ICPD+30: INDIA'S COUNTRY MONITORING REPORT

Sexual and Reproductive Health, Rights and Justice (SRHRJ) of Structurally Excluded Women and Girls in India

Dr P Balasubramanian

CommonHealth

arrow
asian-pacific resource & research centre for women

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BACKGROUND OF THE PUBLICATION

The year 2024 holds a significant milestone – the 30th anniversary of the International Conference on Population and Development (ICPD). This landmark event is a commemoration and an opportunity to review progress in and gaps of the ICPD+30. The UN General Assembly Sessions in September 2024 (UNGA, 2022) will be a platform for this review. The 57th Commission on Population and Development (CPD) session in 2024, as called by the UNFPA, will be dedicated to a discussion of ICPD+30 and has already initiated the process of generating evidence on it.

Within this global context, the Asian Pacific Resource and Research Centre for Women (ARROW), a regional women's rights organisation in Malaysia, has embarked on a collaborative journey. Together with its national partners, it has diligently generated evidence on progress and gaps in the sexual and reproductive health and rights (SRHR) situation in 17 countries. This report on India's country monitoring is a testament to the collective study conducted by ARROW's partners in these countries. The research was aimed at monitoring progress and the gaps in the Indian government commitment to the ICPD PoA, with a specific focus on the SRHR of young people and adults.

This research, the outcome of diligent effort by CommonHealth in India, a multi-state coalition of organisations and individuals, holds immense significance. It was prepared for advocacy at the 2023 Asia Pacific Population Conference (APPC) at the regional level, during the 2024 global review process at the Commission on Population and Development (CPD), and through national-level advocacy with different stakeholders. "ICPD+30: India's Country Monitoring Report" is not just a document but a beacon of hope, guiding us towards a future where SRHRs are universally respected and protected. The objectives of the research were:

- To document progress, gaps, and challenges in implementing the ICPD Programme of Action at the national level;

- To generate evidence on key SRHR issues identified, particularly on young people's sexuality and maternal healthcare, including abortion, to inform national-level advocacy on universal access to SRHR; and
- To generate evidence on key SRHR issues relating to marginalised women and girls.

The following three publications were produced under the ICPD+30: India's Country Monitoring Research:

1. "Review of National Policies and Programmes, and Synthesis of Literature on Sexual and Reproductive Health in India (1995-2022)";
2. "Sexual and Reproductive Health, Rights and Justice of Structurally Excluded Women and Girls in India"; and
3. "Are Sustainable Development Goals Furthering the Agenda of Gender Equality? Review of the Progress in India."

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ACKNOWLEDGEMENTS

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Special thanks to CommonHealth member organisations; RUWSEC Tamil Nadu, SAHAJ Baroda, SAHALI Pune, SAHAYOG Odisha, and YP Foundation Delhi for their state-specific reports on documenting the sexual and reproductive health and rights (SRHR) issues of marginalised women from their respective constituencies. These reports provided a base for developing this publication on SRHR issues of structurally excluded girls and women.

We sincerely appreciate the useful comments and insights provided by Dr TK Sundari Ravindran while developing the report. Her critical input and valuable suggestions have significantly enhanced the quality of our work. We also extend our special thanks to Dr Alka Barua for her dedicated support in reviewing the report and providing constructive feedback on revising the earlier drafts and, Ms Riju Dhakal, Ms Anjali Shenoi, Ms Nur Hazwani Husin, and other ARROW team members for their diligent review of the report and valuable input for finalisation.

We thank Ms Swati Shinde, Programme Manager of CommonHealth and the SAHAJ team for providing administrative support for the study.

CommonHealth Team

LIST OF ACRONYMS AND ABBREVIATIONS

APL	-	Above Poverty Line
AIDS	–	Acquire Immune Deficiency Syndrome
ARROW	–	Asian Pacific Resource and Research Centre for Women
BC	–	Backward Caste
BPL	–	Below Poverty Line
D&C	–	Dilatation and Curettage
GBV	–	Gender Based Violence
HIV	–	Human Immunodeficiency Virus
ICPD	–	International Conference on Population and Development (ICPD)
ICPD+30	–	International Conference on Population and Development after 30 years
IIPS	–	International Institute of Population Sciences
IMR	–	Infant Mortality Rate
MGNREGA	–	Mahatma Gandhi National Rural Employment Guarantee Act
MoHFW	–	Ministry of Health and Family Welfare
NFHS	–	National Family Health Survey
NGO	–	Non–Governmental Organisation
PoA	–	Programme of Action
PVTs	–	Particularly Vulnerable Tribes
RUWSEC	–	Rural Women's Social Education Centre
SAHAJ	-	Society for Health Alternatives
SAHELI	-	Sex Worker's Collective NGO
SAHAYOG	-	A NGO in Odisha
SC	–	Scheduled Caste
SDGs	–	Sustainable Development Goals
SRH	–	Sexual and Reproductive Health

SRHR	–	Sexual and Reproductive Health and Rights
SRHRJ	–	Sexual and Reproductive Health, Rights and Justice
SRR	–	Sexual and Reproductive Rights
ST	–	Scheduled Tribes
STIs	–	Sexually Transmitted Infections
TYPF	-	The Youth-Led Organisation in Delhi
UNFPA	–	United Nations Fund for Population Activities
WHO	–	World Health Organisation

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SEXUAL AND REPRODUCTIVE HEALTH, RIGHTS AND JUSTICE (SRHRJ) OF STRUCTURALLY EXCLUDED WOMEN AND GIRLS IN INDIA

1. INTRODUCTION

Sexual and reproductive health and rights (SRHR) refer to attaining the highest possible level of sexual and reproductive health. The United Nations reports that women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination (OHCHRC 2023).

A marginalised group is a group of people that does not enjoy the same privileges as the rest of society and suffers from multiple deprivations. Marginalised communities are those excluded from mainstream social, economic, educational, and/or cultural life. Examples of marginalised populations include but are not limited to, groups excluded due to race, gender identity, sexual orientation, age, physical ability, language, and/or migration status. Marginalisation occurs due to unequal power relationships between social groups (Baah et al. 2019). Marginalised groups are also called structurally excluded groups and communities.

Many studies in India show that the SRH issues of adolescents and young people are rarely addressed. Awareness about SRH among young people is very poor. In a study conducted in Uttar Pradesh, a large majority of the girls (86%) reported that they were completely unprepared for their first menstrual period, and 64 per cent reported that they felt scared of menarche (Santhya et al. 2017). In another study covering 634 college-going Scheduled Caste (SC) girls in Tamil Nadu, 44 per cent reported that they had experienced their first menstruation without having any idea about it (Ravishankar 2017). The National Family Health Survey (NFHS)-5 (2019-21) survey findings of India suggested that the proportion of young women (15-24 years) using a hygienic method of menstrual protection was slightly lower among girls from the Scheduled Castes and Tribes, than in the other communities. Likewise, 95 per cent of women in the highest wealth quintile, as against 53 per cent in the poorest quintile, used some hygienic method of menstrual protection (IIPS 2019-21).

A large-scale study of 50,848 youth in the age group of 15-24 years, reported that 37 per cent of young men and 45 per cent of young women knew a woman could get pregnant on the first sexual encounter (IIPS 2006-07). The unmet need for family planning remains highest among adolescents (20%) (IIPS & MOHFW 2015). It is also found that a significant factor delaying timely access to safe abortion services is the lack of awareness among the young about: the legality of abortion, facilities providing safe and legal abortions, and providers of legal abortion services (UNICEF 2013).

The maternal mortality rate was high for adolescents – 45 per cent of all maternal deaths in India were reported among 15–24-year-olds (GoI 2011). The results of the NFHS-5 (2019-21) survey show that the total fertility rate is slightly higher among Scheduled Castes (SCs) (2.08) and Scheduled Tribes (STs) (2.09) than among other caste groups (1.79). Similarly, poor women and those belonging to SC/ST communities have higher infant mortality rates (40.7 per 1,000 live births) than other communities (28).

Evidence also shows that the nutritional status of marginalised women is poor in India (Biswas et al. 2023). The rate varied significantly by caste and household economic status. The prevalence of anaemia among SCs (59.2 %) and STs (64.6 %) is substantially higher than it is for the other communities (56.4%); also, it was 67 per cent in the lowest wealth quintile against 51 per cent in the highest wealth quintile (IIPS 2019-21).

Again, women belonging to poor households and marginalised caste groups are more susceptible to spousal violence than others. The prevalence of domestic violence was noticeably higher among Scheduled Castes (32.3%) and Tribes (34.7%) compared with the national average (29 per cent). More importantly, among women in the lowest wealth quintile, 41 per cent suffered from spousal violence, but in the highest wealth quintile, it was only 19.7 per cent (IIPS 2019-21).

There are many studies in India which explored caste disparities in health and inequities in access to and utilisation of SRH services by economically weaker and socially deprived sections of women (Kavitha 1997, Sivagami 2003, Krishnamoorthy 2004, Ramachandran 2004, Balasubramanian & Sundari 2014). Due to their poor socio-economic conditions, Scheduled Caste and Tribal women living in urban slums tend to postpone seeking health services. Only in extreme situations do they take steps to visit a health facility. Healthcare-related discrimination against marginalised women is common in the country.

The NFHS-4 (2015-16) data reported that 70.4 per cent of Scheduled Caste women had problems accessing healthcare (IIPS 2015-16). Another study conducted in 17 districts of Andhra Pradesh, Bihar, Tamil Nadu, and Uttar Pradesh indicates

discrimination faced by Scheduled Caste women in accessing healthcare services in government hospitals (NCHR, 2006). The discrimination and violence Scheduled Caste women encounter at a young age have a dominating effect on their lives. One study (Indian Institute of Dalit Studies 2013) indicates that the average age of death for Scheduled Caste women was 14.6 years lower than it was for higher caste women.

Above all, the most vulnerable communities were ravaged by the Covid-19 pandemic, climate change, and conflict. Vulnerable women were severely affected by the inaccessibility of maternal health, contraception, and abortion services due to the Covid-19 pandemic (CommonHealth 2022).

Against this backdrop, CommonHealth – a rights-based multi-state coalition of organisations and individuals (that advocates increased access to SRHS to improve the health conditions of women and marginalised communities) conducted a qualitative study during 2019-20 to document the SRHR of structurally excluded girls and women in India. The main aim of the research was to document the SRHR issues of marginalised women in India as experienced by them during different stages of their lives, and to understand the gaps and barriers in accessing and utilising healthcare services. Thus, the evidence generated could be used to plan suitable advocacy strategies to work with various stakeholders, especially for mobilising communities, and to work with policymakers to make appropriate and sustainable changes at multiple levels.

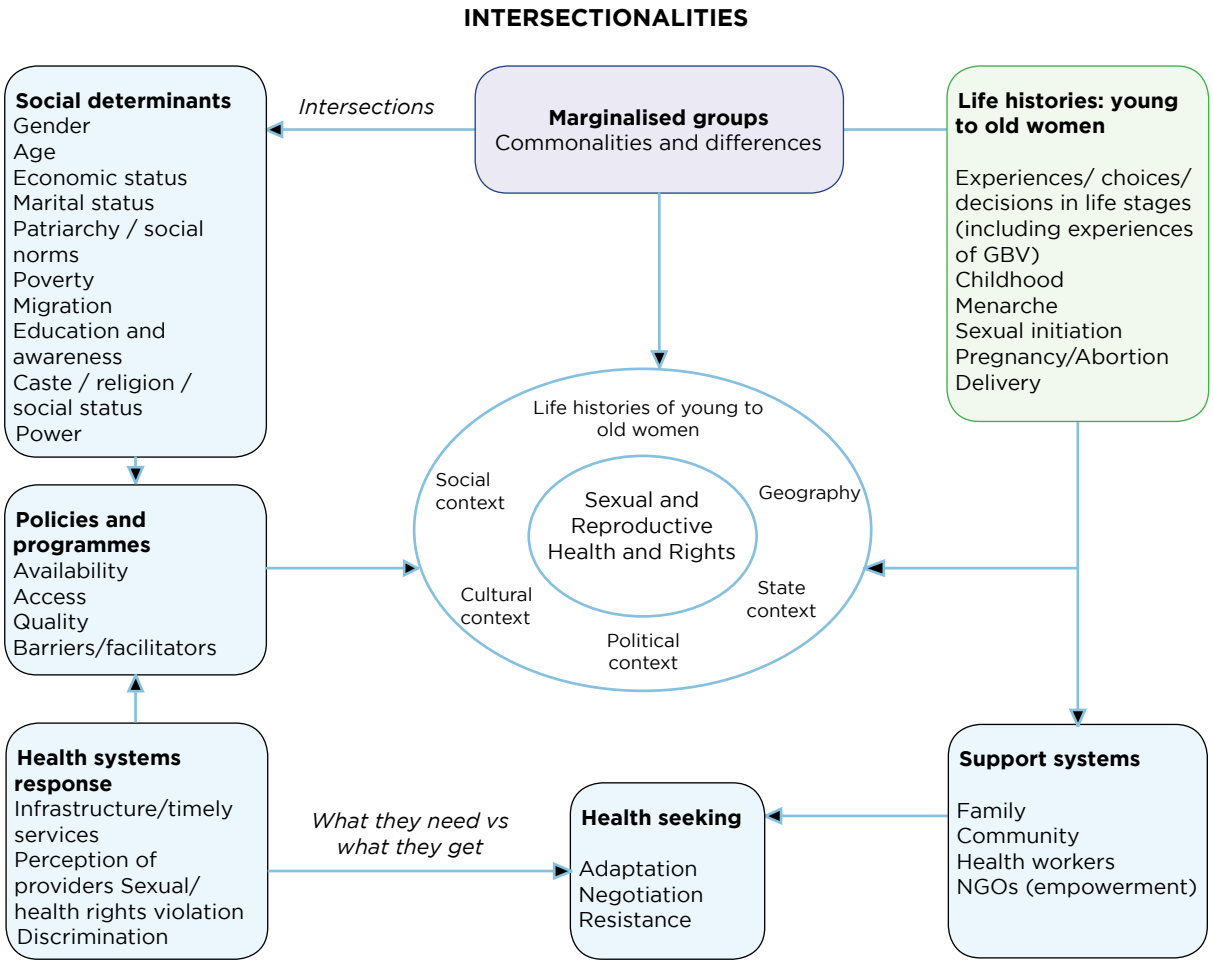
This report compiles the findings of the studies carried out by CommonHealth's five partner organisations (details of the organisations are provided in the next section). The study was conducted in four states and one union territory namely: Gujarat, Maharashtra, Odisha, Tamil Nadu, and New Delhi.

