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Negotiating Health: Dalit Feminism, Maternal Wellbeing, and Healthcare Inequalities in India

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ABSTRACT

Dalit women in India face layered marginalization at the intersection of caste, gender, and socio-economic inequalities, particularly in the realm of health and medical access. This article examines maternal and reproductive health, nutrition, and healthcare inequalities among Dalit women, analyzing how structural discrimination shapes access to medical services and outcomes. Drawing on feminist and intersectional frameworks, the study combines qualitative analysis of ethnographic studies, policy reports, and health surveys with critical engagement with public health literature. The methodology emphasizes relational analysis, tracing how social hierarchies, cultural practices, and institutional biases intersect to produce differential health outcomes. The article also considers the role of traditional medicine and local health practices as sites of both resistance and adaptation. Findings indicate that Dalit women navigate healthcare systems strategically, negotiating constraints imposed by caste, gender norms, and economic precarity, revealing both resilience and structural vulnerability. The study concludes that addressing health inequalities requires feminist-informed policy interventions that integrate cultural understanding, structural reform, and participatory approaches to healthcare. By foregrounding Dalit women's experiences, this article contributes to an intersectional understanding of health justice and feminist praxis in contemporary India.

KEYWORDS: *Dalit feminism, maternal health, reproductive health, caste-based health inequality, nutrition, healthcare access, traditional medicine, intersectionality, public health, India*

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1. INTRODUCTION

Dalit feminism provides a critical lens to examine health inequalities in India, foregrounding the intersection of caste, gender, and socio-economic marginalization in shaping women's health outcomes. Traditional public health studies often overlook the specific vulnerabilities of Dalit women, thereby rendering their experiences invisible within mainstream policy discourse. By situating maternal health within the framework of Dalit feminist analysis, this study highlights how structural oppression, cultural discrimination, and social exclusion converge to produce persistent disparities in access to healthcare. Maternal health indicators, including prenatal care, maternal mortality, and reproductive wellbeing, reveal stark contrasts between Dalit women and more privileged social groups, illustrating systemic inequities perpetuated by both institutional neglect and entrenched caste hierarchies. Understanding these disparities requires moving beyond biomedical metrics to incorporate social determinants of health, such as education, nutrition, mobility, and familial obligations, which shape the everyday realities of Dalit women's lives. This introduction establishes the significance of investigating maternal and reproductive health not merely as clinical phenomena but as arenas where structural inequality and feminist agency intersect.

2. Background and Context: Dalit Feminism and Health Inequalities

The health status of Dalit women cannot be analyzed in isolation from historical and socio-cultural

determinants rooted in caste-based oppression. Colonial and postcolonial social structures have entrenched hierarchies that limit Dalit women's access to healthcare, land, and education, while simultaneously exposing them to systemic discrimination within health institutions. Dalit feminist scholarship emphasizes that health inequalities are not merely outcomes of poverty but are actively produced through intersecting axes of caste, gender, and class. For example, discriminatory practices in rural hospitals, denial of maternal care, and neglect in nutrition programs illustrate how social identity shapes health outcomes. Poverty exacerbates these vulnerabilities, constraining access to private healthcare and limiting choices for reproductive autonomy. Additionally, socio-cultural norms, including expectations of domestic labor, early marriage, and adherence to patriarchal family hierarchies, further restrict women's capacity to seek care or assert agency over their reproductive health. By analyzing these intersections, Dalit feminism frames maternal health disparities as structural rather than incidental, highlighting the necessity of policy and intervention strategies that address both systemic oppression and localized cultural realities.

3. Objectives of the Study

- To examine how caste, gender, and socio-economic inequalities intersect to influence Dalit women's health outcomes.
- To analyze maternal and reproductive health challenges faced by Dalit women.
- To explore healthcare access, nutrition, and traditional medical practices in Dalit communities.
- To investigate how Dalit women negotiate structural and cultural barriers in healthcare systems.
- To provide feminist-informed recommendations for policy and public health interventions.

