Marginalisation and Access to Safe Abortion
A Case Study on the Struggles of a Narikuravar Woman in Kumbakonam, Tamil Nadu

Bhuvaneswari Sunil*

This paper explores the realities and complexities experienced by women in marginalised communities in accessing safe abortion services. It specifically explores the experiences that shape the perceptions and behaviour of Narikuruvar women towards accessing both public and private reproductive healthcare facilities. This is illustrated by the case of a married Narikuravar woman who had undergone self-induced abortion in Kumbakonam, a town in Tamil Nadu. In addition, the paper examines the circumstances that force women in the margins to adopt unsafe, self-induced abortion and discusses the strategies used by the Narikuravar woman for self-induced abortion. This is a qualitative research study and has used a phenomenological lens to capture the individual experiences of the woman across diverse life events associated with pregnancy, motherhood and abortion. The paper describes how contextual factors such as lack of access to resources and decision-making structures intersect with other cultural and gender identities of women. The principal argument here is that the needs, aspirations, interests, knowledge and agency of women from marginalised communities are not recognised in public and private decision-making spaces, and this impacts on women's sexual and reproductive rights.

Keywords : Induced abortion, unsafe abortion, reproductive health, Narikuravar women, marginalised, exclusion, access.

I

Introduction

Access to safe abortion services is crucial for women's realisation of their reproductive rights. However, access to safe abortion services become fraught with complexities in the socio-economic and cultural spaces of marginalised and vulnerable women. Within the right to health framework, vulnerability means deprivation of the rights to certain individuals and groups who have been denied the rights of in exercising agency (Chatterjee and Sheoran, 2005). Similarly, marginalisation is a process by which some groups of people are being pushed or kept out of the system, or are being maintained in a peripheral, disadvantaged position within that system (Khanday and Akram, 2012). Such vulnerable and marginalised groups of people become disadvantaged as compared to others mainly on account of their reduced access to livelihood opportunities, medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing and sanitation. This paper aims to demonstrate how women of the Narikuravar community face

*Ph.D. Scholar, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai, India.

the double discrimination of gendered and community-related vulnerabilities in accessing safe abortion services. Narikuravar in Tamil Nadu are a nomadic community, which was denotified from its criminal status in mid-20th century, and which is now classified as belonging to the Most Backward Class.[1]

By illustrating the case of a married Narikuravar woman who had undergone a self-induced abortion, this paper examines the complexities that emerge in her day-to-day experiences in accessing reproductive health services and facilities. It also examines the nature of vulnerability and marginalisation of women from the perspective of the Narikuravar woman. It further illustrates the strategies availed by the Narikuravar woman while practising self-induced abortion and their implication regarding their marginality and vulnerability.

The Medical Termination of Pregnancy (MTP) Act, 1971, terms abortion as legal in India. The MTP Act does not necessarily provide women the choice to terminate a pregnancy. However, it may be viewed as progressive because it allows for safe abortion services up to 20 weeks of pregnancy under certain conditions, through certified providers of MTP. Many women from poor, vulnerable and marginalised communities still find it extremely difficult to access safe abortion services. Studies have observed that women belonging to de-notified tribes and most backward classes have poor health outcomes (Tiphagne, 2015). Among denotified tribes and other socially excluded communities, women bear the brunt of the exclusion, because of the ways in which the state and society stigmatise them, resulting in the feminisation of stigma (Agrawal, 2004). The poor health outcomes among women from constitutionally defined Most Backward Classes may be attributed to poverty, under-nutrition, lack of sanitation facilities, hygiene, safe drinking water, and access to healthcare as well as feminisation of stigma and socio-cultural barriers which prevent them from utilising the available services (Tiphagne, 2015, Agrawal, 2004, Korra, 2017, Radhakrishna, 2007).