1.1 Conceptual Framework Used

CommonHealth members collectively evolved a conceptual framework to guide the study. The broad objective was to understand the circumstances in which certain events occurred and also what transpired between consecutive events. The SRHR areas of focus in the study were childhood and menarche, sexual initiation and sexual lives – including marriage, use of contraceptives, pregnancy and postnatal experiences, and sexual and reproductive morbidities. 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 families, the community, and the health system. Overall, it tries to understand women's experiences from an intersectional angle, i.e., how various social determinants like age, gender,

class, caste, social status, and related vulnerabilities influence women's health and how women adapt, negotiate, and resist to get what they need, particularly in terms of their SRH choices. An attempt to capture some key concepts central to this study is shown in Figure 1.

Figure 1 Conceptual framework



1.2 Data

This report is based on in-depth interviews with 44 marginalised women and girls from four states: Tamil Nadu, Maharashtra, Gujarat, Odisha, and the union territory of New Delhi. The participants in the study belonged to different marginalised groups including Dalits[1], tribals, unmarried and married women, and sex workers from urban slums. CommonHealth partner organisations (Rural Women's Social Education Centre – RUWSEC from Tamil Nadu, SAHELI from Maharashtra, SAHAJ from Gujarat, SAHAYOG from Odisha and The YP Foundation - TYPF from New Delhi) working in their respective states and union territory, conducted the field studies and prepared state-specific reports. The CommonHealth team developed the common research tools and trained the field investigators. Field data was collected from May 2019 to March 2020 in all five sites.

1 Dalits refers to Scheduled Castes, both these terms are interchangeably used in the report. The word Scheduled Caste is more widely used in official communication in India.

2. SEXUAL, REPRODUCTIVE HEALTH AND RIGHTS SITUATION OF GIRLS AND WOMEN IN THE STUDY AREA

2.1 Socioeconomic Situation in the Study States

Table 1 presents the socio-economic situation of the study area. Three of the states, Tamil Nadu, Gujarat, and Maharashtra, are the most industrialised in India, with consistently high economic growth rates and high urbanisation. The national capital, New Delhi, is an urban centre, where more than 98 per cent of the population live in urban areas. However, in Odisha, a large majority (83 per cent) live in rural areas. About one-fifth of the population in Odisha belong to the Scheduled Tribes, and 17 per cent belong to Scheduled Castes. Odisha has the third-highest number of tribal people in the country. Following Odisha, Gujarat has the highest proportion of the Scheduled Tribe population. About one-fifth of Tamil Nadu's population belongs to the Scheduled Castes, but the proportion of Scheduled Tribes in its population is very low.

Table 1: Socio-Demographic and Economic Situation of the Study States 2011

Indicators	Gujarat	Delhi	Maharashtra	Odisha	Tamil Nadu
Population in millions	60.4	16.78	112.4	41.97	72.18
Overall sex ratio	919	868	929	941	943
Percentage of SC population	6.74	16.75	11.8	17.13	20.01
Percentage of ST population	14.75	NA	9.4	22.85	1.1

Indicators	Gujarat	Delhi	Maharashtra	Odisha	Tamil Nadu
Percentage of population aged 15-29 years	28	30.4	28.4	26.9	26.8
Population Density	302	11297	365	269	555
Percentage of urban population	42.6	97.5	45.22	16.69	48.4
Literacy rate of population aged 7+ (Total)	78.03	86.25	82.34	72.87	80.09
Male	85.75	90.94	88.38	81.59	86.77
Female	69.68	80.76	75.87	64.01	73.44

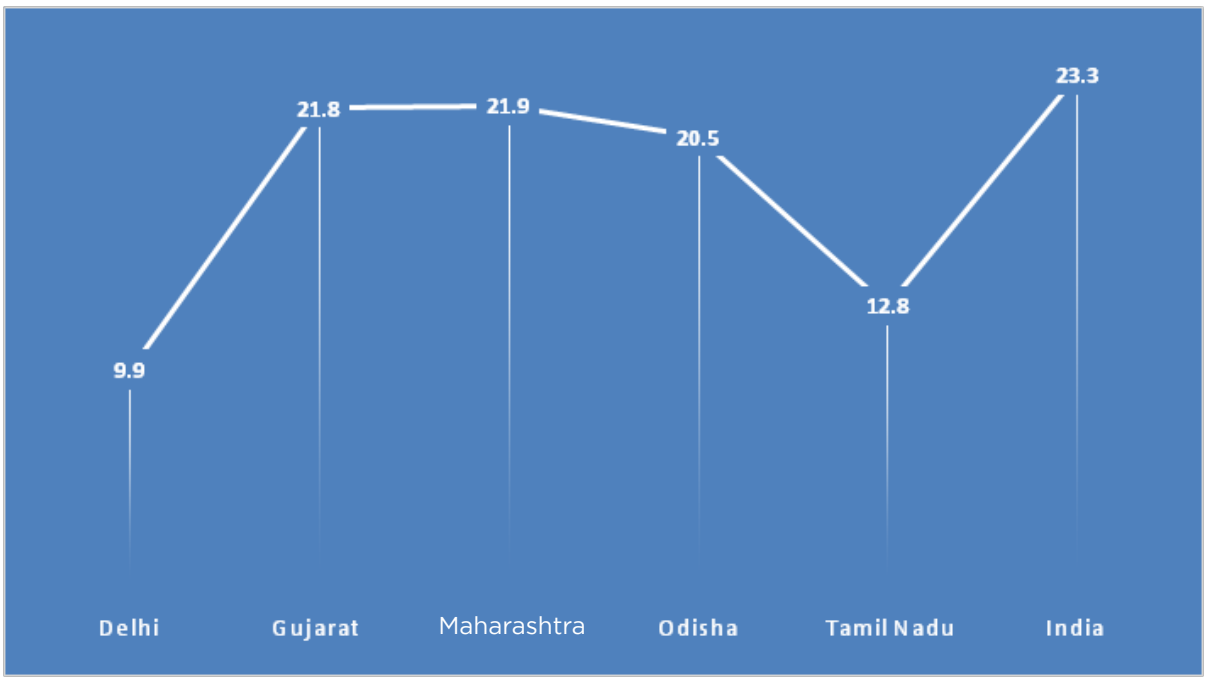
Source: 2011 Census

The overall sex ratio was low in Delhi compared to the other sites, possibly due to high male-dominated migration to the urban metropolitan city. Delhi's population density was 11,297 persons per square km, almost 30 times higher than the national average (382). Even though overall literacy was high in all the states, there was a wide gender gap in all the sites, more prominently in two states, where the rate of female illiteracy was significantly high, 36 per cent in Odisha and 30 per cent in Gujarat. Similar results were also observed in the latest NFHS-5 (2019-21) survey, which showed the rate of female illiteracy in the 15-49 age group was 30 per cent in Odisha and 27 per cent in Gujarat (IIPS 2019-21).

2.2 SRHR Situation in the Study States

This section provides the current SRHR situation of the study states (Odisha, Gujarat, Maharashtra, Tamil Nadu and New Delhi). Early age at marriage of girls is still an issue in India. The proportion of married women (20-25 years) who, at the time of their marriage were below the legal age of 18 years, was low in all five states compared to the national average (23.3 per cent). However, more than one-fifth of the women in Gujarat, Maharashtra, and Odisha got married when they were below 18 years; this ratio is lower in Delhi (9.9) and Tamil Nadu (12.8) (IIPS 2019-21).

Figure 2: State-wise percentage of women (20-24 years) married before 18 years, 2019-21



Source: NFHS 5 2019-21

It is seen from the graph that child marriage is still an issue in the study sites (Figure 2). The rates could be high among marginalised groups; however, disaggregated data by caste and economic status of women who married at less than 18 years is unavailable. The adolescent fertility rate was also high in Maharashtra (47 per 1,000 women aged 15-19 years) and Odisha (40), followed by Gujarat (34) and Tamil Nadu (34); it is low in Delhi (19) (IIPS 2019-21).

Table 2: Caste-wise SRHR Indicators for Women in India and Study States, 2019-21

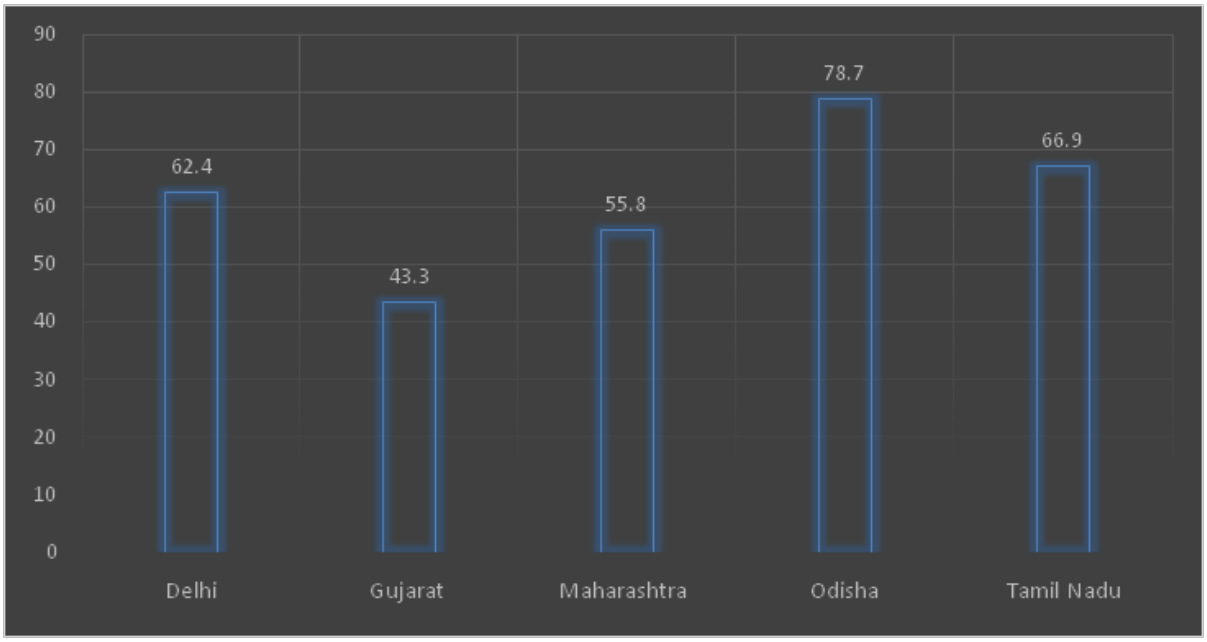
	Delhi	Gujarat	Maharashtra	Odisha	Tamil Nadu	India
Selected SRHR Indicators						
Total fertility rate (children per woman)						
Scheduled Caste	1.64	1.71	1.57	1.85	1.78	2.08
Scheduled Tribe	1.24	2.04	2.06	2.11	1.87	2.09
Other Backward Castes	1.78	1.95	1.67	1.7	1.74	2.02
Others	1.5	1.6	1.63	1.59	1.65	1.78
Total	**1.62**	**1.86**	**1.71**	**1.82**	**1.76**	**1.99**
Infant mortality rate (IMR)						
Scheduled Caste	24.8	48.5	21.1	36	25.3	40.7
Scheduled Tribe	NA	31.9	31.1	55.9	NA	41.6
Other Backward Castes	23.7	29.4	18.5	24..1	15.5	34.1
Others	23.6	23.4	20.9	27.2		28
Total	**24.5**	**31.2**	**23.2**	**36.3**	**18.6**	**38.4**
Contraception: Married women using any modern methods of contraception (%)						
Scheduled Caste	57.9	49.9	63.8	52.5	67.10	57
Scheduled Tribe	56.5	61.1	61.8	47	64.30	55.1
Other Backward Castes	57.6	53.3	66.2	49.6	65.00	56.6
Others	58.5	51.8	63.1	45.5	61.20	56.4
Total	**57.7**	**53.6**	**63.8**	**48.8**	**65.5**	**56.4**
Total unmet need for contraception (%)						
Scheduled Caste	6.5	11.4	9	6.7	6.7	9.2
Scheduled Tribe	7.4	7.3	9.9	6.2	4.7	9.2
Other Backward Castes	5.7	10.7	9.2	7.6	7.7	9.6
Others	5.7	10.7	9.7	8	13.9	9.4
Total	**6.1**	**10.3**	**9.6**	**7.2**	**7.5**	**9.4**
Maternal Health						
Mothers who had at least 4 antenatal care visits (%)						
Scheduled Caste	73.7	76.7	68.7	79.6	57.40	55.30
Scheduled Tribe	83.6	77.6	65.5	69.8	54.00	57.60
Other Backward Castes	82.4	75.2	70.5	82.3	51.40	57.20
Others	78.1	80.8	71.6	82	56.40	64.40
Total	**77.2**	**76.9**	**70.9**	**78**	**53.40**	**58.50**