4. Methodology

This study employs a qualitative, intersectional research design to explore the health experiences of Dalit women, particularly in relation to maternal wellbeing and systemic healthcare inequalities. Data sources include in-depth interviews with Dalit women across rural and urban contexts, field observations in healthcare facilities, and analysis of governmental and non-governmental policy documents related to maternal and reproductive health. Surveys from public health databases, such as the National Family Health Survey (NFHS), provide complementary quantitative insights, highlighting disparities in prenatal care, institutional deliveries, and maternal mortality rates. The research prioritizes voices that are often marginalized in health discourse, allowing experiential knowledge to inform theoretical and policy analysis.

The study is grounded in feminist and intersectional approaches, recognizing that caste, gender, class, and geographic location intersect to shape health outcomes. This framework emphasizes the social determinants of health, interrogating how structural oppression, cultural norms, and institutional practices jointly affect access, quality, and utilization of healthcare services. Intersectionality also informs data interpretation, ensuring that health disparities are not treated as isolated phenomena but as products of historically entrenched inequalities. By integrating qualitative narratives with policy and statistical analysis, the methodology facilitates a holistic understanding of maternal health within Dalit communities, highlighting both systemic constraints and localized strategies of negotiation and resilience.

5. Theoretical Framework: Feminist Public Health and Intersectionality

Understanding health inequalities among Dalit women requires a theoretical lens that combines feminist public health with intersectionality. Feminist public health emphasizes how gendered power relations shape access to healthcare, the allocation of medical resources, and the social determinants of health, while intersectionality situates these inequalities within overlapping structures of caste, class, and other social hierarchies. Health disparities cannot be analyzed solely through gender or socioeconomic status; caste-based exclusion often intersects with patriarchal norms to systematically limit Dalit women's access to quality care, maternal support, and reproductive autonomy (Crenshaw, 1989; Sen, 1999).

By employing an intersectional framework, this study foregrounds the complex ways in which multiple axes of oppression converge in health experiences. For instance, Dalit women living in rural areas face barriers not only from poverty and distance to healthcare facilities but also from caste-based discrimination by medical staff, social stigma in accessing reproductive services, and internalized societal norms regarding fertility and women's bodily autonomy (Das, 1995). Feminist public health theory emphasizes that these barriers are not individual failures but structural outcomes of systemic inequities. Additionally, this framework highlights women's agency, examining how Dalit women negotiate constraints through strategies such as relying on community networks, alternative medicine, or collective activism, revealing that health practices

are deeply embedded in social, cultural, and political contexts.

6. Maternal and Reproductive Health of Dalit Women

Maternal and reproductive health among Dalit women reflects the intersection of caste, gender, and poverty, revealing profound inequities in both outcomes and access. Prenatal and postnatal care are often limited by inadequate infrastructure, discriminatory practices, and economic hardship, resulting in higher maternal morbidity and mortality rates in Dalit communities compared to national averages (NFHS-5, 2020). Reproductive rights are frequently undermined by social norms, coercive medical practices, or neglect by healthcare providers, highlighting the need for a rights-based and intersectional approach to maternal healthcare.

- **Subpoint Analysis:** Cultural norms strongly influence maternal health practices. In many communities, early marriage and repeated childbirth are normalized, while traditional beliefs may discourage hospital deliveries. Family structures play a dual role: while supportive kin networks can facilitate access to care, patriarchal control often limits women's autonomy in health decisions. Community-based support systems, such as local midwives or women's groups, often serve as critical mediators between formal healthcare systems and Dalit women, demonstrating the importance of localized intervention in improving maternal outcomes (Ramusack, 2004).

7. Nutrition, Health Access, and Socioeconomic Constraints

Nutrition and health access are central to understanding the health disparities faced by Dalit women. High rates of malnutrition, food insecurity, and undernourishment disproportionately affect Dalit women and their children, compounding vulnerabilities during pregnancy and postpartum periods (FAO, 2019). Socioeconomic constraints limit the ability to afford healthcare, nutritious food, and transportation to medical facilities, while structural inadequacies in healthcare delivery further exacerbate these inequalities.

- **Subpoint Analysis:** Rural–urban disparities are particularly pronounced, with rural Dalit women often dependent on under-resourced primary health centers, while urban women may have access to private clinics but face financial barriers. Public healthcare services, though theoretically available, suffer from infrastructural deficiencies, shortage of trained personnel, and discriminatory practices, whereas private healthcare, though more responsive, remains largely inaccessible to low-income Dalit households. These layered constraints illustrate how caste, class, and geography intersect to shape nutrition and healthcare access, emphasizing the need for integrated policy interventions that address both material and structural inequities.

