interventions have not enhanced women's access to employment, property and credit. Women remain economically dependent on their men-folk and powerless (Jeffrey et.al. 1989: 62). Women are considered as free workers in the household within our all-over society whether they belong to Brahmin or Dalit they have to work in the household. The Brahmin women get more time to take rest due to the ideology of impurity of the body after childbirth whereas the ritual of observing impurity seen less in Dalit households.

Dalit women's difficulties related to reproductive health services do not end in terms of not having rest but also access to nutritious food. This does not only have implication on their health but also their child. In this context, it is important to discuss the issue of nutrition which is linked to income and other factors. Similarly, its impact on breast feeding has to be understood along caste and class lines.

'Look at me! How kamzor (weak) I am? Can I produce enough milk to feed my baby? To produce enough milk for feeding my child I have to feed myself properly. And we are unable to produce enough food for us. So, it is obvious I was unable to produce milk for my baby therefore I have doodhpilana (breastfed) my daughter till 6-7 months after that I started giving her uparkadoodh (bottle milk).'

[Excerpts from an interview with Dalit woman from Dharampur village who was a widow since six years, after a year of her baby girl born.]

'It was quite same during pregnancy like normal life diet but after delivery my diet consisted of achhi khurak (nutritious food) than earlier like I would take doodh (milk),dahi (curd) ghee (purified butter) and maas machali (non-vegetarian) items like meat, fish, egg, etc. on regular basis. As, it happens with every delivered mother food intake is related to the capability of her and her family's affordability. And foremost, it is up to their paisa (economic status) which decides what to eat before and after delivery.'

[Excerpts from an interview with a Dalit woman from *Dharampur* village.]

'I have breast fed both of my children at least for 6 months. After that, as per elders' suggestion I started giving them light food. My elders said feed your baby with food otherwise he will not eat food in future. He will ask only your milk. So, after six months I started giving my babies light food along with my milk.'

[Excerpts from an interview with Brahmin woman from Dharampur village.]

Field data indicated the variation in nutritional intake between Dalits and Brahmin women and its linkage with lower economic status. It showed that the availability of nutritious food is depended on income of the household. It emphasizes on the economic conditions of the women which play a significant role in deciding the intake of nutrition. Secondly, women's access to nutrition is interrelated to breastfeeding practices and infant's health. To breastfeed a child, a woman should take nutritious diet during pregnancy as per the views of ANMs. Due to nutritious diet a woman can breastfeed her child properly. However, the economic condition of Dalit women is the output of their social conditions which do not allow Dalit women to have nutritious food which the above quotes capture. As a result, as these quotes showed some Dalit women only could afford to breastfeed their children till six months and some others could not continue breast feed at least for six months. Whereas in the case of Brahmin women, not only they have access to nutritious food but also could breast feed their children uninterruptedly till two years.

As discussed earlier, Dalits low income is related to their low paid occupation in recent time as well as owing to their landlessness. Whereas the Brahmin *Brahmins* have land and income to feed their female members properly. So, Dalit women's lack of access to nutritious food and defying of public health measures of breastfeeding has to be understood from this larger socio-economic order. In the both selected fields the *Brahmins* and the Dalits have unequal economic status and this influence their nutritional intake during pregnancy and it is nothing to do with their behaviour. This raised the question that for whom this breast feeding was designed in reproductive health campaign of the state. These insights points that it was meant ideally for *savarna* women as they are in a position to have rest, nutritious food and a healthy infant. Thus, the Indian state's persuasion for a safe motherhood programme, actually imply a kind of coercion for *Dalit* women especially if their economic securities are not taken care of by the state. Point to be noted here that technically there are public provisioning of food for low income households and especially for pregnant women. However, these activities are channelised and delivered through Brahmin men who siphon off these rations eventually. As a result, these nutritious foods do not reach to the *Dalit* women as revealed by some of the women.

A woman's switch to motherhood is not limited only to the process birth itself but it consist of more constituents related to mothering. The capacity to breast feed is frequently seen as part of the successful transition to being a 'good' mother (Britton 1998:64). The expectation that let-down of milk would occur during the process of feeding the baby is usually welcomed by the women. A few women experienced very little leaking of breast milk while breast feeding. So, the women sometimes doubted their ability to feed their baby, even though the baby appeared content and thriving (ibid: 77). The new concept of nutrition and disease are

transforming understanding of the mother's body, baby's body and the relationship between the two. Some of these concepts have the potential to save lives. But when this transformation is occurring in the context of a developmentalist discourse, which reinforces social differences by equating poverty and non-bio-medical practices with "underdevelopment", the new concepts of the body are unevenly conveyed and may be resisted because of the condescending way in which they are imparted (Hollen 2003:6).

Nonetheless, Dalit women too share experience like Brahmin women when they receive special treatment after delivery especially nutritious food.

'During pregnancy it was normal and like earlier and after delivery the khuraak (diet) was changed. My diet was rich of energy sources like mixture of milk and dry fruits and purified butter (ghee) etc.'

[Excerpts from an interview with the Dalit woman from Dharampur village of a lower class household.]

As the quote shows, Dalit women too experience patriarchy in their households. For instance, they do not receive special treatment during pregnancy, however, during the post-partum period, they receive special treatment. Kumar (2002), writes about nutrition and reproduction among Dalit women in Rajasthan that with regard to the nutrition of mothers, it is common knowledge among mothers that special foods are eaten not before but after childbirth, and then it is only for fifteen to twenty days (ibid: 121).

Unlike women from other social groups in India, Dalit women face three overlapping disadvantages. First, they face the disadvantage of being women with all the attendant difficulties of living in a male-patriarchal society. Secondly, they suffer the disadvantage of being Dalit as they face the opprobrium that higher caste Hindu society instinctively heaps upon the Dalits. Thirdly, by the virtue of being Dalit they are more likely to spend a lifetime in poverty. Given this trinity of disadvantages, the problems of Dalit women are distinct from, and arguably considerably more severe than, that of higher caste women who apart from gender handicaps are not burdened by perceptions of inferiority or by a life of poverty (Barooah, Sadhana, and Thorat 2012: 5).

IV. CONCLUSION

This study concludes that the access to reproductive healthcare is low among schedule caste woman compared to Brahmin woman. The way they choose reproductive health services for delivery, availing vaccinations and post natal care shows the economic difference in their economic statuses. Women's development programmes do not always deal with nutrition or food security per se, but they promote sustainable livelihoods- by empowering women through knowledge, awareness and access to key resources that can facilitate their livelihood activities. One strategy for breaking the cycle of malnutrition that affect one generation to the next would be to prevent low birth weight. Low birth weight is a consequence of low pre-pregnancy weight, young maternal age, and inadequate weight gain during pregnancy. Low weight of the pregnant women decides the breastfeeding practice among them which leads to cause of infant mortality in this study of the village. It was found in the field data that due to malnutrition, women of low economic group who are mostly Dalit/schedule caste women of the village are following less breastfeeding practices.

Thus, it is obvious that as field insights indicate that Dalit women experiencing triple discrimination; first by the being women by their men-folk, secondly by their low economic status in the outer world, and lastly by their caste status which is considered as low in the social hierarchy. Here, it is not only the economic conditions which are barring the Dalit women to avail health care but their inherent economic status that percolates into their lives through their caste status. At the same time, Dalit women deal with the violence rather being a passive victim of this systemic inequality.

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