	Delhi	Gujarat	Maharashtra	Odisha	Tamil Nadu	India
Institutional births (%)						
Scheduled Caste	90.3	93.4	96.1	94.3	99.4	87.30
Scheduled Tribe	92.6	89.3	84.8	82.8	100	82.30
Other Backward Castes	91.6	95	96.8	96.1	99.7	89.50
Others	93.7	97.5	96.1	98.1	100	91.20
Total	**92**	**94**	**95**	**92**	**100**	**88.60**
Institutional births in public facilities (%)	62.4	43.3	55.8	78.7	66.9	66.80
Nutritional Status						
Women aged 15-49 years who are anaemic (%)						
Scheduled Caste	53.8	63.2	58	67.2	57.4	59.20
Scheduled Tribe	51.5	78.3	59.7	71.7	59	64.60
Other Backward Castes	47.6	63.1	55.1	60.5	51.4	54.60
Others	48.6	60.6	50.1	58.7	56.5	56.40
Total	**49.9**	**65**	**54.2**	**64.3**	**53.4**	**57.00**

Source: Compiled from NFHS 5 2019-21 survey report

Almost all the deliveries in Tamil Nadu were institutional; in all the other states, only 5-8 per cent of deliveries took place in the home (Table 2). It is important to note that in the national capital of Delhi home deliveries were about 8 per cent. The public sector share in institutional deliveries was very high in Odisha at 79 per cent, whereas in Gujarat, 43 per cent used government health centres (Figure 3). The World Health Organisation (WHO) says the ideal rate for C-sections is between 10-15 per cent of all deliveries, but the C-section rates in all five states were higher. It was the highest in Tamil Nadu (44%), followed by Maharashtra (25.4%), Delhi (23.6%), Gujarat (21%), and Odisha (21.6%) (IIPS 2019-21). The reasons for the high rate of C-sections in Tamil Nadu need further exploration. The maternal mortality ratio in Odisha remains high, at 119 per hundred thousand live births, while the other four states have reached the SDG target of below 70 (SRS 2018-20). The latest SDG India Index has given the top ranking to Gujarat's SDG 3.

Figure 3: Percentage of Births in Public Facility to Total Institutional Deliveries in Study States, 2019-21



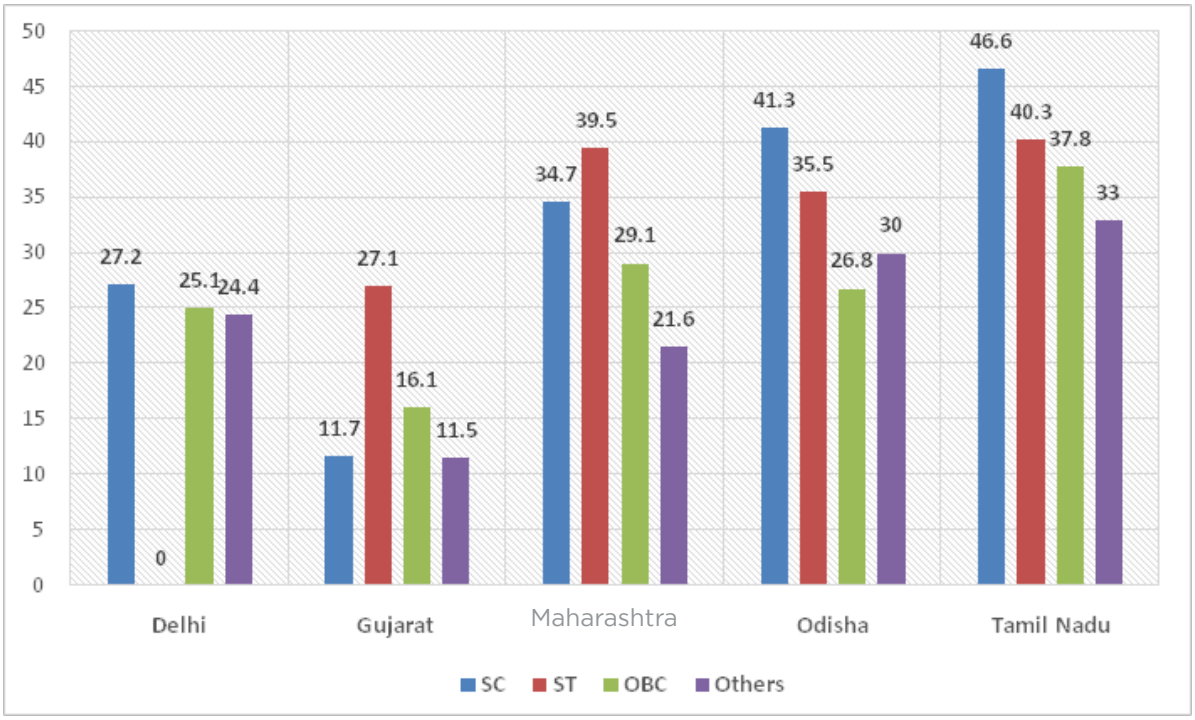
Source: NFHS 5 2019-21

The total fertility rates (TFR) in these states are below the replacement level, and range between 1.6 and 1.8 children. The TFR is slightly higher among the Scheduled Castes and Scheduled Tribes than in the other castes in almost all states. The use of modern contraceptive methods among currently married women in the reproductive age group was highest in Tamil Nadu (66.5%) and Maharashtra (63.3%), followed by Gujarat (53.6%) and Odisha (48.8%). The unmet need for contraception was around 10 per cent in Gujarat and Maharashtra; in the three remaining states, it was 6-7 per cent (IIPS 2019-21).

The prevalence of anaemia among women in the 15-49 year age group was much higher in Gujarat (65%) and Odisha (64.3%) than in the other states (Delhi 49.5%, Maharashtra 54.2%, and Tamil Nadu 53.4%). As expected in all the states, the prevalence of anaemia among women was significantly higher among the Scheduled Castes and Tribes than among women of other castes (IIPS 2019-21).

The prevalence of domestic violence among women who had ever married was very high in Tamil Nadu (40%), more than three times higher than in Gujarat (16). After Tamil Nadu, Odisha has the second-highest rate (32.6) (Figure 4). The reasons for the high prevalence of domestic violence in these two states need further exploration. It is also evident from the results that in all five states, women of marginalised castes are more susceptible to violence than others (IIPS 2019-21).

Figure 4: Caste-wise Gender-based Violence Among Ever-married Women (18-49 years) in the Study States, 2019-21



Source: NFHS 5 2019-21

3. FINDINGS FROM THE FIELD STUDY

3.1 Profile of the Study Participants

In total, 44 women participated in the study: 14 from Gujarat, 11 from Tamil Nadu, 9 from New Delhi, and 5 each from Odisha and Maharashtra. Of these, 28 lived in urban areas, and 16 were from rural areas. The ages of the respondents ranged between 18 and 65 (Table 3). About two-thirds (26/44) of the respondents were below 25, 15 women were between 26 and 45, and 3 respondents were 46 and above.

Table 3: Profile of Study Participants (Number)

Characteristics	RURAL		URBAN			TOTAL
	Tamil Nadu	Odisha	New Delhi	Gujarat	Maharashtra	
Age						
<=25 years	4		9	13		**26**
26-35	5	1		1	1	**8**
36-45	1	4			2	**7**
46 and above	1				2	**3**
Total	**11**	**5**	**9**	**14**	**5**	**44**
Religion						
Hindu	7	5	3	14	5	**34**
Christian	4					**4**
Muslim			6			**6**
Caste						
Dalits (Scheduled Caste)	11		1	2	4	**18**
Scheduled Tribals		5		12		**17**

Characteristics	RURAL		URBAN			TOTAL
	Tamil Nadu	Odisha	New Delhi	Gujarat	Maharashtra	
Others (Backward Class)			8		1	**9**
Family Type						
Nuclear	10	4	8	8	5	**35**
Joint	1	1	1	6		**9**
Educational Status						
Illiterate	1	4			4	**9**
1-5 yrs. of schooling	1	1		2		**4**
6-8 yrs. of schooling				2	1	**3**
9-12 yrs. of schooling	9		6	8		**23**
Diploma and Degree			3	2		**5**
Migration Status						
Migrated			5	2	5	**12**
Not Migrated	11	5	4	12		**32**
Occupation						
MGNREGA	3					**3**
Agricultural labour	3	4				**7**
Other labour	2					**2**
Homemaker	1		2	8		**11**
Student and unemployed	1		5			**6**
Others	1	1	2	6	5	**15**
Household Economic Status						
BPL Card	11	5	3		5	**24**
APL card			6	14		**20**
Marital Status						
Unmarried	1		9	7		**17**
Married and living with a spouse	6	5		7		**18**

Characteristics	RURAL		URBAN			TOTAL
	Tamil Nadu	Odisha	New Delhi	Gujarat	Maharashtra	
Separated/ widow	4				5	**9**
If Married Age at Marriage	NA					
< 18 years	5	2			4	**11**
18-19		3			1	**4**
20-21	2			2		**4**
22 and above	3			5		**8**
Total	**10**	**5**		**7**	**5**	**27**
Number Of Living Children	NA					
0	4			1	1	**6**
1 and 2	4	2		6	2	**14**
Three and above	2	3			2	**7**
Total	**10**	**5**			**5**	**27**

A little over three-fourths of the respondents (34/44) were Hindus; 6 women were Muslim, and the remaining 4 from the Christian faith. About four-fifths of the respondents (35/44) belonged to the socially disadvantaged Scheduled Castes and Scheduled Tribes, and 9 women were from backward caste groups (8 in Delhi and 1 in Maharashtra). In terms of education, more than half the women (23/44) had 9-12 years of schooling, 7 respondents had 1-8 years of schooling, and 5 others had college education. Those with a college education were young women from the urban areas of Delhi and Gujarat. Nine respondents in the study did not have any formal education. Four-fifths of the respondents (35/44) lived in nuclear families. Interestingly, 12 of 44 (5 each in Delhi and Maharashtra, and 2 in Gujarat) had migrated to urban areas for livelihood opportunities.

A high proportion of respondents, about one-third, were salaried employees in private enterprises, domestic workers, company workers, and tailors; one-fourth were homemakers; and nine were daily-wage workers. Six respondents were students. Three women in Tamil Nadu reported that their main occupation was working through MGNREGA (the Mahatma Gandhi National Rural Employment Guarantee Act).

More than half (24 out of 44) of the women belonged to Below-Poverty-Line (BPL) families, and 18 were from Above-Poverty-Line (APL) households. Notably, all the APL respondents lived in the urban slums of Delhi and Gujarat. Two respondents in Gujarat did not possess ration cards.[2] All five women from Odisha belonged to 'Particularly Vulnerable Tribes' (PVTs) – a primitive tribal group. Only one of the tribal women from Odisha could get a caste certificate to avail of the benefits from tribal welfare schemes.

Over three-fifths of the respondents (27/44) were women who had ever married (18 were currently married, and 9 were separated or widowed), and 17 were unmarried. Among the married women, about two-fifths (11/27) had got married before they were 18, the legal age for marriages, 8 were married between the ages of 18 and 21, and 8 women got married after they turned 21. About half the married women (14/27) had one or two living children; 7 of the respondents had 3 children, and the other 6 were nulliparous.

