Reproductive Health and Rights in the Lives of Marginalized Urban Young Women – A Study From Vadodara, Gujarat

A Study Report
July 2021

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wards alternatives in health and development

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ACKNOWLEDGEMENTS

Reproductive health and rights in the lives of marginalized women – a study from Vadodara, Gujarat was undertaken with the support of CommonHealth – Coalition for Reproductive Health and Safe Abortion. This study involved months of conversations with all research partners who supported the process, contextualization and understanding of complex phenomena. We gained a lot from conversations with Dr. Balasubramanium (RUWSEC, Tamil Nadu), Tejaswi and Mandakini (SAHELI HIV/AIDS Karyakarta Sangh, Pune). We thank Shruti Arora and Dr. Sauvik Payne (The YP Foundation, Delhi) and Bijayalakshmi Rautaray (SAHYOG, Odisha) for being a constant support system during this study.

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Research Team
Manushi Sheth, Parigna Talati, Krishna Damor and Bhanu Chauhan
July 2021

INTRODUCTION

Reproductive Health Histories of Women of Marginalized Communities of Vadodara was undertaken by SAHAJ with the support of CommonHealth – Coalition of Reproductive Health and Safe Abortion (CH). This study is a part of CH's research to understand sexual and reproductive health histories of marginalized women of different communities across India. This study involved months of conversations with all research partners who supported the process, contextualization and understanding of complex phenomena. The study has provided SAHAJ rich insights for SAHAJ's future programmes.

SAHAJ—Society for Health Alternatives—works with communities by educating them on their rights and empowering them to claim their entitlements in the **Health and Education** sectors. SAHAJ was founded in Vadodara, Gujarat in 1984 with an idea of providing a supportive and facilitative atmosphere to persons interested in doing original work in the area of Health and Education. The common strand for all work of SAHAJ has been a conscious focus on marginalized and deprived communities.

CommonHealth, constituted in 2006, is a rights-based, multi-state coalition of organizations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities.

Objectives of this study

Through the documentation of case studies of 14 young girls/women from low-income neighbourhoods in Vadodara city, this study attempts to understand their sexual and reproductive health experiences, as well as the enablers and barriers to realisation of their sexual and reproductive health rights.

The Framework

The study tried to capture more than just the salient reproductive events such as menstruation and pregnancy in women's lives. The framework adopted for this study attempts to understand the interactions in reproductive health events and their interface with women's gendered lives within the households, the community and the health system. Overall, it tries to understand women's experiences from the intersectionality lens, i.e., how various social determinants like age, gender, class/caste, social status (determined by poverty, caste, marital status, position in their family, occupation, etc.) and related vulnerabilities determine or influence young women's health and how young women adapt, negotiate and resist to get what they need, particularly in terms of reproductive health choices.

The study includes respondents who are married (some with children and some without) or single, from nuclear or joint families, educated or school drop-outs, working outside the house or as home-makers, 'beneficiaries' and health-care providers to provide a response from as diverse a sample as possible.

The Context

Gujarat is an economically prosperous and well governed state in western India, but lags behind other similar states in social indicators. Deep rooted cultural and social practices like early and forced marriages, female youth illiteracy, caste discrimination are more evident in Gujarat than in other States and make the young population more vulnerable[i].

Gujarat's female sex ratio at birth has been deteriorating [1]. Around 22 percent of women age 20-24 years are married before age 18 years (NFHS 5) [2]. Less than half the urban girls (47.9 percent) make it to secondary school and complete 10 years of schooling (NFHS 5).

Health indicators are as wanting. High levels of malnutrition and anemia have been a long standing problem in Gujarat. In fact, 65 percent women between 15 and 49 years are anaemic (NFHS 5) and anaemia has worsened in the last five years. Only around 54 percent married women use modern methods of contraception. Access to safe abortions and contraceptives still remain services with little or no scope for informed choice for the young population.

Gujarat's health system is amongst the better ones in the country. The latest SDG India Index has given the top ranking to Gujarat's SDG 3 *Ensure Health and Well Being*[ii]. But it still fails to cater to the needs of vulnerable women and girls, especially in remote areas. Vadodara city has a reputed medical college hospital accessed not only by the city's poor but also people from neighbouring states and districts. The urban health network of the Municipal Corporation is reasonably good, but does not particularly serve the sexual and reproductive health needs of women and girls – most rely on the private health sector, or the tertiary medical college hospital.

About the programme context, the Rashtriya Kishore Swasthya Karyakram (RKSK) and SABLA are not available in urban areas. Since 2014, RKSK has been a pilot programme in ten districts only. Although SABLA is supposed to be universal, it is not implemented in urban Vadodara. Currently only the Mamta Taruni Abhiyan [3], limited to girls between 10 and 19 years, operates in the low income neighbourhoods of Vadodara. The beneficiaries are the select 20 girls enrolled in the anganwadi records. The anganwadi worker (AWW) is supposed to provide SRH information but she does not go beyond two topics, menstruation and nutrition. Peer educators selected by the AWW are only supposed to mobilise adolescents to take the services, they do not have any role as educators or guides. The Anganwadis also provide 'take home rations' or supplementary nutrition to the enrolled 20 girls. The major focus of the ASHAs, the second frontline worker, are certain target oriented tasks for married women, related to ante natal, post natal care and contraception. Although the ASHA is supposed to stock sanitary pads that girls can buy at subsidised rates, many times there is no stock. The third cadre, ANMs (Auxiliary Nurse Midwives) are supposed to conduct sessions with adolescent girls on menstrual health problems, nutrition, care of under five children. These sessions are part of the monthly Mamta Divas (Maternity Day), to be managed within the already tight schedule of antenatal checkups of pregnant women and vaccination for children.

1 The sex ratio of Gujarat is around 919 compared to 943 which is a national average of India. Sex ratio for SC and ST was reported to 931 and 981 respectively. (Census 2011)

2 The National Family Health Survey (NFHS) is a large scale, multi-round survey conducted in a representative sample of households throughout India. To retrieve for latest NFHS 5 (Gujarat Factsheet), http://rchiips.org/NFHS/NFHS-5_FCTS/FactSheet_GJ.pdf

3 This is a community level intervention to cater the need of adolescents girls in the age group of 10 to 19 years in rural areas. It is an add-on to Mamta Divas which provides fixed day services to pregnant and lactating mothers and under five children. This Government of Gujarat's initiative is an important outreach service for adolescents.

Adolescent SRH clinics are conducted at the Urban Primary Health Centre (UPHC) and Ward level Community Health Centre on Monday 3 to 5 pm for girls, and Tuesday 3 to 5 pm for boys[4]. There is either a male or a lady doctor in the UPHC, not both. Thus, it is not necessary that the Tuesday boys' clinic will have a male doctor. Boys feel shy to approach a lady doctor. The ARSH services are limited to dispensing medicines and giving information on the dose. Counselling or other information on prevention or post care is missing. Adolescents prefer going to the private practitioners for their SRH most of whom have non-allopathy degrees.

Basic health and sexuality education is missing in school curriculum - comprehensive sexuality is a far cry. Biology chapters in the textbooks (reproductive organs, menstruation, conception, contraception) contain technical language, inappropriate terms and inadequate explanations. For example, Reproductive Tract Infections/Sexually Transmitted Infections find their place in the chapter on excretory system (Gujarat State curriculum). Teachers skip these chapters in class and expect the students to read them on their own. Questions on these chapters in the examination papers, are included as choice questions, giving a message that these topics are not important.

As in other cities Vadodara has its share of low income neighbourhoods, bastis or slums as they are commonly called. The bastis that SAHAJ works in are very poor in terms of precarity, infrastructure and living conditions. Some of them are just off the banks of the river or in low lying areas and thus prone to flooding. Another has a railway line running through it making it dangerous for children and older people. A few of them are poor quality low income housing redeveloped by the Municipal Corporation. The people living here are migrants, both from within the state as well as from other states like the distant Uttar Pradesh and Bihar, and neighbouring states like Madhya Pradesh, Maharashtra and Rajasthan. Majority of the men are daily wage workers and are associated with occupations in construction, fabrication, painting, driving etc. Women work as domestic help. Most communities have rigid community norms resulting in low levels of girls' education, early marriage, alcoholism and aggressive masculinities amongst men and boys.

It is in this context that SAHAJ[5]– a non-governmental organization - has been implementing an adolescents' and young people's programme in around 20 low income neighbourhoods in Vadodara city, for over two decades. The population is mainly socially and economically vulnerable groups – scheduled castes, other backward castes and scheduled tribes, migrants, and working class people. The interventions - capacity building of peer leaders, organising girls' and boys' into collectives, imparting knowledge and skills, engaging with parents on adolescents' and young peoples' rights issue - aim to develop leadership among the adolescent boys and girls, with a gender and rights perspective. A large part of the programme is around adolescent reproductive and sexual health, developing appropriate interventions to address the needs and issues articulated by adolescents and young people[iii,iv,v].

Situation of Adolescents in Gujarat

In Gujarat, adolescents and youth are around 30 percent of the total population, nearly 1.78 crores. In such a huge share of population, the issues of adolescent and young people in Gujarat are as follows.

4 Our field engagement over the last two decades provides several insights into how these programmes are implemented.

5 SAHAJ - a 36-year-old non-governmental organization (NGO)- has been working with different groups of adolescents and youth (between ages of 10 and 24 years) for 15 years.(www.sahaj.org.in)

Sex ratio

Sex ratio of adolescents in age of 10-19 and young people from 15-24 are 869 and 881 respectively which is lower than India. (Census 2011)

Education

To understand situation of education of Gujarat, these charts mentioned below contains required indicators.