The right to sexual and reproductive health implies that "people can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (United Nations Fund for Population Activities [UNFPA], 2014: 45)". Implicit in this last condition are the right of men and women to have access to contraceptive information and services of their choice to regulate their fertility, and to have access to safe abortion services for indications that are permitted by law (ibid). Nevertheless, ground realities illustrate that health inequities exist; women are marginalised in their day-to-day life, and they become vulnerable as their basic rights to access safe sexual and reproductive rights are denied. For instance, Jejeebhoy et al., (2012) have observed that women in rural areas of India have inadequate access to safe abortion services. Recent data shows that 15.6 million abortions took place in India in 2015, of which 73 per cent were medication abortions that happened outside the health facilities (Singh et al., 2018). In Tamil Nadu, according to a 2012 study, only a fifth of the Primary Health Centres (PHC) was equipped with operation theatres, and less than 5 per cent of the 24/7 PHCs provided MTPs (Sunil and Ravindran, 2012).

[1] According to some activists and academicians, there are no denotified tribes in Tamil Nadu, although denotified communities exist. The Narikuravars are nomadic tribes, whose primary occupation was hunting. However, these communities were notified as Criminal Tribes by the British under the Criminal Tribes Act, 1871. Apart from enforcing their identity as criminals, such enforcements also prevented them from practising their traditional livelihoods. Their access to forest resources was also constrained by law. Several people turned to other occupations such as selling beaded ornaments. The Criminal Tribes Act of 1952 repealed the notification, thereby de-notifying the tribal communities. In Tamil Nadu, though the Narikuravars are lobbying for the Scheduled Tribe status, they are currently classified constitutionally as the Most Backward Class.

Studies have noted that women who underwent an abortion by uncertified providers experienced multiple post-abortion morbidities (Banerjee and Anderson, 2012; Bhattacharya et al., 2010). Research has also shown that self-induced abortion could result in incomplete abortion and complications such as multiple organ failures and septic abortions (ibid). Self-induced abortion is reported to be usually practised through the self-administration of abortifacient-drugs (Ramachandar and Pelto, 2005). Some of the reasons for self-induction of abortion or seeking care from unqualified providers included cost, perception of pain and adverse effects, fear of surgical abortion, convenience, desire for fewer clinic visits, and to cope with the gendered household roles (Ganatra et al., 2010, Sri and Ravindran, 2012, Berer, 2005). However, there is no published data on abortion practices of women from marginalised communities.

II

Methodology

This paper is a part of the author's doctoral research work that examines the motherhood and abortion experiences of 16 married women across diverse caste segments and social locations in Kumbakonam,[2] Tamil Nadu. The group includes Hindu women drawn from diverse social classes, castes, age-groups, employment status, education, geographic location and ethnicity.[3] The fieldwork for this research was carried out during the year 2015-2016. The larger study from which this case study is drawn, used a phenomenological approach to capture the experiences across diverse events associated with pregnancy, motherhood, and abortion among the respondents of the study. Based on the phenomenological method described by Giorgi (1985), the respondent was asked to describe personal dimensions of a situation experienced in daily life. From the description, the researcher identified its essence, the most invariable parts of that experience, located within a context. Narratives shed light on the essential meaning of "being-in-the-world to the lived truth" (Lindseth and Norberg, 2004) and helped in analysing the meaning governing women's decision-making and the actions shaping their identities, agency, and the nature of relationships with other actors in their everyday lives. The study used observation and in-depth interviews to collect data. I used an observation checklist and an interview guide for data-collection. The transcripts of interviews were used to identify the main and sub-themes. I then correlated the themes to the literature on the subject, based on my intersubjective experience.

Of the 16 respondents interviewed for the larger study, the case of the Narikuravar woman Vanathi[4] remains unique. Her experiences, capabilities and strategies differ from those of other women respondents in the study. Factors such as ethnicity, culture, prevailing gender relations, nature of livelihoods and the historicity of exclusion may have contributed to the uniqueness of this case.

This paper, narrated in the form of a case study, is based on my interactions with the Narikuravar woman. I identified the respondent through convergent interviews that I had conducted initially with a few young Narikuravar women who were selling beaded jewellery near the temple premises

[2] Kumbakonam is a temple town, located within Thanjavur district of Tamil Nadu. It is predominantly agricultural and rural. Kumbakonam is one of the health blocks in the district with five PHCs and one head Quarters hospital located in Kumbakonam Municipality. Most of the private clinics and hospitals are located in the Kumbakonam municipality area

[3] Narikuravars do not identify themselves as Hindus. My respondent said that they have a clan Goddess such as Kali (Goddess Parvathy) and Eswaran (Lord Shiva), to whom they offer animal sacrifice.