3.2 Growing Up Poor, Marginalised, and Female

As most of the respondents in the study belonged to the socially and economically oppressed caste groups of Dalits and Scheduled Tribes and or lived in urban slums, their families did not have regular employment or incomes. Their parents were economically deprived and unable to support their education, food, and basic healthcare needs. Almost all the respondents except 7 (5 in urban Delhi, and one each from Tamil Nadu and Gujarat) who participated in the study mentioned that their parents were impoverished and had a difficult time in bringing them up. A 21-year-old unmarried Dalit girl in Tamil Nadu narrated her family's situation:

My mother's daily wage work was the only source of family income; my father receives Rs.1,000 per month under the disability support scheme (leg disability). I have two older siblings. My parents are suffering a lot to meet the household expenses. **Tamil Nadu**

It is vividly apparent from the narratives of the respondents that household poverty was the main reason for illiteracy among marginalised girls and women; 9 respondents in the study were illiterate, 4 of them were from tribal castes in Odisha, and they reported that their parents were unable to send them to schools. Likewise, 16 out of 35 respondents who had a school education shared that they had to drop out and were unable to go to college because of financial constraints and domestic responsibilities:

2 Ration cards are an official document issued by state governments in India to households that are eligible to purchase subsidised food grain from the Public Distribution System under the National Food Security Act (NFSA) 2013.

I was the eldest among all my siblings (three brothers and one sister). At the age of six, I lost my mother. Then my father got married again, as my siblings were ill and there was no one to look after them. I started cooking at a very early age (around eight years). Due to my family's situation, I never went to school. **Odisha**

I studied until the fifth grade in school. As I am the eldest child and have two younger brothers and one sister, I had to take on the household chores and look after my siblings. Therefore, I stopped going to school in the fifth grade and got married instead. **Gujarat**

Seven respondents in the study were children when they lost their father or mother – the family's breadwinner. The loss exacerbated their poverty and forced them to enter child labour and shoulder heavy household responsibilities:

When I was five years old, my mother died of uterus cancer. After that, I had to take the entire responsibility of cooking and taking care of the household chores. Looking after my two younger brothers was left to me. My aunt was with me to support me. **Maharashtra**

It is clear from the study that being the daughter of a single parent and or belonging to a family that had migrated increased their chances of dropping out of school. A 19-year-old respondent from Delhi said:

When I was in class 10th, my elder sister got married. Then, managing my studies and all the domestic work became difficult, so I dropped out. **Delhi**

Many rural women from Odisha and Tamil Nadu reported that their childhood poverty forced them to work at a very young age:

I did not go to school. My older sister and I worked on a farm 3 km from our house, earning Rs.6 and Rs.7.50 daily, respectively. Our earnings enabled us to eat and dress. **Odisha**

It was observed from the narratives of the women that there were instances of children being sent away to stay with grandparents, as their parents could not look after them due to poverty or being involved in wage work. A 22-year-old married tribal woman stated:

I have been staying with my grandmother because there were so many members in my father's family, and they could not feed all the family members, so they kept me with my grandmother. **Gujarat**

Due to the severe poverty in her family, the heavy household workload, and domestic violence, a respondent left her village in search of a job at the age of eight. She was 'trafficked' by a woman and then sold to a brothel owner. Her entire life collapsed completely.

Due to the heavy workload and insufficient food in their households, many respondents in the study had physical and mental health problems during their childhood. The loss of family members, especially the breadwinner of the family, further aggravated their health conditions. The illnesses experienced included mental stress and trauma (due to the loss of family members), poor nutrition, heart problems, disabilities, and wounds. The following story of a woman illustrates how the villagers misinterpreted their health problems, which were mainly due to her poor nutrition:

Our friends used to call me a 'ponam' (corpse). Because of my weakness, many times I would have severe neck pain and suddenly fall down like a dead person, so one of my friends called me a corpse and the name stuck 'see there, a corpse is going'. **Tamil Nadu**

An unmarried adolescent girl said:

During my childhood, I had a vision problem and could not see for almost one and a half years. I was taken for treatment to various hospitals, but it was in vain; it was only after a few years that I gained my vision. **Gujarat**

A few respondents also indicated that they faced caste-based discrimination in their community and schools at a young age. Despite all these difficulties and miseries, school life and childhood friendships were the happiest moments in many women's lives. Most of the respondents mentioned that there were unforgettably happy moment in their lives:

I enjoyed school life. We used to walk to school, and we made fun of each other, chatted about the class events, and collectively ate the mangos and coconuts gathered from the nearby fields on our way back from school; those were the happiest moments in our school lives. **Tamil Nadu**

3.3 Gender and Social Norms Affecting Women's Life Opportunities

Cultural norms, gender, and patriarchal values and norms are very strong in Indian society, especially among marginalised communities and groups. Gender-based discrimination within the family is the most common form of discrimination that girls and women face during their childhood. This includes differential treatment for their brothers by parents, grandparents, and other elders in the family and kinship. Other common forms of discrimination the respondents mentioned were discrimination in allowing mobility, in the division of labour, in food practices, education, decision-making related to clothes, etc. A few respondents reported that their parents' behaviour showed disparity between their brothers and themselves with regard to education, food, and healthcare:

In our community, in general, people do not allow girls to go to school because they will get married and go to another's house. They think girls were supposed to do only household work. **Maharashtra**

A 19-year-old girl spoke about disparities her parents exhibited in giving food to her and her brother:

My mother often favours my brothers with eggs and does not give any to my sisters and me. **Delhi**

Many respondents in the study reported that their parents did not show any gender disparity in how they were raised in their childhood. However, once the girls attained puberty, they imposed various restrictions on how they dressed, their mobility, and their relationships with the opposite sex. Other gender norms for young, unmarried women that were frequently reported were: They were expected not to argue with their brothers, or have intimate relationships before marriage, to wear body-covering clothes both at home and outside, to seek permission before going out, not to go out alone in the dark, to cook and serve food to the males members of the family, to wake up before their brothers to perform the domestic chores, etc. Almost all the respondents reported that their mobility was restricted after puberty. An unmarried girl narrated:

Didi, everything changes after periods... Ammi wants to know everything now - what I am doing and why I am doing it. Why does she want to know? When they see something, even neighbours complain to my parents. **Delhi**

A few respondents stated that their brothers (who in two instances were younger than the girls) also controlled their mobility and reinforced gender norms. An unmarried girl said:

I have a very strict elder brother who controls me completely. He restricts me from going out alone and checks my mobile phone, which I do not like. **Gujarat**.

Gender norms are reinforced through different institutions. Family, society, and educational institutions imposed strict dress codes on girls. Long skirts and loose blouses were to be worn, and nothing ornamental was allowed. A 42-year-old tribal woman said:

After puberty, there was a transition from wearing shirts and trousers to wearing a saree. **Odisha**

Other girls indicated how gender norms control their autonomy:

My mother constantly forced me to carry a dupatta before stepping out of home. My father did not allow me to study after class 12 because it would be difficult for them to find a suitable boy for a highly educated daughter. **Delhi**

Girls described how they were told to be 'good girls' and dress appropriately in educational institutions:

Madam in my school asked me to change my style by saying "You are too fashionable, that's why this is happening to you (boys teasing me)." **Gujarat**

The social narrative on hormonal changes and sexual attraction during puberty is loaded with protectionist attitudes and moral panic about girls maturing and going astray. There are hardly any positive narratives by young women. If parents or neighbours get to know about a relationship, they blame it on the girl. On occasions when parents learnt about a relationship, the girls were strongly reprimanded for not considering their family's honour, and attempted to discipline the girls by punishing them for the actions. Hence, the most important advice parents and relatives provided was to be careful with boys and behave honourably. The most common reasons cited for the restrictions are 'safety concerns and fear that something wrong may happen, including sexual violence' and the 'fear that the girl may go astray or get into a relationship', which is against the family honour:

After I attained puberty, my mother advised me not to talk freely with boys; even if a boy asked me to do something, I should not respond to him. Our parents were afraid that if we responded to a boy's request, it would give them a chance to touch our bodies. That is why they imposed controls over us. **Tamil Nadu**

In many instances, parents told their daughters that the family honour is in in their hands. One respondent quoted, 'My mother told me, your honour is in your own hands.' An unmarried girl from Delhi stated that:

Pre-marital sex cannot be forgiven in our religion. Secondly, if people find out, parents (ammi-abbu) lose face in the eyes of society. It is better to not do it than regret it later. **Delhi**

One respondent reported being seen with her boyfriend, and she was terrified when she went home. The 21-year-old tribal woman said:

I thought my father would not let me live (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 backs. Then, they made me understand that whatever I had done was wrong. I also agree with them. Whatever they say is correct. **Gujarat**

Five women in the study (three from Tamil Nadu) had to discontinue their education because of their transgression of gender norms or inappropriate behaviour. Once their parents came to know of, or even had a suspicion, of their friendship with a young man, they stopped the girls' studies immediately:

I secured 187 marks in accountancy, but my parents did not allow me to continue my studies. They said to let the results come, and they would decide, but they immediately arranged my marriage out of fear that I may elope with a boy I loved. **Tamil Nadu**

The following narrative describes how the existing traditional norms destroyed a girl's ambition:

I did a parlour course, but there was no space to open a parlour. Then, I learned to stitch but did not get space to do that professionally. I have killed my heart's desires. There is no space where I can practice at home. They do not allow me to go and work outside. I told my mother I had found a parlour to work in, which was very close to our house. However, my father did not allow it. He only listens to his family and traditions. **Delhi**

Only two young respondents in the study stated that their parents did not impose hard restrictions or gender norms during childhood. A 21-year-old unmarried girl in New Delhi remembers her childhood:

I had a boy's haircut and wore pants and shirt. Since there were no boys in the family, my father treated me like a boy. **Delhi**

Most respondents from Delhi, Gujarat, and Tamil Nadu reported that they had experienced love and romantic relationships in their adolescence. With a few exceptions, all the others had to discontinue their romantic relations for various reasons – belonging to different castes, classes, and religions. An unmarried girl from Gujarat reported:

I loved a boy who was very supportive of me. In my family, love marriages are not allowed but he belongs to a different community. If I marry him, I must cut all relations with my family. Finally, I left his relationship for my family. **Gujarat**

Another girl narrated the younger generation's views:

Nowadays, love marriages are becoming acceptable in our community particularly amongst the younger generation; it is a trend that 'respectable girls' must marry their boyfriends. Nevertheless, both should belong to the same caste and religion. **Delhi**

Gender power relations are manifested in many ways and in various 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, and mothers to a lesser extent. In many stories, as discussed above, we see that brothers have assumed the mantle of protectors. Even girls who earn their living, and sometimes even support their families financially, struggle to assert their independence against their brothers.

3.4 Bodily Autonomy and SRHRJ

Bodily autonomy is the right to make decisions about one's body, life, and future, and is a key component of sexual and reproductive health, rights, and justice (SRHRJ). Bodily autonomy is defined as the right to make decisions about your own body, life, and future without coercion or violence. It includes deciding whether to have sex or not, to use contraceptives, or visit the doctor. Bodily autonomy has long been recognised as a fundamental human right (MSI United States 2023).

Lack of information on sexual and reproductive health: As enshrined in the ICPD POA, Chapter VII - Section D (on human sexuality and gender relations), access to accurate, scientific information about sexual and reproductive health is one of the SRH rights of adolescents and young people. However, almost all the girls and women in the study mentioned that they did not have any SRH information before they attained menarche or got married.

Poor Awareness about Menarche

About three-fourths of the participants (34/44) in the study had no prior knowledge about menarche before they attained it. A 35-year-old woman from Maharashtra reported:

I started menstruation when I went to my uncle's marriage. I was terrified and unaware of why I was bleeding. Afterwards, my cousin explained that it was normal, and said, "You have grown up now". **Maharashtra**

A 21-year-old woman in urban Gujarat narrated:

I did not know. I was afraid. There was no itching or pain at the urinary place, but the blood flowed continuously. **Gujarat**

Many of these participants tried hiding it from their family members, believing something abnormal had happened to them. A rural respondent from Tamil Nadu who had three elder sisters reported:

When I was young, all the girls in my village used to go to a big well. I used to climb the well and keep jumping. There were stones and rocks on side walls of the well. As blood was on my skirt, I thought I might have gotten hurt somewhere, or something had pierced me or caused an internal injury while I was diving in the well. When I showed it to my mother, she smiled and told me to remain silent, saying it was a happy news. **Tamil Nadu**

It was also evident from the women's narratives that there are some myths and misconceptions about menarche and menstruation that prevent girls and women from performing their routine activities, participating in social events, restricting their mobility and limiting their interactions with family members and friends:

I was unaware of anything related to menarche or menstruation, and my aunt told me that I have to go and hide in someone else's house for as many days as the astrologer says. Otherwise, it will bring bad luck to my brother and others in the family. **Odisha.**

Only 10 young participants in the study (9 urban and one rural), in their early 20s, had some information about menarche before they attained it; 7 had learned about it from NGO workshops, 2 from school education, and another learned about it from her elder sister. They felt that the culture of talking openly about their bodies helped them understand their bodies better. One respondent from Delhi shared that she now feels more confident in arguing with her mother if the latter attempts to impose some community norms like not watering the plants, not praying, etc., during her menarche. Moreover, she felt that because menstruation is a 'natural' phenomenon and gives women the power to procreate, how can it be 'napak' (impure or dirty). Menstrual health education enhanced her strength to challenge existing myths and misconceptions.