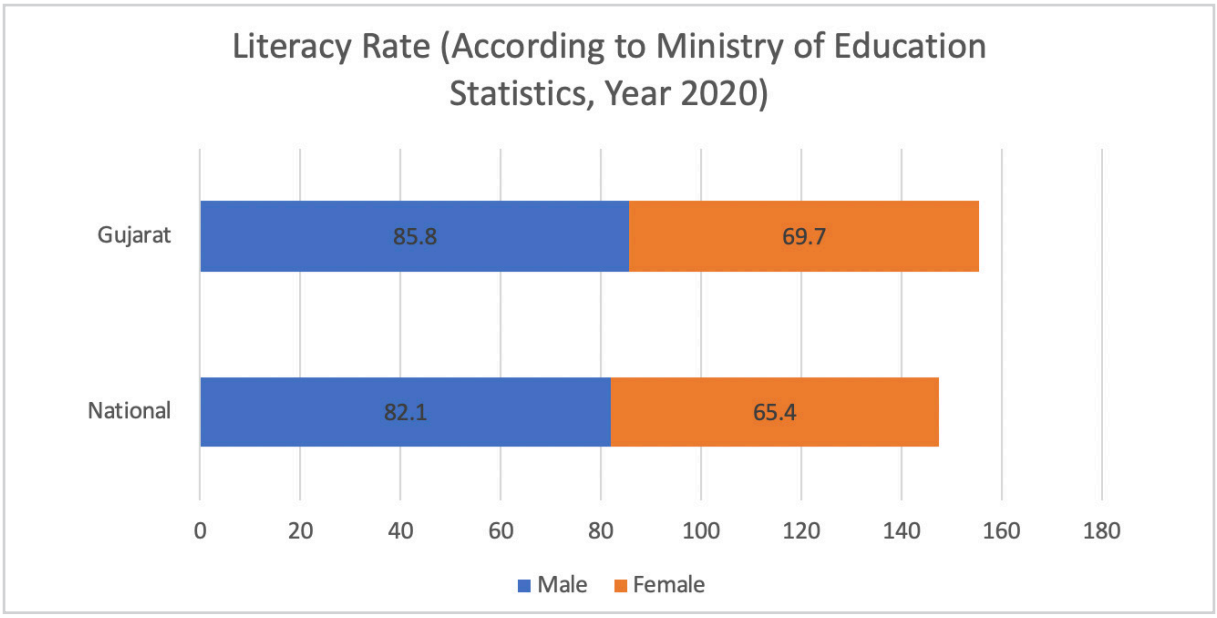

Figure 1 Literacy Rate (According to Ministry of Education Statistics, Year 2020)

Figure 1 shows national and state comparison of literacy rate. Figure 2 mentioned below describes caste based gross enrolment ration of women in higher education.

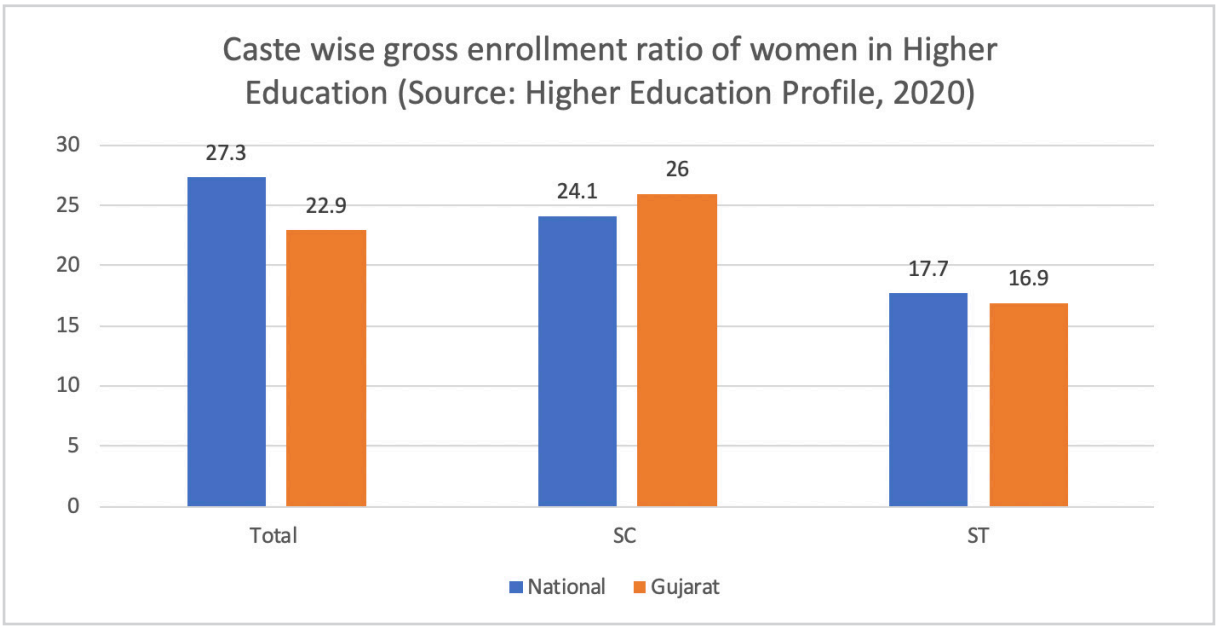

Figure 2 Caste Wise Gross Enrollment Ration in Women of Higher Education.

Figure 3 below describes number of girls who have completed 10 years of education in Gujarat.

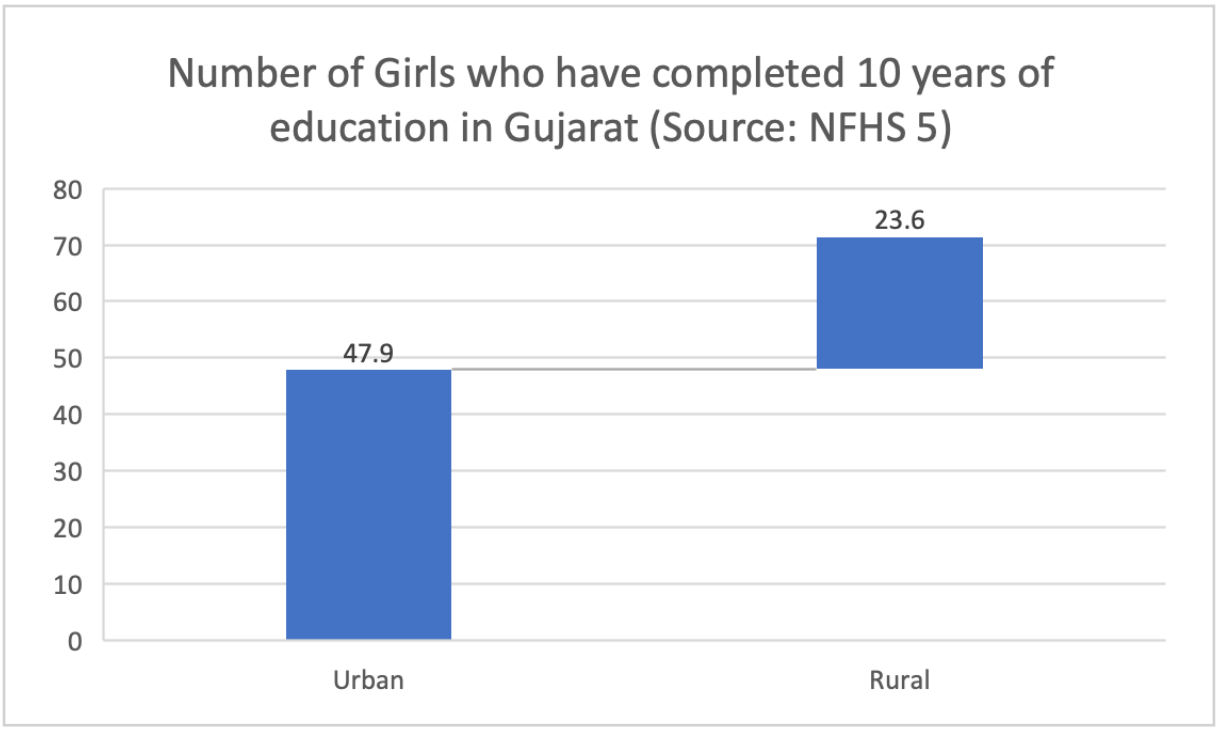

Figure 3 Number of Girls who have completed 10 years of education in Gujarat

Health and Nutrition

Nutrition status of women

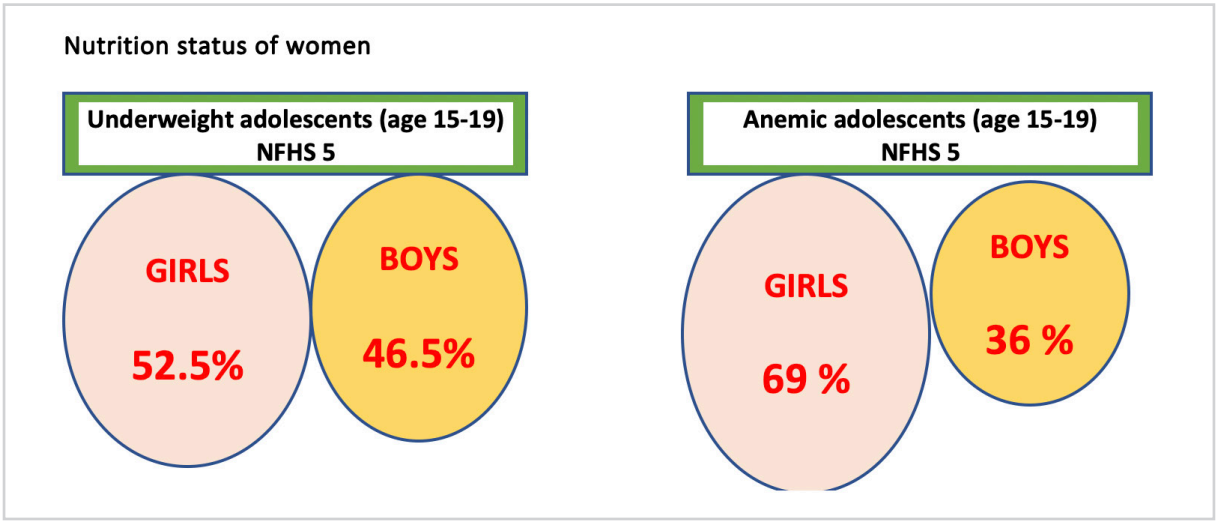

Figure 4 Nutrition Status of women

Figure 4 shows that the nutrition status of adolescent girls is poorer than boys and it worsened since NFHS 4.

