ICPD+30 MONITORING RESEARCH

Untold Stories: Reproductive Life Histories of Marginalized Women and Girls in India

A SUMMARY REPORT

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asian-pacific resource & research centre for women

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BACKGROUND

The 1994 International Conference on Population and Development (ICPD) marked a significant shift from target-oriented demographic goals to focusing on the needs of women's and men's reproductive rights. The year 2024 marks a significant milestone—the 30th anniversary of the ICPD. A series of events at the global, regional, and national levels have been planned to commemorate the 30th anniversary and to review progress and the gaps in implementing the ICPD Programme of Action (PoA). To facilitate the process, the Asian Pacific Resource and Research Centre for Women (ARROW), Malaysia, in collaboration with CommonHealth in India, has generated evidence on gains and gaps in the sexual and reproductive health and rights (SRHR) situation in India. The project is titled "ICPD+30: India's Country Monitoring Research"; this summary report has been prepared as part of the project, for broader dissemination of the research findings.

This report provides an overview of the sexual reproductive health and rights (SRHR) issues of marginalized women in India as experienced by them during different stages of their lives, and the gaps and barriers they face in accessing and utilizing healthcare services. These results have been drawn from a qualitative study conducted in four Indian states and the union territory of Delhi. The study was based on in-depth interviews and field data collected between May 2019 and March 2020 by CommonHealth's partner organizations[1] in different states of India.

A total of 44 marginalized women and girls participated in the study, representing various groups, including SC/STs, economically poor unmarried and married women living in urban slums, and sex workers. Of them, 18 belonged to the Dalit community, 17 were from Adivasi communities, and 9 belonged to other backward caste groups. The respondents' ages ranged from 18 to 65. In terms of marital status, 18 were married and living with a spouse, 9 were separated/widowed, and the remaining 17 were unmarried.

1 The five states and partner organizations involved in the research were SAHAJ (Gujarat), SAHELI (Maharashtra), SAHAYOG (Odisha), RUWSEC (Tamil Nadu), and YP Foundation (New Delhi).

KEY FINDINGS FROM THE STUDY

1. Growing up poor, marginalized, and female

Being female and poor, and belonging to marginalized communities, the participants in the study suffered from severe malnutrition and childhood morbidities. Many of them could not continue their education because of family financial constraints and domestic responsibilities.

> *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**
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> *I did not go to school. My elder 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 clothe ourselves.* **Odisha**
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> *As I am the eldest child and have two younger brothers and a sister, I had to take on the household chores and look after my siblings. Therefore, I stopped going to school in the fifth grade.* **Gujarat**

2. Gender and social norms affecting women's life opportunities

Gender norms and restrictions become stricter once girls attain puberty, exposing them to even greater pressures and restrictions on their mobility, forms of attire, and education, and to greater control over their relationships with the opposite sex.

> *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**.

Five women in the study had to discontinue their education because they transgressed gender norms or for inappropriate behavior. Once their parents came to know of, or even suspected, their friendship with a young man, they stopped the girls' studies.

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

Parents often tell their daughters that the family honor is in their hands. One respondent, however, said, 'My mother told me your honor is in your own hands.'

> *Premarital 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 not to do it than regret it later.* **Delhi**

3. Poor awareness about sexuality and reproduction

About three-fourths of the participants in the study had no knowledge about menarche prior to attaining it. A 21-year-old woman in urban Gujarat narrated:

> *I did not know what menarche was, so I was afraid when it started. There was no itching or pain in the urinary passage, but blood flowed continuously.* **Gujarat**

Lack of awareness about their sexuality, conception, and contraception puts young girls at risk of unwanted pregnancies, and also to the denial of or non-availability of abortion services for unmarried girls, and forced marriages.

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

> *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 because I had fever. They took blood tests. When I asked the doctor 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**

4. Sexual and reproductive rights

Many of the women married before the legal age of 18 years. Their stories depict the negative impact of child marriages on their lives, as this led to further vulnerabilities. Many had forced marriages.

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

The following narrative of a rural respondent indicates how sexual norms biased against women govern women's decision-making processes:

> *He was already married, which I did not know during my love relationship. He had completely hidden that from me, and I discovered 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**

The first sexual experiences of most married women were not comfortable or pleasurable. They were events that caused much anxiety, concern, worry, and, at times, trauma. Masculinity and men's violent sexual behavior were a source of considerable concern for women.

> *He is a strong man. If he puts one leg on you, you cannot even move. I disliked it, lost consciousness, and had severe stomach aches after that.* ***Odisha***

> *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**

5. Gender-based violence against women and girls

Psychological violence: About three-fourths of the participants in the study reported experiencing one or more instances of emotional violence by their family members, teachers, or friends:

> *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**

Women who became pregnant before they were married faced severe punishment in the form of isolation from the community and withdrawal of family support. A girl who lost her boyfriend in an accident, while being pregnant at the time, narrated why she had left her native place:

> *We were unable to terminate my pregnancy as it had crossed over five months. Then, 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**

Extreme suspicion by the husband was a form of psychological violence. A few of the married women reported:

> *He is very suspicious. I could not talk with my relatives or visit them, and I could not sit and chat with my younger or elder brothers or my uncles. They should not be playful, nor should I. There is so much behavior he finds 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 that if I sit next to someone, I will make him my husband.* **Odisha**