Poor Knowledge about Sexuality

Sex and sexuality are still controversial issues in India; there are so many socio-cultural norms surrounding them. Discussing these issues with others is considered taboo, even among married couples, hence, information on sexuality is hard to come by. All that the women learnt was to fear sex and to avoid interactions with the opposite sex, so that nothing 'dishonourable' (premarital sex) would occur. Many respondents in the study stated they were nervous and did not talk about it with anyone. Most respondents (29/44) had no knowledge about sex; most of the married women got information after their marriage. Five of the seven married respondents from Gujarat and all the married women from Odisha and Tamil Nadu shared that they did not have any knowledge about sexual relationships before getting married. A 22-year-old urban married tribal woman reported:

On the first night of marriage, I did not even know that we have to sleep in the same room. **Gujarat**

A woman fell in love with a man and became intimate with him without any prior knowledge about sexual intercourse, conceptions, or safe sex. A 21-year-old married Dalit woman said:

Even in a love relationship, I did not know about all these. I just thought it was an affectionate feeling. I was not fully involved and did not know much in detail. Even after marriage, I was unclear about all this information (about sexual relations). I learned about all these aspects after two or three months of marriage. **Tamil Nadu**

Unlike in other states, many tribal women from Odisha who participated in the study viewed sex as being only for procreation:

I was married at 18. Neither I nor my husband knew what a marriage implied. For a year, we did not have intercourse – I would cook, clean, serve my in-laws and husband, eat, and both would sleep next to each other in the same room. After this, I went home for a year and, upon questioning, revealed that I had not had sex with my husband. My grandmother then explained to me about it, and I wouldn't say I liked it. I said, 'No, no, I cannot do that'. 'If you tell me to do this, I will not go to that house. You are asking me to sleep together (with husband), do this and do that; I will not go (to my in-law's home)'. 'We are telling for your good and to get a child,' my grandmother said. **Odisha**

Only 15 women in the urban slums of Gujarat and Delhi had some prior information about menstruation and reproductive health from NGO workers and social media. Almost all of them were unmarried. A twenty-year-old college-going girl reported:

I attended a session on reproductive health run by an NGO centre in our area. From the session, I learnt the basics about menstruation. I had irregular menstruation, and when I shared, they also encouraged me to visit a doctor for the same. **Delhi**.

Poor Knowledge of Conception and Contraception

All the married women from Odisha, Maharashtra, and Tamil Nadu, and five of the seven married respondents from Gujarat (25/27) said that they had no knowledge about sexual relationships or conception before they got married. A 32-year-old tribal woman stated that she did not even know that the absence of menses was a symptom of conception:

When I conceived, I had no idea that my menses would stop, and I had to ask my sister-in-law why I was not menstruating. **Odisha.**

Poor knowledge about conception appears to be an important factor responsible for pregnancies among unwed women: 12 of the 44 respondents in the study had had premarital sex; 6 became pregnant before marriage, but none had known that a single incident of sexual intercourse could lead to conception; and many did not even know that a missed period could be a sign of pregnancy. A 34-year-old rural Dalit woman mentioned how ignorant she had been:

I did not even know that the absence of menstruation is a symptom of conception. After six months, we (she and her partner) went to the hospital for my fever. They took blood tests, and I asked him why. He told me it was for fever, but later, the doctor told me I was pregnant. If I had known all these matters (about how pregnancy happens and how contraception can prevent it) at that time, I could have avoided becoming pregnant. **Tamil Nadu**

One of the women, who had an irregular menstrual cycle, got to know of her pregnancy only in the fifth month of gestation, when her boyfriend died in an accident. She narrated how her life was turned upside down because of her ignorance. That situation, and the social exclusion she subsequently experienced, forced her to enter into sex work. The 32-year-old sex worker describes her misery below:

We were in love with each other. We used to meet once a week or twice, kiss each other and have sex once or twice a month, but I did not know that could lead to pregnancy and did not even realise I was pregnant till the fifth month of gestation. After that, nobody helped us. **Maharashtra**

Another unmarried 19-year-old girl from Delhi, who experienced a similar situation, delivered a baby and gave it up for adoption. She stated what she knew about conception and contraception:

We had had sex two or three times. I just assumed he would know about protection and use it. Furthermore, I had never thought that I could get pregnant. When I learned I was pregnant, I was so scared I could not gather the courage to tell anyone. My biggest fear was what people would think of me and what kind of girl I was. I finally confided in a friend. **Delhi**

It is clear from the narratives that poor knowledge about sexuality, conception and contraception have ended in pregnancies among unwed women. These women have to face the consequences of these pregnancies due to prevailing socio-cultural and gender norms.

A large majority of married women in the study did not know what could be used to prevent unwanted pregnancies. A 24-year-old married woman from an urban slum stated:

The second pregnancy was unplanned as I was not aware of what to use to prevent it. **Gujarat**

Some of them learned about one or two contraceptive methods after having children:

After having two children, I attended an NGO training session and then only learnt about what the modern methods of contraception are. **Tamil Nadu**

3.5 Sexual and Reproductive Rights

Early or Forced Marriages:

When and whom to marry is an essential aspect of women's sexual and reproductive rights. Although the legal age for marriage in India is 18 years for girls, about two-fifths of the married respondents (11/27) in the study got married below the legal age of marriage, which makes them more vulnerable to sexual and reproductive health risks and rights violations. A 32-year-old woman stated:

I got married within 2 to 3 years of menarche - I think I was less than 16 years old. ***Maharashtra***

The woman's consent for marriage was rarely sought in an arranged marriage. Most married women (19/27) reported that their parents did not ask for their consent before fixing the marriage. A tribal woman who got married at 17 said:

They did not ask me. My parents said, 'With whomsoever we decide to marry our daughter, she will marry him. She will not refuse'...I did not want it. **Odisha**

Another woman from Gujarat also shared that she and her fiancé did not even have the chance to see or talk to each other before marriage. A 26-year-old married woman said:

In my community, marriage is mostly arranged by the elders. The girl only gets to see the boy when she offers him and his family tea when they visit her. The boy and the girl are not even allowed to speak with each other. **Gujarat**

Only three married respondents in the study (two from Gujarat and one from Tamil Nadu) said their parents respected their right to choose their husbands. A rural woman who had an arranged marriage had interacted with the prospective groom and consented to her marriage:

He came with a marriage proposal. I met him formally at my relatives' house and we spoke with each other. I asked about his background, education, and occupation. I put forward two conditions for him to marry me, and he readily accepted. Then I consented to marry him. **Tamil Nadu**

In many instances their marriages were forced: the reason was that their parents discovered their daughter was 'friendly' with a boy. For two respondents, once their parents knew of their daughter's friendship with a boy (not 'love' in one case), they stopped her schooling and forced her into an arranged marriage for the sake of the family honour. Some 'love' marriages may also be considered as 'forced' because the women were forced to marry, consequent to becoming pregnant before marriage. The following narrative of a rural respondent indicates how sexual norms are biased against women and how these govern women's decision-making process:

He was already married, and I did not know about it during my love relationship. He had completely hidden that information from me. I knew it only after I conceived. As I was pregnant, I could not do anything, and my family members arranged my marriage with him. **Tamil Nadu**

Existing social norms compelled the girl to acquiesce to her family's decision without knowing anything about her partner's qualities, or likes and dislikes, and without weighing the pros and cons of the relationship. Most of the girls were in their teens, exploring their sexuality, but became trapped in marriage.

First Sexual Experience

For almost all the married women, their first sexual experience was not pleasant, and in fact it was terrible. Except for three married women and one unmarried girl who was in a sexual relationship, all the others (29/33) reported that their first sexual experience was forced and unpleasant (Table 4). They also said it caused much anxiety, concern, and worry. A forty-year-old tribal woman from Odisha called her first sexual experience terrible. Due to severe pain and a stomach ache, she was afraid of sexual intercourse and of her husband, whom she describes as a big, strong man. "Wouldn't someone be scared seeing such a man? He is a strong man. If he puts one leg on you, you can't even move."

I disliked it, lost consciousness, and had severe stomach aches after that. **Odisha**

A 35-year-old woman from Maharashtra narrated how she was traumatised and injured on her private parts:

After my marriage, I had a very traumatic first sexual experience with my husband. When I was fast asleep, he forced himself on me and had intercourse with me. I tried to resist and shout, but it was of no use. I cried and cried and started cursing him. I started having heavy bleeding, so he took me to the government hospital. **Maharashtra**

Table 4: Sexual and Reproductive Rights of Study Participants

	No of respondents
Type of Marriage	
Arranged	20
Love	7
Total (Married Women)	**27**
Consented in marriage	8
Not consented and forced marriage	19
Total (Married Women)	**27**
Sexuality	
Premarital sex	11
Unwed pregnancies	6
First sexual experience was forced and unpleasant (**Total 29/33**) (27 married and six girls who were in sexual relations)	29
Type of Morden Contraceptive Method Ever Used	
Copper-T	3
Oral pills	3
Injectable contraceptive	1
Male condom* all were sex workers	4
Female contraceptive operation	5
Total Users (27 Ever Married)	16

	No of respondents
Experienced One or More Unwanted Pregnancies (Married and Unmarried)	
Yes	22
No	11
Total (27 married and six girls in sexual relations)	33
Ever Experienced Gender Based Violence	
Sexual	26
Physical	29
Emotional	31
Total (27 Married and 17 Unmarried Women)	**44**

Reproductive Decision-Making and Autonomy

Women's freedom and autonomy in making decisions on whether, when and how many children to have is a part of their reproductive rights and key to their reproductive health. Most of the married women in the study were deprived of their rights over their bodies.

Generally, women are increasingly pressured to conceive a child soon after marriage. If a woman does not conceive within a few months of marriage, she is criticised both by her family and by society. After having one or two children, the participants tried to limit their family size, but in many instances, their husbands and in-laws controlled their decisions. A Dalit woman with two living children said:

I was desperate to get the operation, as I could not afford to bring up one more child. While I was ready for the operation, he stopped me, saying that his parents would like to get another grandchild. **Tamil Nadu**

A twenty-four-year-old woman from Gujarat with two children also mentioned that she wanted to have an operation to prevent a pregnancy, but her husband and in-laws would not allow her:

My mother-in-law said that it would be good if the second boy comes. I thought that as I have one boy and if a girl comes, I will go for an operation, but my mother-in-law said no. **Gujarat**

When women try to negotiate with their partners and in-laws and try to exercise their reproductive rights, they are threatened with being sent back to their natal homes. The following statement of a woman narrates how she was threatened:

I delivered a baby girl in the GH. The hospital staff asked me to have a sterilisation operation, but my husband did not agree to it. He told me strictly that if I had the operation, I should go and stay with my mother and not come back to him. **Tamil Nadu**

There were instances when women were not allowed to use the contraceptive methods of their choice and could not exercise their rights even though they had severe health problems. Consequently, a few women had multiple abortions:

My husband's blood group was 'O' positive, and mine 'B' negative. The doctor asked me to have sterilisation after having a second child. However, my husband did not allow me to go for it, saying we would have as many children as possible. Sexual violence is a regular event for me. I had two more children and two abortions, and after that only I was able to get the contraceptive operation. **Tamil Nadu**

Three of the participants in the study – a woman from Gujarat and two others in Tamil Nadu – planned to terminate their pregnancies, but were prevented from doing so by their husbands and in-laws:

I had not aborted my pregnancy because my mother-in-law asked me not to. **Gujarat**

3.6 Gender-based Violence against Women and Girls

Gender-based violence against women and girls is a deep-rooted public health and human rights issue. The issue usually originate from unequal gender power relations between men and women. Violence within the family is about power dynamics and gender, e.g., in-laws, husband, etc., and the power structure within the families normalises violence which influences women's sexual and reproductive rights. Further, violence is used to reinforce gender norms. Poverty and alcoholism exacerbate violence. Additionally, in the name of protection, women are victimised within their households, emotional and physical torture are repeated daily to reinforce the subordination. The participants were very poor and not employed in paid occupations. Under this situation, men can control women's mobility

and decision-making in all situations, starting from their fundamental rights to their sexual and reproductive rights.