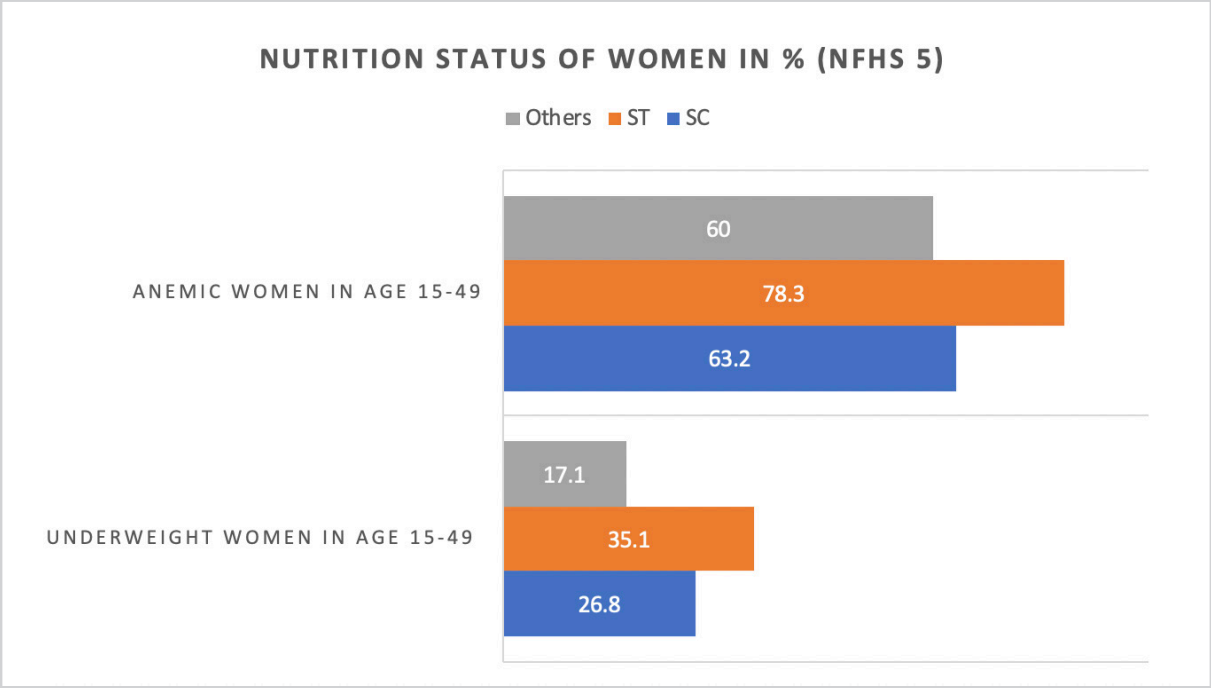

Figure 5 Status of Anemia amongst Women

Figure 5 shows that there is a high prevalence of anaemia and malnutrition amongst the tribal women.

Sexual and reproductive health of women

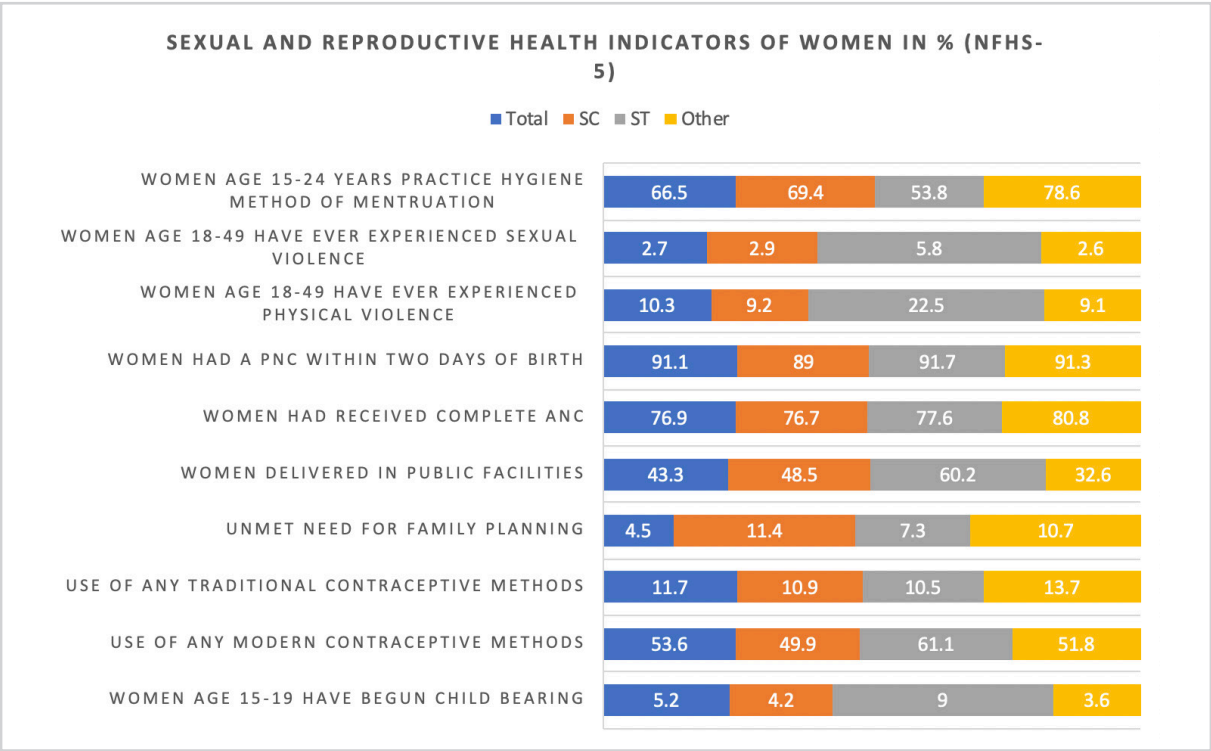

Figure 6 Sexual and Reproductive Health Indicators of Women

Figure 6 shows the reproductive and sexual health vulnerabilities amongst women in Gujarat. Practicing menstrual hygiene, experiencing violence and child bearing in early age are more concerned amongst tribal women; while need of contraception and using public health facilities for delivery are worsened in women belongs from Schedule Caste.

METHODOLOGY

The study documented young women's narratives of their sexual and reproductive lives through in-depth interviews and Focus Group Discussions about their lives, with a focus on sexual and reproductive health, the pathways to different reproductive events in their lives and the underlying determinants. The method sought to document women's and frontline service providers' own stories as data, and apply a gender and rights lens to analyse and interpret the data. The steps followed are mentioned in figure 7.

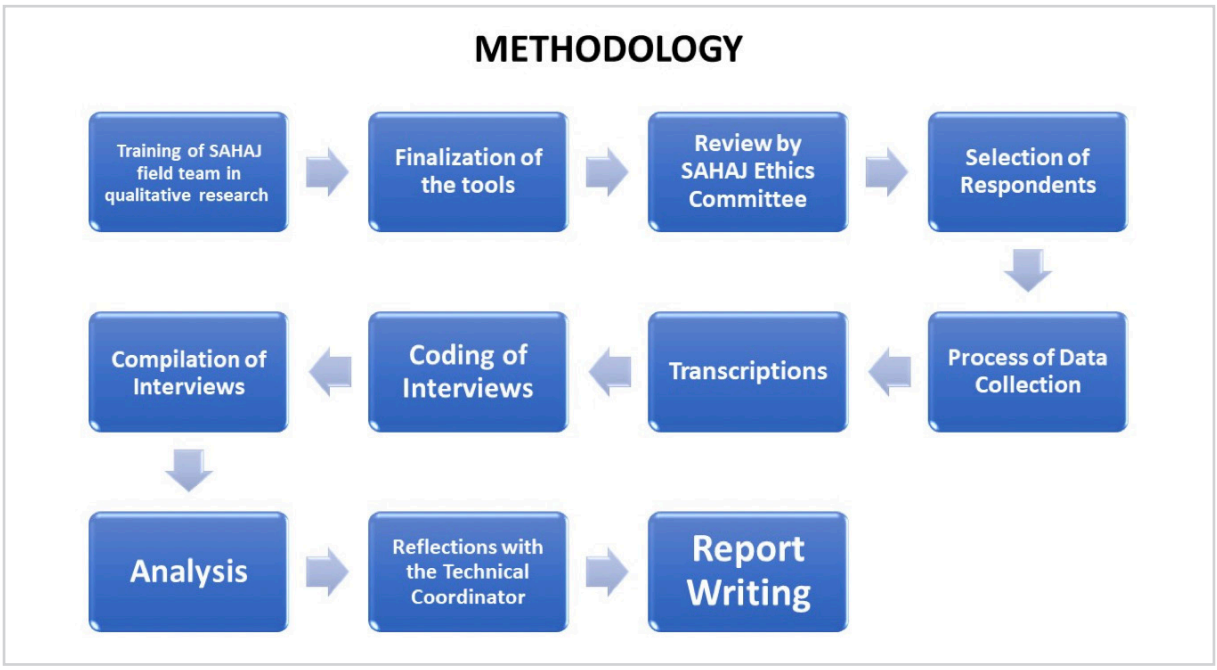

Figure 7 Methodology at a Glance

Finalization of the tools

During a CommonHealth Methodology Workshop (December 21-23, 2018, Mumbai) a common tool covering the life stages of women and different tools for service providers were prepared. These were then translated into Gujarati. After getting written approval from the SAHAJ Ethics Committee, two interviews were piloted in urban Vadodara, one with an unmarried and the second with a married tribal woman. Based on the experiences of pilot interviews, the tools were revised and finalized.

Sample

We selected the category of 'Young Women' in the age group of 18 to 24 years (either married/ unmarried/ single) from the Schedule Tribes. The sample size of 16 was agreed upon at the CommonHealth Methodology Workshop but due to the COVID pandemic and the resultant lockdown, 14 interviews could be completed.

The respondents were selected purposively from six bastis in Vadodara city where SAHAJ is working. Selection of bastis was also purposive to include the different geographical locations socio economic background, and representation of tribal communities. Criteria for selecting respondents were their tribal identity, and their age. Two respondents from Schedule Caste (SC) were considered because of their strong desire to participate in the study. Marital status was also considered for ensuring representation of this group of young married women/adolescent girls.