[4] Name changed to ensure confidentiality

of Kumbakonam. During the convergent interviews, I explained the purpose of my research and enquired about the prevalence of abortion among married women.

Subsequently, a young Narikuravar woman introduced me to her neighbour and aunt. I informed the Narikuravar community about the intended objectives of my research. The headman of their community gave me permission to enter their village and discuss my research with the women. Building trust with all the members of the community was a crucial step in this particular field site. Along with regular home visits, I had to engage in several sessions of informal group discussions with women and girls in the community. We discussed issues related to the lifestyle, occupation, notions on the education of the girl child, general health problems and health-seeking behaviour of the people in the community.

Over a couple of months, Vanathi felt comfortable enough to share her life experiences with me. I initiated the formal in-depth interviews after she expressed her trust in me. She also permitted me to record her conversations. The interviews were conducted in three sessions of two to three hours. The site for the interview was the living space of the respondent in her hut. The first two sessions were held in October 2015 and were followed by another interview in April 2016. The gap between consecutive interviews gave me sufficient time to review the transcripts, identify the gaps and seek clarification of the original responses. The interviews were recorded in Tamil and later translated into English.

This paper has its limitations. The insights drawn from the experience of one woman may not necessarily reflect the experience of marginalised women in her and other backward communities. Moreover, my position as an outsider in the life-space of Vanathi was undoubtedly a hindrance to understanding the suffering that women like her undergo. However skilled and equipped I am in the subject area of my research, my ability to capture the true essence of Vanathi's lived reality is limited. Across her conversations with me, there were clear-cut boundaries that alienated me from her immediate lifeworld. To her, I was an outsider on par with the experts and other formal health care providers, while her immediate life-space consisted of her husband, her children, her in-laws and her Narikuravar community. On many occasions, she referred to her beliefs, practices, and experiences as 'mine' or 'ours' referring to the women in her community, in contrast to 'yours' signifying my presence as the outside researcher. She shared many of her struggles, though she was hesitant in the beginning. However, towards the end of the final interview session, Vanathi had developed considerable trust and emotional involvement with me. Moreover, such sharing happened voluntarily without my insistence. The following sections narrate critical insights drawn from the interactions.

III

The Life and World of Narikuravar Women

The Narikuravars, residing on the outskirts of Kumbakonam, are a close-knit community. They live in small huts with thatched roofs, clustered together. The local people refer to the men and women of this community as 'Kuravan' and 'Kurathi', respectively. The men are usually involved in hunting small animals and birds which they sell in the local market. Both men and women (including young girls) are engaged in making and selling beaded jewellery in specific spots in the temple town. Some young girls from this community have begun to pursue an education in a nearby government school

and are not involved in any entrepreneurial activities. However, in many instances, girls drop out of school and engage in selling beaded jewellery.

The Narikuravar lead a frugal existence, with most adults living on one meal a day, either bought from road-side vendors for a low price, or left-over food from the town's wealthier population. Some adults have 'prasad' from the temples as a meal. Most families buy breakfast for their children from a local shop, and the government's mid-day meal scheme ensures lunch for school-going children. . It is the responsibility of either the man or the woman, whoever reached home first, to cook their dinner. Another interesting feature is that, following childbirth in the family, it is the responsibility of the husband to prepare food for the family. This practice continues for a few months. During this time, the mother who has given birth to the child is supposed to take adequate rest. This normative behaviour is carried forward through the concept of *'theetu'*.[5]

School-going boys and girls are routinely teased by their classmates as *kuravan* or *kurathi* in a demeaning manner. People rarely identify them by their names, but refer to them as the 'daughter of kurathi' or *'pasimani oosimani vikravanga'* (those selling beads and needles). The indigenous dialect of the Narikuravars and their unique physical attires, ornaments and other associated cultural practices contribute to such stereotyping and exclusionary practices. Middle-aged and senior kurathi women still wear a skirt and a blouse, with the half-saree draped in their style (in contrast to the modern saree culture). However, I also came across a few young adolescent girls who regularly wear the churidar and kurta.

The historicity of their exclusion, which identifies them as thieves and criminals, continues even today. Conversations with elderly Narikuravar women revealed the frustration, helplessness, and vulnerability of their social identity and position. According to an older Narikuravar woman,

> "We are always viewed as thieves and robbers!...If anything goes missing anywhere, the police will first come looking for us! They come…search, and sometimes harass us."