Physical and sexual violence**:** Among the respondents, there was a high prevalence of physical violence (29 out of 44 respondents) and sexual violence (26 out of 44); many of the respondents, in fact, faced extreme forms of violence:

> *My sisters-in-law abused me with all sorts of heinous acts like putting chili powder in my bathing water or on my clothes, breaking my bangles, breaking my chappals, and so on.* ***Gujarat***
>
> *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 from the unbearable pain. Immediately, my neighbors took me to the hospital, where they took out the baby and buried it.* **Tamil Nadu**

Non-consensual sex was commonly reported; almost all married women and some unmarried participants reported that they had had non-consensual sex. An unmarried girl reported:

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

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 thinks I am his wife and it is unnecessary to ask for my consent. I will not go to that extreme and will not fight with him; I keep calm, and he does what he wants.* **Tamil Nadu**
>
> *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**

6. Resistance and resilience

The results of the study also show that marginalized girls and women have been resisting and challenging social norms and customs that affect their lives, but only a few have overcome these. A respondent wants to ask society one question:

> *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**
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> *He put many restrictions on me; he kept framing rules for me, which I disliked. Above all, he suspected my fidelity. Therefore, I left him.* **Tamil Nadu**

7. Health system factors

Despite heavy out-of-pocket expenditures, poor women chose private institutions for their delivery care because of the poor quality of care and non-availability of services in public health facilities.

> *The nursing staff kept asking me to push and push, using derogatory language, such as, you must have enjoyed sleeping with your husband; why are you crying now?* **Maharashtra.**
>
> *During the delivery, 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**

The non-availability of, and the stigma and discrimination related to abortion services at both public and private facilities were also reported. These often resulted in unwed pregnancies and forced marriages.

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

CONCLUSION

Overall, the study shows that caste, poverty, and gender intersect and affect women's education, health, and life opportunities. The lack of women's awareness about sexual and reproductive health and of their autonomy and control over their bodies are clear violations of the rights of marginalized 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 sexual and reproductive health services for them and the denial of and discrimination in the provision of these services complicate their lives and increase their misery and strife. Thus, structural issues such as poverty, caste, cultural and religious beliefs, the absence of socially accessible SRH services, and the absence or gaps in sexuality education programs have severely impacted the status of marginalized women's sexual and reproductive health and rights .

RECOMMENDATIONS

For the UN and other policy-making bodies

- Ensure government commitments to recognize and safeguard marginalized women's and girls' sexual and reproductive health and rights;
- Develop policies and programs that adopt a life-course approach in addressing gender norms that are harmful to women and girls, from birth and early childhood to post-menopausal and later years; and
- Provide sufficient funding to CSOs working on women's health and rights for conducting gender and sexual and reproductive health activities with girls and women from structurally excluded groups.

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 marginalized communities can expand their access to career options and life planning;
- Enact and amend laws to a) prohibit forced child marriages among girls, b) criminalize adolescent sexuality, and c) prohibit sexual violence within marriage;
- Provide the right to sexuality information through existing programs, such as the RBSK/School Health program, so that they include issues of consent, sexual violence, etc.; on this, the government should work with CSOs to reach out to young people and tribal and hard-to-reach populations;
- Implement an adolescent-friendly health clinic on an expanded scale. Adolescent friendly and non-judgmental health services, including contraception and abortion, should be available in all government hospitals;
- Implement special programs to empower women and girls from marginalized communities through leadership and self-defense training, building up their self-confidence and ability to manage challenging situations assertively;

- Recognize marital rape and intimate partner violence as serious public health and rights issues; additionally, strictly implement laws to prevent sexual harassment in public places and the trafficking of women for sexual exploitation.
- Ensure sexual and reproductive health services are included in universal health coverage packages. While the public sector is the primary source of sexual and reproductive health services for the poor, 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 sexual and reproductive health services including services for gender-based violence.
- Strengthen public health facilities to ensure that marginalized women and girls get access to high-quality sexual and reproductive health services without any stigma, discrimination, or delay.

For Civil Society Organizations (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 enhance women's autonomy to seek healthcare services and be healthy. There is a great need to conduct community-based awareness programs and campaigns to challenge the patriarchal values, norms, and cultural beliefs that affect women's lives;
- Conduct sensitization programs for health workers and Panchayati Raj (local government) institutions on gender and sexual and reproductive health to address the needs of marginalized 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 Panchayati Raj institution representatives to provide first-level support for women affected by gender-based violence and to refer them to appropriate centers for further support and follow-up. Support systems

like shelter homes, district domestic violence protection officers, women's police, and one-stop center services should be widely popularized. CSOs can work to support and complement government services, especially in providing counseling and legal services to survivors of physical and sexual violence;

- Implement rehabilitation programs 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 evidence generation founded on an intersectional and social justice lens to inform policy and action on specific groups such as SC/STs, persons with disabilities, women living with HIV/ADIS, migrant workers, and frontline health workers, specifically in light of increasing incidences of gender-based violence, mental health problems, and teenage pregnancies. CSOs can draw on this evidence to advocate with the government to better implement international treaties and agreements, national policies, and programs; and, above all
- Encourage much-needed solidarity between civil society groups and cross-movement building to address caste, gender, and other intersecting factors that violate SRHR.

A detailed report of the study is available at https://commonhealth.in/ch-publications/

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.

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