Four health care providers' interviews were decided to be done during the workshop, but only two were possible due to the sudden lockdown. One was with the Anganwadi worker in one of the project areas where SAHAJ is working and the other with the ASHA, who is associated with SAHAJ for last 15 years as a link worker.

Process of Data Collection

Field Officers of SAHAJ helped in mapping out the possible respondents based on the criteria, from their respective bastis. The total number of possible respondents was more than 30 at the time of the Field Officers' survey but the situation was quite different when researchers went to the field for conducting interviews. Migration and full day engagement in labour work reduced the number of respondents and the research team was finally left with little choice. Field Officers took the prior permission and appointment for interviews and accordingly a team of two or three (team leader and researchers) went for the interviews. One researcher facilitated the interview, and the other took notes. The Team leader played the role of co-facilitator and observer.

The research team comprised of SAHAJ's community programmes' staff, all post graduates with at least five years of community mobilising experience. The researchers are proficient in the local language Gujarati. The research team underwent training comprising of purpose and rationale of the study, conceptual framework, interview skills, note taking and expansion of field notes, transcription, coding and analysis in several phases.

To ensure privacy for women and increase their comfort levels, interviews were conducted, as far as possible, away from their homes. Most of the women (n=12) were interviewed in one sitting and the remaining two were in two sittings each. The length of the interviews varied between 45 minutes and 2 hrs 53 minutes. Following the review of the draft report, based on the reviewers' feedback, short interviews were done in December- January 2021 (after one year of first round of data collection) with four respondents to probe further on their experiences of childbirth. Team also conducted four FGDs with young tribal women and adolescent girls to explore more about vulnerabilities/ privileges due to their tribal status, in February 2021.

The main criterion for selecting the health care providers was that the respondents should be from the same bastis where women's interviews were conducted. This process became smoother as SAHAJ is already engaged with the Anganwadi workers and ASHAs in our Adolescent Rights' project. Anganwadi worker was asked to come at SAHAJ office and the team went to the house of ASHA for her interview. Both interviews were completed in one sitting and the average length of interview was 1hr 21 minutes.

Transcription

A two day training to check quality of transcriptions and to discuss coding and its process was organized in December 2019 in Mumbai. After the meeting a few points were decided to expedite the process of data collection. These points were:

1. Each organisation team would deploy two interviewing teams to accelerate the process. In each, one member would conduct the interview and the other would be the note taker. Only one member in the group would conduct interview.
2. After each interview, the team should sit together and review the interview.
3. The researcher who conducted the interview would do the transcription, as this person would be able to recall the details resulting in a good quality transcript.

GBOARD software was used for transcription. Team members had to be careful about the punctuation as this is not captured through the software. Team members found it useful as it reduced the time of typing work.

Systems were set up for internal peer reviews by the two teams of each others' transcripts. Supervision and mentoring were also provided by support persons.

Coding of Interviews

Coding methods and a framework were introduced in the Mumbai training in December 2019. Coding was done at two levels. 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, health related to SRH, etc) and the second level of coding followed the conceptual framework of the study. Codes like Gender, Power, Rights, Vulnerability, Health, Health System Context, Health Seeking and Resistance were the second level of codes derived from the conceptual framework.

First, all interviews were coded at the first level of the coding framework. More than one person coded each interview independently. Each pair then discussed the codes and finalised the codes. After completion of the first level of codes, the researchers did the second level of coding. A sample of the coded transcripts were reviewed by the Technical Coordinator. To ensure quality of coding, once again peer reviews of each coded interview were done.

Report Writing

The report was collectively written by the research team, with different members taking responsibility for different sections. It was reviewed and finalised by the technical guide. And then sent for external review.

Challenges

In conducting interviews

There were two cases of single interview. In one, the girl could not give time for the second interview as she got a job in a hotel. In another case, the woman left for her maternal home as she was pregnant. However, as the first interviews contained rich data, it was decided to consider these interviews as part of the study.

The age group to be interviewed was defined as 18-24 years. However, in some cases, the girls did not know their right age. During age verification at the time of the interview, the

team would realize that the woman would be more than 24 years of age and had to be dropped and new respondents had to be located. This happened in one case. With one woman respondent, the Field Officer had confirmed her age as 24 years, but in the interview she said she was 26 years old. The data was very rich so the interview was included.

Sometimes, the interviewer faced difficulty in getting information on certain topics/issues. For example, in two interviews, the respondents could not recollect much about their childhood and school days. The reasons cited were that the school experience was not so good and not much importance (dhyan) was given to education. Majority of the respondents were not comfortable discussing sexual relationships. In some cases, despite the interviewer giving personal examples or using different probing tactics, the respondent would not open up. Some respondents would try to divert the topic or distract the interviewer by saying 'How can you ask this?' Or 'How much is your salary? ' Then interviewer would then shift to another theme and then come back to the topic. If there was still resistance or discomfort, the interviewer would drop the topic.

Three respondents did not allow recording and the team had to rely on their notes. The advantage was that transcription was faster and easier.

The team found that after closing the recording, the respondent would talk more freely and give important information. During the interview, they would keep looking at the recorder. This tendency was especially noticeable in the interviews with service providers.

Research team members as interviewers also admitted to being conscious of the recorders in a few initial interviews. In later interviews they became more comfortable.

In Transcription

Quality: Initially the interviews were supposed to be outsourced for transcription. A trial showed that this was more time consuming as the person would not know the context. After some discussions and the December 2019 CommonHealth Methodology Workshop, the team realized that their quality of transcription would be best as they were directly involved.

Each transcription would take around 5 to 6 hours and could not be completed in one sitting as the work was exhausting for the team.

In order to make the respondent comfortable, the interviewers had to do a lot of relationship building talks. This increased their transcription work.

Limitations

Managing the research work and the training, with their ongoing programme commitments by the team members, affected the timeline. As team has been through a rigorous training and capacity building activities through out the process, there was no scope for other SAHAJ staff, to contribute in between. Though this study is focused on reproductive and sexual health across the life cycle, because of the young women's and adolescents' short life span many later life stages and reproductive events were untouched.

RESULTS

Profile of the Respondents

Of the 14 respondents, nine were in the age group of 20 -24 years, four were in the age group of 18 to 19 years and one was 26 years old. Other details are as follows:

- Social group - all from marginalised social groups,
- Education - ranging from five years of schooling to graduation.
- Marital status - mix of married and single young women
- Migration status - Six had migrated to Vadodara from other parts of Gujarat, four for marriage, and two for livelihood.
- Thirteen respondents belonged to male headed households - six with fathers as heads, four with fathers-in-law and three with husbands as heads of households. One respondent's family was headed by her mother who is a 'Helper' in an anganwadi.
- Occupation of heads of households - mainly daily wage earners - six daily wagers on construction sites, one auto rickshaw[6] driver. Two heads of the families were farmers and one a security guard. A few families were relatively better off – contractors on construction sites.
- Occupation of respondents - Eight were homemakers, five married, two unmarried and one engaged.
- Six respondents were employed, three worked as domestic help (two were married and one was unmarried). Three others, all unmarried, were in relatively formal employment; two working in loans and sales departments in a bank and a shopping mall respectively and one in the administration department of a nursing home.
- Average monthly income of the domestic helpers with average 5 hours of work per day was Rs 7300 or USD 100 per month while the women employed in the service sector earned around Rs 9200 or USD 127 average per month.

6 Autorickshaws are a form of transport in India, like a three wheeler taxi that can carry two passengers. Autorickshaws are bought (or hired) by individual men, often with bank credit, and earn them around USD 10 to 15 on a good day.

Focus group discussion participants matched the profile of the 14 respondents.

Table 1 Profile of Respondents (N= 14)

Age						
Sr No	**ST/SC**	**18 to 20 years**	**21 to 23 years**	**24 to 26 years**		
1	ST	3 (21%)	8 (57%)	1 (7%)		
2	SC	1 (7%)	1 (7%)	0		
3	Total	4 (28%)	9 (65%)	1 (7%)		
Education						
Sr No.	**ST/SC**	**Class I to V**	**Class VI to VIII**	**Class IX to X**	**Class XI to XII**	**College**
1	ST	2 (14%)	2 (14%)	3 (21%)	4 (28%)	1 (7%)
2	SC	0	0	1 (7%)	0	1 (7%)
3	Total	2 (14%)	2 (14%)	4 (28%)	4 (28%)	2 (14%)
Marital Status						
Sr No.	**ST/SC**	**Married**	**Unmarried**	**Engaged**		
1	ST	7 (50%)	5 (36%)	0		
2	SC	0	1 (7%)	1 (7%)		
3	Total	7 (50%)	6 (43%)	1 (7%)		
Occupation						
Sr No.	**ST/SC**	**Homemaker**	**Domestic Helper**	**Services**		
1	ST	7 (50%)	3 (21%)	2 (14%)		
2	SC	1 (7%)	0	1 (7%)		
3	Total	8 (58%)	3 (21%)	3 (21%)		

FINDINGS

Vulnerability

The 14 young women interviewed for this study shared vulnerabilities of different kinds during the course of their lives. Poverty, precarious livelihoods of family members, seasonal wage labour and migrant status, played out in different ways in their lives. Another set of vulnerabilities was related to their lack of knowledge about many aspects of their sexual and reproductive lives. And then some also spoke about how they felt emotionally vulnerable in matters to do with relationships.

Poverty

Due to poverty, respondents faced various consequences, like being sent away to stay with grandparents as their parents could not look after them, starting to work early to manage family responsibilities, taking responsibility for younger siblings at a young age as parents were working.

Due to financial constraints, respondents had to drop out of school or had to choose different – read affordable - educational courses. Due to this, their livelihood possibilities were limited. Five respondents shared that they had to drop out of school because of financial constraints. Two out of five dropped out in primary school and the other three did not continue their education after secondary school. Two respondents said that they had to stop their education because they had to look after their younger siblings.