The abortion experience of the Narikuravar woman presented below has to be understood within the larger context and historicity of exclusion that the community experiences. Through this case study, this paper attempts to demonstrate the lack of access to abortion which is shaped by failure to recognise the needs and aspirations of the woman alongside denial of meaningful opportunities for decent and dignified livelihoods, safe housing and reliable social networks.

IV

'Motherhood and Right to Abort – Their Way or My Way'

Vanathi, a Narikuravar woman, believes that she got married to her husband sometime between the ages of 18 to 22. She estimated her present age to be between 25 and 30 and reported that she had been married for the last six to eight years. It was her husband's second marriage. He married Vanathi when his relationship with his first wife failed. The household of Vanathi consists of her father, husband, and three children. Her father owns the house in which the family lives.

[5] *Theetu* is a culturally represented term that denotes isolating the woman during different occasions associated with her body. For instance, following delivery, theetu is a period when the woman is not allowed to cook or come outside her house for a specified period. In some cultures, it also refers to the monthly menstrual period. During post-abortion, as the woman experiences bleeding, theetu is enforced for a stipulated period. In my opinion, the cultural construct of theetu is yet another recursive process that constrains the freedom of women.

Vanathi has three sons aged six, five and two-and-a-half, respectively. She had delivered a baby boy for the fourth time. But this child (immediately after birth) was given away for adoption, outside their caste and community. A distant relative had facilitated the adoption.[6] Multiple cultural factors shape such decisions of Narikuravars. The community has a keen preference for girls over boys. The preference for daughters is because, among the Narikuravars, the bridegroom's family has to pay a bride price of Rs.50,000 at the time of marriage. Besides, it is also widely perceived that the man, once married, is likely to listen to his wife because she is the one who meets his sexual needs, and is unlikely to support his parents in their old age. I observed that most of the Narikuravar households preferred to have two boys and two girls.

During my fieldwork, Vanathi's husband was the only earning member of the family. Vanathi was unable to pursue her business due to poor health. Vanathi's husband earns Rs. 200-300 per day by selling beads or animals. They keep aside approximately Rs. 150 to 200 for buying beads and accessories for their business. Apart from this, their daily expenses amounted to Rs. 100 to 150. The expenditure was related mainly to travel, tea, betel leaves for chewing and groceries. They allocated a portion of this income for the next day's tea and breakfast for children. They also spent money on buying alcohol. Most of the men and women (including Vanathi) in the community were habitual drinkers. According to Vanathi,

> "On many occasions, my husband fails to get me brandy, and this leads to a quarrel… In our community, after delivery, the mother is given brandy to drink to get rid of the *mangathvali* (post-delivery pain)… However, as days progressed, we became addicted to it."

The Narikuravar households are economically vulnerable and this leads to a hand-to-mouth existence. Their vulnerability deepens on days of heavy rains or if they don't have the money to pay for the beads and accessories. Vanathi explains:

> "Even if I go to the bus stand to sell the beads, I may end up getting around 50 to 60 rupees a day, out of which I have to spend for tea, five rupees for bus fare, 20 rupees for betel leaves and tobacco…then, what is left? These days, there are many sellers in the bus stand. There is a lot of competition, and at the same time, there is not much of a profit. Furthermore, the police also restrict us from doing our business in many places. What can we do then?"

Pregnancy, risk, and the decision to abort: Vanathi decided to seek an abortion at four months' gestation when she realised that she was pregnant for the fifth time. Two factors influenced her decision to have an abortion. One, Vanathi developed uterine prolapse during her fourth delivery. Health care providers had warned her against future pregnancies as hazardous to her health and life. Two, according to the community's belief systems, her pointed belly at four months suggested that she would once again give birth to a baby boy. Her husband did not want any more male children and therefore wanted her to have an abortion.

Accessing abortion in public health care settings: Vanathi did not obtain abortion from a health care provider or hospital in either the public or the private sector. According to her, these services and institutions were more of a threat to the Narikuravar women. Justifying her decision not to approach a health facility for abortion, Vanathi narrated the harrowing experiences of one of her neighbours:

[6] There are claims at the field level that these are not adoptions but the sale of newborn babies. Should this be true, it points to child trafficking at the community level.