Psychological Violence

About three-fourths of participants (31/44) reported they had experienced one or more instances of emotional violence by their family members, teachers, and friends. Many respondents said their parents, teachers, and fellow students had inflicted violence on them during their adolescence. A few young girls reported that their school environment was not safe. The following narrative describes how their teachers were biased:

Our teachers always blamed us, the girls, for being harassed by boys instead of saying anything to the boys who harassed us. **Gujarat**

All six women who had unwed pregnancies faced severe punishments in the form of isolation from the community and withdrawal of family support, something women depend on most in the Indian context. A girl who lost her boyfriend in an accident and was pregnant at the time narrated why she left her native place:

We were unable to terminate my pregnancy as it crossed over five months, we had no other option; with severe stress, my mother took me to Mumbai, thinking that everybody in my native place would blame me for the premarital pregnancy. **Delhi**

Irrespective of whether the woman had been forced to marry or had chosen her own partner, psychological violence permeated many women's lives. Men's control over women's mobility, a heavy household burden, and dowry demands were narrated by married women respondents from Tamil Nadu and Maharashtra as reasons for domestic violence. Women faced difficulties in adapting to the control exercised by their in-laws:

When I was in my marital home, I faced severe stress and violence. We had agricultural land, and I had to **c***ook for everyone, but I did not have the right to serve myself food. My mother-in-law harassed me a lot and even beat me up. She would give me only one meal in a whole day.* **Maharashtra**

Many married women from Gujarat and Odisha reported that their in-laws had strict control over what they wore. One tribal woman in Odisha described how her mother-in-law taught her to cover her face with her saree and not appear in front of her brother-in-law or father-in-law (these

are Odia customs and not traditional tribal customs). Another respondent from Gujarat also shared a story of similar controls:

I was used to wearing a salwar kameez in my maternal home, and here, I was compelled by my in-laws to wear a sari and cover my face with my pallu (laaj) in the presence of elders in the family. **Gujarat**

'Suspicion' from the husband was a form of psychological violence a few of the married women reported:

He is very suspicious. I should not talk with relatives or visit my relatives, and I should not sit and chat with my younger or elder brother or with my uncles. They should not be playful, nor should I. There is so much behaviour he found to be unacceptable. **Tamil Nadu**

The spouse's alcoholism was another source of psychological stress for the women:

He is an alcoholic and doubts me. He thinks if I sit next to someone, I will make him my husband. **Odisha**

Six participants, three married and three unmarried girls, reported they had faced caste-related psychological violence. They were discriminated against and humiliated based on their caste. While talking about romantic relationships, three of them spoke about having to give up relationships as the boys were from different castes. One said that she had become very weak in her relationship; because of experiences she had in her life, she believes that she should not have a boyfriend anymore:

But now it is not like that. We had a caste issue. We may have faced problems later on; thus, it is better to back off right now. **Gujarat**

I was in an inter-caste relationship; my boyfriend's family would not accept his choice of girl to marry, and the only option he saw was eloping. Since I thought that eloping with a boy from another caste would bring disrespect to my family, it was better to end the relationship, I broke his relationship and was emotionally upset. **Delhi**

There are six childless respondents in the study. There were instances of the community harassing women because of their childlessness or for not having a son:

I experienced a lot of sadness as I lost four babies, but I never regretted not having sons. However, people said 'my face is inauspicious'. My sister-in-law was telling me, I had no child, and who will see the face? Still, they are telling me 'anthukudi' because I don't have a male child. **Odisha**

Another woman described the societal pressure she had to face due to her childlessness:

*A few of his relatives say that if one buys a cow, one would get milk from it, but nothing beneficial has come out of him marrying me. I have overheard some people say that he (my husband) has built a large house in the village, but that there was not a single child to rule it as an heir. A few have advised us saying "instead of constructing a pucca house, you should have spent one or two lakhs and got test tube babies***. Tamil Nadu**

Physical Violence

Many participants in the study reported physical violence. About two-thirds of them (29/44) stated that they had constantly been subjected to physical violence. Almost all the rural participants and women who migrated from rural areas to urban Maharashtra had been subjected to physical violence by their intimate partners or family members at some point in their lives. For two of the rural respondents this happened only one, but for all others, it was a regular occurrence. The rural-urban differential is significant: among urban respondents, a few did not face any physical violence, which might be due to the age factor as the urban respondents (21/28) were relatively young, aged below 25 years, and about half were unmarried. On the other hand, in rural areas, almost all except one were married, and many (11/16) were over 26 years old.

Unmarried girls faced violence at their schools and colleges as well. Four out of nine girls from Delhi reported that either they or other students had received corporal punishment from their teachers. An 18-year-old unmarried girl describes how her school teacher abused her:

One of my lady teachers slapped me when she saw me talking to one of the boys from my school during recess. **Gujarat**

Four out of five women from Maharashtra who participated in the research reported that they faced severe physical violence from their in-laws. When she could not bear the violence, one woman left her house and twice attempted suicide. Finally, she left her village and moved to a city for survival. There she was trafficked by an unknown woman and sold to a brothel owner. Her life after that became completely miserable; she is now HIV-positive, surviving without any social support:

My in-laws were very abusive; they started doubting if I was having an affair with the boy with whom I was in love. My mother-in-law used to beat me up, and my brother-in-law used to give me fumes of chilli powder. Then again, my husband was not bothered about it. **Maharashtra**

Married participants from Gujarat also reported that their in-laws had been violent with them. The following narrative describe heinous acts of physical violence one of them faced:

My sisters-in-law abused me with all sorts of heinous acts like putting chilli powder in my bathing water or on my clothes, breaking my bangles, breaking my chappals, and so on. **Gujarat**

A few women in Tamil Nadu also spoke of dowry-related violence. A woman who had a 'love marriage' said that even after seven years of marriage, her mother-in-law still demanded a dowry, and her husband did not oppose his mother. The experience of a woman living with a disability was worrying as she had one stillbirth and a miscarriage due to physical violence, once by her intimate partner and another time by her sister-in-law. It is clear from her narrative that her disability has increased her vulnerability to being exposed to physical violence:

When I was pregnant, I was not feeling well, so I did not cook food. At that time, my husband came and kicked me hard in my stomach, and I fainted with unbearable pain. Immediately, my neighbours took me to the hospital, where they took out the baby and buried it. **Tamil Nadu**

All the married women in Tamil Nadu would use the word 'torture' when they spoke about their husbands' physical or even psychological violence.

Likewise, almost all the participants from Odisha and Tamil Nadu (9/11) were victims of severe physical violence. Alcoholism and suspicion about women's fidelity were the main reasons for wife beating:

He would beat me with a pipe. When he drinks, he beats me and abuses me for no reason. ***Odisha***

He was drunk. He closed the front door and beat me severely, took the tube light bulb, injured me in the face and eyes. He kicked me hard in the stomach. I collapsed. I shouted for help, and my son broke the door and saved me. After the incident, I was hospitalised for several months, and I am still surviving with all these complications. **Tamil Nadu**

Non-Consensual Sex and Sexual Violence

Married and unmarried women widely report non-consensual sex. Five unmarried girls in Delhi and Gujarat reported that they were forced to have non-consensual sex, and one other mentioned that when asked to have sex, 'I could neither say yes nor no.' Only one or two said that their intercourse was consensual:

My partner exerted power in coercing me into a sexual relationship. **Delhi**

Non-consensual sex was a common experience for many women who had been married. Even women who had engaged in sex before marriage with a person they were attracted to said that the sex was not consensual:

I did not know how it happened to me. I was working in a telephone booth in the nearby town. It was not like an office; it was just a single room. He was also working in the town and used to come to my office. We developed a romantic relationship. I think we had sex two or three times in my office, but it was not with my consent. **Tamil Nadu**

Many married respondents accepted this as a routine part of their lives. Many married men seemed to think, 'After all, she is my wife, and there is no need to ask her consent for sex':

Generally, he does not come and ask for it. He will think I am his wife, and there is no need to ask for it. I will not go to that extreme and will not fight with him; I keep calm, and he will do what he wants. **Tamil Nadu**

Only three married women in the study reported that their husbands were very understanding and they did not experience any non-consensual sex.

Sexual Violence

All five women in Pune, Maharashtra, were minors when they had their first sexual experiences; it was a violent experience for three of them. The following narrative describes how a woman lost her bodily autonomy at the age of 16 years:

When I was fast asleep, my husband forced himself on me and had intercourse. I tried to resist and shout, but it was of no use. I cried and cried, and started cursing my husband. I started having heavy bleeding, so he took me to the government hospital, where the doctor did not say anything but just gave me medicines. My husband told the doctor that due to first intercourse, I had pain and bleeding. He communicated with the doctor, and I was listening. **Maharashtra**

Most of the married participants from Tamil Nadu and Odisha reported that refusal to have sex is a common cause for wife-beating in their community. Increasing alcoholism and drug addiction among men has also led to increased spousal violence. A tribal woman from Odisha narrated how her husband forced her to have sex:

One day, I refused to have sex with him, as I was not interested; he asked me, are you interested in someone else and beat me. Finally, he forced me into sex by tying my hands behind me with a towel. I was terrified and felt suffocated and shouted for help, but it was no use. **Odisha**

For the older woman in the study, sex had never been enjoyable or consensual; it was always forced and violent. A cancer survivor in Tamil Nadu still has traumatic memories of being forced to have sex the day after her D&C, which she described as having a near-death experience. She still firmly believed that it was because of the excessive and forceful sex and continued miscarriages that she had uterus cancer and a hysterectomy:

He was very interested in sex. It was not out of love or affection; it was always hard and coercive. He would even wish to have sex in the agricultural field. When I refused, he beat me up with a wooden rod stick; once there was sugarcane at home, he beat me up with that. The most terrible time was when I had a miscarriage and underwent a D&C. He forced me to have sex on the following day itself. I felt like my internal organs were torn, and I was crushed with the pain in my private parts, but he had what he wanted and only then left me alone. **Tamil Nadu**

Sexual Harassment Outside the Home

Sexual harassment of marginalised girls and women in public places is another important rights issue reported by the respondents. There were instances when girls, who faced sexual harassment by unknown persons in public places, did not even recognise or rebel against it, but were noticed and protected by people around them:

One day, the bus on which I was travelling was crowded, so we had to stand in the bus. I think I was 13 years old and had not even attained menarche. A young man (who looked like an indecent fellow) stood near me and touched my breasts, but I did not recognise what he was doing; I thought he was doing it because of the heavy crowd on the bus. Gradually, he started pressing my breasts with his elbows. A woman who was standing next to me saw what he was doing. Being a rural girl, I had never seen such behaviour. The woman took a safety pin from her purse and pierced his hand. He was taken aback and moved away from me. **Tamil Nadu**

In another case, two girls from Delhi reported instances of sexual harassment in their school by a teacher and some outsiders. In both cases, the girls could not take action against the perpetrators. In one, the girl was discouraged from doing so by others as it would have affected the 'business' of the school owners; in the other incident, her schoolmate was gang-raped and murdered in the school by boys from outside, but the school authorities suppressed the situation by bribing the victim's family. It appears, from these narratives, that young girls are unable to initiate action against the perpetrators of sexual harassment.

A few married women also reported sexual harassment by known persons. After finding out about the violence faced by two women from their intimate partners, other men in their villages began sexually harassing them, believing that their problems were due to unsatisfactory sexual lives with their husbands:

Whenever my husband quarrelled with me in a drunken state, he used to state "you are a sick person and not suitable for sex". On overhearing this, a man in my village one day asked me, "It seems that you did not have penetrative sex with your husband, and that is why your body gets very weak. Can we have it now?" I got furious and shouted at him, all this happened and these fellows approached me because of my husband's irresponsible talk. **Tamil Nadu**

All five sex workers in the study reported sexual harassment by their clients and the brothel owner. One of them recalled being taken away and harassed by the police in a raid. She said,

Once a police raid took place and I was arrested, the police asked me to take off all my clothes and saw my private parts to check whether I have hair or not. **Maharashtra**

3.7 Resistance and Resilience

The culture of violence and impunity, both within the home and in public, was identified as a running thread in the lives of young women since their childhood. As the respondents entered the adolescent stage of life, they began experiencing restrictions from family and community, and stricter gender and sexual norms, and tried putting up resistance against the norms. These marginalised girls and women have been resisting and challenging social norms and customs that affect their lives, but only a few have overcome these. Some others, especially young girls and women, have started to challenge the existing socio-cultural beliefs on sexuality, gender norms, menstruation, dowry and gender-based violence against women. Unmarried girls mentioned:

When my mother said not to go near the pooja room or where they kept the gods' photos at home, I would reply by saying goddesses are also women only and has nothing to do with that. She also says I must wash my hair before going to the temple or other room or place wherever God's photo is kept at home. She keeps telling me all this, but I do not bother with it. **Tamil Nadu**

When a respondent tried challenging gender norms in her adolescence, she was reprimanded. The following statement indicated how gender operated when she was young:

If I asked to visit my paternal aunt's place, my parents refused, saying boys would be there. Then I responded, "What will happen if the boys will be there? I want to go. What will the boys tell? You are a male horse (a local term for someone not feminine)". **Odisha**

Many unmarried girls who participated in the study voiced strong sentiments against the sexual entitlement boys and men enjoy, as it was perceived that 'bad girls' have boyfriends, whereas boys were not answerable in the same way girls were. Given this belief, it was found that most of them were

straddling the thin line of what was socially acceptable and unacceptable in intimate relationships, for fear of a personal backlash or hurt they may cause their family if they made autonomous decisions in their romantic relationships. Some unmarried girls ask why gender norms apply only to girls, not to boys. A respondent wants to ask one question to society:

Why is a girl considered bad if she has a lot of male friends? How does having a boyfriend make the girl lack character? **Gujarat**

One social norm dictates that a woman has to marry the man of their parent's choice; the girl's consent is rarely ever sought in an arranged marriage. However, women have started to challenge this social norm. One participant challenged this by directly talking to her prospective bridegroom and putting forward her conditions, one of which was that there should not be any demand for dowry, and he accepted. Currently, she has a non-violent and healthy relationship with her husband:

That evening, he visited my aunt's house to see me formally. We spoke with each other. I asked about his background, education, and occupation, and I put forward two conditions if he wanted to marry me: I said, "1) I don't have any siblings, so I have to take care of my parents in their old age; you should also agree to shoulder their joy and sorrows; 2) You and your family members should not ask for any dowry. If you agree to these two points, I can marry you; otherwise, leave the matter here itself." My husband said, "I agree with the conditions and like your boldness." Therefore, mine is not a love marriage, but it was arranged according to my wishes and selection. **Tamil Nadu**

Despite facing all manner of violence and miseries, most of the married women we interviewed continued living with their husbands for the sake of their children's well-being and society, but not for anything else. None of them reported the violence to the police or sought any external help in dealing with the violence. Two women, one who had suffered external and internal physical injuries, and the other who had attempted self-immolation, did not disclose any facts about the domestic violence to the healthcare providers when they asked for details. Both tried to protect their husbands, saying that these were accidents. Thus, prevailing patriarchal and societal norms prohibit women from seeking support services or action against their violent husbands.