> *"I have studied till fifth grade - as I am the eldest sibling and have two younger brothers and one sister, I had to do household chores, and had to look after my siblings. So I dropped out of school from fifth grade and got married".*
>
> *– Kajal*

Poverty created other emotional issues for these young girls. Sunita[7] described how she began distancing herself from her peers because of fear of peer pressure.

7 All names changed.

Sunita (name changed) is a 19 years old, tribal college going adolescent. Her financial condition is a little tight and she has to live frugally and think twice before spending her money. When she was asked about her friends, she said she did not have any. Because, when she started going to college, she had a big group of friends and they used to spend at least Rs. 200 a month for gifts on each other's birthdays. Every month, some friend had a birthday. Sunita could not afford to contribute for the celebrations hence she stopped participating in gatherings with friends. She cannot afford tuition classes but all of her friends go for these. She stopped talking to her friends because she does not want them to think that she would ask them for their notes from the tuition classes.

This is an illustration of respondent Sunita of the impacts of poverty and psychological vulnerability.

All of these and other vulnerabilities resulted in experiences of marginalization that impacted on the young women's sexual and reproductive health rights as described in subsequent sections.

Against the narrative of poverty and hardship, we can also see how schemes for tribal welfare may have had some results. Sheela, originally from Devgadh Bariya, a tribal majority district, obviously belongs to the 'creamy layer' - her family owns a Scorpio jeep, a Bullet motorcycle and a three storied house albeit in a low income neighbourhood.

Lack of Awareness and Knowledge

Lack of educational opportunities, resulted in low exposure and confidence. Sheekha shared about her first experience of going out of the house on her own.

> *"so when I went out for the job for the first time, I was so scared - how am I going to manage in an auto alone ... how am I going to reach there [her workplace] what type of people will I meet in my job?".*

Another set of vulnerabilities were related to lack of information about a range of subjects that the respondents considered important about their bodies including menstruation, sexual intercourse and contraceptives.

Half of the respondents (n=7) said that they knew nothing about the menstrual period when it came the first time; five were aware about menstruation. The source of information for the unmarried young women was through the NGO representatives, for the married respondent through a friend. Twelve of 14 respondents shared beliefs and rituals followed during menstruation, five of them felt that their mobility was restricted once they started menstruation.

> *"I did not know. I was afraid. There was no itching or pain at the urinary place but the blood was flowing continuously".*
>
> *– Kajal*
> *(21 years, tribal married woman, working as a domestic helper)*

About Sexual Intercourse

Five respondents shared that they did not have any knowledge of a sexual relationship before getting married. On the first night of marriage, they were nervous and they did not talk about it with anyone.

> *"I did not even know that we have to sleep in the same room"*
>
> *– Seema*
> *(22 years, married tribal woman, living in nuclear family)*

Knowledge of Contraceptives

Ten out of the fourteen respondents talked about contraceptives, seven of them were married, two were unmarried and one was engaged. Out of the ten, seven had no or very limited awareness on contraceptive methods. Four out of the seven married women did not know about what could be used to prevent unwanted pregnancy. Three unmarried girls who talked about contraceptives, were aware that condom could prevent pregnancy. Two married respondents (Parul and Urmila) were not using any contraception. They were not aware of any contraception methods. Sheela, a 24 year, tribal married woman spoke about her unplanned pregnancy: "It was unplanned as I was not aware of what to use to prevent pregnancy". (Sheela - 24 year, tribal married woman)

Relationships and Vulnerability

Seven respondents were married at the time of interview whereas, five respondents were single, one respondent was in relationship and one was engaged at the time of interview. Married respondents shared that their relationship with their husband is good. Two respondents reported that they have supportive husbands. Only one married respondent mentioned about one episode of non-consensual sex. One respondent has shared that she is able to express her sexual desires with her husband.

One married respondent stated that her husband fights with her when she does not fulfil the household responsibilities which as a daughter-in-law she is expected to do.

> *''About household chores. If I haven't done some work... like if I haven't washed clothes properly and they are dirty.. so why you did not wash it properly.... and all that we fight about. He gets angry."*
>
> *Sheela*
> *(A 24 year, tribal married woman with good financial condition)*

Two single respondents who do not have any relationship history mention that they are willing to find a husband who is supportive of their aspirations

While talking about romantic relationships, two respondents spoke about having to give up their relationships due to difference in their castes.

"We had a caste issue. We may have faced problems later on, thus it is better to back off right now"

– Usha
(22 years, graduate unmarried adolescent, working in a bank)

One shared that when her family found out about her relationship, she had to face violence. Another said that she had become very weak and vulnerable in that relationship. As a result of her life experiences, she believes that she should not have a boyfriend anymore.

While discussing marriage, four respondents said that they were scared and nervous about life after marriage. At their natal home, they lived with freedom whereas, at their marital home they were nervous about the restrictions and changes in life. One respondent shared that her husband does not allow her to work after marriage. Two respondents also shared that they got married at the age of 16, when they were very young.

"After marriage all the work load was different. At your father's place who works so much? Here I have to do all the work, there it was not much less work".

Sheela
(26 years, tribal married woman)

GENDER

Gender plays out in different ways in the respondents' lives. The interviews highlight the social beliefs about girls and boys, as well as the prevailing gender norms in their communities, and the results of these in terms of social control and discriminatory treatment that was meted out to them. The responses of almost all the women interviewed indicate that they did not immediately admit to or recognise the gender based discrimination that they faced - all except one respondent felt that they were given equal treatment as their siblings including their brothers. However, despite their claims and perceptions that there was no gender discrimination within the families, there is enough evidence of how they are deprived of opportunities and how control is exercised over their lives, simply because they are daughters.

Respondents shared reasons for discontinuation of their education. Of course poverty was a major factor, but within that reality of poverty were gender related reasons, as seen in ....'s quote above. Another young woman was deprived of education because of cultural norms of low value for girls' education and their early marriages, as well as the accepted societal notion that girls cannot be better educated than their husbands.

> *Parul said "I wanted to study till Class 12, but in our community girls are not allowed to go in for higher studies." She is one of those who left school after Class 5 because of siblings' responsibility.*

Social Control

Another theme that runs through the interviews is the different forms of control experienced by these young women because of gender norms. The control was on their mobility, dressing up, use of mobile phones, education, work and employment, or on their relationships.

Meena (26 year old married tribal woman) shared how her mobility was restricted by her natal and marital families. When she was an adolescent, her father would not allow her to go anywhere. And now after marriage, she is not allowed to go out even for shopping, her mother and father-in-law have taken over that task.

One respondent shared that she felt threatened by her mother's disapproval, so she could never think of having an affair or feel attraction towards any boy. Four women (three unmarried and one married) shared their experiences about relationships and how families reacted when they got to know. Two of them faced the consequences of either being beaten by her elder brother or father and being forced to leave her job.

A respondent was caught with her boyfriend and she was extremely scared when she went home. She also believes that going out with boys is wrong, an example of internalising the prevailing social norms about how 'good girls' behave. When she was asked about it, she said,

'' I was thinking that my father would not leave me alive (laughing) but he did not hit me much. He just slapped me two or three times [emphasis ours] and asked me why I was doing this behind their back? Then they made me understand that whatever I had done was wrong. I also agree with them. Whatever they say is correct."

- Reema
(21 years, tribal unmarried young woman, working as a domestic helper)

Another respondent Sonal described how she was controlled by her brother. Although she was working, earning her living, and owned a vehicle, her brother would see to it that she only went to work and come back. And he would keep an eye on her earnings, savings and expenses. While her father was liberal, her brother had assumed the mantle of the patriarch in the family!

Gender norms are reinforced through multiple institutions. Girls described how they were schooled to be 'good girls', dress appropriately in educational institutions, in marital families.

"Madam in my school asked me to change my own style by saying that you are fashionable that's why this is happening to you (boys teasing me). Why is it like this? Why can't girls dress up, have interest in fashion"?

- Sudha
(18 years, a tribal unmarried adolescent)

An unmarried adolescent shared how her brother does not allow her to wear pants and sleeveless dresses. All married respondents said that after marriage they faced restrictions on how they can dress. Many said that they have to wear saris in their marital homes. They also have to take 'laaj' (a veil) in front of elders and male members of their families. Two out of seven respondents said that they wear 'salwar-kameez' when their in-laws are not around.

Gender Power Relations affecting Reproductive Health

Many respondents could not access the reproductive services due to societal norms, lack of decision-making power or awareness about it. In one case, decision of continuing the pregnancy was by her husband though the woman wanted to terminate it.

The most common reason for choosing contraceptive pills was that the husband did not like to use the condom. Two out of three contraceptive pills users denied getting support from their husbands.

Seema (22 years, married tribal woman, living in nuclear family) said "My husband does not like condom. I go and take pills. Once I forgot to take pills and got pregnant. My child, Vihaan, just came because of this reason"

Sita wanted to go for operation (sterilization) after her second delivery. Her husband also wanted the same but her mother- and father-in-law said "no, - Its good to have a second son, then the two brothers can handle the work in the farm."

Resisting Gender Power Relations within Marriage

Three married respondents spoke about how they asserted themselves in their marital families. Leaving the marital home was an option that these young women exercised.

Varsha (name changed) had an arranged marriage when she was 18 years old. Her marital family was living in Dharva (District Dahod). Her father-in-law had two wives. She and her husband were living with their stepmother-in-law, two step-sisters-in-law, and father-in-law after marriage.

Her marital family was non-vegetarian whereas she was a vegetarian and she had never cooked non-vegetarian food. After marriage, her mother-in-law asked her to cook non-veg food. Varsha politely said 'no'. Her mother-in-law told her, ''now you will have to learn to cook and eat it, too. '' Varsha was not comfortable. She firmly said 'no' but her mother-in-law and sister-in-law kept forcing her. Once her sister-in-law even tried to deceive her and fed her non-vegetarian food without telling her what it was. Varsha ate it and vomited immediately after eating. Because of this, there were frequent conflicts in the house. Once they put the chili powder in her bathing water and all the clothes. They did not have a proper bathroom and Varsha used to bathe in the dark. She could not see the chilly and wore clothes. Varsha had chilly all over her body, even in her private parts.

She left her marital home and lived with her parents for some time. After six months her husband came and convinced her to return. Varsha firmly said she did not want to go back. Her husband assured her that they would go and live alone in the city. She agreed and they reconciled. Now they are living in a nuclear family, happily.