"My neighbour, a young girl, had a spontaneous abortion immediately after her marriage. They first went to a private clinic….We can go to a hospital only at four to five months of pregnancy...In the private clinic, they began to scan her by placing a tube through her vagina. They said that there were still some (products of conception) left inside her stomach [uterus]! Her bleeding had not stopped. They demanded 5000 rupees to perform the abortion. She bargained with them saying that she had only 1000 rupees….They refused to carry out the abortion. She pleaded with them to evacuate her uterus completely and promised to pay 1500 rupees by borrowing from someone. She then had to go to the government hospital where she underwent a bitter experience. The hospital staff were not at all humane. They did not give even an injection or tablet to her (for pain-relief). The nurse in the government hospital took it (product of conception) out by directly putting a big *kambi* (iron rod or wire). It was very painful! Tell me, how will we go to such places?"

I also realised after interacting with Vanathi, that she and other women from her community had limited admittance to the Government General Hospital. She preferred the *'aspathri'* – the PHC – which was nearer and less intimidating.

Vanathi lamented,

"We never go to the *periya aspathri* (Government General Hospital). None of us in our community like that place. The *aspathri* (PHC), which is nearby, is alright… they conduct our deliveries. If the delivery takes place in this *aspathri* (PHC), we return home immediately. However, if it becomes very complicated, we are always referred to the *periya aspathri*… But they do not want to take us in there… They ask us 'Why have you come here?'. We have to give them money! Unless we give them 1000 rupees, they do not even bother to see us. We have to request innumerable times to examine the patient...

In our culture, if the bag of water bursts, we are asked to exert pressure and our stomach is massaged. The baby will come out, and it is cleaned. But quite strangely, in these hospitals, they will say, *mukku, mukku* (Push, Push)! Where do we have the stamina to push?... Moreover, in these hospitals, people ask us to have food immediately after delivery. On the other hand, in our culture, we maintain *pathiyam* (a strict and controlled diet) for the first three days. We do not eat during these days. We have coffee and maybe a bun, once or twice in a day. If we eat, the baby might get affected with *maantham* (an indigestion problem among newborns and infants). Gradually, after a month, we start eating plain rice that is cooked well with a bland *rasam* made of tomatoes, a green chilli, and some pepper powder."

Health coverage in the study area is generally good and provided through primary health centres located within a 1km radius of many settlements. However, only the district government hospital (8 km) provided D&C usually as a procedure for evacuating the uterus when women presented following a spontaneous abortion with or without morbidities. I learnt that government hospitals did not provide abortion unless a sterilisation procedure is accepted.

Narikuravar women see the PHC as a place promoting institutional deliveries. For any delivery-related complications, induced abortion, and other reproductive health problems, women are referred to the district general hospital. Thus, access to services is limited to facilities where Narikuravar women experience loss of dignity.

Vanathi's views on sterilisation hints at how the women in this community feel culturally alien to mainstream healthcare practices. According to Vanathi,

"That sister who comes here (the government's Village Health Nurse) always insists on the operation (sterilisation). People in our community consider it a bad sign to have

> a protruding stomach after delivery. But, after the operation, the hospital people leave our stomach untied… and when we start our normal diet, it will bulge out. In our community we believe that with a bloated tummy after delivery, we cannot walk or even go around seven villages. Many women who underwent the operation have big paunches. After delivery we usually tie a long cloth around the stomach as we do during our menstrual period."

To my query, 'Is that why you did not go for the operation?' Vanathi laughed and replied,

> "It is not always like that…. I also wanted to have the operation…. However, I had to maintain *theetu* after the abortion of my fifth child. There was a lot of bleeding…. So, I was asked to visit the hospital after the *theetu.* However, when I asked my mother-in-law to accompany me to the hospital, she declined and said that she was unwell and also that she did not have enough money to travel. During the time of *theetu* itself, the sixth one stayed back.[7] (she conceived for a sixth time)…. God has given me one more child, and now I will give birth. I am just hoping for a girl! Everybody says that it will be a girl. Maybe, after that I will go for operation….(On a lighter note), there are women in my community who have gone through the operation after giving birth to three to six children as well!"