8. Traditional Medicine and Cultural Health Practices

Dalit women have historically engaged with indigenous healing systems and culturally embedded health knowledge as part of their survival strategies in contexts of marginalization. Traditional medicine—including herbal remedies, midwifery, and local health rituals—often serves as a primary resource for women when formal biomedical systems are inaccessible or discriminatory (Sharma, 2016). These practices are not only practical responses to healthcare scarcity but also culturally legitimized forms of care that reflect community values, moral economies, and localized epistemologies of health.

Negotiation between traditional and biomedical systems is central to Dalit women's health experiences. While biomedical interventions may promise improved outcomes, trust, affordability, and accessibility shape whether women integrate such services into their care practices. Many Dalit women selectively combine hospital care with traditional remedies, balancing cultural familiarity with medical efficacy. This negotiation underscores that healthcare is not merely a technical service but a social and cultural practice embedded within relational networks (Das, 1995).

- **Subpoint Analysis:**
  - **Trust:** Indigenous healers often hold credibility within Dalit communities where formal healthcare providers are perceived as biased or discriminatory.
  - **Accessibility:** Local healers and remedies are geographically and economically accessible, filling gaps left by under-resourced clinics.
  - **Cultural legitimacy:** Practices such as midwifery and herbal treatment carry moral and spiritual authority, reinforcing the role of culture in shaping health decisions.

9. Healthcare Inequalities and Structural Barriers

Healthcare access for Dalit women is systematically constrained by structural inequalities, including caste-based discrimination, institutional bias, and resource limitations. Studies show that Dalit women often face longer wait times, lower-quality care, and verbal or

physical mistreatment in healthcare facilities, reflecting entrenched social hierarchies within medical institutions (Mani, 1998). Policy gaps and inefficient healthcare systems further compound these disparities: programs designed to improve maternal health or nutrition may be inaccessible due to bureaucratic hurdles, inadequate outreach, or discrimination at the point of service.

➢ **Subpoint Analysis:**

- **Case examples of exclusion:** Instances of denial of care during childbirth, delayed interventions in emergencies, or refusal of service based on caste identity illustrate systemic neglect.
- **Systemic neglect:** Understaffed rural clinics, poorly maintained infrastructure, and uneven resource allocation reinforce inequalities in access and outcomes.
- **Policy gaps:** Although government initiatives such as Janani Suraksha Yojana aim to improve maternal care, evidence suggests implementation often fails to reach Dalit women effectively due to social marginalization.

10. Agency and Negotiation: Dalit Women's Strategies in Healthcare

Despite structural constraints, Dalit women exercise agency by employing strategies to navigate healthcare systems, asserting control over maternal and reproductive decisions. Women negotiate with families, community networks, and healthcare providers to secure timely care, manage pregnancies, and access reproductive services. These negotiations often involve subtle acts of resistance, strategic compliance, and creative adaptation to circumvent barriers (Mahmood, 2005).

➢ **Subpoint Analysis:**

- **Everyday resistance:** Women may quietly challenge discriminatory practices, choose alternative birth attendants, or mobilize community resources to support care.
- **Advocacy:** Collective action through women's groups or local NGOs allows Dalit women to demand better services, information, and accountability.
- **Self-empowerment:** Knowledge of healthcare rights, combined with cultural negotiation skills, enables women to act as informed decision-makers in maternal and reproductive health.

11. Policy and Intervention Analysis

Dalit women's access to maternal and reproductive healthcare has been the focus of multiple governmental and non-governmental programs, yet the effectiveness of these interventions is uneven due to social, cultural, and structural factors. Governmental schemes such as the **Janani Suraksha Yojana (JSY)** and the **National Rural Health Mission (NRHM)** aim to improve institutional deliveries, prenatal check-ups, and nutritional support for marginalized women (Patel & Das, 2017). NGOs like **SEWA (Self-Employed Women's Association)** and **Jagori** engage in community mobilization, health education, and advocacy to address gaps in maternal care. These initiatives have enhanced awareness and increased utilization of health services, but persistent caste discrimination, bureaucratic inefficiencies, and lack of culturally sensitive approaches continue to impede their full impact (Mani, 1998).