Sita's resistance was not against her in-laws but against her husband – '.... he scolded me. I went to my mother's house. Then they came home to pick me up and I came back.'

While most of our respondents have not been able to take their reproductive decisions, some have asserted themselves.

> *"Then after two kids, I didn't want any more. I decided to get done operation (Sterilisation)"*
>
> *- Meena*

RIGHTS

Respondents shared experiences related to a right to express, right to education, right to medical termination of pregnancy, right to choose, right to continue the pregnancy, right to information. Respondents could not articulate their rights or name them properly, but they could certainly identify violation of their rights. In relation to the 'right to information', almost all respondents spoke about lack of information and guidance about education and career options, about menstruation, pregnancy and contraceptives.

Rights over own body

Two married respondents spoke about their rights over their bodies. One shared that she made the decision to get her sterilisation operation done.

"The child's father was saying no, but I will go for the operation". Meena(26 years, tribal married woman, with no power)

Another woman said that she had not aborted her pregnancy because her mother-in-law asked her not to. She added that she wants to do an operation to prevent pregnancy but her husband and in-laws are not supporting this.

"Mother-in-law was saying that it would be good if the second boy comes. I was thinking that I have one boy and if a girl comes I will go for an operation but my mother- in- law says no". Sita (24 years, married tribal woman, having two children with pregnancy)

ACCESS TO SRHR SERVICES

Access to contraception and safe abortion

Ten out of fourteen women talked about contraceptives, seven of them were married, two were unmarried and one was engaged.

Awareness on contraceptive methods was very limited amongst the respondents. Four out of the seven married women did not know about how to prevent pregnancy. Three unmarried girls who talked about contraceptives, were aware about the condom as one of the methods to prevent pregnancy. Five out of the seven married women interviewed, have used modern contraceptive methods. The most common method used by women was contraceptive pills (three out of five women); one had used an injectable and one had experience of an IUD. Due to lack of awareness and not getting support from husband for using condom, six out of seven women had continued unplanned pregnancies.

Access to health care during pregnancy and childbirth

Six women shared their experiences of pregnancy. They have shared information about all the deliveries they had.

Meena described her experience of Caesarean Section. In her first pregnancy, the family had to bear expenses of around Rs. 50,000 for which they had to sell some of her gold jewellery. In her second pregnancy also they had an expense of Rs. 60,000 which was paid by her father.

"My water had broken. We had gone to the village for Holi. We went to the hospital. They said the baby has come down. They said it would be a Caesarean section and one of the two would survive, the mother or the baby (I- oh..) Then they brought me to Vadodara. By then it (foetus) was dry. So they did a Caesarean."

Health Care Providers' Perspectives and their effect on Access to SRH Services

The two frontline health care providers who we interviewed are steeped in the same gender norms as the community that they serve. They face similar struggles that our other respondents face – the struggles of negotiating with the husbands and in-laws for the permission to work, the pressures of combining motherhood and duties as a daughter-in-law and wife with demands of their occupations. And they had similar notions of the boundaries that should be drawn/ are required for girls and women, when they started out as health care providers. The difference between Lila's perspectives then and now is clearly due to the long and deep engagement that she has had with our organisation, SAHAJ. She attributes her woman/girl centred perspective, the confidence and trust that the community has in her, to the training that she has received from SAHAJ.

The *Anganwadi* Worker's perspective, on the other hand, is that '*girls have to be controlled - all girls, whether school going or drop outs are in relationships…. can be easily identified from their behaviour, even their physical appearance makes them stand out. Such girls (girls in relationship) have fuller breasts, broad hips and walk in a typical manner…. girls make fool of us when they say they do not have phones. They have small simple phones usually gifted to them by their boyfriends. They hide them in their bras or in small pockets….'* She seems to be proud of her righteous attitude, asserting that the girls would never dare to ask her for pregnancy test kits! And describing an incident when she told a young married woman, who wanted information on abortion, that she would tell her in-laws about this! As is typical of many health care providers, she does not want to take risks with patients and thus ends up shirking her responsibilities of providing even the basic level of health care that is within her job description. Her perspective on need to work with adolescents is based on stereotypical gender notions of girls as 'future mothers' who need to be looked after well so that the children born to them will be healthy.

Both health care providers agreed that it is important to work with boys and men to prevent violence against women and girls, and to promote women's reproductive health, including contraceptive behaviour.

Violation of other rights and impact on SRHR

The stories narrated by the young women show us that their sexual and reproductive health rights are inextricably linked with their other rights - right to equal opportunities, to education, to information and support, right to equality, right to non-discrimination. Given below are two case stories that exemplify how multiple vulnerabilities because of their intergenerational and historic marginalization, interact with other factors in their lives to have an impact on the respondents' sexual and reproductive health rights.

Seema (name changed) is 22 years old. When she was two years old, her father left her with her grandparents' as he was not earning enough to look after all his family members. In her young age, she was anaemic and used to fall sick very frequently. She had to drop out of school after Class 8 because of poor health.

Seema got married when she was 16 years old. She and her husband started working together as farm labourers after marriage. They lived on the farm and would send 60% of their hard earned money to his parents who were living in another village. His parents forced them to send more money as they were planning their younger son's marriage. Seema and her husband took a loan from the owner of the farm so that the wedding ceremony could take place peacefully. Subsequently, Seema and her husband had to work really hard to pay back the loan. No one from their family supported them or even acknowledged their help.

After a few months Seema got pregnant. They moved in with her husband's family. Her husband began working as a farm labourer in this village. When she was pregnant, she needed nutritious food and a healthy environment. She told us, that her in laws ate only 'mamara' (puffed rice snack) and tea, both for lunch and dinner. She was already suffering from malnourishment and anaemia since her young age. Being deprived of nutrition she delivered a malnourished female baby after five months of pregnancy. The baby died a few hours after her birth. This pregnancy was unplanned.

Seema convinced her husband to leave her in law's house and move away to Vadodara. In Vadodara she got pregnant again. This time she went to her mother's home during

pregnancy. She also started taking medicines for anaemia. She took medicines for 6 months which cost around Rs. 7,000. After nine months she delivered a boy through normal childbirth at Sayaji Hospital of Vadodara. After two years she was pregnant again. She was taking medicines for anaemia again. When she went to visit the doctor at Sayaji Hospital in the eighth month, the doctor admitted her and she delivered a baby girl the next day. She had complications in the delivery and she was in the hospital for 20 days post delivery due to weakness. Now her condition is much better. She told us that all her three pregnancies were unplanned.

Sheela (name changed) is a 24-year-old married tribal woman. She lives in a joint family in Vadodara. Her family is economically stable - her husband and father-in-law both work on construction sites. Their assets include two three-storied houses, a Scorpio (four-wheeler vehicle), and a bullet (two-wheeler motorcycle). Her child goes to a private nursery school which costs Rs. 30,000 per annum (USD 500 approximately).

As a child, Sheela was good in sports. She was selected as a player for the school volleyball team when she was in Class 6. She received a scholarship for free education from Class 8 in a nearby town. But she did not like the hostel and returned to her village school after a year and continued there till she finished high school. Every day she cycled to her school 5 kms away. When she was in the hostel, she wore jeans and T-shirts but in her village girls were not allowed to wear such clothes.

Girls from her community are married as soon as they are 18 years old. Sheela had always wanted to marry a person who had a job. But her parents arranged her marriage. Sheela wanted to study further, to be a nurse. Although her father and her parents-in-law did not oppose her studying nursing after marriage, her husband did not approve of this. He argued that he had not studied after Class 12 and was construction work. If she became a nurse, it would neither match with his profession nor his qualification. Sheela was disappointed.

Sheela's pregnancy was confirmed two months after her marriage. She has sickle cell although her husband does not carry it. She had a difficult pregnancy – nausea and vomiting. She registered in a private hospital for ante natal care. Her first delivery was normal, conducted by a doctor and nurse in the Vadodara hospital. She had an IUCD (Copper T) inserted after her first delivery. But she removed it after about five months on the advice of her family and friends, because she complained of weakness. She shared that she got pregnant twice after her first delivery. She missed her periods and assuming she was pregnant her husband bought pills for abortion from the medical store - both times.

Her second pregnancy happened when her son was five years old. She suffered from nausea throughout her second pregnancy too. Sheela's mother-in-law was very caring. She did not allow her to do any work during her pregnancy. She made sure that Sheela ate nutritious food. Sheela had complete bed rest for three months during her second pregnancy.

As mentioned earlier, she received nine iron sucrose injections at the time of delivery. Her delivery was normal and she did not have a problem or any high-risk symptoms after delivery. She was discharged from the hospital the day after the delivery. Her family incurred high expenditure for her ante natal care and hospital childbirth.

Seema's family's acute poverty *(violation of the family's right to a decent standard of living)* led to her being sent away to grandparents' home. She suffered from malnutrition and anaemia right from childhood and this affected her general health so much that she had to drop out of school after Class 8 *(violation of right to health and education)*. Early marriage (violation of rights to development, self determination) into an equally impoverished family did not improve matters. An unplanned pregnancy *(violation of rights to bodily autonomy, highest available standard of SRH care)*, pressure of an unpaid loan, hard physical labour, poor nutrition during pregnancy all took their toll and resulted in a poor pregnancy outcome *(violation of right to SRH)*. She was successful in asserting herself and managed to change her story by moving into a city with better work opportunities for her husband. Two more unplanned pregnancies but care and support from her parents and husband, with high expenditure to improve her nutritional status, resulted in two children although with complications in the second delivery (violation of right to affordable SRH services). She had three unplanned pregnancies within six years, one with an adverse outcome and another with complications *(violation of right to SRH)*.

Sheela's story on the other hand shows how the genetic disadvantages of her tribal identity – Sickle Cell anaemia – were offset by a relatively better off material condition and care by her mother in law during two difficult pregnancies. Gender norms in the childhood, relatively liberal, allowed her as a girl to excel in sports and win a sports scholarship, to go away to a hostel, to cycle 5 kms to school till Class 12. But gender norms around marriage, became an obstacle for her aspirations *(violation of rights to self determination, to development)*. Her relationship with her husband, on the one hand, prevented her from fulfilling her desires to develop herself further. On the other hand, his support enabled exercise of bodily autonomy, through use of contraceptives and help to terminate two suspected pregnancies.