Accessing abortion through other channels: Following her decision to abort the fifth child, both Vanathi and her husband went to the pharmacy and explained to the chemist about their predicament. The chemist then provided her the abortion pills for a price of 500 rupees. He also took the signatures from both of them certifying that he was not responsible for any untoward incidents following the consumption of the pills. The chemist also gave her the directions for taking the pills. During one of our first interview sessions (after almost two months of her abortion experience), Vanathi said,

> "The chemist gave me abortion pills to be consumed only for three days. He instructed me to take the pill with water. There were five tablets in the strip…"

The second and third interview sessions were held with Vanathi after a period of five to six months respectively. During these interactions, Vanathi revealed that she took one pill for three days each, after breakfast. Vanathi recollects that she menstruated on the very first day of consuming the pill. However, she observed that the flow did not stop for almost a month. Commenting on prolonged bleeding, Vanathi said,

> "My people pointed out that if the bleeding prolonged, then it would be harmful to my body. Therefore, they asked me to eat rice with a special curry made from plantain flowers and onions. They said that it would flush away all the leftover stuff (products of conception) from the stomach (uterus) *(pisuru ethavuthu iruntha vandhidum)*. I acted on their advice, and it all got cleared. Besides, I ate pineapple. It kept my body cool and light like a flower."

Vanathi continued to share her abortion experience, though without much emotional involvement:

> "I cleaned the extra stuff (products of conception) myself! .... Once you take the pill, it will come out…. I continued pressing my stomach… then, I took that (the products of conception) in a cover and threw it far away. I had mild cramps when it came out and was feeling very tired. I placed thick clothes on my vaginal

[7] Indicating that she became pregnant again. Later, as I was writing this paper, I came to know from the grassroot health worker that the baby born to her of the 'sixth' pregnancy following the abortion did not survive. And she finally underwent the sterilisation procedure. As the grassroot health worker was transferred to another location, it was not possible for her to ascertain the details of the delivery or cause of death of the newborn.

area and took rest for two days…. I also took some pills for body pain …. I rested for two days, eating rice, bun and having some tea. I became alright. That's all."

My body, My vulnerability! Neither his nor theirs!: Vanathi believes that she became pregnant again within a month of this abortion experience. By the time I was having the third interview session with her, she was five months pregnant. On my inquiry of whether her husband asked her to undergo abortion this time as well, she replied,

"He asked me to take the abortion pills again. I refused and said, 'I will die if as much blood is going to come out of me again.' Already I am feeling weak and tired!"

I sensed from my brief conversations with her during this time that she was not happy with her husband (although she was not letting him down). As I probed further on why her husband was not accompanying her for sterilisation, she replied with a feeling of discontent,

"There are already enough quarrels going on between us. I took those abortion pills, only after he asked me to do so, didn't I?"

Vanathi's abortion experience also indicates how bodily issues and health concerns have affected her very survival. During one of our last interview sessions, Vanathi spoke in an emotional and pained tone:

"When I was undergoing such a crisis, he (her husband) did not go to work!... He sat idly at home mending the *koodu* (cages). There was no income. He did not even bother about me. He got me neither a soda nor a coffee. He quarreled with me and went to his mother's house. He took my children as well... He left me to fend for myself. He was angry with me because I was not going out to sell the beads. You know that I am not allowed to get out of the house following an abortion? Post-abortion, we have a one-month *theetu*…. If a lactating mother sees me in my theetu, it is believed that her infant will have some *dosham* (curse) and it could affect the health of that child…. If they get affected by the dosham then we have to spend around 5000 to 6000 rupees…. To address that dosham, we need to offer a mudikayar (sanctified thread). To fetch those threads, we to go to Tiruchi or Vaikundam Malai, … otherwise that child will die…. How can I go out then? .... My health has also deteriorated! I feel so tired and have severe body pain. He was not even ready to take me to a doctor…. Being my husband, he has the responsibility of supporting me during my crisis. Instead, sitting idle without doing any job and hurting his wife is not decent. I hope you agree with me! .... I cannot eat those idlis sold by the street vendors for breakfast. I feel nauseated. It is much better when my husband makes some hot rasam and rice for me. But he is not at all interested in my health."