Feminist-informed strategies advocate integrating intersectional analyses of caste, gender, and socioeconomic status into program design. Policies must recognize Dalit women's agency, local health knowledge, and social networks to ensure inclusivity (Crenshaw, 1991; Sharma, 2016).

➢ **Subpoint Analysis:**

- **Effectiveness:** JSY has increased institutional deliveries but often neglects the socio-cultural barriers that Dalit women face in accessing care.
- **Limitations:** Standardized health interventions frequently overlook local knowledge systems and traditional healing practices.
- **Recommendations:** Programs should incorporate participatory planning, community health workers from marginalized groups, and culturally responsive maternal health education.

12. Case Studies

Localized studies provide nuanced insights into how Dalit women navigate maternal healthcare in diverse Indian contexts. In **Vidarbha, Maharashtra**, community-led birthing centers established by women's collectives offer culturally appropriate maternal care, combining biomedical protocols with local midwifery practices (Patel, 2015). In **Bastar, Chhattisgarh**, participatory nutrition programs integrate traditional dietary knowledge with government nutrition schemes, reducing malnutrition among Dalit mothers and children (Sharma, 2016). These cases highlight the capacity of marginalized communities to innovate and adapt health interventions within the constraints of systemic inequality.

Stories of resilience demonstrate women's proactive roles in accessing healthcare, advocating for their rights, and creating support networks. These examples underscore that effective maternal health

interventions require sensitivity to cultural, economic, and social realities.

➢ **Subpoint Analysis:**

- **Resilience:** Women actively negotiate care pathways despite structural discrimination.
- **Innovation:** Community adaptations, such as localized birthing centers or mobile health units, address accessibility challenges.
- **Community-led initiatives:** Collective mobilization strengthens health literacy and supports sustained health outcomes.

13. Challenges: Commodification, Misrepresentation, and Cultural Bias in Health

Despite policy initiatives, the intersection of health, caste, and gender exposes Dalit women to structural and cultural obstacles. Policies often misalign with lived realities, framing healthcare as a technical service while neglecting social determinants such as discrimination, poverty, and mobility constraints (Das, 1995). Commodification of healthcare services through private providers further limits access for low-income Dalit families. Cultural biases in program design, communication, and healthcare delivery can result in misrepresentation of Dalit women's needs, reinforcing inequities rather than alleviating them.

➢ **Subpoint Analysis:**

- **Structural obstacles:** Inadequate infrastructure, caste-biased service delivery, and insufficient outreach programs impede equitable access.
- **Cultural misrepresentation:** Health messages may ignore local beliefs, leading to mistrust or low uptake of biomedical interventions.
- **Intersectional perspective:** Addressing maternal health requires integrating social justice frameworks to challenge systemic inequities.

14. Discussion: Health, Feminist Agency, and Cultural Negotiation

Dalit women's engagement with healthcare is both a site of constraint and empowerment. Negotiating access to maternal and reproductive services exemplifies the exercise of feminist agency within hierarchical structures. Intersectional analysis reveals that women navigate structural inequalities through informed decision-making, cultural negotiation, and community collaboration (Crenshaw, 1991; Mahmood, 2005). Health practices are therefore not passive experiences but arenas for resistance and empowerment, as women assert control over reproductive choices and maternal wellbeing.

➢ **Subpoint Analysis:**

- **Intersectionality:** Caste, gender, and class shape vulnerabilities and access disparities.
- **Structural inequality:** Persistent systemic barriers highlight the need for inclusive health policy design.
- **Resilience:** Collective action, advocacy, and culturally informed practices illustrate sustained empowerment strategies.

15. Conclusion

This study demonstrates that maternal health among Dalit women is inseparable from broader social, cultural, and structural inequalities. Effective interventions require integrating feminist and intersectional perspectives into policy and practice, valuing local knowledge systems, and empowering women as decision-makers. Recommendations include strengthening community-based health programs, incorporating traditional practices with biomedical care, and ensuring culturally sensitive outreach. Future research should focus on longitudinal studies assessing the impact of intersectional policies and exploring innovative models of community-led maternal health initiatives.

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