Seema and Sheela's narratives reveal how their rural and tribal status, poverty and social cultural gender norms played out to violate their rights. Sheela's story also indicates that fulfillment of these other human rights – right to a better standard of living, to education, to care and support - could lead to realisation of some of her SRHR.

These two stories typify how many of the human and adolescent rights spelt out in our conceptual framework, were violated in the 14 respondents' young lives – rights to equality because of gender discrimination, to self determination, education, nutrition, health, development of full potential, care and support, participation, and many others. We discuss below in some detail how these young women's critical rights to education and information and support were violated because of their material conditions and social positions.

Contextual Factors as Enablers and Barriers

Contextual factors have a major role to play in the realisation of young women's rights. The contextual factors lie in various domains – social, political, policies/programmes/laws – as well as at various levels – individual, family, community, and macro systems. In the section that follows, we examine the enablers and barriers for young women's sexual and reproductive health rights along these contextual dimensions.

At an individual level, an enabler that emerges from our interviews is the personal agency exercised by some of our respondents. Usha spoke about how she continued her education despite opposition by her natal family, and Sonal, who, once she was exposed to the discussions and analysis, decided that menstruation rituals are restrictive, and she would not follow them. Meena and Sita took decisions to go for the sterilisation operations.

Within families we saw examples of progressive fathers and supportive husbands who did

not stand in the way of some individual respondents' desires and initiatives - Parul was accompanied by her husband when she decided to terminate her pregnancy. Kajal's father did not stand in her way when she exercised her right to choose and selected her life partner.

There are several examples of support at the community level - friends and peer groups, as well as seasoned community facilitators or animators like the SAHAJ field workers. The research team members also observed that the neighbourhoods where SAHAJ has had longer engagement, appear to have a little more liberal atmosphere than those where our engagement is more recent. Attitudes towards gender based discrimination and gender norms seem to be changing gradually in areas where SAHAJ has had sustained involvement.

The larger policy and programme environment has also created some enabling factors. Policies for adolescents and young peoples' health and empowerment like the ARSH Strategy have resulted in programmes like the RKSK, SABLA[8] with some rights' elements in their designs. These programmes and schemes provide some space that can be leveraged through social accountability efforts by young people and civil society organisations.

Adolescent health issues, like menstrual hygiene and nutrition have gained currency and been made part of job descriptions of frontline workers, like the ASHA and the Anganwadi Worker. At the local community level, support for adolescents' and young peoples' SRH issues is mandated. There is also a flip side to this as we will see further on.

The barriers for realisation of young women's sexual and reproductive health rights lie largely in the structural and systemic realm. We saw from the respondents' stories that a combination of poverty, social disadvantage, and rigid and regressive cultural practices and gender norms, prevent them from availing opportunities for education, employment and economic empowerment and realising their rights to development and also indirectly, and ultimately, their access to the highest standard of sexual and reproductive health care.

Sexual and reproductive health rights are also hampered by systemic factors like lack of sexuality education in schools, lack of SRH information and counselling by the health system. We saw from the interviews that girls' right to SRH information is seriously compromised, and the reason is that Sexuality is a taboo subject, not to be discussed. There are also moralistic overtones to Sexuality as we saw from the interview with the Anganwadi Worker when she said that 'the girls would never dare to ask her for contraceptive pills', implying that unmarried girls are not supposed to need contraceptives.

Gendered notions of women's reproductive health issues were also seen in the Anganwadi Worker's interview when she reported that she told the young woman who wanted information on termination of pregnancy, that she would tell her parents in law. Her response to the woman seems to reflect the belief that women have to fulfil their roles as mothers, and if they do not, they have to be reported to their families. (Similar gendered notions are reflected in adolescent girls' nutritional programmes that address the girls as 'future mothers', rather than individuals in their own right.)

Longstanding and increasing politicisation of certain core SRHR issues connected with sexuality, for example, abortion, or the right to choose, also create a backlash for young women. The two Scheduled Caste respondents in our study mentioned caste as a factor that prevented them from continuing a relationship with a boy of their choice – the fear of social repercussions was unspoken.

8 SABLA is a government-initiated scheme primarily for out of school adolescent girls providing them services on nutrition, health and vocations through the ICDS, but confined to rural and tribal population.

DISCUSSION

This study consisting of life stories of 14 young women living in urban poor neighbourhoods of one of the most developed states in India, provides rich insights into the vulnerabilities they experience in their short lives and how these vulnerabilities influence and impact their sexual and reproductive health and rights. These girls live in Vadodara, possibly the most cosmopolitan city in Gujarat. Gujarat is a state that is recognised as one of the better performing states overall, with a good health system and good governance. The economic indicators of Gujarat are better than many other states, having fifth highest GSDP among 33 Indian States and Union Territories. Yet the social indicators are wanting. Nutrition has been a concern for Gujarat for long. NFHS 5 (2019-20) shows that malnutrition and anaemia in pregnant women and in children has in fact worsened since NFHS 4 (2015-16). Anaemia in non-pregnant women has increased to 65.1 percent (NFHS 5) from 55.1 percent (NFHS 4). Violence against pregnant women has increased since 2015-16. One in five girls in Gujarat gets married before the legal age. Around 22 percent of women in the age group of 20 to 24 years were married before they were 18. Gujarat has a lower sex ratio than India despite it being purported to be the most economically developed state. Gujarat has also been seeing some rapid expansion of infrastructure in cities and towns. Malls are proliferating which means that opportunities for young people for employment in these spaces are also increasing.

Determinants of Vulnerabilities Experienced by Young Women

The 14 stories show that within this context of 'shining' and 'vibrant' Gujarat, the most striking aspect is that social determinants of health like poverty and economic hardship, difficulty in access to education, and social factors like cultural and gender norms affect their lives in many adverse ways. Poverty was the reason why a few of them were sent away to live with grandparents so that there would be one less mouth to feed. This was also a major reason why girls had to drop out of school or choose a less expensive stream. Girls expressed that they had aspirations - to be a nurse, to be a police officer – but these were unaffordable options, and many of them had to switch to other career options that would give quicker returns. Cultural and gender norms too stopped them from pursuing their dreams of higher education – 'wives cannot be more educated than husbands', 'only certain kinds of subjects and careers can be pursued by girls', and so on.

Increasing consumerism and burgeoning markets put new and different pressures on young people, as seen in Sunita's story above. In the prevailing climate of increasing consumerism in a state like Gujarat, girls aspire to be financially independent, but opportunities are limited especially for girls from a weak socio-economic background. The effects of market-led aspirations in these urban poor communities was also seen in the narratives of the Anganwadi Worker interviewed – she stated that parents in her basti prefer to send their toddlers to private day care centres and not to the government Anganwadi.

While Vadodara is seen as an educational centre of some repute nationally, this research showed an interesting pattern in the limited sample in our study. Our sample consisted of 12 tribal girls and two Schedule Caste girls. Out of the 12 tribal girls, four had come to Vadodara

from their natal homes in tribal districts only after marriage (that is, within the last five to seven years) while all others were long time residents of Vadodara and had assimilated into the urban culture. This is probably one reason why we did not really see too many differences between the tribal and the SC girls' lives. One aspect that was noted by our team members, who have a sustained engagement in the bastis where these young women live, was that the tribal girls coming from the districts possibly had higher levels of education (proportionally) than the tribal girls who grew up in urban Vadodara – two out of four migrated tribal daughters-in-law were educated upto Class 12 while only two of the ten long term residents in Vadodara were educated upto and beyond Class 12. One reason for this could be that there are many more education (and other) schemes for tribal areas including Ashramshalas or residential schools, and women's colleges like in Nardipur, Dumyani etc. And in contrast, while Vadodara is a centre for higher education for the privileged and the elite coming from across the country, very little attention is given to education for the poor and working class. In Gujarat, private schools outnumber government schools and when it comes to paying for education, parents prefer to pay for sons' education rather than daughters. Despite schemes like Vahli Dikri Yojana and Kanya Kelavani, the SRS Baseline Survey of 2014 showed that Gujarat was 20th amongst 21 states when it came to girls' attendance rates in schools. In reality, the Government's claim of free education for girls in Gujarat is belied.

Gender Issues

Gender was another major social determinant of SRHR in the respondents' lives. Gender norms can be seen, deeply internalised by the young women themselves, within the families as well as in their social groups or communities. This is reflected in the internalisation of the notions of 'good girls' and 'good wives' by most respondents. 'Good girls' are not supposed to talk to boys. If they do and are chastised (even beaten), then what is wrong? They deserve it, is what they believe. 'Good girls' also have to follow dress codes – not wear sleeveless tops, not wear pants. 'Good wives' are expected to adjust to the new family and new home, with all the dress codes of saris and *'ghunghat'*. Almost all our respondents stated that their mobility was severely restricted. Banning of mobile phones for minor girls by caste panchayats in Gujarat made national headlines in 2016 (IE, February 22, 2016). There was also one heartening example of a positive deviation from the established gender norms – Sheela as a volleyball player was encouraged and actually received a scholarship for a residential school!

Girls have also internalised that they are not entitled to any share of their father's property, as was stated by Sita, a married tribal woman. Gender roles are also deeply internalised – Kajal, five months pregnant at the time of the interview, stated that she wished for a daughter because *'she would help her in her household chores when she grew up.'*

Gender roles are sharply defined – little girls are expected to drop out of school to take care of their younger siblings. Brothers are the guardians of their sisters' morality and good conduct, and can follow them around, or monitor their phone calls, and even fathers hesitate to challenge this neo-masculinity assumed by their sons. New brides into the family are free labour for all kinds of unpaid care work, as well as free labour for agriculture in the families' fields. Wives have to toe the lines drawn by their insecure husbands – bright and ambitious young women cannot study further because their husbands have studied only up till a certain level. Young brides are expected to bear sons – 'Son is valued more in our community. Our respect increases with birth of a son' as stated by Sita. One trend noted by the research team was that the unmarried girls – daughters - in our sample, appeared far more autonomous

that the married young women – the daughters-in-law whom we interviewed. The married women had even more layers of permissions to negotiate starting with the husbands and then the parents-in-laws.