Other aspects related to reproductive health also add up to her vulnerability.

"Sometimes, we get infected by *pulla karuppu* (some kind of vaginal infection). When we approach the health centre or the medical shop, they give some ointment. The skin around the vagina becomes dark, irritating and itchy. In spite of using a lot of soap, the itching continues. If I scratch to relieve the itching, it will begin to burn…. Yesterday, I bought an ointment from the medical shop that cost Rs.35. During our periods, we (including other women) try to use cotton (pads) by attaching it to the cloth. However, I have no respite from the itching."

During my fieldwork, I realised that Vanathi and many other women among the *Narikuravars* have several gynaecological morbidities such as white discharge, abdominal pain, and rashes in the vaginal area. I also realised that, except for sterilisation, Narikuravar women knew almost nothing about any other contraceptive method such as oral contraceptive pills or IUD, or natural methods such as the 'Rhythm' method. They visited hospitals to take injections on occasions such as high fever, severe vomiting or diarrhoea. Moreover, institutions like the primary health centre did not

provide any ointment or creams meant for treating women's vaginal infections. The pharmacist played a major role in facilitating many of their health related decisions.[8] Reproductive morbidities such as vaginal infections need to be understood in the context of the unsafe abortion experiences that Vanathi underwent. Medical conditions such as uterine prolapse have increased the complexities of her day-to-day life-struggles. Further, the concept of *theetu*, a practice of ritual pollution, and other social belief systems restrict her mobility and income-earning opportunities, limiting her access to healthcare.

V

Discussion

The findings of this study have the limitation of representing just a single case study. However, the insights gained speak of the larger constraints faced by several women of this community. The historicity of exclusion and marginalisation has certainly affected both men and women in the Narikuravar community. When compared with mainstream society, both men and women in this community are deprived of decent work opportunities and are often ostracised and discriminated against by the very agents that are meant to support their well-being. The above narratives explain how diverse factors such as insecure and marginal livelihoods, poor economic conditions, distrust of the formal health services and providers, and lack of availability of abortion at the primary care level restrict women's access to safe abortion services.

However, my field observations also show that the Narikuravar women are not only marginalised and oppressed by the external context, but also by factors that are an inherent part of their day-to-day lives. Although Narikuravar women have better physical mobility as compared to women of mainstream society in Kumbakonam, they are expected to use their mobility to earn money and contribute to the household. In fact, their spaces of freedom and decision-making are quite limited. This calls to question the emphasis on economic upliftment as a key strategy to empower women. Another point to reflect on is the vulnerabilities experienced by women because of their reproductive role, despite relatively egalitarian gender roles in everyday life. Narikuravar men and women maintain some kind of egalitarianism in their roles. Unlike the mainstream society in Kumbakonam, they prefer girl children over boys; they cook for one another, and share their income. However, when the woman becomes pregnant, or a mother, or undergoes abortion, the norms governing her day-to-day life change. The very actors who enabled her freedom during the pre-delivery or pre-abortion phase constrain her mobility, decision-making capabilities, and even her survival.

The present case study also highlights the need for ensuring access to safe abortion services to many marginalised women. The reproductive health burdens of vulnerable and marginalised women increase because of the dire absence of public provisions in medical abortion services. Health disadvantages among these women are higher also due to the discriminatory and corrupt practices followed by both public and private health care providers (Ramachander and Pelto, 2004). In this regard, both public and private health care institutions need to re-constitute as gender-sensitive agents of support, care and change. These actors also have to recognise the intersectional dimensions of women's marginalisation and oppression as well by other axes of domination besides patriarchy.

[8] Similar observations have been made by Sri and Ravindran (2012).

Be it a Narikuravar woman or a dalit woman, my field observations show that all have similar stories of exclusion and humiliating experiences while accessing health care at public or private institutions. What differentiates a Narikuravar woman from others may be that she has the courage to clean herself by massaging her abdomen following a failed abortion attempt, while the others would have probably not dared to do so. However, this expression of courage should not be misconstrued as signs of her empowerment. Instead, it showcases the poor plight of women who are denied safe abortion services and are forced to undergo self-induced unsafe abortion. The findings of this paper thus emphasise the need to provide safe abortion services to women from marginalised communities without discrimination; recognise their needs, identities and aspirations, and ensure that they are adequately represented.