Many of the married women in the study who had experienced domestic violence, did not seek any support or help from the outside, but went back

to their natal home for some time and then returned. They shuttle between their natal and marital homes. In many instances, the natal home members support the women when needed. A respondent from Odisha who faced spousal violence from an alcoholic husband would spend an equal amount of time in her natal house as in her marital home, moving between them every three months or so. The following narrative shows how a woman tries to negotiate with her husband:

I left my marital home and lived with my parents for some time. After six months, my husband came and convinced me to return. I said firmly that I did not want to go back. He assured me that we would go and live alone in the city. Then I agreed, and now we live happily as a nuclear family. **Gujarat**

The following narrative describes how society normalises GBV and how helpless a woman feels:

I went to my natal home and was very angry with the people there. I said, 'You did a great job marrying me off to him. There is neither peace nor happiness. He always gets drunk and abuses me.' Then the family member said, 'This is all your fate; whatever is written in your fate, you will face that.' **Odisha**

In an effort to overcome GBV, some women tried to work outside their home and have some economic independence. One respondent stated that her husband would not allow her to work for wages, but she insisted on working so that she was not dependent on him for anything. Going out to work also enabled them to interact with other women in the village. Another woman likewise reported that she got some relief from her mental stress when she went to work:

I work in a company that gives me some peace of mind; there I am focussing on my work and have many co-workers to interact with. **Tamil Nadu**

Despite the challenges and violence in their marital relations, some women in the study are carrying on with their lives hoping their situation will change some day, believing their husbands will change their behaviour and lead a happy life with their children and families. A respondent narrated:

I faced extreme forms of violence. Once I decided to go to immerse myself in the sea. My daughter came and consoled me, and then she brought me here. Now I am living only for my children, nothing else. **Tamil Nadu**

A young respondent said her husband was extremely suspicious and violent, so she decided to leave him and get a divorce. Three other women from the study said they were now living separately:

He put many restrictions on me; he kept framing rules for me, and I did not like it. Above all, he suspected my fidelity. Therefore, I left him. **Tamil Nadu**

In their marital relationships, women have been rebelling, fighting, and opposing the sexual and gender-based violence they are exposed to. Seven married women in the study left their violent relationships, four of whom were from Tamil Nadu eventually got divorced. A 54-year-old woman respondent boldly removed her thirumangalyam/thali – mangalsuthra – when her husband married another woman, saying there was no meaning to her wearing it. She has been living separately from her husband for 15 years. Despite these huge tides in her personal life, she said that the confidence she gained through her training from an NGO led her to make concrete and correct decisions in her life; she now lives alone as a cancer survivor. Only a very few women sought help from outside, mostly support from local NGOs for their required services.

However, three other respondents from Maharashtra reported that when they were unable to bear the extreme domestic violence from their husbands and or in-laws, they left their homes in search of employment, so as to live independent of their husbands and in-laws. However, they were trapped in trafficking and forced to enter sex work. That further complicated their lives. Two of them tried to return but were unable to due to stigma and the fear of being rejected by their children:

I am terrified that due to the high stigma attached to sex work, nobody in my natal family can accept this fact. I am also often worried about my children, that if they came to know about this reality, I may lose them altogether. **Maharashtra**

3.8 Sexual and Reproductive Health

This section examines women's experiences in accessing sexual and reproductive healthcare services. The health of poor, marginalised women was already compromised at the time they enter adulthood due to poverty, poor nutrition, and heavy workloads. Lacking the power to make decisions in their families, and with limited knowledge on sexuality, conception, and contraception led to further deterioration in their SRH. Subsequently, poor relationships with their husbands and in-laws may have contributed to the general neglect of their health and well-being. Sexual violence and intimate partner violence also increased the risk of frequent pregnancies and gynaecological problems. Above all, unequal access to the required SRHR services and non-availability and poor quality of healthcare services contributed to the deterioration in the health of poor women.

Maternal Health

From the narratives of married women, it is evident that poor, marginalised women mostly used public health facilities for maternal healthcare services. However, there are state-specific differences: in Maharashtra, three of the five women had had children before their entry into sex work. All of them used public health facilities for their delivery. On the other hand, those who delivered after entering sex work did so at private health facilities. This may be due to discrimination and stigma in accessing services in the public sector.

From the interviews with tribal women in Odisha, it is seen that deliveries at home were more common due to the lack of transport facilities or money to go to a hospital. Only two women who had delivery complications accessed government health facilities. A 30-year-old tribal woman who had four home deliveries said:

All my children were born in my maternal home (no money to go to hospital) and delivered at home by myself. A female relative cut the cord. The relative checked whether it was time for delivery by pouring oil on the navel. (If it runs out, she is going to deliver; if not, there is still time). **Odisha**

Despite high out-of-pocket expenditures for accessing private services, more than half the married women in Gujarat used private services for delivery care. The poor quality of care and non-availability of services in the public sector were the reasons given for this. A 24-year-old married tribal woman stated:

In my first delivery, we spent around Rs.50,000 for which we had to sell some of my gold jewellery. In my second pregnancy, there was an expense of Rs.60,000 for the delivery, and my father paid this as we did not have the money. **Gujarat**

However, Dalit women in Tamil Nadu mostly used public health facilities for antenatal, delivery, and contraceptive services, mainly to avoid heavy out-of-pocket expenditure in private hospitals and to avail of government maternity benefits (conditional cash transfers of Rs.14,000 for poor women accessing maternal healthcare services in public health facilities).

In the study, many married women reported poor quality of delivery care services in public health facilities. A 35-year-old woman from Maharashtra narrated how she was humiliated by the healthcare providers in the public health facility during her delivery. This happened even before she entered into sex work:

I was in tremendous pain. The nursing staff kept asking me to push and push, using derogatory language, for example, "You must have enjoyed sleeping with your husband; why are you crying now?" **Maharashtra**

One 40-year-old woman reportedly had very poor quality delivery care services in a private hospital. The providers had abused her both verbally and physically:

During the delivery time, the healthcare providers abused me very badly, both verbally and physically. They shouted at me saying, "Don't you have sex with your husband after you are pregnant?" **Tamil Nadu**

Contraceptive Use

In the study, only 16 of the 27 currently married women had ever used a modern method of contraception. Five of them underwent sterilisation operations, three used oral pills, three used Copper-T's, and one used an injectable contraceptive. Only four sex workers ever used condoms as protection against HIV/AIDS, but did not use them with regular customers. Among the sex workers, a respondent who had been engaged in sex work for more than 25 years had never used condoms, thus making her vulnerable to STIs and HIV/AIDS:

I never used a condom in my entire life as a practising sex worker. **Maharashtra.**

Female sterilisation was the only method most married respondents used, only a very few used a spacing method for contraception. Many of them were interested in inserting the Copper-T after their first or second delivery but had it removed for various reasons. Women said that they could not get a regular supply of oral pills, and the men did not want to use condoms.

Likewise, none of the five tribal participants from Odisha had ever used any modern method of contraception. A respondent from Gujarat reported that she practised the natural method, but did not want to use a modern method, believing it could affect her health:

After the ASHA explained the rhythm method, we practised it. My fifth child is three years old. Recently, the ANM asked me to get a contraceptive operation, but I refused. I felt I would become weak after a tubectomy, and my husband does not work enough, so I needed to take care of my family. **Gujarat.**

It was clear from the women's narratives that they mostly used public health facilities for contraceptive services. However, a few of them reported that they had to make repeated visits and requests for service. Even then the response was poor and there were delays in receiving services:

After having two daughters, I went to a government medical college hospital requesting a female sterilisation operation, saying that I had two children and was taking tablets for neurological problems. They asked me to come on the day of menstruation, delayed it by conducting this and that test, and they did not do the operation. I went there again on the last day of my menstruation. They did all the tests, including the HIV test and completed all the formalities, then they took me to the operation theatre, but on that particular day, the anaesthetic doctor did not turn up, so they asked me to come the next day. We went the next day after head bathing; they refused to do it, saying that my menstrual bleeding had stopped. Then they asked me to come the next month. I was fed up, but they did not do the operation. Then, I conceived again for the third time. **Tamil Nadu**

Two respondents from Tamil Nadu mentioned that the intra-uterine device is inserted in women in PHCs and government hospitals without the women's consent. The following narrative of a respondent described the insertion of a Copper-T without her sister-in-law's knowledge in the government hospital:

My sister-in-law first delivered a girl baby in the government hospital. At that time, without informing her, they had inserted a Copper-T. When the child was four years old, she started to wonder why she did not conceive

again, and she began to get pain in the upper abdomen. She then went to the government hospital for a check-up, and there they asked her to take a scan. After seeing the scan report, they informed her that there was Copper-T. When the doctors asked her, she did not know. She was not at all aware that there was a Copper-T inside her uterus. She realised it only after four years when the Copper-T was removed. **Tamil Nadu**

There are also myths and misconceptions about contraception, especially about the Copper-T:

They inserted a Copper-T after my first delivery. However, I removed it after five months on the advice of my family and friends. They said that my weakness was because of it. I got pregnant twice and terminated them using abortion pills. My husband got pills from the medical store both times. **Gujarat**

Abortions

As a result of non-consensual sex and sexual violence, many women encountered unwanted pregnancies. A few terminated their pregnancies. However, there were several socio-cultural barriers and stigmas in accessing abortion services. There were instances of denial of abortion services to unmarried girls. It was apparent from the narratives of young women that abortion services were inaccessible and not available to marginalised unmarried girls.

All the six unwed respondents who had pregnancies and tried to abort them did not succeeded, as it was not legal until the Act was amended in 2021. Four respondents were forced to marry the man responsible, two others delivered the babies – one gave it up for adoption and the other's child was abducted. The lives of the women became miserable because of their social exclusion. They were ostracised and experienced extreme violence in their families.

One unwed woman who became pregnant, but lost her boyfriend in an accident tried to terminate the pregnancy, but despite many efforts, she failed. She delivered her baby, who was abducted by a stranger:

When my mother noticed that my stomach was looking larger, she realised that I was pregnant, and she took me to the clinic for an abortion. They asked for 5,000 rupees, but I was five months pregnant, so an abortion was not possible. Then I was forced to complete the term and deliver a baby. **Maharashtra**

After tackling all the barriers and facing the stigma, when the women met the healthcare provider, the cost of an abortion in the private sector was an important obstacle to accessing the services:

The doctor demanded 15 thousand rupees for the abortion, and my mother took me back, saying it was better to marry the person. **Tamil Nadu**

As reported earlier, condoms were not regularly used among sex workers, so they all had unwanted pregnancies that were aborted. All five sex workers in the study had multiple abortions, and all of them used private providers for the abortion services due to the non-availability of the services, stigma, and discrimination at public facilities:

Before the age of 25, I had three abortions. All three were medical abortions (and injections) done with the help of a local private medical. **Maharashtra**

Many married respondents could not access reproductive services due to societal norms, lack of decision-making power, or awareness. A few who had abortion reported that men seemed to think that abortion was a simple procedure, and that the woman could go through it repeatedly. All of them said that their husbands did not object to their going for an abortion; in fact they were all in favour of it. The husband of the disabled woman in Tamil Nadu believed that an abortion was very simple, so he suggested aborting the current pregnancy:

Now I am in the sixth month of my seventh pregnancy (three living children, an abortion, a stillbirth and one child loss). Even now, he told me to take some tablets to get rid of the pregnancy. **Tamil Nadu**

Most of the abortion users visited private facilities for abortion services, rather than face numerous negative factors like stigma and discrimination, non-availability of services, and poor quality of care in public health facilities.

4.
SUMMARY AND DISCUSSIONS

The qualitative study based on in-depth interviews with 44 respondents from five states of India brings out how marginalised girls and women face multiple deprivations and denial of their rights – social, economic, reproductive and sexual, as well as the right to healthcare. Gender and other axes of vulnerability put women in a position of powerlessness. Gender intersects with other marginalisations based on caste, class, age, geographical location, religion, migration, etc.

Five out of six multi-dimensionally poor people in India live in households belonging to a Scheduled Tribe, Scheduled Caste or Other Backward Class (United Nations 2021). Underprivileged people are predominantly landless, agricultural and other industrial wageworkers and live in rural areas or urban slums, and most of them do not have regular incomes or wages. Thus, caste is an important determinant of people's economic status. In this study, except for a few respondents who were from the urban slums of Delhi and Gujarat, all the respondents belonged to below-poverty-level households, and a large majority were from Scheduled Castes and Tribes.

The narratives of the women show that during their childhood and adolescence, household poverty, economic hardship, and gender norms severely affected the education and life opportunities of marginalised girls. The results show many instances of girls dropping out of schools, and being forced to work at home or outside their food and subsistence.

Gender roles are sharply defined – little girls are expected to drop out of school to take care of their younger siblings. Many respondents from Gujarat and Delhi repeatedly mentioned that their brothers are the guardians of their morality and good conduct, and can follow them around or monitor their phone calls. Even fathers hesitate to challenge this neo-masculinity assumed by their sons. Cultural beliefs and gender norms also stopped them from pursuing their dreams of higher education – "wives cannot be more educated than husbands". People living in urban slums felt it would be difficult to find a groom with matching qualifications for a girl with higher education. There are recorded instances of people saying that educating a girl is like watering a neighbour's garden.

A few educated young girls and women said they are rarely allowed to work outside the home, and that opportunities for them are controlled, even though they

have aspirations. As a result of deprivation and heavy workloads at a young age, the health of many of these girls and young women in Tamil Nadu, Odisha, and Maharashtra has been adversely affected; also nutritional deficiency disorders are very common among marginalised girls. Thus, the social determinants of health, like poverty, economic hardship, and difficulty accessing education, and social factors such as cultural and gender norms, affect their lives in many adverse ways.

The stories of these women also show that gender norms and restrictions become tough once girls attain puberty, exposing them to excessive pressure and restrictions on their mobility, form of attire, and education, and control over their relationships with the opposite sex. Almost all of our respondents stated that their mobility was severely restricted after puberty. Their stories highlight that many young women explore their sexuality, but the control exercised over them is severe. The influence of social and gender norms is vast and deep-rooted. These women live in a culture where outside control over their body and sexuality is the norm, and there is a high price to pay for digressions from the norm. Girls who do not follow the existing norms are considered to be 'bad'.

Gender norms are also deeply internalised by the young women themselves, within their families, as well as in their social groups or communities. This is reflected in the internalisation of the notion of 'good girls' and 'good wives' by most of the young 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 – they should not wear clothes such as sleeveless tops and pants. New 'good brides' are expected to adjust to their new families and homes, with all the dress codes of saris and head coverings (*ghunghat*).

Gender and sexual norms at the community level are highly skewed towards upholding patriarchal control over women's sexuality. Society views all relationships of girls with men/boys as love and romance. The girls' parents kept telling them that the family's honour was in their hands. If their parents came to know, or suspected, they were friendly with a young man, they stopped the girls' education immediately and forced them to marry the person of their (parents') choice.

With globalisation and industrialisation, young women have increasing opportunities to study and work outside their homes, and often alongside men. A few of them develop romantic relationships with their co-workers. However, young people in love rarely get an opportunity to spend time together and get to know each other. These relationships are often secret encounters with varying degrees of physical intimacy. Young women get into these relationships without any information about their bodies, sexual relationships, conception, or contraception. As a result, a few of them become pregnant before marriage. Sometimes, there is coercion in sex, but

young men are socially protected for initiating this, whereas women are made to pay the price.

The most significant violation we see in the narratives is the right to reproductive and sexual health information. Except for those women who have been in contact with NGOs, almost all the respondents stated that they did not know about menstruation before it started; neither did they know about sexual relationships before they got married, nor about contraceptives before they ended up with unplanned pregnancies. The lack of awareness about their sexuality, conception, and contraception puts young girls at risk of unwed pregnancies.

Pregnancies in unwed women lead to severe punishment in the form of withdrawal of community and family support, which is something, in the Indian context, women depend on most. Consequently, for the few women who are unable to terminate their pregnancy, getting married to the man responsible is the only way to save the family honour, even if the man is already married. If they belong to a different caste or class, the family arranges a forced marriage with another man to save the family's honour. Control over women's sexuality discourages inter-caste and inter-religious marriages. Forced marriages impact women's decisions on if, when, and whom to marry.

Most married women reported that they were not asked for their consent before their marriage. Importantly, many got married before they attained the legal age of 18 years. The stories also depict the negative impact of child marriages on the lives of girls, leading to further vulnerabilities. Marriage becomes a precondition for women to access SRH services. The lack of knowledge, the judgemental attitudes of family members, and the fear of being called a 'bad woman' caused apprehension and therefore delays in seeking safe abortions. Finally, they are unable to terminate their pregnancies. Criminalising consensual sexual activity among adolescents and the non-availability of abortion services are seen in the narratives of the girls and women.

The first sexual experiences of most married women were not smooth and pleasurable. They were events that caused much anxiety, concern, and worry. Masculinity and men's violent sexual behaviour were of great concern for women. A few respondents reportedly encountered sexual violence when they were young. The narratives of these unmarried girls suggest that it is also important to educate girls on being self-assertive and about 'good and bad touch', that would help them face challenging situations.

At the family level, male–female relationships are rarely cordial or affectionate. All the women who faced GBV mentioned that their relationships with their partners

were not smooth; there was a lot of violence, control, anger, and disappointment in their families. Violence within the family is about gender power dynamics. The power structure within the family normalises violence between intimate partners. When women are very poor and not employed in paid occupations, men control their mobility and decision-making, including in all matters related to sexuality and reproduction. Most of the married women faced extreme forms of violence.

The prevalence of non-consensual sex and sexual violence is high, and is recurrent in many women's lives, and can lead to pregnancies and abortions in unwed women. Even if the husbands were supportive in a few cases, the mothers-in-law were not. Women are unable to use contraceptives or choose to limit the size of their families – there were instances of women being prevented from using contraception or accessing abortion services to limit their family size. Men rarely use contraception; they neither allow women to use it, nor do they use it themselves. At the same time, when women declined their partners' sexual initiatives, the situation ended in physical and emotional violence and suspicion of fidelity. Women's reproductive choices and decisions were primarily controlled by their husbands and in-laws.

It is also found from the narratives of a few respondents that women affected by gender-based violence (GBV) were more susceptible to facing sexual violence by others. Two married women who faced GBV in Tamil Nadu indicated that other men in the community sexually harassed them on learning about their domestic issues. Women had poor pregnancy outcomes like miscarriages and stillbirths due to poor health and GBV. Two sex workers in Maharashtra also said that, when they were unable to tolerate the domestic violence, they left their homes and their husbands. They searched for employment in order to survive, and were trafficked by strangers and sold to brothels. The adaptation to the life of a sex worker was extremely traumatic for all respondents. However, it is also strange to note from their experiences that they got more control over their own lives after they settled into sex work.

One of the sex workers said, "Now I am alone, but I have a nice life. No violence by the in-laws and husband."

The health system also contributes to the poor SRH status of marginalised women; abortion services are denied to unmarried girls, which often has severe overriding effects on their lives and violates their SRH rights. ICPD POA says contraceptives should be provided to people without any coercion. The target-free approach to family planning in India was introduced in the mid-1990s. However, it still exists in indirect forms: coercive insertions of the Copper-T are still reported, and men's involvement in contraception is almost nil. Non-availability of services and poor quality of reproductive healthcare services in public health facilities force women

to incur heavy out-of-pocket costs in private clinics. Despite having good public infrastructural facilities in Gujarat and Maharashtra, women used the private sector for delivery care services and incurred heavy out-of-pocket expenditures. Women in sex work reported that they did not get proper SRH services – whether for contraception, during pregnancy, ANC, or abortions. Denial, social stigma, discrimination, and being subjected to abusive language were their everyday experiences. They had all had multiple abortions, and almost all used private services.

While the study suggests that women's sexual and reproductive health and rights remain much the same as they were a few decades ago, what seems to have changed is girls' and women's unwillingness to accept the violation of their rights as their destiny. Many young girls have started resisting gender and cultural norms of appropriate clothing and gender-based discrimination in education and upbringing. They are also challenging the myths and misconceptions of sexuality and reproductive health. Against all odds, women have shown resistance to unfair gender norms and gender-based violence. They have made strategic decisions about whether to remain in violent relationships or walk out of them. Overall, they showed resilience in challenging and facing the impossible odds against them.

5. CONCLUSION AND RECOMMENDATIONS

Overall, the research shows that caste, class, and gender intersect and affect women's education, health, and life opportunities. The lack of awareness about sexual and reproductive health and of autonomy and control over their bodies is a clear violation of the rights of marginalised women. Due to unequal gender power relations within families, they face extreme forms of domestic violence, which leads to further deterioration in their physical and mental well-being. Finally, the non-availability of essential SRH services to them and the denial of and discrimination in the provision of required services complicates their lives and increases their misery and strife. Thus, structural issues such as poverty, caste, cultural and religious beliefs, the absence of socially accessible sexual and reproductive health services, and the absence or gaps in sexuality education programmes impact the status of marginalised women's sexual and reproductive health and rights.

RECOMMENDATIONS

For UN and other policy-making bodies

- Ensure our government commitments to recognise and safeguard marginalised women's and girls' SRHR;
- Develop policies and programmes to adopt a life-course approach in addressing gender norms right from early childhood to post-menopausal and through the elderly years in a woman's life; and
- Provide sufficient funding to CSOs working on women's health and rights for conducting gender and SRH activities with structurally excluded girls and women.

For the government

- Provide financial incentives, scholarships, and support systems to reduce the economic burden on low-income families, so that girls and young people from marginalised communities to expand their access to career options and life planning;
- Implement special programmes to empower women and girls in the marginalised community through leadership and self-defence training, build up their self-confidence, and manage situations assertively;
- Enact and amend laws to: a) prohibit forced child marriages among girls, b) criminalise adolescent sexuality, and c) prohibit sexual violence within marriage;
- Provide the right to sexuality information through existing programmes, such as the RBSK/School Health programme, to include issues of consent, sexual violence, etc.; the government should work with CSOs to reach out to young people, and tribal and hard-to-reach populations;
- Implement on an expanded scale adolescent-friendly health clinics and AFH services, including contraception and abortion, which should be available in all government hospitals without any judgment;
- Recognise marital rape and intimate partner violence as serious public health and rights issues; also, strictly implement laws to prevent sexual harassment in public places and the trafficking of women for sexual exploitation;

- Include marginalised women in designing and planning social welfare policies and schemes; it is necessary to remove bottlenecks in accessing welfare schemes, like maternity benefit schemes, which originally aimed at promoting the health and well-being of marginalised people;

- Ensure SRH services are included in universal health coverage packages; the public sector is the primary source of SRH care services for the poor, but the quality of services is a major concern; training for healthcare providers and changes in medical curricula are needed to ensure availability, accessibility, acceptability, and quality (AAAQ) for respectful care in SRHR/GBV services; and

- Strengthen public health facilities to ensure that marginalised women and girls get access to high-quality SRH care services without any stigma, discrimination, or delay.

For Civil Society Organisations (CSOs)

- Provide age-appropriate comprehensive sexuality education for adolescents in and out of school; conduct gender and SRH workshops for newly married couples and young married men to prevent domestic violence and promote gender-equal relationships in families;

- Address masculinities to reduce gender-based violence and improve the autonomy of women to seek healthcare services and be healthy; there is a great need to conduct community-based awareness programmes and campaigns to challenge the patriarchal values, norms, and cultural beliefs that affect women's lives;

- Conduct sensitisation programmes for health workers and PRIs on gender and SRH to address the needs of marginalised groups and raise their concerns in appropriate forums, such as patient welfare societies and block health assemblies;

- Develop community-based support systems for the survivors of domestic violence, including CSO representatives, frontline workers and elected panchayat raj institution representatives to provide first-level support for women affected by gender-based violence and to refer them to appropriate centres for further support and follow-up; support systems like shelter homes, district domestic violence protection officers, women's police, and one-stop centre services should be widely popularised; CSOs can work to support and complement government services, especially in providing counselling and legal services to survivors of physical and sexual violence;

- Implement rehabilitation programmes for women who have left violent relationships, including those involved in sex work, to integrate them into society, so they can live safely with dignity;

- Promote research studies and the generation of evidence founded on an intersectional and social justice lens to inform policy and action on specific groups such as tribal, SC/ST, differentially abled, LGBTQIA, women living HIV/ADIS, informal workers, and frontline health workers, specifically in light of increasing incidences of gender-based violence, mental health problems and teenage pregnancies; based on this evidence, CSOs can advocate with the government to better implement international treaties and agreements, national policies, and programmes; and above all

- Encourage a much-needed solidarity between civil society groups and cross-movement building to address caste, gender, and other intersecting factors that violate SRHR.

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About ARROW

Asian-Pacific Resource and Research Centre for Women -ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

About CommonHealth

CommonHealth - Coalition for Reproductive Health and Safe Abortion, constituted in 2006, is a rights-based, multi-state coalition of organisations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities in India. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

CommonHealth

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