We noted that there has been dilution of some of the customary practices of tribals amongst our respondents. Only one young woman, Sita, spoke about the bride price that the boy's family has to give at the time of marriage. On the other hand, both the schedule caste respondents spoke about having to give up relationships with boys of 'other castes' because inter-caste marriages would never be accepted in their families and communities. So there has been no dilution of cultural norms in SC communities, at least as far as marriages are concerned.

As mentioned above, one significant consequence of gender was the lost opportunities for girls to follow their dreams of higher education and gainful employment. Respondents described how they had to persist and sometimes scheme with their friends to be allowed to go out and work.

Gender Power Relations

Gender power relations are manifested in many ways and in many relationships, both within the family and outside. In the natal home, as they are growing up, girls have to deal with the power exercised by their fathers, brothers as well as mothers to a lesser extent. In many stories as discussed above, we see that brothers have assumed the mantle of protectors. Even girls who are earning their own living and sometimes even supporting their families financially, have to struggle to assert their independence against their brothers. Sonal said that she felt that her brother was her enemy, so strong was his control over her. A few respondents who are working have stated that the power equations within their families changed once they were recognised as earning members, as respect for them and their opinions increased.

At another level, we also see girls becoming victims of their own economic empowerment. Two of our respondents who are earning, indicated that they are now feeling trapped by the family, who want to have control over their earnings. One stated that she was discouraged from continuing her education when she wanted to as that would affect the family income.

In the marital homes the situation was worse. Even if the husbands were supportive – and we saw in our sample that most of the married women reported a reasonably good relationship with their husbands - the mothers-in-law wielded a lot of power. Reproductive decisions were largely controlled by the mothers-in-law and to a lesser extent the husbands. In one family, there was downright neglect of the pregnant daughter-in-law including carelessness in feeding her. In another respondent's story, we saw how her sisters-in-law and mother-in-law ill-treated her just because she was a vegetarian. In these two respondents' cases the ill-treatment actually amounted to domestic violence.

Exercising Agency

Against the many narratives of struggle and experiences of powerlessness, the respondents shared some amazing stories of how they reflected on their situations and worked their way around them. There are some accounts of unexpected maturity and viewing their challenges with a different lens. Sunita spoke about how earlier she was extra sensitive and would get hooked onto power displays by others, until she decided to mentally step aside when others provoked her, and watch them make fools of themselves! She now does not give her teasers the satisfaction of knowing that they have upset her, because she has simply decided not

to get upset by their acts. Another similar story of what can be viewed as maturity was the decision of Usha to pursue further studies after her breakup with her boyfriend, to see an opportunity in what must have affected her as an unsurmountable loss at that tender age.

Girls seem to have realised the enormous power of information, knowledge and education and have fought against all odds to continue their education, even financially supporting themselves. They are also determined to continue their jobs in the face of family opposition, because they value the mobility, the different opportunities, the autonomy and the confidence that their job gives them.

Within the husbands' families we saw that at least three of the respondents decided they would not put up with humiliation and ill-treatment and exercised their agency to move out of their parents'-in-law's homes, two with husbands' support, and one even without her husband. A few others narrated how they exercised their reproductive self determination – by terminating pregnancies that they did not want, by deciding to go for terminal methods of contraception when they felt they had the number of children they wanted.

Rights

A combination of underlying social determinants, like poverty, education, gender norms have deprived these girls of many rights. It appears that the violation of the right to information has adversely affected their access to many opportunities, and to attainment of autonomy. And this in turn has affected their right to development, to eventually evolve into informed citizens, who have a right to participate and have a voice.

In addition to their civil and political rights, their **Sexual and Reproductive Health Rights** have also been compromised. Anaemia, malnutrition, Sickle Cell in childhood compromise their reproductive health as they grow older. These risk factors, combined with gender issues, affect their pregnancies. Seema told us that she miscarried in the 5th month of her first pregnancy. She also had a complicated second pregnancy, resulting in the doctor admitting her during a routine antenatal visit in the 8th month of her second pregnancy. Kajal and Meena both had to have Caesarean section childbirths. All of them had unplanned pregnancies, because of lack of knowledge and access to suitable contraceptive care. Post Natal Care is almost non-existent, even after Caesarean Section childbirths.

Cultural, community and family norms forbid almost all respondents from choosing their life partners. There are exceptional families like Sunita's who may allow girls to marry based on their own choice. Girls are also married very early in these communities, a trend also seen in NFHS 5 as one in every five girls in Gujarat is married before the age of 18. Cultural, community and family norms forbid girls from exercising control over their own bodies – husbands and mothers-in-laws decide when the girls should be available for sex and when and how many children they should have. Sexuality is a taboo topic. Respondents did not even want to talk about this. There is no concept of an expressed sexual desire by women, except one respondent, Seema who described how she expresses her sexual desire to her husband. What gladdened our hearts was the fact that most of the married respondents seemed to have non-violent, non-coercive relationships with their husbands.

The most significant violation that we see in our small sample is of the right to reproductive and sexual health information. Almost all the respondents – except those who have been in contact with NGOs – stated that they did not know about menstruation before it started, about sexual relationships before they got married and about contraceptives before they were landed with unplanned pregnancies.

Violation of Reproductive and Sexual Health Rights experienced by the young women, is substantiated by the accounts provided by the two health providers' interviews.

Health System Response

While the union as well as the state government have been designing and implementing the Adolescent Health Strategy and the Rashtriya Kishore Swasthya Karyakram (RKSK) for over a decade, and a host of adolescents' programmes (SABALA, Kishori Shakti Yojana, and so on) evidence suggests that implementation on the ground is weak. A review by Jejeebhoy[9] et al in 2014 pointed out that the adolescent health programmes are limited to safe issues such as nutrition and menstrual hygiene and skirt topics related to sexuality such as access to contraceptives, abortion related information and so on. Programmes also tend to focus on married adolescents, largely excluding unmarried girls, and boys even more. A more recent review of the RKSK[10] (Barua etal, 2020) states that the human and financial resources mobilised for the programme are inadequate and clinical services for adolescents few and far between. The review also found that there is a low level of awareness of the programme among the adolescents and that peer educators need to be better trained and supported.

All of the above match our findings – the health system does not appear to prioritise SRH information and counselling to adolescents and young women, even married ones. Our experience of three decades in Vadodara bastis tells us that Anganwadis barely function, let alone for adolescent girls. Quality of maternal health services even to high risk pregnant women is found to be wanting. Even as menstrual hygiene has been prioritised by the health - and education – system, resulting in access to free or affordable sanitary pads, removing gender discriminatory customary practices is not something the health system is focussing on. Provider attitudes are not conducive to winning confidence of young people – their sensitivity to young people's needs and their training appears to be inadequate.

9 Jejeebhoy, S. J., K. G. Santhya, S. K. Singh et al. 2014. Provision of Adolescent Reproductive and Sexual Health Services in India: Provider Perspectives. New Delhi: Population Council.

10 Barua, A., Watson, K., Plesons, M. et al. Adolescent health programming in India: a rapid review. Reprod Health 17, 87 (2020). https://doi.org/10.1186/s12978-020-00929-4

RECOMMENDATIONS

Recommendations for Community based NGOs

1. Collaborate with the government to fill in the gaps of government service delivery. Complement government services with the non-judgemental sensitivity and trust that adolescents look for.
2. Partner with the government specifically on training for frontline workers on the meaning of adolescent friendly services.
3. Work with the education system on these issues. Promote convergence for SRHR needs of adolescents, including comprehensive sexuality education.
4. Engage with community leaders and other important stakeholders to change gender norms.
5. Work with men and boys on transforming prevailing notions of masculinities.
6. Work on needs of young married couples – preparation for marriage, respectful relationships, negotiation and assertiveness with spouse and family.
7. Ensure that adolescent girls' programmes respond to their aspirations. Create opportunities for girls to further their education, prepare them for employment, facilitate avenues for their employment and livelihoods.
8. Comprehensive Sexuality Education should be started early. Girls urgently need information on contraceptives and safe abortion.

Recommendations for Policies and Programmes

1. Collaborate with suitable NGOs – those working with adolescents with a gender and rights perspective.
2. Ensure training of service providers on the meaning of adolescent friendly services. Commission suitable NGOs to impart such training.
3. Make RKSK universal. Strengthen its implementation based on the evaluations done. Ensure that the service delivery is rights-based and does not take an instrumental view of girls as future mothers. Ensure systematic monitoring of the implementation to fill in the gaps.
4. Male Health Workers are essential to complement the ASHAs – to work with boys and men on sexual and reproductive health issues from a gender justice perspective.
5. Unmarried adolescents as well as young married people should be the focus of the programme.

6. NFHS looks at only spousal violence. Domestic violence that is violence perpetrated by other members of the family should also be estimated through the NFHS.

7. The Family Planning Programme should urgently focus on increasing contraceptive awareness amongst young people.

Recommendations for Community Leaders

1. Demand for the services meant for you – take benefit of the existing services and provisions.

2. Change the mindset of 'government services are bad'. Middle class should use government health and education services, and demand quality.

3. Change perceptions about young people, including girls. Create dialogues with them and facilitate their participation and leadership in local governance. Support girls' leadership and empowerment.

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i Ganeshan, Sudhakar 'Comparative Analysis of Social Indicators Gujarat Vs Uttar Pradesh Vs Tamilnadu Vs Kerala', Medium, 28 August,2020

ii SDG India Index and Dashboard 2020-21: Partnerships in the Decade of Action. UNDP and NITI Aayog, 2021

iii Sudarshan, R. A report of Mid term Evaluation of the project on 'Enhancing Social Accountability through Adolescent and Youth Leadership'. Unpublished report of SAHAJ (2020)

iv Pradhan, A. Summary report of end evaluation of extension phase 2016-18. Unpublished report of SAHAJ (2018).

v Sardeshpande N., Shah H. A report of external evaluation on 'Adolescents as Citizens and Change Agents for Social Accountability', Unpublished report of SAHAJ (2016)

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