References

Agrawal, A. (2004). The Bedias are Rajputs: Caste consciousness of a marginal community. *Contributions to Indian Sociology,* 38(1&2), 221-246.

Banerjee, S. K. & Anderson, K. (2012). Exploring the pathways of unsafe abortion in Madhya Pradesh, India. *Global Public Health,* 7(8), 882-896.

Berer, M. (2005). Medical abortion: issues of choice and acceptability. *Reproductive Health Matters,* 13(26), 25-34.

Bhattacharya, S., Mukherjee, G., Mistri, P., & Pati, S. (2010). Safe abortion still a neglected scenario: a study of septic abortions in a tertiary hospital of rural India. *Online Journal of Health and Allied Sciences,* 9(2), 1-4, Retrieved November 26, 2017, from http://www.ojhas.org/issue34/2010-2-7.htm

Chatterjee, C. & Sheoran, G. (2007). Vulnerable Groups in India. *Centre for Enquiry into Health and Allied Themes,* Mumbai: India.

Ganatra, B., Kalyanwala, S., Elul, B., Coyaji, K., & Tewari, S. (2010). Understanding women's experiences with medical abortion: in-depth interviews with women in two Indian clinics. *Global Public Health,* 5(4), 335-347.

Giorgi Amedeo, P. (1985). *Phenomenological and Psychological Research*. Ducherne University Press, Pittsburg in Sadala and Adorno (2002).

Jejeebhoy, S. J., Kalyanwala, S., Mundle, S., Tank, J., Zavier, A. J., ... Jha, N. (2012). Feasibility of expanding the medication abortion provider base in India to include Ayurvedic physicians and nurses. *International Perspectives on Sexual and Reproductive Health,* 38(3), 133-142.

Khanday, Z. A. & Akram, M. (2012). Health status of marginalized groups in India. *International Journal of Applied Sociology,* 2(6), 60-70.

Korra, V. (2017). Status of Denotified Tribes: Empirical evidence from undivided Andhra Pradesh. *Economic and Political Weekly,* LII(36), 61-66.

Lindseth, A. & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences, 18,* 145–153.

Radhakrishna, M. (2007). Urban Denotified tribes: Competing identities, contested citizenship. *Economic, and Political Weekly,* December 22, 2007, 59-64.

Ramachandar, L. & Pelto, P. J. (2004). Abortion providers and safety of abortion: a community based study in rural district of Tamil Nadu, India. *Reproductive Health Matters,* 12(24 Suppl.), 138-146.

Ramachander, L. & Pelto, P. J. (2005). Medical abortion in rural Tamil Nadu, South India: a quiet transformation. *Reproductive Health Matters,* 13(26), 54-64.

Ravindran, T.K.S. & Sunil, B. (2012). *Access to safe abortion services in Tamil Nadu: Intentions and achievements - An analysis based on secondary sources.* SAHAJ, India. Retrived November 20,2017, from http://www.commonhealth.in/report-pdf/2a.%20 Monograph.%20Access%20to%20safe%20abortion%20services%20in%20Taminnadu%202012.pdf

Sadala, Maria Lu´cia Arau´jo & Adorno, Rubens deCamargo Ferreira. (2002). Phenomenology as a method to investigate the experience lived: a perspective from Husserl and Merleau Ponty's thought. *Journal of Advanced Nursing,* 37(3), 282–293.

Singh, S., Shekhar, C., Acharya, R., Moore, A. M., Stillman, M., Pradhan, M. R., ...Browne, A. (2018). The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health,* 6(1), e111-e120, https://doi.org/10.1016/S2214-109X(17)30453-9.

Sri, B. S. & Ravindran, T.K. (2012). Medical Abortion: Understanding perspectives of rural and marginalised women from rural south India. *International Journal of Gynaecology and Obstetrics, 118*(1 Suppl.), S33-S39.

Tiphagne, A.C. (2015). Feminisation of stigma: The plight of Kal Oddar women*. Indian Journal of Gender Studies,* 22(3), 458-469.

United Nations Fund for Population Activities. (2014). *Programme of Action.* International Conference on Population and Development, Cairo, 5–13 September 1994, UNFPA, Accessed at https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf