Monitoring the Progress of Sustainable Development Goals in Gujarat

Situation Analysis for Selected Targets from SDG3 and SDG5

Compiled by
SAHAJ

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List of Abbreviations

1.	AHS	- Annual Health Surveys
2.	AICB	- All India Confederation of the Blind
3.	AIDS	- Acquired Immune Deficiency Syndrome
4.	ANC	- Antenatal Care
5.	ANM	- Auxiliary Nurse Midwifery
6.	ASHA	- Accredited Social Health Activist
7.	BMI	- Body Mass Index
8.	BPL	- Below Poverty Line
9.	CAG	- Comptroller and Auditor General
10.	CBO	- Community Based Organization
11.	CHC	- Community Health Centre
12.	CRO	- Contract Research Organizations
13.	CSO	- Civil Society Organizations
14.	CWDS	- Centre for Women's Development Studies
15.	CY	- Chiranjeevi Yojana
16.	DBWRF	- Dawoodi Bohra Women's Association for Religious Freedom
17.	DIR	- Domestic Incident Report
18.	DV	- Domestic Violence
19.	DWCD	- Department of Women and Child Development
20.	FDI	- Foreign Direct Investments
21.	FGM/C	- Female Genital Mutilation or Cutting
22.	FIR	- First Information Report
23.	GIDC	- Gujarat Industrial Development Corporation
24.	GLPC	- Gujarat Livelihood Promotion Company
25.	GOI	- Government of India
26.	GRC	- Gender Resource Centre
27.	GSDP	- Gross State Domestic Product
28.	HDI	- Human Development Indicators
29.	HIV	- Human Immunodeficiency Virus
30.	HMIS	- Health Management Information Systems
31.	HPV	- Human Papilloma Virus
32.	IAEG	- SDGs- Inter- Agency and Expert Group on SDG indicator
33.	ICDS	- Integrated Child Development Services
34.	IFA	- Iron and Folic Acid
35.	IGSA	- International Gender & Sexuality Alliance
36.	IMR	- Infant Mortality Rate
37.	IPC	- Indian Penal Code
38.	IPV	- Intimate Partner Violence
39.	JSA	- Jan Swasthya Abhiyan
40.	JSY	- Janani Suraksha Yojana
41.	KMIQFF	- Kashish Mumbai International Queer Film Festival
42.	LGBTQI	- Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Intersex
43.	LHV	- Lady Health Visitor
44.	MA	- Mukhya Mantri Amrutam Yojana
45.	MDG	- Millennium Development Goal
46.	MMR	- Maternal Mortality Rate

47. MOSPI - Ministry of Statistics and Programme implementation
48. NCRB - National Crime Record Bureau
49. NFHS - National Family Health Survey
50. NGO - Non-Government Organizations
51. NHRC - National Human Rights Commission
52. NIOH - National Institute Orthopaedically Handicapped
53. NMHP - National Mental Health Programme
54. NRHM - National Rural Health Mission
55. NRLM - National Rural Livelihood Mission
56. NSS - National Sample Survey
57. OBC - Other Backward Communities
58. PATH - Programme for Appropriate Technology in Health
59. PGN - Practical Gender Needs
60. PHC - Primary Health Centre
61. PIL - Public Interest Litigation
62. PMMSY - Pradhan Mantri Matritava Sahay Yojana
63. PNC - Post Natal Care
64. POCSO - Protection of Children from Sexual Offences
65. PPP - Public Private Partnership
66. PTRC - Peoples Training and Research Center
67. PWD - Persons with Disability
68. PWDVA - Protection of Women from Domestic Violence
69. RCH - Reproductive and Child Health
70. RCI - Rehabilitation Council of India
71. RSBY - Rashtriya Swasthya Bima Yojana
72. SC - Schedule Caste
73. SDG - Sustainable Development Goal
74. SDR - Suicide Death Rate
75. SGI - Strategic Gender Interests
76. SHG - Self Help Groups
77. SRH - Sexual and Reproductive Health
78. SRS - Sexual Reassignment Surgery
79. ST - Schedule Tribe
80. STD - Sexually Transmitted Diseases
81. STI - Sexually Transmitted Infections
82. TFR - Total Fertility Rate
83. TG - Transgender
84. UNAIDS - United Nations Programme on HIV and AIDS
85. UNCRC - United Nations Convention on the Rights of the child
86. UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
87. UNFPA - United Nations Population Fund
88. UNGA - United Nations General Assembly
89. USD - United State Dollar
90. VAW - Violence Against Women
91. VHND - Village and Health Nutrition Day
92. WCD - Women and Child Development
93. WGWLO - Working Group for Women and Land Ownership
94. WHO - World Health Organizations

Preface

Government of India and national and international organizations in the development sector have conducted several studies and produced reports for mapping the demographic, economic, social profile and the status of health and education related services and so on. In this report, SAHAJ has attempted to compile the data from several such sources for the state of Gujarat with the objective of monitoring the development of sustainable development goals in the state.

SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', in select states of India and at the national level wherein we are trying to strengthen the efforts towards achieving the selected targets from two SDGs that revolve around women and girls- SDG-3 (Ensure healthy lives and promote well-being for all at all ages) and SDG-5 (Achieve gender equality and empower all women and girls). The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development process. Thus, the analysis in this report builds on gender analysis and social equality.

Along with the data from secondary sources, SRH and gender equality related experiences of the grassroots organizations working in Gujarat are also compiled in order to depict women's health and gender equality situation for the state. We hope that this report will feed into the local efforts of dialogue with the state officials.

SAHAJ Team,

October 2018

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Executive Summary

In 2015, the international agenda moved from Millennium Development Goal (MDGs) to more detailed and comprehensive Sustainable Development Goals (SDGs) with 17 goals and 169 targets revolving around economic, social and environmental dimensions of development. India is one of the 193 signatories that accepted the SDGs agenda. In India, National Institution for Transforming India (NITI) Aayog is assigned the role to coordinate the Sustainable Development Goal (SDGs) whereas, Ministry of Statistics and Programme Implementation (MoSPI) is involved in enlisting indicators for all the targets. Simultaneously, several civil society organizations and coalitions (such as, Wada Na Todo Abhiyan (WNTA) are working for monitoring India's progress towards achieving SDGs. SAHAJ (Society for Health Alternatives) has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs' in the State of Gujarat, wherein it is trying to strengthen the state and national level efforts towards achieving the selected targets for two SDGs that pertain to women and girls. In a diverse country like India, the processes required to achieve the targets in different contexts and with different communities will vary. The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development processes to include all the marginalized communities in the process of development. Through this project SAHAJ is trying to initiate discussions on evidence based strategies for taking all of them towards achieving the set goals.

This report is based on field experiences of Jan Swasthya Abhiyan members (JSA), consultation meeting from experts in April 2018, and state and national level data from secondary sources including Census of India 2011 and NFHS-4, 2015-16. Considering the differences in sampling methods and different sample sizes, this report does not compare the data but presents data from varied sources with gender and health equality perspective.

The report is divided into six sections. First section describes the profile of Gujarat followed by Section 2 on 'Policy and Programme Environment' that includes information about health policies, women policies, budget for SDG-3 and 5, select programmes and the status of health sector in the State. Section 3 describes the situation of maternal health, family planning and safe abortion services and their social accountability based on secondary data and field experiences of JSA members. Section 4 on violence against women and girls documents violence, help seeking and systemic response to violence. Section 5 is about harmful traditional practices that documents status of child marriages and practices such as D*akkan Pratha* or Witch Hunting and female genital mutilation (FGM). Section 6 –"Leave No One Behind" focuses on issues faced by several marginalized communities such as migrant workers, dalit women, women with disabilities and Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer (LGBTQIs).

Gujarat is one of India's rapidly progressing states in recent times. It has seen tremendous growth both in infrastructure and revenue from different fields in last few decades. Gujarat also has a long and rich history of people's campaigns and struggles for social change since pre independence era. Women's organisations in the state have come together around issues of women's safety, violence against women, livelihoods and women's health rights in the context of SDGs. This is a small but significant step towards rekindling a collective agenda and solidarity. The Government of Gujarat has also taken a few steps towards gender equality and formulated a Gender Policy – the *Nari Gaurav Niti.*

Gujarat has a good economy and claims to be a well-developed state, its health indicators and investment in the health sector, are not commensurate with its economic development. While budgetary provisions for health care have increased, the budgets for addressing the women's social issues get very little financial outlay. Geographic, economic and social (gender) inequities plague the State population. Systemic solutions are often not in sync with the ground realities, are too complex and bureaucratic and provide opportunities for manipulation of procedures, exploitation of people and denial of services to the most vulnerable and disadvantaged population.

Though the State government health infrastructure is good, there is acute shortage of trained human resources. This has very serious implications for providing quality health care services especially to women in rural areas. Moreover, very few women and men are covered by any health scheme or health insurance. Attempts to rope in private partners to improve efficiency of services lack explicit framework for reaching people.

There is decline in the State MMR and IMR but

maternal health remains a staggering challenge, particularly in the rural, tribal interiors and in poor urban pockets. Majority of the women do not receive full ANC care, family planning services and entitlements under different schemes. Systemic shortcoming and social stigma and taboos affect service use. Sustainability of this decline depends on efforts to address poor coverage by recommended "Full" antenatal services, inequities among social groups and questionable quality of services.

Women in the State face different forms of violence but social stigma, unawareness about remedial measures available to them prevent them from taking any pro-active actions. Various studies and cases related to violence discussed in the report highlight the lack of information, lack of counselling services. The studies reiterate one after the other, importance of training of the health staff for handling of cases related to violence. Systemic apathy in pro-actively seeking and managing cases means that data on the issue is sparse and incomplete. Further, insensitive, ill equipped systemic response to those seeking services instead of helping women creates a hostile environment which drives away women victims. The laws such as POCSO while well meaning, are often distant from local context and are exploited to harm women's interests in the patriarchal set up. The inadequate and decreasing budgets further compound the situation.

Harmful practices against women and girls in the state include child marriage and early child bearing continue to be widely prevalent and are fundamentally a violation of girls' right to achieve their full potential. Practices such as witch hunting and FGM are restricted to certain geographic and community pockets but irrespective of their prevalence, these practices prey on the vulnerability of women in a patriarchal society and adversely affect their health. Experiences of grass roots organisations suggest that mere existence and awareness of laws has not helped address even the widely prevalent and acceptable social practices.

Migrant women, Dalit women, women with disability and LGBTQI groups are the identified marginalized groups for Gujarat. These groups struggle for their right to be accepted as equals. Data on many of these groups in not available. The available data highlights the lack of facilities and services for them and the rampant exploitation of and discrimination against these vulnerable communities. Still, the issues of these groups are not on agenda as the groups lack economic, political or media power.

All these issues have significant impact on the targets to be achieved under SDG-3 and 5 and to strengthen the state and national level efforts towards achieving these selected targets it is necessary to refer to the available evidence, collect evidence where it is currently missing, have discussion with various stakeholders associated with women's health and well being and design strategies to address the barriers and utilize the available platforms.

INTRODUCTION

Gender equity and women's health have been at the centre of many development debates over the decades, and these occupy a crucial space in the Sustainable Development Goals (SDGs) set by the United Nations in 2015.

SDGs resulted out of widespread discussions amongst diverse stakeholders. Some of the lacunae of the Millennium Development Goals (MDGs) process such as it being top down and imposed were consciously addressed by the SDGs process. The UN organized many discussions and meetings, solicited inputs including online consultations even from the general public. The process was sought to be transparent and consultative. An Open Working Group was mandated by the UN1. This Open Working Group submitted the proposal "Open Working Group Proposal for Sustainable Development Goals" to the General Assembly in 2014 and proposed a set of 17 goals and 169 targets to be achieved by 2030. In September 2015, UN Member States adopted the post 2015 development agenda at the UN Sustainable Development Summit. The outcome document of the process is titled 'Transforming Our World: The 2030 Agenda for Sustainable Development', and lays out the vision, principles, the Goals and Targets, as well as the means of implementation and follow up of the implementation. Unlike the MDGs, the SDGs went beyond social issues and developing countries and set targets for all countries, across social, economic and environmental dimensions of sustainable development.

Although built upon the MDGs, the SDG agenda broadened the women's health component beyond maternal mortality to include indicators related to Sexual and Reproductive Health (SRH), and elimination of violence against women and practices such as child marriage and female genital mutilation. While gender equity is a separate goal (Goal 5) in the agenda, there is also a policy intention to mainstream a gender perspective in every SDG. The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development process and gender equality has been acknowledged as an important aspect of equitable and inclusive development.

India is one of the 193 signatories that accepted the SDGs agenda in the year 2015. The Government of India is committed to reviewing, revising and formulating policies keeping the SDGs in mind, making this the opportune time for civil society organisations (CSOs) to engage in the process and voice their concerns and recommendations.

SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', with support from Equal Measures 2030, wherein it is trying to strengthen the state and national level efforts towards achieving the selected targets for SDGs – SDG-3 and SDG-5 that revolve around women and girls.

About SAHAJ

SAHAJ (Society for Health Alternatives), a non-government organisation (NGO) registered in 1984, envisions a society with social justice, peace and equal opportunities for all. It focuses on children, adolescents and women in two specific sectors-health and education. It strives to make a practical difference in lives of marginalized women and girls through direct action in the communities and through action research and policy advocacy work. It believes in developing people led programs based on the expressed needs of the communities that it works with. For greater impact, it collaborates with likeminded organizations to form coalitions at state and national level.

Project: In six selected states Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Punjab, SAHAJ worked with a host of partners to prepare reports which would help in conducting state and national level discussion as well as policy dialogue with government officials and other key stakeholders. The present report is a part of SAHAJ's project 'Data driven dialogues for gender equality and SDGs' on-going since October 2017.

The report monitors the progress of selected targets for SDG-3: ensure healthy lives and promote well-being for all at all ages and SDG-5: achieve gender equality and empower all women and girls)

The targets selected for monitoring include

- Reducing maternal mortality (3.1)
- Ensuring universal access to sexual and reproductive health (SRH) services (3.7)
- Eliminating Violence against Women (VAW) in public and private spheres (5.2)

- Eliminating harmful practices such as child, early and forced marriage and female genital mutilation (5.3) and
- Ensuring universal access to SRH rights (5.6)

For monitoring progress across the targets the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) had developed a global indicator framework and general agreement was reached to monitor 232 individual indicators. However, each signatory member country had the freedom to modify the indicators to their own situation. In India the Ministry of Statistics and Programme Implementation (MOSPI) proposed a draft list of indicators in 2017.

Conceptual Framework

A conceptual framework was developed for the project data analysis across two critical dimensions, gender and social equity and health equity.

Gender and social equity

The UN General Assembly recognizes sex as an important stratifier in its resolution (68/261) that states, *'the indicators should be disaggregated ... by income, sex, age, race, ethnicity, migratory status, disability and geographic location…'* The data tables generated through census or surveys show us the differences and inequalities across male and female categories (i.e. sex). While sex is used to represent the biological differences, gender, which is a sociological construct, gives us the context and reasons behind these differences or inequalities. Sex disaggregation merely tells us whether or not there is a difference, whereas a gender analysis tells us whether gender-power inequalities cause or contribute to the observed difference.

Gender analysis is a social analysis that distinguishes the resources, activities, potentials and constraints of women relative to men in a specific socio-economic group and context2. It does not refer only to women but to the differences in the condition and position of women and men, and to the socially constituted relations between them. A gender analysis looks at both- the Practical Gender Needs (PGNs) of women and men, and the Strategic Gender Interests (SGIs), which arise from their social status. There are gender dimensions even to 'women only' indicators such as maternal mortality ratio.

Further, all women (and all men) are not one homogenous group. A Social Equity lens factors in the differences based on caste, class, location, ability, sexuality and such like, into the analysis. This report specifically looks at the data across different social groups such as Scheduled Tribes, Scheduled Tribes and Others, the Rural-Urban population, and different Wealth Quintiles.

Health equity

The World Health Organization (WHO) defines equity as the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" implies that everyone has a fair opportunity to attain her/his full health potential and that no one is disadvantaged from achieving this potential.

In the current analysis, health equity plays an important role as women's health is influenced by their social status, gender roles, control over resources and decision making powers through their knowledge about health issues and access to health services. It becomes particularly important to see if the differences in health status or access to services between male and female are because of their social advantage or disadvantage.

This report documents Gender, Social and Health Equity analyses undertaken in Gujarat data from different sources to understand the factors behind differences among women and men and also intra group differences (based on caste, class etc.). It also includes a gender-analysis of accepted SRHR indicators (wherever possible) and the attempts to better capture the gender and equity dimensions of the issue under scrutiny. Though other gender categories, such as transgender, bisexual or intersex exist, data on these groups is not available. The report therefore is limited to analysis of Male/ Female differences.

Methodology

This report is based on state level data from secondary sources such as policy and budget documents of Government of Gujarat, published research articles and experiences and studies shared by the CSOs working in the State.

The government data sources included in this report are: Census of India 2011, National Family Health Survey-4 (NFHS-4, 2015-16), Rural Health Statistics report (2015), Ministry of Statistics and Programme Implementation (MOSPI, 2017), Central Statistics Office (CSO, 2011), Health in India report of 71st round of National Sample Survey (NSS, 2014), Comptroller and Auditor General (CAG) reports Health Management Information Systems (HMIS), National Crime Records Bureau (NCRB) etc.

These sources have used varied techniques (census, household survey, facility survey, cases records etc.), sampling methods and sample sizes. Surveys such as NFHS and Annual Health Surveys (AHS), analyse the perceptions of household respondents whereas HMIS or NCRB data analysis is based on number of cases registered with clinics or police respectively. In this report data from these sources is analysed to narrate a gender story without any effort to compare disparate data sets. The presented data and analysis are interspersed with commentaries by civil society members as they strive to make sense of it in relation to their own contexts and lived realities.

Structure of the report

This report is divided into six sections:

Section 1. State profile: This section gives a brief glimpse into the civil society history of Gujarat and an idea of the current state situation in the State.

Section 2. Policy and Programme Environment: This section includes information about health and women's development policies, programmes and services and budget for the same in the State.

Section 3. Maternal Health: It includes secondary data and field experiences related to maternal health.

Section 4. Violence against Women and Girls: It includes secondary data and field experiences on violence against women and girls.

Section 5. Harmful and Traditional Practices: It includes secondary data on child/early marriages, and primary studies on Dakkan Pratha or witch hunting and branding of women as witches and female genital mutilation.

Section 6. Leave No One Behind: This section focuses on issues faced by women living with disabilities, Dalit women, LGBTQI community, Dawoodi Bohra women, women migrants and women workers and other marginalized women.

SECTION 1
STATE PROFILE

Gujarat is one of the six selected states under 'Data driven advocacy for gender equality and SDGs' project undertaken by SAHAJ. It came into being as a separate state on May 1, 1960. It is one of India's most rapidly progressing states in recent times and has seen tremendous growth both in infrastructure and revenue from different fields.

The State has undertaken a number of SDG specific efforts. On 22nd July 2016, the Government of Gujarat and United Nations organised a half day consultation on SDGs for all the Principal Secretaries and Heads of the Departments. The Panchayati Raj Ministry has identified 17 SDGs which have a direct link to Panchayat's. Of these, it has prioritised nine and identified several central schemes as the means to achieve the goals1. More recently, from January 2018 onwards, the Health Commissioner of Gujarat has organised a series of meetings with various NGOs in the State to achieve the SDG goals and SAHAJ was part of one such meeting.

Civil society campaigns in Gujarat

Gujarat has a long and rich history of people's campaigns and struggles for social change. Gandhiji's famous Dandi March (1930) as a part of the Independence movement, the Nav Nirman agitation after independence, Anasuya Sarabhai's and Elaben Bhatt's labour movement that brought the labour, cooperative and women's movement together, the Narmada Bachao Andolan are amongst the notable people's struggles in the State. Gujarat has a history of a strong Dalit movement since the early 1980s when the 1981 anti-reservations riots against Dalit's brought a new consciousness to Dalit's in the state. Later, with organisations like the Navsarjan Trust working on the ground, a fledgling Dalit women's movement also started emerging in the state.

Gujarat has also been the home to several grassroots feminist experiments and pioneering community health organisations since the late 1970s and early 1980s. Mahila Samakhya in the 1980s, Mahila Swaraj Abhiyan (a network of women Panchayat members) in the 1990s, and Nari Adalats (grassroots women's courts providing decentralised and quick justice as an alternative to the overburdened legal system), are a few noteworthy examples. In the 1980s autonomous women's organisations and women's rights advocates in Gujarat came together as a Mahila Manch, which met several times over the few years and discussed issues of importance and built a common analysis.

At the turn of the century (2000) many of the abovementioned community based health organisations and women's organisations came together as the Jan Swasthya Abhiyan (JSA) campaigning for 'Health for All'. In 2002 after the Godhra violence women's organisations once again collectively engaged in efforts to seek justice for women who were victims of sexual and other kinds of violence. In the same year, the WGWLO – Working Group for Women and Land Ownership a state based network committed to sustained grassroots action and policy advocacy around the issue of women's land rights, including access and ownership over land and other productive resources was launched. WGWLO today has a diverse membership of more than 40 NGOs and CBO (Community Based Organization) and individuals with varied expertise, across 17 out of total 33 districts of Gujarat. In 2004 with the help of UNFPA, a Gender Resource Centre was set up in the state that helped channel the advocacy efforts and consolidate the efforts of the women's movement in Gujarat. At the time of the World Social Forum in Mumbai in 2004, women's organisations in preparation for the Gujarat Social Forum came together to prepare a 'Black Paper' on women's status in the State and used it widely to mobilise women across the state. The state government efforts of formulating a Gender Policy – the Nari Gaurav Niti in the aftermath of Godhra violence was formally adopted in 2006.

Women researchers and academics and activists forged alliances to coalesce into the Gujarat Forum

for Women's Studies. Members of Women's Studies Centres across the state work together to document the struggles and experiments that women were engaged in. The recent coming together of women's organisations around issues of women's safety, violence against women, livelihoods, and women's health rights, especially the rights of the most vulnerable women – migrants, workers, Dalit's, Muslims to name a few in the context of SDGs, is a small but significant step towards rekindling a collective agenda and solidarity seen through the years in the State.

Socio-demographic profile

Population

Gujarat spans an area of 196,244 sq. km divided into 26 districts. According to Census 2011, is the tenth most populous state of India with a population of 60,383,628.More than half (57.4 percent) the population resides in rural areas. The predominant religion in the State is Hindu (88.6 percent) followed by Muslim (9.7 percent), Jain (1.0 percent), Christian (0.5 percent), Sikh (0.1 percent), Buddhist (0.05 percent) and others (0.03 percent).

Household composition: On average, households in Gujarat are comprised of 4.6 members. Around 13 percent of households are headed by women, with 11 percent of the state's population living in female-headed households[2].

Sex ratio: While Census of India 2011 reported population sex ratio of the state as 919 females per 1000 males, which was one of the lowest (ranked 24 amongst the 29 states in India), more recent data, (NFHS-4 2015-16) reported it to be 950 females per 1000 males (907 in urban areas and 984 in rural areas). The sex ratio of 0-6 years of age in the State is abysmally low at 884 females per 1,000 males, with stark urban (806) and rural (939) differences.

Education

Majority (81 percent -NFHS-4) of children age 6-17 years in Gujarat are enrolled in school. School attendance is high (91 percent) at age 6-14 years, and then drops to 63 percent by age 15-17 years. Gender disparity in school attendance is most in the age group 15-17 years, with 58 percent of girls as compared to 68 percent of boys attending school. The disparity is high amongst adults, 73 percent of women and 90 percent of men in age 15-49 year were literate and 28 percent women and 8 percent men never went to school[2].

JSA members from the State second the increasing gender gap in higher classes. They report that girls stop going to school after finishing middle school. As higher secondary schools are farther away, parents are anxious about girls' safety and girls also have the responsibility of taking care of their home and siblings. In Panchmahals and Mahisagar districts after class 7 girls drop out of school and migrate for cotton picking. In urban areas, girls drop out after class 8 because there are no municipal schools offering free education. Girls' education has to be paid for as only private schools are available[3].

Employment

About 63 percent of the total population belongs to the working age group of 15- 59 years (Census 2011)4 but only 37 percent of all women age 15-49 were employed in the 12 months preceding the survey as compared to 84 percent men in the same age group (NFHS-4) indicating sharp inequities in employment. In rural Gujarat, the female work participation rate fell from 43 percent in 2005 to 32 percent in 2010, worsening further to 28 percent in 2011-12. Urban Gujarat, too, saw a steady but marginal decline. According to a study comparing foreign direct investment and indicators on women's status in Kerala and Gujarat, the factors cited for women pulling out of the work space were their reproductive role, household and care responsibilities, cultural sanctions and patriarchal hierarchies. Continuing in education and migration after marriage was also cited by females as reasons for withdrawal from the labour force in both states.

The JSA members challenged this data and point to the increasing non-formalisation of women's work. According to them, in urban areas, many girls are domestic help, do home based work or get into occupations such as diamond polishing. These occupations are not counted as formal employment. Economists are also challenging the process of data collection and analysis related to informal sector women workers and home based workers.

Income: Though per capita income of Gujarat in 2018 at Rs. 1,56,527 was higher than that at the national level (Rs.1,12,835), it was significantly lower than the neighbouring State of Maharashtra (Rs. 180, 596)[5].

Household characteristics

More than three-quarters (77 percent) of households in Gujarat are pucca (NFHS-4). Almost all

households (96 percent) have electricity and 91percent of the households reported to have access to safe drinking water source though only two thirds (68 percent) have water piped into their dwelling, yard, or plot. There are urban-rural differences with 81 percent households in urban and 58 percent in rural areas having water piped into their dwellings. Clean fuel for cooking was used by just 53 percent with high urban-rural disparity (urban-83.8 percent; rural-26.9 percent).

Improved sanitation facilities were reported by 64 percent households (urban-85 percent; rural-47 percent). According to the MOSPI in 2017, 4 percent of urban households and 48 percent of rural households reported open defecation practices. Availability of clean fuel, sanitation and access to safe water affect women more than men. Lack of access to clean fuel has implications for respiratory disorders and eye infections amongst as many as 73 percent women and lack of proper sanitation facilities to more than 50 percent of the rural women puts them at higher risk of reproductive infections in rural Gujarat.

Selected household possessions

Modes of communication: Almost all urban households (97 percent) and 89 percent of rural households in Gujarat have a mobile phone. This is an important aspect from communication and access point of view. Caste differences are also evident with 37 percent women from scheduled tribe having mobile phones compared to 68 percent women from other castes barring the scheduled caste or other backward castes. Data shows that less than half (48 percent) of the women has a mobile phone (48 percent) that they themselves use. Urban rural disparity is seen with 64 percent of urban women as compared to 35 percent of rural women having phones. Phones are still out of reach for thousands of Gujarati women as a result of gendered power dynamics. Because much of rural India remains highly patriarchal, women's access to phones is restricted. In 2017 a village in Mehsana District decided to fine women Rs 2,100 for using or possessing a mobile phone. Suraj village imposed the ban and it soon spread to other parts of north Gujarat as the politically influential Thakor community initiated a drive to extend the restriction, with support of other OBC communities such as the Rabari and Vankar. As the drive progressed, the community came out with these rules and regulations for women's lifestyle. Community leaders felt that the use of cell phones by unmarried women created a nuisance in society[6].

Land ownership: More than one-third of all households (37 percent) in Gujarat own agricultural land. Agricultural land is owned by 57 percent of rural households and 14 percent of urban households. Gender disparity is evident in asset owning with 27 percent women compared to 59 percent men owning a house alone or jointly with someone else, and 19 percent of women and 41 percent of men own land alone or jointly with someone else. Ownership of land is more common in rural than urban areas for both women and men[3].

WGWLO states that the issue of land ownership by women has not received the attention that it requires. Though women contribute substantially to agriculture and domestic food security, they continue to be denied effective rights to own or control the land that they cultivate. Even among the large and growing body of de facto female-headed households in India - estimated to be about 35 percent - few have direct access to land in their own right7. With more lucrative economic options, increasing number of men move to non-agricultural jobs. As a result, only 53 percent of men compared to 75 percent of women pursue agriculture.

Absence of productive assets places women in an extremely vulnerable position at home and in the community. Studies show that women's independent land rights and control can enhance food security, improve child nutrition, health and education, and even reduce domestic violence7. Women who own land feel greatly empowered and self-confident as well as have more voice, both, at home and in the community. They are in a better position to avail government schemes and institutions. All this leads to enhanced economic and social security. Even if the land possessed by the women is limited and rain-fed, it contributes to enhancing economic security of poor women through both farm and non-farm enterprises[7].

Access to resources

Overall, 89 percent households have a bank or post office account. Yet, less than half of women (49 percent) have a bank or savings account that they themselves use. This percentage, at 74 percent is higher among women who have 12 or more years of schooling3. Fifty-two percent of women have some money that they can decide how to use and the proportion is higher among urban women, increases with age, and is highest (67 percent) among women with 12 or more years of schooling and women who are employed for cash than any other group of women.

BPL and Aadhar cards: BPL cards are held by 32 percent of households and Aadhar card by 79 percent of people (NFHS-4) 2. The story about BPL cards is fraught with controversies. Experience on the ground shows that families who have all kinds' of assets and can hardly be termed as BPL hold BPL cards in the state , while the abjectly poor in many instances cannot get their BPL cards made because of many hurdles. In the context of Aadhar cards, JSA members narrated stories of how people have to actually pay out of pocket to get their required identity documentation done, the repeated visits and harassment at the levels of the Talatis and the Sarpanches and the problems that working class and older people have because of their unclear/ indistinct finger prints. There are also narratives of the immense difficulties that people have to go through, to rectify the mistakes on their original Aadhar cards, to change the address of residence in the event of numerous evictions and demolitions and resettlements especially in urban areas[3].

Health Status

Anaemia continues to be a major health problem in Gujarat, especially among women and children. More than half (55 percent) of women in Gujarat have anaemia. Anaemia is particularly high among women with no schooling, from scheduled tribe and women who are breastfeeding. The prevalence of anaemia among women and men has remained unchanged since NFHS-3 (2006). About half of women (51 percent) and 44 percent of men are either too thin or overweight or obese. Under nutrition is particularly common in the younger age groups, in rural areas, and among the scheduled tribes2. The prevalence of stunting among children under five years of age decreased from 52 percent to 39 percent in the 10 years between NFHS-3 and NFHS-4, and the prevalence of underweight decreased from 45 percent to 39 percent. However, the prevalence of wasting increased from 19 percent to 26 percent.

JSA members talked about the very low levels of Haemoglobin among the women in the communities where they work and about the discrepancies between the Haemoglobin levels estimated at the government and the independent laboratories, and also between ICDS and Health departments. In their experience the Anganwadi Centres do not want to accept and / or record the low levels of nutritional indicators. JSA members also talked about stock outs of Take Home Rations despite the high levels of malnutrition and how there are very few efforts to find local solutions through authentic community participation to address the problems of malnutrition in the state[3].

Performance of the State on two vital indicators selected for analysis in this project showed that Gujarat's IMR is higher than neighbouring Maharashtra and in fact it has shown an increase over the last three SRS figures. While the MMR has decreased over the last four years from 122 to 91, it too is higher than Maharashtra.

Table 1.1: Comparison of IMR and MMR between Gujarat and similar states

STATE	IMR (per 100000 lives) 2016	MMR (per 100000 lives) 2014-16
Gujarat	38	91
Maharashtra	24	61

Source: Sample Registration System[8]

Source of health care: The private health sector is the main source of health care for 56 percent households (urban: 64 percent and rural: 49 percent). Only for 15 percent of households, government or municipal hospital is the main source of health care for members[3].

Health insurance: In Gujarat, three types of health insurances are prevalent: the *Rashtriya Swasthya Bima Yojana* (RSBY), the State health insurance scheme, and a range of privately purchased commercial health insurance schemes. Despite the emergence of a number of health insurance programmes and health schemes, only 23 percent of households in both urban and rural Gujarat have any kind of health insurance that covers at least one member of the household. Only 16 percent of women and 19 percent of men age 15-49 years in the State are covered by any health scheme or health insurance. Coverage is higher among women with 12 or more years of schooling than among those with less schooling or no schooling[2].

In 2012, the state government has launched the *Mukhyamantri Amrutam Yojana* (MA) for tertiary care and in 2018-19 it enhanced the cover (from Rs. 2.5 lakhs to Rs. 3 lakhs per family) and the range of procedures that are covered under this scheme. While there are accounts of poor people getting the benefits of the MA scheme, there are also accounts of the irregularities and malpractices that are routinely uncovered. JSA members spoke about the high amounts that have to be paid to 'agents' who 'help' vulnerable people to get their MA cards on a tatkal (immediate) basis. Their charges range from Rs. 2000 to Rs. 10,000. In many instances fake income

certificates and fake MA cards are produced by these 'agents'. When their duplicity is discovered, there is almost no recourse for effective grievance redressal. There are repeated media reports about empanelled hospitals being barred from the MA Yojana because of irregularities such as taking money from the patients for the procedures and treatment provided, treating patients covered by the scheme and those who are 'regular' differently, i.e. discriminating against them, and so on[9, 10].

The other means which were introduced to benefit people also do not seem to live upto their purpose. BPL Cards at one level are meaningless because many of the welfare schemes actually ask for scores as these cards are issued on the basis of a scoring system. So the question that needs to be asked is – who are the actual recipients of the various government schemes and programmes? Who are the actual people/families/households who get the benefits? Similarly, despite the constitutional validity of the Aadhar cards being challenged in the Supreme Court, 91 government schemes across 19 ministries are linked with this card, making it very difficult for the poor who need the government welfare benefits the most but do not have Aadhar cards to avail of government schemes

In conclusion, geographic, economic and social (gender) inequities plague the State population. Systemic solutions are often not in sync with the ground realities, are too complex and bureaucratic and provide opportunities for manipulation of procedures, exploitation of people and denial of services to the most vulnerable and disadvantaged population.

SECTION 2
POLICY AND PROGRAMME ENVIRONMENT

Health Sector

The Gujarat healthcare system has seen significant growth in the last three years as a result of innovative state policies and inter-departmental schemes, and improvement in the availability and quality of healthcare facilities. State has invested heavily on healthcare infrastructure and has introduced the *Mukhyamantri Amrutum* (MA) Yojana for providing tertiary healthcare treatments to below poverty line (BPL) population. While there have been improvements in the reproductive health outcomes in Gujarat, much more needs to be done.

According to the Raghuram Rajan Committee Report on a Composite Development Index for Indian States, Gujarat's performance on HDI did not match its growth rates. It reported that pivotal sectors such as education and healthcare in the State still lag behind several other Indian states1. NITI Aayog's recent report on 'Healthy States' released in February 2018 ranked Gujarat 4th in terms of overall Performance Index Score after Kerala, Punjab and Tamil Nadu. In terms of incremental change, Gujarat ranked 19th out of the 21 larger States. The report stated that the health system needed to be strengthened to address inequities within the State.

According to Rural Health Statistics 2014-15, the health infrastructure in the State is good with excess of sub-centres (8063 as against 8008 required) and only 3 percent shortfall in Primary Health Centres and 1 percent in Community Health Centres. Yet, in terms of infrastructure too, Gujarat reportedly lags behind other comparable states. The number of functioning Sub-centres, Primary Health Centres and Community Health Centres in Gujarat is less than Maharashtra and Tamil Nadu2. Data from various sources suggests that Gujarat's health indicators and investment in the health sector are not commensurate with its economic development.

Health Programmes and Services

Many programmes and services are designed to address specific health issues. However, these often do not reach the intended beneficiaries such as in case of patients with mental health issues.

The National Mental Health Programme (NMHP) was started in Gujarat in 1999, same year when a judgement was passed stating that each state should have its own policy on mental health. For the first time mental health was referred to in the Ninth Five-Year-Plan and for 'Strengthening of Mental Health Services', a separate scheme made. In the next five year plan this concept was continued and the aim was to 'integrate mental health with rural health'. The state government initiated District Psychiatry units for out- door patients and in 1980-81 eight such centres were set up.

The government infrastructure in the mental health sector comprises four hospitals, one each in Ahmedabad (317 beds), Vadodara (300), Jamnagar (50) and Bhuj (16). These hospitals provide long-term psychiatric care. Psychiatry departments of (government) teaching hospitals at Ahmedabad, Vadodara, Jamnagar, Surat, Rajkot and Bhavnagar provide additional 157 psychiatric beds. Psychiatric beds are also available in the teaching colleges run by municipal corporations at Ahmedabad and Surat; and at private medical colleges at Karamsad and Surendranagar.At the district level, honorary psychiatrists visit district hospitals 2-3 days in a week, with a mental health worker who maintains records. Currently, such services are available in six of the twenty five districts: Bharuch, Panchmahals, Sabarkantha, Junagadh, Mehsana and Banaskantha.

Against this background of an elaborate system for dealing mental health issues, the following case studies from different areas of Maliya in Morbi district of Gujarat highlight the difficulties in accessing these services.

Case Study 1: Twenty four year old Farida lives in Zakariya village. He father died four months ago, her brother and mother keep very unwell as they are highly malnourished. There are unable to work on the salt pans, hence the mother and brother do stitching of bags for the storing of salt. They earn approximately Rs. 125 per day. The work is done for about 8 months in a year, the rest of the year, her brother works as a farm labourer and earns approximately Rs. 150 per day.

According to Farida's brother, she is unable to do any work as she is suffering from mental illness and regular medicines need to be given to her to control her fits. It is necessary that she takes medicines regularly as otherwise her fits make it impossible for her to even sit. She listens to no one and is uncontrollable and shouts and screams. The brother says that she was born like that but for many years she was never taken to any doctor as they were unaware of what should be done and no treatment was available. It was only recently that they took her to a 'bapu' in the block where it was suggested that Farida be taken to a hospital in Morbi. Her treatment in Maniar Hospital in Morbi costs approximately Rs. 1200 every month and it is impossible to get medicines every month as the income of the family is not enough for basic subsistence let alone bear the cost of her medicines for mental health. The family does have a Mukhyamantri Amrutam card, but the illness that Farida suffers from is not covered in any of the hospitals.

Case Study 2: Fifty year old Amnaben of Nava Hanjiyasar has three daughters who are married and stay in their marital homes. She and her husband live alone in their house. Her husband used to work in the salt pans until recently he had a kidney operation. At present there is no earning member in the family as the husband cannot.

Her initial symptoms of mental illness started about seven years ago. According to her daughter, she initially got high fever and pain in the ear. She was taken to the Maliya CHC, but as there was no improvement in her health. Her daughter said that there are times when her mother runs away into the village in the middle of the night. Someone constantly has to be with her so that she does not run away, especially during the night. When she gets attacks she even tears the clothes that she is wearing. Amnaben was taken to private hospitals in Maliya and Morbi. The doctors informed the family that *"magaz ki nas me khoon nahi mil raha"* (the nerves in his brains are not getting blood). The family feels that it is due to the constant heat in the salt pans that has affected her nervous system. They then took her to various private hospitals in Rajkot, Gandhidham and Ahmedabad. At present she is being treated by a private hospital in Ahmedabad. Frequently people from the village go to the city to sell prawns and get the medicines for her from the city. The expenditure on Amnaben's medicines and the treatment on an average is Rs. 60,000 per year. The family had initially borrowed money against the 12 bigha (3 acres) of land, which they have been unable to repay. Presently they have to depend on the money that Amnaben's husband's brother gives. And have to constantly keep borrowing from 'saga sambandhis' or relatives. Her daughter said that Amnaben's health has been better since the past 6 months, the attacks have reduced but have not disappeared.

Case Study 3: Sixty year old Jakkhabhai lives with his wife and one son and one daughter in Nanavada village. He has 6 sons and 3 daughters. He cannot work, his wife and youngest son work. His wife has 4 buffaloes which give milk and she sells the milk, going door to door. On an average she earns Rs. 200 in day. The son herds the buffaloes of neighbours and earns Rs. 200 per day.

Mumtazben says that her husband has been mentally ill for almost 25 years. He does not even sleep and creates a ruckus in the house. At times he hits her and there have been instances when in his hysteria he has even tried to throttle her. In the night he leaves the home and goes around walking and at times banging on doors of neighbours. He talks to himself, randomly starts singing and abusing passersby.

In the initial years he was taken to Maniar Hospital in Morbi by his Mumtazben. Then later he was taken to a private hospital in Gandhidham which is almost 100 km from Maliya. He was admitted in the hospital for about a week, and then his health improved and was brought back to his village. Since then he has been getting his treatment from Maniar Hospital. The medicines need to be administered every 15 to 20 days. The family tries to arrange money in whatever way they can as it becomes very difficult to handle Jakhabbhai if he does not get his medicines and has an attack. Last when they had gone to Maniar Hospital, they were advised to give him injections to control his fits. But the son was asked to sign a consent form saying that if something happens to his father then the hospital will not be held responsible. The son did not agree to the terms hence the doctor told him that he should go to Krishna Multi Speciality Hospital, but it would cost them at least Rs. 500. The son did not have so much money, so he took his father back, buying only the medicines and not the injection.

Case Study 4: Six year old Krish lives with his mother, maternal grandparents and maternal uncle and aunt in Taragadhi village. His father left his mother, Savitaben when she was two months pregnant. Since then she lives with her parents.

Krish studies in class one. He is accompanied by his grandmother to school and she stays with him the entire time. He needs to be helped with all the tasks as he is unable to do any task independently. His mother says that he gets hysteria, from the age of 7 months. From his birth he has been taken to various private hospitals in Morbi, Rajkot, Ahmedabad and Gandhidham. The doctors say that insufficient blood is reaching the brain and hence he has various mental issues. Krish has 50 percent mental retardation as per his disability certificate, and has to get his medicines continuously from various private hospitals. He also has cerebral palsy, which is 70 percent and leads to movement disability affecting his vision, swallowing and speaking. His symptoms are poor coordination, stiff muscles and tremors and frequent seizures. At present he is being treated in Krishna Hospital in Morbi. On an average his family has to spend Rs. 8000 a month on the medicines and travel for Krish's treatment. Over the years they have spent around Rs. 3,00,000 on his treatment. Savitaben earns around Rs. 3000 in a month by working in a local stationery shop. Her parents work on local farms as daily wage labourers and they on an average earn Rs. 6000 in a month. She has not availed any scheme as she is not aware of them (MA, Viklang Sahay Yojana etc.). As Savitaben stays in her maternal home her name is not listed for any of the entitlements that she should be getting. She has to struggle hard to get the money. It is difficult for her to borrow from people as they are aware that her capacity to repay is very limited.

The case studies show that there is no public health system that deals with the issue of mental illnesses in the area which is particularly vulnerable because of extreme poverty, chronic health issues. The people usually do not have much knowledge about health services for mental health. They usually approach the local 'Bapu' or a traditional healer in the community. The *'bapu'* refers them to private doctors in Gandhidham or Morbi. Some people do approach the CHC in Maliya but the doctor himself says that they are not equipped to deal with mental health issues. He says that he usually refers the cases to Morbi or Rajkot Civil Hospitals. Hence the people in the community are then forced to go to private doctors in nearby towns. This being a minority population area perhaps further marginalises them. When a person from this social and economic background approaches a private health service the financial burden on them is tremendous. Family incomes are not regular and the range for the expense on the treatment on mental illness is approximately Rs. 2000 to Rs. 9000 including the travel to the local towns. The situation forces them, they either borrow money or sell their land or sell their jewellery. In some cases the families when unable to mobilise money for the treatment, are at times forced to tie the patient to prevent harm to themselves or others around them.

Human Resources

The shortage of trained human resources (Doctors, Nurses and Specialists) in the government health sector of Gujarat is a very serious issue, especially the tribal areas. As per the National Health Mission (NHM), there are 615 doctors at Primary Health Centre (PHCs) against the 1504 sanctioned posts of doctors. There is also huge shortage of specialists (such as Surgeons, Obstetricians and Gynaecologists, Physicians and Paediatricians). Only 74 specialists are in position in government sector facilities against the required 1280, which can provide tertiary health care services. Important services like Comprehensive and Emergency Obstetric Care are compromised as there are in-adequate Obstetricians and Gynaecologists. The availability of health care human resources has not improved in last decade (from 2005 to 2015), rather the shortage has increased in last ten years and the shortfall of specialists in rural areas which was 996 in 2005, has increased to 1206.

Public Private Partnerships

As an innovative measure to address the shortage of Obstetricians and Gynaecologists in Gujarat the Government of Gujarat introduced the Chiranjeevi Yojana, a Public Private Partnership (PPP) and contracted in private clinics, nursing homes and hospitals for safe deliveries3. Evaluations of the scheme have shown mixed results. Some studies reported substantial reduction in maternal and neo-natal deaths post implementation of the scheme4. But the Annual report of the Comptroller and Auditor General (CAG) of India (2010-11) pointed to gaps in implementation and stated that the five-year-old Chiranjeevi Scheme, had failed to reduce maternal mortality ratio from 389 per 1,00,000 live births to 100 per 1,00,000 live births as set out in its objectives. Currently the scheme has practically fizzled out as private providers find the compensation package too low.

In 2016, the Government of Gujarat announced its Health Policy, 2016 to provide modern medical facilities to remote areas of the state and to overcome the shortage of medical professionals in these areas. The policy essentially focussed on setting up new 'Brownfield' and 'Greenfield' medical colleges in Gujarat in a Public Private Partnership (PPP) mode. The government proposed giving government hospital building and land on lease to private parties to set up a 300 bed 'Brownfield' medical college. For starting 'Greenfield' medical colleges, it proposed giving several reliefs like land at 50 per cent rate of the market rate to the private players. This 2016 policy was a continuation of the trend towards commercialisation and commodification of health care in Gujarat. With its institutional focus, it failed to provide a vision and blueprint for how it would reach health care to its people with poor health indicators and living in distant areas such as the salt pans, the forests, the deserts and coasts.

Commercialisation and ommodification of Health: Medical Tourism

The Medical Tourism Policy of the Government of Gujarat released in December 2006 stated that the government is committed to provide world class facilities to the visiting medical tourists. The policy aimed at developing international standards of treatment facilities in the state. The government also tied up with insurance companies to benefit the foreign medical tourists.

Overtime, Gujarat has become a global hub of reproductive health tourism providing 'first world treatments' at 'third world prices'. According to an ASSOCHAM study in 2013, Gujarat is hub for approximately 40 percent of Contract Research Organizations (CROs) in the country. And Gujarat contributes around 15 percent of the total revenue of around 600 million USD in India5. This is a concern because, Gujarat has seen high profile and controversial trials. Programme for Appropriate Technology in Health (PATH) administered HPV vaccines, which are said to prevent cervical cancer, to 24,000 tribal girls in Andhra Pradesh and Gujarat. These trials dwelled in murky ethical territory as the vaccines were given before they were proven to work and there were deaths of tribal girls in ashramshalas[6].

Health Budgets

An analysis of the health budgets in Gujarat between 2006-07 and 2018-19 shows an increasing trend in investments in health care but still below the desired standards. In 2006-07, the share of investment for health care was just 2.84 percent of the total budget and 0.41 percent of state's Gross State Domestic product (GSDP). While budgetary provisions for health care have increased to 5.23 percent of the state's total budget in 2018-19, they remain below the 8 percent by 2020, recommended by the National Health Policy 2017. Similarly, the share of health care in GSDP remained below 0.70 percent way below the WHO recommendation of 5 percent. According to the National Health Profile 2018, India's per capita spending on health in 2015-16 was Rs.1112. The per capita expenditure as per government data for provisioning of health care services in Gujarat was Rs. 1159 in 2015-16, which increased marginally to Rs. 1185 in 2016-17. In 2017-18, the revised estimate of per capita expenditure for provisioning of health care services is Rs. 1334 and for 2018-19, the projected per capita outlay is Rs. 1479. Gujarat's per capita spending on health is much lower than that of the North Eastern states, Jammu and Kashmir and Himachal Pradesh.

In conclusion, while the Government of has come up with initiatives that can help enhance the current public healthcare system, it has opened avenues for private players to invest and non-residents to benefit disproportionately from the State health system. Can encouraging private players promise sustainable growth for the sector? Will this be enough to better the health indicators of the state? How well can the health system provide the same world class health care to segments of its population living in the salt pans, the forests, the deserts and coasts, the urban poor migrants? These are some questions which need immediate answers.

The analysis in the section above shows that Gujarat needs to reorient its health policies and budgets and revisit its public spending on health to increase it to at least 2 percent of the GSDP as recommended by the National Health Policy 2017.

Women's Development Sector

The status of women in Gujarat in comparison to some other states with lower Foreign Direct Investments (FDI) than Gujarat shows that it is worse off on many indicators. A study comparing the foreign direct investments and women's status indicators in Kerala and Gujarat shows that the indicators for women's status in Kerala, despite the lower FDI and per capita net State Domestic Product, are better than those for Gujarat. Female literacy and women's education beyond 10 years, their employment percentage, in Gujarat are all much lower than in Kerala, as is decision making by women.

Table 2.1: Women's Indicators and some important economic indicators in Kerala and Gujarat (percent)

	Kerala	Gujarat
Mean age for marriage (2004)	22.9	20.5
Female literacy rate (2001)	87.7	57.8
Currently married women who usually participate in household decisions in per cent	62.5	56.7
Women who have experienced spousal violence in per cent	16.4	27.6
Percentage of women with more than 10 years of education	49	24
Percentage of women's employment to total employment (2003)	39.3	12.7
Percentage share in total FDI approved (1991-03)	0.53	6.47
Per capita net state domestic product (SDP) in Rs (2004-05)	27,048	28,355
Average annual growth of state domestic product in per cent (1993-94 to 2003-04)	5	5.7
Range of min wages for unskilled workers in Rs (2005)	72-189	50-99

Source[7]

State Efforts

The Department of Women and Child Development (DWCD) was established to achieve the goals and objectives set for social sector development focusing women and children. The department through policies, institutions, schemes and programmes addresses concerns of women and children in the State of Gujarat. The major activities, entrusted to the DWCD in the State relate to welfare programme activities for women and children including food supplementation; women's empowerment; women's self-help groups; State's Women Commission, Gender Resource Center (GRC) and Gujarat Women's Economic Development Corporation's activities and enforcement of laws such as the prevention of dowry and the prevention of immoral traffic act.

One flagship programme of the Government of Gujarat is the Mission Mangalam with self-help groups across the state. Gujarat Livelihood Promotion Company (GLPC) is the implementation agency for National Rural Livelihoods Mission (NRLM). It has an integrated poverty alleviation approach and creates a single resource platform for stakeholders like Banks, Industry Partners, Micro Finance Institutes and Skill Imparting Institutions, etc. to deliver desired outcomes. It is reported that about 24 lakh women who are currently active under 2 lakh Sakhi Mandals / Self Help Groups (SHGs) are managing funds to the tune of Rs.1000 crores through bank linkages[8].

The audit report available on the website for 2013-14 however shows huge unspent balances. The 2013 audit report of for NRLM the umbrella under which Mission Mangalam is running shows an opening grant of Rs. 303, 866,333, and a year end unspent amount of Rs. 307,708,046 indicating huge under expenditures.[9]

Of all the activities undertaken, the GRC plays a powerful role in supporting the gender equality agenda in the state. The Women's Support Cells in police stations is one such commendable measure undertaken. However, the GRC's potential can be further augmented if its structure includes representatives of the women's movement and women's organisations, if it does research in collaboration with feminist activists, researchers and academicians and publishes the research or makes it public so that women's organisations could base their programmes on the findings. However, less than 2 percent of the state's total budget is spent for activities of DWCD, which has the primary responsibility of empowerment of women. A disaggregated analysis of budgetary allocations reveals that more than 90 percent is actually spent on integrated child development scheme (ICDS) and less than 10 percent for addressing issues of social security and welfare including violence against women.

Moreover, the budgetary allocation has been decreasing over the last four years.

Out of the total outlay for social security and welfare of women, most of it goes for widows' pension, very little is left for increasing women's safety and for addressing violence against women. The state's total budget outlay for 2018-19 is Rs.183, 666 crores. Out of this the total budgetary outlay for the women's welfare, social security, empowerment, economic development is Rs. 62303 crores which includes schemes in categories A and B, which benefit both women and men. Only Rs. 4568 crores are allotted for women specific schemes which in

percentage terms are 2.48 percent. An analysis of the gender budget shows that the probable expenditure for violence against women for 2017-18 was Rs. 54.42 crores and the proposed provision for 2018-19 is Rs. 48.73 crores, a reduction of over Rs. 6 crores. This budget outlay for VAW of Rs. 48.73 crores is only 1.06 percent of the women specific gender responsive budget of Rs. 4568 crores reflecting the low priority given to address the women vulnerabilities in the present patriarchal social structure[10].

Table 2.2: Summary of Women and Child Development Department's budget (Figures in Rupees-crores)

Sr no.	Details	2018-19	2017-18	2016-17	2015-16
1	Total Budget of WCD	2349.51	2056.95	1952.61	1875.52
2	State's Total Budget	183666	172179	151851	139139
3	Percent WCD budget of State's total budget	1.27 percent	1.19 percent	1.29 percent	1.35 percent
4	Total budget outlay for social security and welfare of women in WCD	232.24	216	180	183.08
Out of (4 - above), the budget outlay for Widow pension is as given below.					
	Widow Pension	125.6	120.62	118.32	114.13

Source: *Gender Budget Statement, 2018-19, Gujarat State, Compiled by Pathey Budget Center*[10]

In conclusion, the budget for addressing the women's issues like domestic violence, social protection, assistance in case of rape, and empowerment get very little financial outlay, the larger share of budget outlay is earmarked for providing pension to widows, who fulfil certain economic conditions, the contemporary issued being faced by women like justice, rehabilitation to the victims of domestic violence have not properly looked into, the budget outlay is meagre, not shown under separate budget head like other states.

In view of women's vulnerabilities and challenges they face, the policy environment in Gujarat needs to change and the inequities need to be addressed. Budgets have to be increased and spent appropriately. The Gender Resource Centre and Women's Studies Centres need to be supported by the state government to spearhead a radical programme for bringing about gender equity at diverse spheres and levels in the state.

As concluded by Saxena et al[11], "Gujarat has experienced rapid growth and is one of the wealthiest states in India and is also showing improvement in overall health status. However, improvements in the health of the general population do not lead to the removal of disadvantage in society. To achieve the desired targets under MDG in an equitable manner, there is an urgent need to review the existing policies implemented by the state to reduce such health inequalities. Furthermore, the State of Gujarat should also design systems to monitor equity. Greater attention needs to be directed towards the assessment of health deprivation among the poor."

SECTION 3
MATERNAL HEALTH

This section talks about SDG3 - ensuring health lives and promoting well being for all at all ages. There are many health targets and indicators for these SDGs ***(Annexure)***. This section focuses on indicators 3.1 about reducing MMR to less than 70 per 100,000 live births and 3.7 about ensuring universal accesses to sexual and reproductive health (SRH) services, by the year 2030.

The National Health Policy, 2017 states that the goal for India is to reduce Maternal Mortality Ratio (MMR) to 100 by 2020 and increase antenatal care coverage to 90 percent and skilled birth attendance to more than 90 percent by 2025. To achieve these targets, India has developed a roadmap, "India New- born Action Plan"[1].

Maternal Mortality Ratio

According to the SRS data Gujarat's MMR declined from 122 in 2010-12 to 91 in 2014-16. Given this trend, reducing SDG target 3.1 of MMR to 70 by 2030 appears possible.

Table 3.1: MMR based on the SRS data

	2010-12	2011-13	2014-16
MMR	122	112	91

Source: *Sample Registration Surveys*[2]

While the reduction in MMR in Gujarat is certainly a cause for celebration, there is need to examine who are the women who are dying and why are they dying. Maternal deaths have to be viewed from the perspective of health inequities and every preventable maternal death has to be considered as violation of a woman's right to life. In an analysis of facility based maternal deaths in South Gujarat, Patel et al found that majority of maternal deaths were in rural areas, in patients who were illiterate and/or from low socioeconomic strata of the society[3].The Government of India has mandated maternal death reviews since 2010. Government of Gujarat conducts them but does not either discuss it or publish the reports regularly4.

Maternal morbidities

Morbidities associated with child bearing are generally unaccounted for and invisible in the maternal health agenda. An important phenomenon to be tracked is 'near misses' where a women's pregnancy may not result in a death but she goes through complications and emergencies and is 'saved' from a becoming a maternal death statistic. Near misses can result in severe long term morbidities. Paying heed to causes of near misses and learning about the actions and interventions that prevent the maternal death contribute to programmatic improvements.

Maternal health services

According to Gujarat NFHS-4 data, 71 percent of mothers had four or more antenatal care (ANC) visits, 76 percent received iron and folic acid (IFA) supplements, but only 37 percent consumed them for the recommended 100 days or more and only 30.7 percent reported receipt of "Full" ANC. Majority of these mothers (88.2 percent) had institutional delivery and 63 percent of the mothers received postnatal care with 48 hours. Fear of ***Caesarean section***, surgery, disrespectful behaviour, and unfamiliar environment at health facilities prevent mothers from seeking recommended care during pregnancy.

As per NFHS data about 18.4 percent of deliveries were by Caesarean section. Caesarean sections is an essential part of Emergency Obstetric Care and is effective in saving maternal and infant lives only when they are required for medically indicated reasons.. WHO states that the ideal rate for Caesarian sections at the population level is between 10 and 15 percent, only 5.5 percent Caesarean sections in rural areas were in public facilities and 20 percent were in the private sector suggesting an unmet need that the public sector is not able to fulfil at the moment. Public facilities in the rural areas need to be strengthened to provide the Caesarean sections to prevent exploitation and money making by the private sector.

Table 3.2: Some indicators of maternity and delivery care

Indicators	NFHS-3 Total (percent)	NFHS-4 Total (percent)	RURAL (percent)	URBAN (percent)	INDIA Total (percent)
Full ANC	20.7	30.7	24	39.6	21
Four ANCs during pregnancy	50.5	70.6	63.2	80.5	51.2
Institutional delivery	52.7	88.7	85.5	93.4	78.9
PNC during 48 hours	51.8	63.4	60.3	67.5	62.4
C- Section	8.9	18.4	12	27.8	17.2
C- Section (Public Health Facility)	13.8	10.8	5.5	20.4	11.9
C- Section (Private Health Facility)	18	26.6	20.1	33.9	40.9

Source: *Gujarat NFHS-45 and NFHS-3*[6]

The maternal care coverage in the State was significantly better than the national average. But there were urban-rural disparities. More urban women were likely to have received maternal care services and have Caesarean section as compared to their rural counterpart. Regarding men's involvement, 75 percent men in urban and 70 percent in rural areas were present during at least one antenatal check received by the spouse and between 37 to 58 percent of them were told about the signs of specific pregnancy complications[6].

In almost three fourths of the mothers, maternal care was provided by skilled service providers, particularly in mothers younger than 34 years of age, from urban areas and / or in mothers from SC, ST or OBC.

Table 3.3: Gujarat data on source of receiving ANC services (NFHS-4)[6]

Background characteristic	Doctor	ANM/ nurse/ midwife/ LHV	Dai (TBA)	Community/ village health worker	Anganwadi/ ICDS worker	ASHA	No one	Receiving ANC from a skilled provider*
Mother's age at birth								
<20	66.5	11.9	0.6	0.4	3.0	1.9	15.7	78.4
20-34	71.9	9.1	0.4	0.1	3.4	2.0	13.1	81.0
35-49	63.2	10.2	0.8	0.0	2.4	1.5	21.8	73.4
Residence								
Urban	82.5	5.8	0.2	0.1	1.4	0.3	9.8	88.2
Rural	62.5	12.2	0.5	0.1	4.7	3.3	16.6	74.7
Caste/ tribe								
SC	68.2	10.1	1.1	0.0	3.5	2.5	14.6	78.4
ST	53.7	13.4	1.4	0.3	6.0	4.6	20.7	67.1
OBC	72.0	10.0	0.1	0.0	3.6	1.7	12.5	82.1

SC-Scheduled caste ST-Scheduled tribe OBC- Other backward class
**This includes combined percentages of women receiving ANC from doctors and nurses/LHV/midwife*

Quality of services: Data on maternal health care utilisation shows that facility based deliveries are increasing, as quality of services is known to impact service use, the focus has now shifted to monitoring the quality of maternal health care both in the facilities and in the outreach programme. Identification of high risk symptoms by frontline workers such as ASHAs and ANMs and rational use of ultra sound are important issues for consideration. Also, while the standard operating procedures ensure technical quality of care, there are questions about whether the services incorporate women's perspectives including all the indicators for Respectful Maternity Care.

A study by Patel et al (2012) pointed out lack of proper maternal health services that resulted in poor utilization of ANC and PNC services and even leading to infant deaths. Only 29 percent mothers in the study had received "Full" ANC and 60 percent had delivered at home attended to by untrained personnel. Not a single delivery took place at PHCs or its sub centres and in 25 percent cases, there was poor cord care7.

Inequities in maternal health: Saxena et al in their paper had stated that "inequities in maternal health care utilization persist despite Gujarat being "one of the most economically developed states of India." Their paper underlined, "Structural determinants like caste group, wealth, and education as significant determinants of three antenatal care (ANC) visits, institutional deliveries, and use of any modern method of family planning"[8].

NFHS-4 data showed that while coverage by services was higher among urban areas, mothers from rural areas and. Scheduled tribe were more likely to receive financial assistance under JSY than mothers from urban area and any other caste/tribe.

Utilization was found to be poor in rural areas of Surendranagar district of Gujarat in a study by Bhimani et al (2016) that brought out many significant socio cultural barriers like caste, women's literacy, husband's literacy, occupation of women, socio-economic class and parity of women affecting the utilization of services[9].

Safe abortion services

There are no recent studies on abortion in the state. Gujarat was one of the six states included in the Lancet 2018 study on abortion incidence and unintended pregnancies. This study estimated that at the national level, the abortion rate was 47 abortions (42•2–52•1) per 1000 women aged 15–49 years. About 3•4 million of the abortions (22 percent) were obtained in health facilities, 11•5 million (73 percent) abortions were medication abortions done outside of health facilities, and 0•8 million (5 percent) abortions were done outside of health facilities using methods other than medication abortion[10, 11].

These findings are based on six State aggregate data. Unfortunately data for Gujarat state which can help us understand the situation is still not available. A small qualitative study done in Vadodara bastis (slums) showed that most of the women still believe that abortion is illegal12. While 'pills for abortion' is the preferred method, these are not provided through the government hospitals. The women therefore opt for the private sector providers who give them some kind of pills for abortion

JSA members working on adolescents' rights' interventions in the state report about young girls' abortion needs and the unsafe abortions that they resort to because of the stigma and unawareness about services. These experiences suggest that to provide safe and confidential service provision data on service needs and use in the State is imperative.

Family planning services

NFHS-4 data showed that while awareness about family planning was near universal, over time there was a decline in use of family planning methods across demographic, economic and social groups of eligible couples.

Table 3.4: Current use of contraception by background characteristic

	NFHS-4	NFHS-3
Background characteristic	**Any Method**	**Any Method**
Age		
15-19	13.7	13.0
20-24	21.8	39.5
25-29	38.3	65.8
30-39	54.2	80.3
40-49	59.4	77.9
Residence		
Urban	47.1	67.6
Rural	46.7	65.9
Schooling		
No schooling	52.1	67.1
<5 years complete	53.9	65.2
5-9 years complete	44.7	65.8
10-11 years complete	43.5	67.6
Religion		
Hindu	47.4	67.0
Muslim	40.5	60.9
Caste/tribe		
Scheduled caste	47.0	64.1
Scheduled tribe	48.1	61.7
Other backward class	47.3	69.0

Source: *NFHS-4[5], NFHS-3[6]*

There was a commensurate increase in unmet need particularly for spacing methods. This was particularly pronounced in women younger than 30 years of age. Women wanted to space their next pregnancy but either did not have access to these services or the gender relations and cultural beliefs were a barrier in accessing these. Findings of the qualitative study in Vadodara supported the poor use of family planning methods. Almost one-fifth of interviewed women in the study expressed helplessness in making contraceptive decisions related to their use.

Table 3.5: Need and demand for family planning among currently married women

Background characteristic	NFHS-4				NFHS-3			
	Unmet need for family planning				Unmet need for family planning			
	For Spacing	For Limiting	Total	Percentage of demand satisfied	For Spacing	For Limiting	Total	Percentage of demand satisfied
Age								
15-19	27.4	5.1	32.5	29.7	19.9	2.3	22.2	36.9
20-24	20.1	10.7	30.8	41.4	12.6	4.1	16.7	70.3
25-29	10.9	16.4	27.3	58.4	4	7.3	11.4	85.3
30-34	3.8	14.3	18.1	73.6	1.7	4.5	6.2	92.7
35-39	1	8.6	9.6	85.8	0.6	2.8	3.5	96
Residence								
Urban	6.4	12.2	18.6	71.6	3.9	4.4	8.2	89.1
Rural	6.8	8.8	15.6	74.9	4.6	3.2	7.9	89.3
Schooling								
No schooling	3.5	8	11.4	82	3.2	3.9	7.1	90.4
<5 years complete	3.9	7.8	11.7	82.2	5.3	4.9	10.2	86.4
5-9 years complete	8	10.9	18.9	70.3	6.1	3	9.1	87.8
10-11 years complete	7.7	10.9	18.6	70.1	3	3.9	7	90.6
Religion								
Hindu	6.5	10.3	16.7	73.9	4.3	3.5	7.8	89.6
Muslim	9	10.7	19.7	67.3	4.8	6	10.8	84.9
Caste/tribe								
Scheduled caste	6.9	10	16.9	73.6	5.6	4.5	10	86.5
Scheduled tribe	6.2	9.2	15.3	75.8	5.9	3.8	9.8	86.3
Other backward class	7	10.2	17.2	73.3	4.4	3.5	7.9	89.4
Other	6.1	10.7	16.8	73.5	3.2	3.6	6.9	90.9

Source: *NFHS-4[5], NFHS-3[6]*

One drawback of the data presented is that only married couples are covered both in the NFHS and in routine State HMIS. The Unmet Need for methods is therefore under estimated as need of the unmarried is not included. The term 'family planning' in itself is restrictive as it leaves out all those who are not in the Eligible Couple register, those for whom contraceptive use would be a taboo like single men and women, including widows and divorced persons. Using a neutral term like 'contraceptive use' and collection of data from all men and women in reproductive age group would perhaps be a more realistic reflection of need and use in the population.

Community action and social accountability

According to a recent paper published by George et al (2018) civil society efforts to strengthen community participation and action for health are particularly important in Gujarat, given that the state has resources and capacity, but faces challenges in ensuring that services reach those most in need. The study examined the equity effects of community action for maternal health led by Non-Government Organizations (NGOs) on facility deliveries and the underlying implementation processes with implications for strengthening accountability of maternity care across three districts of Gujarat, India. Over three years, the NGOs supported community action for maternal health, investing significantly in capacity building and facilitation to foster improved mutual understanding, trust and

collaboration across disparate actors across various levels of the health system in rural Gujarat[13].

Despite the challenges faced, in the marginalised districts of Gujarat[a], women reported substantial increases in receipt of information of entitlements and utilization of antenatal and delivery care. Community based collectives with NGO support monitored health services, engaged with health providers and local authorities and over time overcame implementation challenges (lack of staff, services, facilities, medicine stock, laboratory tests, equipment's) to strengthen public sector services. These accountability efforts resulted in improvements in utilisation of public sector services and a shift away from private care seeking, particularly for the marginalised[13]. In both the marginalized and wealthier districts, a switch from private facilities to public ones was observed for the most vulnerable.

In phase 2, the local village heads (panchayats) and councils (Gram Sabha) were also included in the community action to strengthen social accountability for maternal health. An evaluation study of this phase, showed significant improvements in knowledge levels of ANC services available, high-risk symptoms, handling emergency obstetric situations, maternal-health entitlements, and maternal death reviews. Significant improvements were seen in understanding about maternal health as a Gram Sabha issue and the responsibilities of the Panchayat members towards maternal health. There was an increase in the number and variety of maternal health issues discussed in Gram Sabha meetings and in participation of community members and local health system-actors.

The study pointed that with systematic multi-method dissemination of key maternal health messages, along with discussions and actions through the Panchayat and other community members can succeed in making maternal health a community issue[14].

Maternal health issues of concern for Jan Swasthya Abhiyan (JSA) Gujarat

JSA members raised a number of concerns about maternal health and available services. They said that quality of antenatal care provided through the Mamta Divas (Village Health and Nutrition Days) is not satisfactory and the most vulnerable women get excluded from the Mamta Divas sessions15. Social Autopsies done by JSA members showed that blood availability, multiple referrals and denial of care in facilities first accessed were serious issues that resulted in maternal deaths[16].

Studies done by members of the JSA indicate that poor women face enormous difficulties in accessing maternity entitlements like the Janani SurakshaYojana. Also, despite the promise of cashless deliveries in public health facilities under the Janani Shishu Suraksha Karyakram, women are denied services in public health facilities and have to finally go to private facilities where they incur out of pocket expenditure. Even in public health facilities, families end up paying for what is promised free and is considered a first step to Universal Health Care16.The NFHS-4 data showed that average out of pocket expenditure per delivery in a public facility was Rs. 2136 (Urban: Rs. 2331 and Rural: Rs. 2020). The transition to the Pradhan Mantri Matritava Sahay Yojana has resulted in huge delays and in some cases non payment of the maternity benefit. The PMMSY is discriminatory in its conditionalities of only women with one child being eligible for the benefit and the scheme is in direct contradiction with the provisions of the National Food Security Act.

[a] Marginalized districts of Gujarat are- Vadodara, Dahod and Narmada

Studies on entitlements and maternal health

A cross sectional study done on predictors of maternal health services utilization by poor, rural women: a comparative study in Indian States of Gujarat and Tamil Nadu discussed the world's largest conditional cash transfer scheme, Janani Suraksha Yojana (JSY), to increase poor women's access to institutional delivery. Gujarat augmented JSY with the state-funded Chiranjeevi Yojana (CY) scheme, contracting with private physicians for delivery services. This study showed that JSY/CY entitlements predicted institutional delivery in Gujarat. Overall, assistance from health financing schemes, good road access to health facilities, and socio-demographic and obstetric factors were associated with differential use of maternity health services by poor, rural women in the two states. It recommended that policymakers and practitioners should promote financing schemes to increase access, including consideration of incentives for antenatal care, and address health system and social factors in designing state-level interventions to promote safe motherhood[17].

However, in another study conducted on the Chiranjeevi Yojana program in Gujarat, the results of the study showed that out of 901 women surveyed in 129 facilities, 150 (16 percent) were CY beneficiaries but only 36 (24 percent) of them received complete cashless delivery. It concluded that CY beneficiaries experienced a substantially subsidized childbirth expense compared to women who delivered in non-accredited private facilities. However, despite the government's efforts at increasing access to delivery services for poor women in the private sector, uptake was low and very few women experienced a cashless delivery[18].

JSA members have been continuously raising the issue of maternity and other entitlements and continuity of care for the migrant populations. Many times these populations fall through the cracks of the health system information systems. Documentation of identity, proof of residence etc. become huge issues for these vulnerable populations.

In conclusion, maternal health remains a staggering challenge, particularly in the rural, tribal interiors and in poor urban pockets. Majority of the women do not receive full ANC care, family planning services and entitlements under different schemes. Systemic shortcoming and social stigma and taboos affect service use. Qualitative data on determinants of service use is mostly from small studies. Attempts at community engagement in social accountability have shown promising results. Since the health of a mother and child is a more telling measure of a nation's state than economic indicator; there is a need to strengthen health systems, invest in increasing health literacy and improved family support and address inequities in health and available services.

SECTION 4
VIOLENCE AGAINST WOMEN AND GIRLS

According to NFHS-4, about one-fifth (19 percent) of women age 15-49 years in Gujarat have experienced physical or sexual violence.1 But a recent report on violence against women (VAW) in Gujarat suggests that there is gross under estimate of figures for violence against women. According to the data in this report, nine women were raped every week in Gujarat in 2017, of which one was in Ahmedabad. The data for crime in the State in 2017 released by the State Director General of Police draws a sorry picture of women in Gujarat. According to the data, every day 14 women in the State became victims of various crimes such as molestation, sexual harassment, abduction, cruelty, dowry harassment, and rape or died due to dowry harassment. The increase in crime has been significant in cities with Ahmedabad being the worst city in this regard2.

Violence against women

According to National Crime Record Bureau (NCRB) 2016 report, there were 8532 cases of crimes against women in Gujarat, out of which 'cruelty by husband or his relatives' (Sec. 498 A) were 3732, kidnapping and abduction of women were 2146, rapes 966 and sexual harassment were 473. The data from both NFHS and NCRB needs to be read with some caution because a number of incidents go unreported due to the prevailing social stigma, inadequate and ineffective criminal justice systems and other institutional mechanisms, aggravating impunity and disabling convictions. Another challenge is the lack of socio-economic disaggregation of data making it difficult to capture the severity and diversity of the issue3. Moreover, NCRB data did not show any reported cases of domestic violence or dowry (Table 4.1).

Table 4.1: Cases registered under various Acts for women

	Dowry Prohibition Act, 1961		Protection of Women from Domestic Violence Act, 2005		Immoral Traffic (Prevention) Act, 1956		Total – Crime against Women Related SLL Acts		Rape (Total)		Unnatural Offences	
	No. of Victims	Crime Rate	No. of Victims	Crime Rate	No. of Victims	Crime Rate	No. of Victims	Crime Rate	No. of Victims	Crime Rate	No. of Victims	Crime Rate
Gujarat	0	0.0	0	0.0	96	0.1	96	0.0	986	3.3	41	0.1
India	9683	1.6	437	0.1	3387	0.2	13546	1.7	39068	6.3	5732	0.9

Source: *NCRB 2016*[3]

Experts in the April 2018 consultation raised the issue of 'Intimate partner Violence' or (IPV) which extends the term domestic violence to same sex relationships as well as adolescents' relationships. They argued that this was a more realistic representation of the current family sexual politics which the current data points did not capture.

Spousal violence

Overall, 20 percent of ever-married women had reportedly experienced spousal physical or sexual violence, 12 percent had experienced emotional violence from their husband and 14 percent had experienced such violence in the past 12 months. Only 4 percent of the women reported that their husbands forced them to have sex against their wishes. Although the prevalence of spousal violence was lower among more educated women, 13 percent of women who had at least 12 years of schooling reported having experienced physical or sexual spousal violence. Women whose husbands consumed alcohol were more likely than women whose husbands did not consume alcohol to experience spousal violence, especially when the husband was drunk.

Table 4.2: Married women experienced violence

Indicators	NFHS-4			NFHS-3 (2005-06)	India NFHS-4
	Urban	Rural	Total	Total	Total
Ever-married women who have ever experienced spousal violence (percent)	14.1	24.8	20.1	27.5	28.8
Ever-married women who have experienced violence during any pregnancy (percent)	0.4	3.0	1.8	Not asked	3.3

Source: *NFHS-4*[1]

Violence during pregnancy

NFHS-4 reported that 2 percent of women who had ever been pregnant had ever experienced physical violence during one or more of their pregnancies. Further analysis showed that women who were in their adolescence (3 percent), from Scheduled Tribe (5 percent) and rural area (3 percent) were more likely than women who were older, from other castes and urban area to have experienced violence during pregnancy. Also, widowed, divorced, separated or deserted women (5 percent) and women with five and more children (4 percent) were more likely than currently married and low parity women to have experienced violence during pregnancy[1].

Table 4.3: Experience of violence during pregnancy

Background characteristic	Percentage who experienced violence during pregnancy	Number of women who have ever been pregnant
Age		
15-19	3	56
20-24	1.1	357
25-29	1.1	495
30-39	2	1,026
40-49	2.3	810
Residence		
Urban	0.4	1,206
Rural	3	1,539
Caste/ tribe		
Scheduled caste	2.1	307
Scheduled tribe	5.1	414
Other backward class	1.1	1,194

Source: *NFHS-4*[1]

Help seeking behaviour

About three-fourths (72 percent) of women who experienced violence had neither sought help nor told anyone about the violence. Less than a tenth of them confided into someone about the abuse and one fifth sought help. Of those who sought help, only 4 percent sought help from the police and rest sought help from within the family. This is very telling and was corroborated by a study in Patan district described a little later.

Table 4.4: Women age 15-49 who have ever experienced violence whether they have ever sought help

Help seeking	Ever-married	Never married	Total
Never sought help and never told anyone	71.6	76.3	72.0
Never sought help but told someone	9.3	9.1	9.3
Sought help	19.1	14.6	18.7

Source: *NFHS-4*[1]

Health system response

In a study by SWATI (2017) on making rural health care delivery system more responsive to Domestic Violence (DV) in Patan district of Gujarat, they found that hospital was usually the first point of contact for women when abused although they tried to hide it and did not go to the police. SWATI made a chain with ASHA being the first link for early detection. They began their work in year 2012 from Radhanpur village. They had found that women came from areas up to 5-10 kms away just to take medical treatment. Their trained counsellors dealt with cases of sexual assault and suicide. In just 16 months, they came across 379 cases related to violence. Also based on the indicator framework (social, emotional/psychological, clinical and reproductive condition indicators) drawn from responses of women, from the 1000 women surveyed by the cells in the out-patient department, more than half (520 out of 1000) showed symptoms suggestive of DV. They recommended that as hospitals were safe spaces for women to visit and easily access (acquiring permission from family was easier), nurses and doctors should get regular training on domestic violence identification and protocols to help women and the training should be a part of their medical curriculum4.

Mehta (2013) in a study conducted in five major teaching hospitals of the state pointed out that most women reached the hospital as a last resort and the survivors had a great need for sharing their experiences even if they did not report DV as a cause of health problem. While the study revealed that women overall had good experience with the health system, the negative experiences were mainly due to the lack of information about services and procedures as well as being left unattended for long period of time[5].

In a tripartite project in Vadodara, between a government hospital, an NGO and a university, on women survivors of violence, the researchers came across three types of violence cases DV, rape (including consensual sex wherein one or both partners were underage) and sexual assault cases. The study highlighted the issues faced in the government hospital6

Shelter homes

Prita Jha in her paper, "A jail, not a shelter - women refuges in India", discussed the lack of shelter homes for minors and victims of honour killings and experiences of women in shelter homes under the Protection of Women from Domestic Violence (PWDVA) Act 2005. She narrated the case of a woman who took refuge in an Ahmedabad based shelter home. She found that people working in shelters did not receive any type of training. So the quality of care provided in these homes is poor. They do not have knowledge or sensitization on how to deal with the people with mental health issues. They use derogatory language, like *'paagal hai'* (is mad). She was also appalled and shocked by the extreme unhygienic and jail-like conditions there.

Around 2013-14 some Gujarat based NGOs filed a Public Interest Litigation (PIL) after reading news reports about girls escaping from shelter homes. Their PIL, Writ Petition 321 of 2014 was on poor living conditions of the shelter homes, based on evidence gathered from women who had lived there. The judge went beyond the call of duty to help the case. He observed that the laws related to shelter homes had not changed since 1950s and directed that a new set of laws and rules be drafted. As a result drafting new rules was a significant first step.

Jha had pointed out that sensitizing the police and shelter home staff to domestic violence and mental health issues was important as many women victims of DV suffer from mental health issues. The purpose of shelter is as a place for rehabilitation and livelihood so that the women become independent. The staff has to be aware of rehabilitation process, education, and livelihood that women should get in the shelter to become empowered. People who are working in the shelters should be educated on these matters. She proposed that monitoring of the shelters should be done both locally and by the state. One NGO representative and a *sangthan* (collective) woman or a local person, sensitive to this issue, should be part of the monitoring committee. District and state level structures should be engaged in monitoring and periodically reviewing the rules, and these should be constituted[6].

Implementation of laws

Prita Jha's articles and accounts point towards the need for better implementation of laws and court disposal of cases to help reduce VAW. According to the NCRB 2016 data, the rate of court disposal and conviction is very low in the country as seen in Table 4.5.

Table 4.5: Court disposal of crime against women cases

	Total cases for trial during the Year 2016	No. of cases disposed by plea bargaining	Cases convicted	Cases acquitted or discharged
Gujarat	73657	5	122	3415
India	1342060	818	23094	98994

Source: *NCRB 2016*[3]

Jha reported that in Gujarat, the average time for domestic violence proceedings is between 1-2 years, but there are cases continuing beyond two, and exceptionally, three years, which defeats the intention of providing a quick remedy to women. There is no data to show the percentage of cases in which Judges are making emergency, ex parte or interim orders without ordering a Domestic Incident Report (DIR) first[7].

The increasing popularity of PWDVA (Protection of Women from Domestic Violence Act, 2005) compared to other legislations shows that survivor's preferred the convenience of securing all remedies in one court. There was marked unawareness of this Act amongst the lower judiciary and resistance to its use. While technical issues are easier to resolve; what is much more difficult to change is the patriarchal ideology, as can be seen in the Manilla's case.

Manilla's Case[7]

"Manilla", one of the Peace and Equality Cell cases, who had filed proceedings following a violent assault for the second time agreed to a compromise for the sake of her son's educational and economic future. She was however extremely embarrassed when the Judge commented, in the presence of her husband, that in future she should not leave home and file court proceedings but tolerate a few slaps here and there to keep the family together. Such off-the-record misogynistic remarks, coupled with many discretionary exercises of power to grant adjournments which delay court proceedings endlessly, force many women into needless compromise.

However, there are some issues that apply to almost all states: insufficient budget allocation; lack of appropriate data collection; lack of suitable coordination and monitoring systems to measure infrastructural support; and training and functioning of the most important stakeholders, namely protection officers, counsellors, service providers and the lower judiciary.

Kidnapping, Abduction, POCSO versus Consensual Elopement

NCRB data for 2016 showed that though few, kidnapping and abduction incidents were largely for compelling the girls or woman to get married. The rate for these crimes in the State as per the NCRB data was significantly lower than the national average[6].

Table 4.6: Offences affecting the Human Body

	Kidnapping & Abduction (K & A)				Rape (Total)		Unnatural offences	
	K & A of women to compel her for marriage		K & A for other reasons					
	Number of victims	Crime rate	Number of victims	Crime rate	Number of victims	Crime rate	Number of victims	Crime rate
Gujarat	1149	3.8	358	0.5	986	3.3	41	0.1
India	33796	5.5	19467	1.5	39068	6.3	5732	0.9

Source: *NCRB 2016*[3]

In ANANDI's field areas in Dahod, Panchmahals, and Morbi, the *nyay samitis* (local justice committees) began reporting many cases of abduction since 2012-13. Initially the ANANDI team and the *Sangathan* (women's collective) team thought there is actually an increase of kidnapping and abduction and hence a study was taken up to look at records of police stations in the area. What was found was that in all cases the girl's side was able to give a fair amount of details of the boy and his family. This made the organisation take up a much larger study in which they studied the records from 2013-15 for the three districts. There were 1500 such criminal cases filed. They selected 731 cases where kidnapping and abduction sections were applied.

The analysis of these cases showed that the largest distribution of cases was below 18 years which is the legal age of marriage for girls. Girls faced maximum violence/abuse while commuting, felt vulnerable and alone and in this vulnerable state, if a boy talked nicely with them, they gravitated towards him. The police filed the case based on parents' reports which were mostly false as they knew that it was elopement for marriage and not abduction. There was usually a delay of 2-15 days in reporting the case. Only 20 percent cases were registered within 48 hours.

Detailed interactions with 29 out of the 731 cases of young girls brought out additional findings. Many girls eloped because they were being forced by parents for early marriage when they wanted to study. They thought it was better to leave the home with a friend whom they were at least acquainted with. In 38.6 percent cases POCSO was applied in FIRs for those below 18 years of age and in 6.4 percent cases POCSO was applied when it was not applicable. Despite the directives of the Juvenile Justice Act, minors are brought to the police stations, sometimes even at night, without lady constables. Community leaders used the law to enhance the pressure on boy's family to pay davo. There were no clear-cut directions on where a case was supposed to be transferred if the missing minor was not found within four months. Girls in Nari Niketan have faced violence.

The research also revealed that many girls got pregnant within six months of their running away in the hope of their parents accepting them. This increased the risk to their health as there were questions about they receiving recommended maternity care services. Fearing the law going against them, these girls kept quiet. So the POCSO Act actually worked against the young girls and increased their vulnerability.

Another observation in the area was that rape cases registered a decline because these cases shifted into POCSO. The lower number of reported rape cases did not reflect women's improved safety.

ANANDI's experience with POCSO

ANANDI conducted a joint workshop with the police and adolescents. They found that POSCO is more known than the Persons with Disability (PWD) Act.

In its experience in the field, ANANDI found that adivasi girls did not have access to media or even smart phones. They wanted someone to talk to them. Their main goal was to move away from the current environment they lived in. Therefore on their free will they went with boys. They were not aware about sexual consent or bothered about whether they were being used or whether there was sexual violence. Only when it got really bad, did they realize that they were better off with their parents. In 30 percent cases, they ran away because from parental home as they did not want to marry the person parents had chosen.

In some cases, marriage was fixed to a boy who was 4-5 years younger than the girl and she did not want to marry him. So she ran away. If she did get married to the younger boy, then in some cases, she consented to sex with the father-in-law or the elder brother-in-law. But there were also cases wherein she was abused or forced upon by these men. So girls preferred to select a boy of their choice and run away.

In ANANDI's work area, *Dava pratha* (tradition of claim) was a common practice and in earlier times very little amount was charged. It was actually progressive as both got to choose their partners. But now, because of POCSO and people being aware of other laws, money charged in the name of dava sometimes going into lakhs. Ultimately the girls suffer as husbands accepted to pay the amount but then the burden of repaying that amount was shifted to the girl and she had to work harder to repay the amount.

The data showed that after the introduction of POCSO Act in 2013, and increased awareness and reporting, the number of cases under POCSO almost doubled between 2014 and 2015. Increase was also seen in Kidnapping and Abduction. These increases were largely due to false registering of such cases by parents objecting to consensual elopement. While there were few cases of real abduction, the larger picture that emerged was that the girls wanted choice. There is no provision in the current legal framework for consensual running away of minors. In this situation, the POCSO Act should not criminalize the boy because it is actually consensual even though below age. While ANANDI acknowledged that law will do its work when it's a case of actual trafficking, they wondered if the very law (POCSO) meant to save girls, was in fact working negatively for them.

Budgets for Violence against Women in Gujarat

The implications of the SWATI study have to be related to the One Stop Crisis Centres and the Nirbhaya Fund created by Government of India. In Gujarat, the grant for three One Stop Crisis Centres in 2016-17, was only Rs. 52 lakhs for three districts, Rajkot, Kutch and Sabarkantha.

The Budget provision for implementing PWDVA is just Rs. 16 lakh in 2018-19, as the post of Protection Officers has been merged with Dowry Prohibition Officer appointed at District and Municipal Corporation. The budget for implementing such an important Act is grossly inadequate. The budget outlay for VAW is already in-adequate and unspent amount is leading to its further decrease. These budget estimates and expenditures for addressing the various issues of VAW and protection of women's rights, indicate that the expenditure has never been consistent against budget outlay. Table 4.7 shows that the expenditure under the selected line items is even less than the budget estimates, which reflect the low priority given to address the women's vulnerabilities8.

The revised estimates suggest that there would be even less expenditure for Women Commissionerate, Mahila Marg Darshan Kendra, State Women's Commission, rape survivors and rehabilitation of sex workers in 2017-18.

Table 4.7: Budget for Prevention of VAW

Sr. No.	Details	2016-17- Budget Estimates	2016-17 Expenditure	2017-18- Budget Estimates	2017-18- Revised Estimates
1	Directorate of Securities	53.02 Lakh	26.52 Lakh	53.14 Lakh	38.39 Lakh
2	Commissionerate of Women and Child Development	9.16 crore	4.90 crore	7.91 crore	7 crore
3	Expenses and development of institutions under moral and social hygiene and other services	4.31 crore	2.8955 crore	3.42 crore	3.56 crore
4	Mahila Marg Darshan Kendras	12.021 crore	7.07 crore	12.69 crore	8.26 crore
5	State Commission for Women	1.97 crore	1.0019 crore	1.9293 crore	1.72 crore
6	Swadhar Gruh shelter homes for women	6.48 crore	0 crore	2.96 crore	5.15 crore
7	Financial Assistance & Support Services to Rape Victims	1 crore	0.75 crore	1 crore	0.250 crore
8	Nari Adalats	6.5414 crore	6.5414 crore	6.6 crore	6.6 crore
9	Women Help Line	6.07 crore	7.30 crore	5.89 crore	5.89 crore
10	Scheme of Rehabilitation of Sex Workers	7 crore	0	2.50 crore	0.51 crore

Source : *Gender Budget Statement*[8]

An expenditure of Rs. 4.90 crore was reported against the budget estimates of Rs. 9.16 crore for functioning of Commissionerate of Women and Child in 2016-17. Thus, there was under spending of Rs. 4.26 crore. Similarly, the under spending for Expenses and development of institutions under moral and social hygiene and other services in 2016-17 was Rs.1.41 crore, Mahila Marg Darshan Kendra Rs. 5 crore and for Swadhar Gruh (introduced by the GOI for providing shelter and minimum needs to women in difficult circumstances) is Rs. 6.48 crore. Under spending for providing assistance to rape victim was Rs. 25 lakhs and there was no expenditure for the Scheme of Rehabilitation of Sex Workers in Gujarat, although the budget estimates was Rs. 7 crore.

Mental health and VAW

Mental health issues amongst women are only recently gaining attention thanks to advocates and human rights activists working in this field. But patriarchal mindsets combined with lack of awareness are still two of the biggest barriers women have to face both as a cause of it or lack of treatment for it.

A recent media article based on the Global Burden of Disease Study (1990-2016), points out that suicide death rate (SDR) in 26 states of India has reduced. Unfortunately, Gujarat is amongst the three states that have reported a rise. The article elaborates about the Jeevan Aastha suicide helpline that began in 2015 under the government's Suraksha Setu program. More than 80 percent of calls received by the helpline are from women attempting suicide or contemplating it. On an average, it gets 75 calls daily. Of these, 60 are from women and 15 percent calls are from women suffering from domestic abuse. Of the 177 missing women rescued by 181 Abhyam Women's Helpline in the past three and a half years, 44 (25 percent) had run away from home due to domestic violence. Besides this, the article also discusses how women are untreated for mental illnesses and that there are increasing cases of abandoning of elderly mothers by their children9.

In conclusion, VAW in different forms, emotional, physical and sexual exists but is often under reported due to social stigma and unawareness about steps taken to address these. The systemic response is often not safe and supportive as care givers or service providers themselves are insensitive, ill equipped to deal with the issue and therefore operate in a hostile environment for women victims. The laws while well meaning, are often open to exploitation to harm the women's interests in a patriarchal set up, as they are often not rooted in local social realities. The inadequate and decreasing budgets for VAW further compound the situation.

SECTION 5
HARMFUL TRADITIONAL PRACTICES

While traditional practices with the potential to harm woman's health such as early marriage and child bearing are widely prevalent in certain regions of the country, and some areas of the State, those such as witch hunting and genital mutilation though they exist, are rare. Hardly any studies or data are available in public domain on the latter. We have to rely on newspaper reports. Generally deaths due to women branded as witches are very low but women are harassed and tortured. Genital mutilation in Bohra communities is known to exist but data is an issue.

Early marriage and child bearing

There has been a decline in child marriage prevalence rate from 38.7 percent in 2005-06 to 24.9 percent in 2015-16. In 2015-16, one fourth of the women aged 20-24 years were married before age 18 years. The prevalence in rural areas was almost double of that in urban areas1. Very young girls are also becoming mothers; almost 16 percent of all the girls and 11 percent girls from Scheduled Tribe families begin child bearing by 19 years[2]. This early marriage and childbearing is a violation of a girls' right to achieve her full potential

Table 5.1: NFHS data on early marriage

Indicators	Urban NFHS-4 (2015 -16)	Rural NFHS-4 (2015 -16)	Total NFHS-4 (2015 -16)	Total NFHS-3 (2005-06)
Women age 20-24 years married before age 18 years (percent)	17.2	30.7	24.9	38.7
Total fertility rate (children per woman)	1.8	2.2	2	2.4
Women age 15-19 years who were already mothers or pregnant at the time of the survey (percent)	4.2	7.9	6.5	12.7

Source: Gujarat NFHS data

UNICEF report on child marriage[3] reports that Atta satta the practice of one set of brother and sister being married to another set of brother and sister is common in Gujarat. In the event of irreconcilable differences of one couple, the other couple has to perforce break their marriage as well. The declining sex ratio in the state, where child marriage is prevalent for both boys and girls, has forced communities to marry off their children as soon as they find a suitable alliance (UNICEF, 2012).

Muslim groups have been opposing the law on child marriage on grounds that it is against the Muslim Personal Law, and a recent judgement by the Gujarat High Court upholding the marriage of a minor Muslim girl as legal has started another debate on the role of religion in social issues.

Teenage pregnancy

Among young women age 15-19 years in Gujarat, 7 percent have already had a live birth or are pregnant with their first child. One percent of women age 15-16 years has started childbearing, but this proportion increases sharply to 10 percent among women who are 18 years old and to 16 percent among women who are 19 years old. There are disparities between educational and caste groups. Twenty-one percent of young women who have no schooling have begun childbearing, compared to only 1 percent

of young women who have 12 or more years of schooling who have begun childbearing. Almost 11 percent of the Scheduled Tribe girls had begun child bearing before the age of 19 compared to 7.2 percent Scheduled Caste and 6.1 percent Other Backward Caste girls (NFHS-4). Thus, it is seen that teenage pregnancies are decreasing, and improved education helps to delay child bearing age[4].

Table 5. 2: Teenage pregnancy and motherhood

Background characteristic	Percentage of women age 15-19 years who:		Percentage of women age 15-19 years who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
Age				
15	0.4	0.5	0.9	719
16	0.6	0.8	1.4	733
17	1.7	1.5	3.3	689
18	6.9	3.3	10.2	847
19	12.4	3.5	15.9	721
Residence				
Urban	2.8	1.4	4.2	1,447
Rural	5.6	2.4	7.9	2,262
Marital status				
Never married	0	0	0.1	3,180
Currently married	31.9	14.1	46	517
Caste/ tribe				
Scheduled caste	3.4	3.8	7.2	476
Scheduled tribe	8.6	2	10.7	584
Other backward class	4.4	1.8	6.1	1,682

Source: NFHS-4[4]

Witch hunting practises

In the 2016 NCRB report, the motive for at least 14 murders in Gujarat was mentioned as witchcraft. While the data did not specify the gender or whether the person was killed for being a witch or it was a form of sacrifice in the name of witchcraft, it does point out the deeply rooted mindset towards witchcraft5. Witch hunting or dakan pratha is rampant in Gujarat in Dangs, Sabarkantha, Panchmahal, Dahod, Narmada, Tapi, Surat, and Mahisagar districts.

ANANDI's work on Witch Hunting[6]

ANANDI's work since 2000 shows that the forms of violence related to witch-hunting include using abusive language, threats to kill them, intimidation by groups/individuals in public, at night, at home, with weapons/stones. Women are often thrown out of homes and chased out of the village and refused entry into the village. Sometimes such women are murdered. A collective analysis shows that these were women whose husbands had died and they got the property or strong women who stood up for themselves or they were women who had refused sexual advances. In order to suppress them, such false beliefs were spread.

Women labeled witches often do not file a complaint, despite repeated violence. There is no specific law in Gujarat on witch hunting. Reporting is only done when the situation becomes extreme and life threatening. Very few FIRs are filed - the women would be turned away and told to solve the issue in the Panchayat. The police themselves use terms like *dakan* (witch).

Since dakan pratha has its roots in social beliefs and traditions, it is difficult to eradicate. Tribal leaders are unwilling to take up the issue in the community. Initially, even the members of the women's collectives believed in the concept of *dakans*.

Interventions required are counseling and building community support to prevent violence. Following ANANDI's interventions, higher level police officers and elected leaders have participated in campaigns against witch hunting and pledged to take action against violators and cases have been recorded. But getting the system to respond is very difficult as the police in tribal areas often use the opportunity for extortion of money from both parties. However, the fact that earlier police were not accepting to register such cases and now they are doing so itself sends a strong message to the community.

Female genital mutilation

Female genital mutilation or cutting (FGM/C) is the collective name given to several different traditional practices involving partial or total removal of the female external genitalia or other injury to the female genital organs for cultural reasons. FGM/C is recognized as a harmful practice, and has no known health benefits. It violates the human rights of children and women.

We could not get direct data on FGM in Gujarat. However, it is known to be practiced amongst the Dawoodi Bohra community in Gujarat and is known as *khatna*. The ritual of *khatna* is a pre-pubescent coming-of-age ceremony that is typically carried out when the female child is seven years but may be done in later years.

Most commonly, *khatna* on girls is "performed by *mullanis*, women who have semi-religious standing, or by dais or midwives, or by women with some experience". These women though usually literate, lack knowledge or understanding of the female anatomy, nor do they have any formal training in medicine, nursing or first aid. *Khatna* is carried out without anaesthesia in the closed confines of a "darkened" room. The tools used are usually an '*astro*' or a barber's razor or a shaving blade depending on the preference of the *mullani*.

Within the Dawoodi Bohra community, there is a lot of social pressure and cultural intimidation to continue the practice of *khatna/khafd* (FGM/C), and to withhold and safeguard their cultural and religious identity. The fear of ex-communication, and the rigid control exercised over community members by the clergy, ensures that few people openly speak out against the practice of FGM/C.

FGM/C is a gross denial of social equality, and exposes the societal and patriarchal pressures exerted on *Bohra* women. The ancestral ritual of khatna, is a grim and poignant reminder of the unchallenged strength, power and influence of patriarchal hierarchies over the women of the *Dawoodi Bohra community*[7].

Unfortunately, vast majority of Bohra women believe in it and subject their daughters to this custom.

"She was circumcised at the age of seven. She lives in Mumbai, but during her vacations she went to Surat (Gujarat) to her grandmother's place where khatna was performed on her. She is a well-educated girl and did her graduation in Sociology in which she also did a project on FGM in Africa. She revealed that in comparison to India, African countries perform a harsher form of FGM. She has a daughter and intends to circumcise her because she wants her to enter the masjid (mosque) like a male. For her daughter to be treated as an equal to men, she justifies the practice of khatna[8].

There has been some progress on the issue. A first of its kind study "The Clitoral Hood a Contested Site" released in 2017 on the issue comprised of in-depth interviews with 83 women and 11 men – both proponents and opponents of FGM, from Gujarat, Maharashtra, Madhya Pradesh, Rajasthan, Kerala as well as from the United States, Canada and United Arab Emirates, countries with significant Bohra diaspora[9]. The study showed that three fourths of the interviewed respondents had subjected their daughters to the practice and almost all (97 percent) of the female respondents recalled their own FGM in childhood to be very painful. While 33 per cent of these female respondents said FGM has had an adverse impact on their sexual life, 10 per cent reported frequent urinary tract infections, and incontinence, with one reported case of excessive bleeding. A majority of the female respondents reported that they suffered from felt low self-esteem, feelings of shame, betrayal and anger, and suffered from depression as a direct consequence of FGM.

A news report based on the study pointed out those 88 respondents said they cumulatively knew 1,248 women in their families who had undergone *khafz* (female genital mutilation). Also, the prevalence of the practice varied from 64 per cent in upper income groups to 100 per cent among poorer families indicating that lower income groups were more vulnerable to pressure and surveillance from religious heads.

The study also debunked the myth that men from the community were oblivious to the practice and showed that they were involved in the perpetuation of the practice on political and personal levels with many insisting on marrying women who had been "cut".

The Dawoodi Bohra Women's Association for Religious Freedom (DBWRF), who are in favour of the practice, also issued a statement disapproving the study. Samina Kanchwala, Secretary, DBWRF said *khafz* is circumcision and not mutilation. *"Khafz* is a harmless cultural/religious practice unique to the Dawoodi Bohra community. We reiterate that there is no place for any kind of mutilation in the Dawoodi Bohra religion and culture[10]."

Durga Nandini of Change.org, India said that first public evidence on the existence of FGM came in December 2015 in the form of an online petition asking for its ban supported by over 1 lakh people. Masooma Ranalvi, an FGM survivor and founder of We Speak Out, said that there was a move to ban FGM across the world but the Government of India was not listening to pleas of women from their community. Sometime back, the DWCD was all set to issue an advisory on the FGM ban to all states but never went ahead with it.

The interplay of the issue and denial by the government that it exists in India is interesting. An article in the Indian Express highlighted the current situation on the issue11. It said that the Government of India had chosen to refute and dismiss the report and had also denied the prevalence of Female Genital Cutting/Mutilation in the country.

In May 2017, after a high court advocate, Sunita Tiwari, filed a PIL in the Supreme Court asking for a ban on FGC/M, Menaka Gandhi came out in the press stating that FGC/M in India would be banned. She also stated that her ministry would write to the leader of the Bohra community and ask him to stop the practice in the Bohra community. Later that year, Gandhi and officials from her ministry also met activists working to end female genital cutting, expressing keenness to end the practice in India. Yet in a turncoat move, the government told the Supreme Court in December 2017 that there is no "official data" to prove the existence of FGC/M in India. The claim came also after years of steady and significant increases in the number of women and men coming out against the practice of FGC/M in those practices where it was found to occur. Women

have publicly shared their own stories of mutilation on social media and through other mediums. Yet, the government quoted lack of "official data".

Though it is practiced by a small minority, the prevalence of cultural practices such as FGC/M is symptomatic of a larger problem where female body being 'impure', 'excessive' and in some cultures, even 'evil'. And finally, in April 2018, the central government acknowledged the prevalence of the practice and urged the Supreme Court to issue guidelines on how to curb the occurrence of FGC/M. In July 2018 the Indian Express reported that the Supreme Court made it clear that it cannot direct doctors to perform genital mutilation of minor girls of the Dawoodi Bohra Muslim community and questioned the "scientific justification", if any, behind the procedure. Indira Jaisingh, the lawyer had argued that genital cutting of minor girls for non-medical purposes constitutes an offence under the IPC and the POCSO[12].

Way back in December 2012, United Nations General Assembly (UNGA) came up with a resolution to eliminate FGM from the world. It has designated 6th February as the international day for Zero tolerance for FGM. The sentiment is echoed by United Nations Convention on the Rights of the child (UNCRC) and the UN universal declaration of human rights, of which India is a signatory. The SC verdict is eagerly awaited; however a greater challenge than the SC verdict is societal acceptance[12].

In conclusion, harmful practices such as early marriage and child bearing continue to be widely prevalent, while those such as witch hunting and FGM are restricted to certain geographic and community pockets. What is evident from the data is that irrespective of their prevalence, these practices prey on the vulnerability of women in a patriarchal society and adversely affects their health. Experiences of grass roots organisations also suggest that mere existence and awareness of laws does not ameliorate widely prevalent and acceptable social practices.

SECTION 6
HARMFUL TRADITIONAL PRACTICES

This section documents the issues faced by women migrants, Dalit women, women living with disabilities and LGBTQI community.

A. Migrant women

The Economic Survey of India 2017 estimated that the magnitude of inter-state migration in India was close to 9 million annually between 2011 and 2016. Census 2011 pegged the total number of internal migrants in the country at a staggering 139 million and about 30 percent of the population were reported as migrants by place of birth[1]. Apart from Delhi, Maharashtra and Tamil Nadu, Gujarat is one of the major destination states and women constitute an overwhelming majority of migrants[2].

In Gujarat, according to official data there are 1 million workers employed in 26,088 factories in whole of Gujarat. The data appears unreliable as Surat has 0.6-0.8 million workers from Odisha alone. There are equal numbers of workers from other states like Maharashtra, Rajasthan, UP, Bihar and southern states. There are 3121 factories in Surat district but official website does not give the data of numbers of workers employed therein. Number of women workers reported in official data is around 50,000 which have remained unchanged for many years despite the industrial 'progress' in Gujarat.

Migrant women workers contribute to National and State economy through their labour, and yet there is no government data on the extent of their contribution and profile of these women who form this large group. Also today there is a huge outflow of women migrants to other countries and that needs to be investigated from the same perspective as well[3]. Some recent data on migration population in India highlights the plights and vulnerabilities of women migrants but these studies also lack numbers.

A report by the United Nations Educational, Scientific and Cultural Organisation says gender perspective on internal migration in India is imperative, but missing. The design of the Census and NSSO data surveys enable respondents to give only a single reason for migration. Though marriage is reported by women as the most prominent reason for migration, women's labour migration and economic contribution remain inadequately captured owing to this mono causal approach. This has contributed towards undercounting of women's migration for employment. Yet, it is a well-known fact that poor migrants are often employed in risky jobs resulting in industrial accidents, exposure to hazardous chemicals and are exposed to long working hours and unhygienic conditions. They are susceptible to infectious diseases because of their poor, crowded and unhygienic living conditions. Data on how this affects women and the consequences is hardly available.

Table 6.1: Magnitude and Pattern of Internal Female Migration (percent)

State	Intra District	Inter District	Total	From other states	From other countries
Gujarat	63	28.6	91.6	8.1	0.33

Source: *(Computed from) Household Survey Data of NSSO 55th Round.*

Note: *The above data is only data available on Gujarat migrant female worker4. Rest no data was available in NFHS or Census for Gujarat.*

A JSA member who works on the issue reported5 that women migrants suffer inequality in wages as they are routinely paid less than men for equivalent tasks. These women migrants face double discrimination, encountering difficulties peculiar to migrants, coupled with their specific vulnerability as victims of gender-based violence i.e. physical, sexual or psychological abuse, exploitation and trafficking. Women migrants are highly vulnerable to sexual abuse and violence at the hands of labour market intermediaries. They have no support, legal, police or otherwise. The Inter-State Migrant Workmen Act of 1979 is hardly ever implemented to protect the rights of labour migrants. Concerns related to gender and migration is not addressed, and the rights of women migrants do not find an equal place in city development plans.

Their health issues arise out of poor and unsafe working and living conditions, long working hours and lack of occupational health and safety. There is a greater threat of nutritional diseases, occupational illnesses, communicable diseases, alcoholism and HIV and AIDS amongst migrant populations. Lack of access to services impacts women who often continue working during their pregnancy, have low birth weight babies and remain underweight mothers. These women also lack awareness of health services, laws, schemes or policies, as well as their rights as workers. The JSA member specifically talked about the issues of migrant brick kiln workers, the problems faced by especially the pregnant women. They are not identified by the government and neither their home state supports them, nor the state where they have migrated and are contributing their labour to. Their awareness about various health schemes is very low and the supervisors of these kilns do not assist them in availing health facilities[6]. They face wage discrimination, sexual violence and various types of exclusion, such as restricted access to the public distribution system for food, to shelter and medical facilities, and even have limited voting rights. Many women migrant construction workers are denied access to crèches, drinking water, sanitation, and toilets.

Some Gujarat based studies

A background policy paper on "Entitlements of Seasonal Migrant Construction Workers to Housing, Basic Services and Social Infrastructure in Gujarat`s Cities" examined the legislative, policy and governance context that shaped the entitlements of seasonal migrant construction workers to housing, basic services and social infrastructures in Gujarat's three largest cities of Ahmedabad, Surat and Vadodara. The purpose was to understand the reasons for their marginalized living conditions in the city and the constraints and possibilities for improving these. (Desai, 2017) The study had data on skilled and unskilled workers. However it did not have the data on the gender, caste/marginalised people[7].

Another study conducted in 2014, focused on internal migration of labour that is temporary, seasonal and is from rural to urban areas. It was observed that rural to urban migration has increased significantly in the countries in the South in the recent decades and is expected to rise further in the future with the process of development. The study observed the problems faced by the migrant workers and concluded that there is a need to identify them and solve the problems faced by them every aspect (Hirway et al 2014) [8].

Aajeevika organization's study in Ahmedabad found that there are approximately 1.3 to 1.7 million labour migrants in the city who come from the north, west and east India. Over the years they have come to be identified with specific sectors – tribal migrants from Madhya Pradesh and Rajasthan form the construction workforce; seasonal migrants from Bihar are head-loaders and cart pushers; migrants from Uttar Pradesh dominate as factory workers and drivers; from Odisha they are mostly associated with plumbing work, and the diamond cutting industry. A large majority of them hail from historically marginalized groups such as the SCs and STs, which adds to their vulnerability. The study however lacked a gender/feminist lens and issues of women workers were not focussed upon[9].

Destitute and single mothers in urban areas: A point of view

The urban *bastis* (slums) have a considerable population of single migrant women. Many of these women work as 'Domestic Help' or as unorganised workers. A number of them are either destitute, divorced or widows. These women form a vulnerable section of the society where their status as a single woman adds to the other vulnerabilities like poverty, low status of education and age. Widows as young as 24 years are found in urban slums who are mothers to at least two children by then. They live alone or with relatives but have to fend for themselves and their children. This compels them to opt for any kind of work. Sexual exploitation and denial of services to them just on account of their present marital status is a great disadvantage to these women. Their reluctance in approaching the service providers for services and counselling due to biased attitudes of the service providers and the fear of being exposed in the society results in unsafe practices such as abortions by informal providers or self-prescribed abortion pills.

(JSA member who works in urban slums)

In conclusion, Women constitute an overwhelming majority of migrants. They suffer the consequences of being migrants and women, in addition to inherent socio-cultural prejudices and economic deprivations. Migration adds to the existing baggage of inequality and discrimination. Concerns related to gender and migrations are not addressed, and the rights of women migrants do not find an equal place in city development plans. Access to economic, social and health benefits are denied because of hostile attitudes, discriminatory practices and even legal frameworks based on the "sons of the soil" ideology[10]. India is a signatory to international conventions and protocols for the prevention of gender-based discrimination and trafficking in transnational migration, similar legislation needs to be put in place for internal migration of women in India[11].

B. Occupational health of women workers[a1]

In India, data on number of accidents taking place at work, number of workers dying, number of workers getting permanently disabled is not available because there is no legal provision to report the cases to the Government except for registered factories, mines (Under Factories and Mines Act) and for registered construction sites and docks. Similarly, under the Pesticides Act, cases of poisoning due to pesticides are to be reported. In spite of legal provision, accidents and deaths are rarely reported.

More than 50 percent of workers are agriculture workers who have no legal cover for health and safety at work. Government of India has not ratified ILO C.155 (1981) which would require it to extend legal cover for Health and Safety (H & S) to all workers in all economic sectors. Health, education and financial services are organized sectors with considerable presence of women, yet they are completely out of coverage for protection of Health and Safety at work. Health sector in particular is very hazardous as workers can get infected but women's safety is limited to sexual harassment. In the textile processing units of Surat, women workers are employed but employers submitting the annual return under Factory Act, rarely show

women workers on their records. They report that no woman worker was paid maternity benefit by them. This is serious under or misreporting but there is no one to question them. In fact large numbers of units do not bother to submit the returns. There is only one lady inspector of factories in the State who has responsibility to monitor enforcement of provisions for women workers all across Gujarat. The Lady Inspector is assigned tasks unrelated to the inspection responsibilities under the guise that as a woman she cannot travel across the state. Against this background, we highlight some cases from a range of different occupations.

a Note prepared by Jagdish Patel (Peoples Training and Research Center- PTRC)

Deaths due to exposure in a chemical factory

On June 23, 2011 PTRC released its report on exposure to a chemical known as Polyacrylate at a factory named Corel Pharma Chem in Kadi in north Gujarat. Toxicity of the material was not much known. Among the exposed women, there was death of a young women worker and another one was bed ridden for 4-5 months. A male worker also died. One woman died after prolonged illness and her husband committed suicide as he was worried about her treatment expenses. When PTRC wrote a letter to the Chief Justice, Gujarat High Court, the Court filed Suo Moto Public Interest litigation and served notice to the employer and the State. Later, it ordered National Institute of Occupational Health to submit a report after carrying out medical check-ups. The Institute reported that several workers were suffering from lung disease following dust exposure and few others were suffering from liver disease following exposure to chemicals.

Silicosis

Agate workers: Khambhat is well known for agate or bead craft since centuries. Earlier it was a pure handicraft but after introduction of electricity, the pace of work increased. Grinding the stone on emery wheels driven by electricity generates large amounts of very fine dust containing silica, which when inhaled reaches the alveoli of the lungs, causing Silicosis. Many workers have died of Silicosis and continue to die. Large numbers of women work as grinders and hence death rate among women is high. PTRC ran weekly clinic in Khambhat from 2007-2017 to identify and diagnose silicosis patients from among exposed population. It generated scientific data on silicosis prevalence and deaths. In a decade (2005-10), 167 deaths were reported.

Though Silicosis is a compensable disease under Workman Compensation Act, there was not a single case of claim till 2010, due to the complex social situation. Since 2010, following Supreme Court order directing National Human Rights Commission to negotiate with States to pay relief to the silicosis victims, PTRC filed nine complaints before the Commission, involving 112 deaths in Agate industry in the Khambhat area. In December 2017, the Commission passed the recommendations to the Government of Gujarat and finally in 2018 it paid Rs. 4 lakhs to several families as relief.

Quartz industry tribal workers: Around 1970s Silica stone crushing industry started in Godhra town which now houses more than 15 crushers. In 1980 Gujarat Industrial Development Corporation (GIDC) invited the National Institute of Occupational Health (NIOH) to study of the ambient air in GIDC, Godhra as these stone crushing units were heavily polluting the air. The study revealed high percentage of total and respirable dust in the workplace and noted that exposure of even six months, could cause silicosis. The Factory Inspector then started looking for cases of silicosis and compensation claims were filed in Godhra.

In 2000, a large numbers of workers in Chhotaudepur taluka of Vaododara district (now Chhotaudepur is a district) were found to suffer from Silicosis. Local organizations claimed that 500 workers had already died. The State Health Department and NIOH examined and managed the workers. In 2004 vernacular newspapers reported that the tribal workers of Dahod district were affected by Silicosis. A total of 238 workers who had migrated to work in these units from tribal areas in Madhya Pradesh died of silicosis and upon recommendations of NHRC and in response to a Supreme Court order, the Government of Gujarat paid Rs.3 lakh to each of them.

Asbestosis

Asbestos is a very toxic chemical. Raw asbestos fibres are used for insulating the outer surface of boilers in thermal power plants. In Ahmedabad workers engaged in insulation were found to suffer from asbestosis. In a few cases spouses of workers were also found to have asbestosis because of secondary exposure to work clothes of their husbands.

Women workers of Salt Pans

Gujarat supplies 70 percent of the nation's salt with its longest sea coast. In the Little Rann of Kutchh around 100,000 families are involved in salt production. Families migrate to the land allotted to them by the administration and live there for eight months of the year. They have no access to basic amenities, health care services, educational facilities or other civic services. Women are affected the most. There is no ANC available to women working there;

deliveries take place under the open skies. Workers go bare feet into the salt pans and the brine water enters their bodies from the feet. As a result they suffer from high blood pressure. They also suffer from heat strokes, skin problems and malnutrition.

C. Dalit women

According to Census 2011, in Gujarat, SC form 16.2 percent and ST form 8.2 percent of the population1. The data from the NFHS-4 shows that more than one-tenth (11 percent) of households in Gujarat have household heads who belong to a scheduled caste, 15 percent belong to a scheduled tribe, and 41 percent belong to other backward class. Women from the Scheduled Tribes had the worst indicators and can be considered the most vulnerable. The SC and OBC fared somewhat better on these indicators.

Health of Dalit women

Nutritional status: More than two thirds of SC/ ST women were categorised as thin. Nutritional status of ST women was poorest with more than 41 percent being thin and another 21.7 percent being moderately to severely thin[2].

Table 6.2: Nutrition Status-Body mass Index status of women 15-49 years (percent)

Caste/tribe	Body mass Index of women			
	<18.5 (total thin)	<17.0 (moderately/ severely thin)	≥25.0 (overweight or obese)	≥30.0 (obese)
Scheduled caste	29.2	15	19.7	4.8
Scheduled tribe	40.6	21.7	10.8	2
Other backward class	27.6	13.4	22.8	6.6
Other	18.8	8.4	33.6	11.4
Don't know	27.2	13.2	20.8	4.7

Source: *NFHS-4*[2]

Note: Body Mass Index is expressed as the ratio of weight in kilograms to the square of height in meters (kg/m^2)

Fertility: SC/ST women were found to have higher Total fertility rate (TFR) and around 17.9 percent of them had already entered motherhood during their teenage years.

Table 6.3: Women age 15-19 years who have begun childbearing (percent)

Teenage pregnancy and motherhood		
Caste/tribe	Gujarat	India
Scheduled caste	7.2	8.8
Scheduled tribe	10.7	10.5
Other backward class	6.1	7
Other	3.3	7.5
Don't know	(17.8)	17.5

Source: *NFHS-4*[2]

Maternal care: Receipt of antenatal (ANC) care was lower among SC, ST women as compared to other castes, particularly so among the ST women. Only two thirds of the ST women had received ANC, one fifth had received the recommended "Full" ANC, and a little more than three fourths of these women had institutional deliveries. Postnatal care within 48 hours of delivery was similar across castes. Data also showed that these women, especially the ST women were more likely to use the government facilities for delivery than the other castes.

Table 6.4: Maternal care (percent)

	Scheduled caste	Scheduled tribe	Other backward class	Other
ANC by skilled provider	78.4	67.1	82.1	87.6
"Full" antenatal care	33.0	19.4	29.7	38.7
Delivery in a health facility	88.6	76.6	90.5	94.9
Delivery in government facility	35.8	44.0	31.4	24.8
Delivery in private facility	52.8	32.6	59	70.1
PNC by skilled provider	77.3	70.4	71.6	68.4
PNC within 48 hours	68.7	64.8	66.4	66.4

Source: *NFHS-4*[2]

Family planning services: As far as family planning method use was concerned, as opposed to national scenario modern method use was higher among ST women in the State. Overall use of family planning methods was somewhat similar across castes.

Table 6.5: Current use of contraception by background characteristic (percent)

Caste/tribe	Any modern method		Female Sterilization		Male Sterilization	
	Gujarat	India	Gujarat	India	Gujarat	India
Scheduled caste	43.7	49.2	35.9	38.5	0.0	0.3
Scheduled tribe	46.7	45	41.8	36.5	0.7	0.5
Other backward class	43.1	46.5	34.3	37.3	0.0	0.2
Other	41.6	49.9	27.9	32	0.0	0.2
Don't know	32.5	39.5	27.5	25.4	0.0	0.1

Source: *NFHS-4*[2]

Violence against Dalit women

Government data shows that crime rate for atrocities against scheduled castes (SCs) in Gujarat were 32.5 percent in 2016, above the national average of 20.4 percent. As many as 1,321 atrocities against Dalits were reported, according to a submission in the Rajya Sabha on July 26 2017. Atrocities against Dalits are on a rise in the State to the tune of 31 percent from 1,009 cases in 2015 to 1,321 in 2016. Comparatively, at the national level the increase in atrocities was 6 percent from 38,564 in 2015 to 41,014 in 2016[3].

While rate for assault, sexual harassment and rape of ST women in the State was lower than the national level, kidnapping and abduction of women was reportedly higher.

Table 6.6: Crime/Atrocities against Scheduled Tribes

	Assault on ST Women to Outrage Her Modesty(Total)		Sexual Harassment		Kidnapping & Abduction				Rape	
					K & A of ST Women to Compel Her For Marriage		K & A for Other Reasons			
	Number of Victims	Crime Rate	Number of Victims	Crime Rate	Number of Victims	Crime Rate	Number of Victims	Crime Rate	Number of Victims	Crime Rate
Gujarat	25	0.3	12	0.1	14	0.2	4	0.0	34	0.4
India	840	0.8	298	0.3	51	0	52	0.0	975	0.9

Source: *NCRB 2016*[4]

Spousal violence: Spousal violence was also higher among the Dalit women. Violence during pregnancy was reportedly higher among ST women.

Table 6.7: Spousal Violence and violence during pregnancy (percent)

Spousal Violence - emotional, physical, or sexual violence	
Caste/tribe	
Scheduled caste	26.4
Scheduled tribe	34.3
Other backward class	23.0
Other	16.4
Don't know	20.2
Violence during Pregnancy	
Scheduled caste	2.1
Scheduled tribe	5.1
Other backward class	1.1
Other	1.3
Don't know	0.0

Source: *NFHS-4*[2]

Further analysis of gender attitudes showed that both men and women from these castes were more likely to justify reasons for spousal violence on grounds of poor cooking skills, refusal of conjugal rights, neglect of household and children and argumentative, unfaithful behaviours by wives / women.

Table 6.8: Gender role attitudes (percent)

Caste/tribe	Agree that a husband is justified in hitting or beating his wife for at least one specified reasons[a]		Agree that a wife is justified in refusing to have sex with her husband for all specified reasons[b]		Agree that when a wife refuses to have sex with her husband, he does not have the right to any of the four\ specified reasons[c]
	Women	Men	Women	Men	Men
Scheduled caste	38.3	28.0	62.8	65.0	74.6
Scheduled tribe	43.0	32.6	58.6	51.8	72.8
Other backward class	35.4	28.9	62.7	61.5	75.2
Other	28.7	22.8	66.1	65.6	81.2
Don't know	29.2	(26.1)	(78.0)	(77.0)	(92.1)

a Specified reasons: Goes out without telling him, neglects the house or children, argues with him, refuses to have sexual intercourse with him, doesn't cook properly, unfaithful, and shows disrespect for in-laws.

b Specified reasons: knows husband has a sexually transmitted disease\ husband has sex with other women, and is tired or not in the mood.

c Specified behaviours: gets angry and reprimands her, refuses to give her financial support, uses force to have sex, and has sex with another woman.

Lack of evidence

Very few systematic research studies have been conducted in Gujarat. Data from two studies highlights some of the challenges faced by these women.

A study by Navsarjan Trust aims to showed that Dalit women remain vulnerable to violence that pervades their villages, their homes and their most intimate relationships. This violence is perpetrated not only by Non-Dalit men, but also by members of the women's own communities and households. The study addresses a special subset of violence termed "accidental deaths of Dalit women." These deaths are classified as accidental as no one is accused of causing the death. Data also showed that the frequency of crime against Dalits had remained unchanged over the five year period of this study[5].

Another study conducted on "Negotiating respectability: comparing the experiences of poor and middle class young urban women in India" explored the intimate relationships of young slum-dwelling Dalit women in Mumbai and young middle class women in Baroda, Gujarat. They traced the gendered ideals of respectability shape women's freedom of movement and relationships. The comparison produces new insights into the ways that class, caste and location cut across gender to shape young women's lives in India. The Dalit women showed more active resistance to an ideal which they struggled to achieve, despite heavy control and surveillance over their movement and relationships[6].

The Gujarat context: Issues and vulnerabilities[7]

According to a JSA member who works with the Dalits, in Gujarat, the community is spread over 12,000 villages. There is a big challenge of internal displacement and atrocities against them.

There has been a big internal displacement of Dalits involved in manual scavenging. Almost all (95 percent) of them are women but men take the decision of displacement to urban areas. This displacement to slums increases these women's vulnerability to different forms of sexual violence.

Dalits have been attacked over a land dispute, women have been physically harms and raped and yet till date they have not received justice. While the women suffered these atrocities, the Dalit male leaders negotiated with the other side for a settlement, instead of punishing the perpetrators.

In study in Bhavnagar, Kutch and Rajkot, 70 percent of the cases were family or community based violence and 30 percent were caste-based violence. While domestic violence against women was hidden, unnatural deaths of women were seen in the form of burns, followed by poisoning and drowning were reported. Researchers observed that Dalits often turned hostile in courts and this was the major challenge faced by them to get justice.

There is the issue of sexual trafficking of Dalit girls in the State. They undergo trauma, have identity issues and their trauma is not understood even within their families. In urban areas, there is no community bonding leaving the girls more vulnerable to sexual encounters. The reluctance of family and community to support these girls is evident. Dalit women also do not get access to justice very easily. A 15 year old girl studying in 10th standard was raped. She got justice although POCSO was not implemented at that time. But after winning the case, the girl was shamed and boycotted by the village. She attempted suicide by burning herself. She was brought to the Ahmedabad Civil Hospital, where she died the following morning. The villagers did not allow her body to be bought into the village and she was cremated in the hospital. In the recent years, a woman who was sexually attacked around the time of Una flogging case, police did not use the appropriate IPC (Indian Penal Code) sections in her complaint.

Valmiki sub-caste is considered as the lowest sub-caste among Dalits. Women belonging to Valmiki sub-caste are given work related to toilet and open defecation cleaning. Majority of these women across the country continue to be held captive by the inhuman and degrading tradition of manual scavenging. It is because of this caste-based tradition that they remain deprived of their constitutional and statutory rights to equality, liberty, education and social development. However, the Government of Gujarat refuses to accept the existence of this practice though GOI data shows that Gujarat stands fourth in manual scavenging.

Many of the migrant workers are Dalit women and these women are exploited for many purposes including surrogacy. In 2010, Navsarjan Trust conducted a study titled "Understanding Untouchability" to understand the prevalence of untouchability practices against Dalits in 1589 villages from 12 districts of Gujarat. It identified 98 forms of untouchability practices stratified in six major categories. One thing that stood out in this study was that the Valmiki community faced majority of discrimination in comparison to the other Dalit communities. It also found that the ANMs and dais (traditional birth attendants) practiced untouchability with Dalits. These women's' situation often is so vulnerable that they have deliveries in the open with no one helping them[8].

A study on 100 elected women representatives showed that there were villages where these women were not even allowed to sit on chairs. And if the elected woman was a widow, people did not want to even see her face. Some of these elected Dalit women had never even been to a Panchayat office.

D. Women living with disabilities

The government data on disability is from Census 2011. It whole ranges of disabilities including visual, auditory, speech, movement, mental retardation etc. In all categories and in all age groups, the number of males is higher1, 2. It is not clear if this is because of under-reporting of disabled girls due to social and cultural bias/pressure. The Niti Aayog acknowledges that the persons with disabilities (PwDs) experience stigma and compromised dignity in their daily life.

At a daylong workshop in June 2016, organized by the New Delhi-based Centre for Women's Development Studies (CWDS) in collaboration with the All India Confederation of the Blind (AICB) on the theme 'Creating bridges between visually challenged women and the Women's Movement', a number of adult blind girls shared their personal experiences of how people in general remained mere spectators in broad daylight while they were subjected to harassment and molestation in the public places.

Many among them acknowledged the existing gap between the women's movement in India and the indifference towards understanding the nuances of disabled women's daily ordeal. The psychological and emotional toll is immense on disabled women rape survivors in India. Depression, helplessness and neglect from the family are quite rampant. Majority of the NGOs working in the disability sector are based in metro cities such as Delhi and Mumbai. A handful of them are engaged in advocacy related to sexual harassment cases. As a consequence, the abuse and violence faced by women with disabilities residing in the country's backwaters remains unheard or is swept under the carpet. They talked about the societal notion that disabled women are 'asexual' and re-iterated that having ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the Indian government is duty bound to ensure that the disabled women access public places and services without any inhibition and fear[3].

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Situation of disabled women and the Gujarat quake

On January 26, 2001, a devastating earthquake struck western India killing around 14,000 people, injuring over 150,000 and leaving millions homeless. The disaster left hundreds of people with disabilities, such as the loss of limbs due to amputations and spinal injuries resulting in paraplegia.

In villages and towns across the most severely-hit region of Kutch, disabled women recount their experiences of being abandoned by their husbands and in-laws, shunned by their communities and subjected to constant mental torture by their families who remind them daily of the "burden" they have become.

"It would have been better if I had had my legs amputated, rather than be in a wheelchair," says Mayaba Laluba Solanki, 34, who lost the ability to walk when her home in the town of Anjar came tumbling down on that fateful morning. "I could then perhaps have got artificial limbs, and walk with the help of a crutch – at least then people would have more likely accepted me." Mayaba had a three-month-old baby girl when her husband abandoned her and their child, saying that he could not be seen with such "shame" in his village.

There are other women, whose wedding engagements were broken or were turned out by their own parents, who now live a lonely existence. Some are so depressed by their treatment that they have attempted suicide by self-immolation – pouring kerosene over themselves and setting themselves alight. Parents of girls who were disabled by the quake also have serious concerns about their future in a society which largely perceives that a woman's only role in life is to get married and care for her husband, his family and their children[6].

Niti Aayog said that the National Policy for PwDs, 2006 needs to be revised and the estimates of number of people coping with various types of disabilities should be realistic. Education and skill training should be given to people with disabilities. Rehabilitation Council of India (RCI) should be established. Independent functioning of the National Board of Examination in Rehabilitation under the RCI should be ensured. Aids should be provided to approximately 3.5 lakh beneficiaries every year[7].

E. Issues of LGBTQI Community

Thursday, September 6, 2018, history was created when India's Supreme Court decriminalised a portion of Section 377 (a colonial era provision that criminalizes private consensual sexual acts between same sex adults) of the Indian Penal Code in a landmark ruling. "Any discrimination on the basis of sexual orientation violates fundamental rights," said the Chief Justice of India, who was head of the five-judge bench. Activist Kavi's Humsafar Trust, a charity that works with India's LGBTQI community, included a crises data report in its petition to the top court. It said less than 20 percent of those surveyed had publicly revealed their sexual identity while two out of every five homosexuals in the country had faced blackmail after the top court had re-criminalised homosexuality in 2013.

While no such data is available for Gujarat, the ruling is at least a way forward. Jubilations could be felt in organizations like Lakshya, Forum Foundation, Chuval Gram Seva Trust, Queer Abad and Vikalp Women's Group who have been working for a more inclusive society and providing legitimate spaces for the LGBTQI group in Gujarat.

The 'coming out' of a Royal Prince

Manvendra Singh, known as the gay prince of erstwhile Rajpipla state has been a champion to the cause since years. He openly declared his orientation and fights for their rights. In 2006 when he came out publically about his sexual orientation there was backlash with people burning his effigies and his family disowning him for bringing dishonour to the family. He said,

"I knew that they would never accept me for who I truly am, but I also knew that I could no longer live a lie. I wanted to come out because I had gotten involved with activism and I felt it was no longer right to live in the closet. I came out as gay to a Gujarati daily because I wanted people to openly discuss homosexuality since it's a hidden affair with a lot of stigma attached."

He began Lakshya Trust in 2000. Lakshya has reached 17,000 gays in Gujarat and won a 2006 UNAIDS award. According to Lakshya Trust they have 2500 members in Vadodara, 1500 in Rajkot and 2000 in Surat. Getting data on the community is one of the hardest as identification and disclosure are important aspects to consider. While legally now they cannot be legally decriminalized, and have equal rights, however, crossing the socio-cultural taboos will still take time. So while more data will be available we hope in near future, more needs to be done. There are still many cultural challenges that need to be addressed and awareness and education will play key roles.

He created South Asia's first academic module on the LGBTQI community. The mandatory course, titled "Proclivity of Gender: Socio-Legal Approach to LGBTQI community", will be taught at the Karnavati University in Ahmedabad, Gujarat. His goal is to foster inclusivity through education and bring to the forefront topics like legal rights, Section 377 of the Indian Penal Code, socio-cultural aspects of the community and the history of LGBTQI rights movements in India and around the world. The course will also cover mental and physical health and HIV/AIDS and age-related issues within the community. The course was launched in September, is open to all students of Law and liberal studies and already over 60 higher secondary school students and Ph.D. scholars from across the country have signed up for the course.

Manvendra plans an exclusive nursing home for HIV/AIDS patients in Rajpipla1 and to convert a 15-acre property into an old age home for members of the gay community. He has planned to construct 50 cottages and rooms to provide a safe and happy home to those in needs. Apart from providing people with shelter, senior citizens here would also be provided with employment opportunities if they wish to remain active[2- 3.]

Gay Parades in Gujarat

The first Gay Pride Parade was held in Surat in 2013 with around 170 members of the LGBTQI community demanding rights equivalent to married couples as well as equal social acceptance in the society. The rally had participants not just from Surat, but also from across the country as well as overseas. The parade, Gujarat LGBTQI Pride Festival (GLGBTPF), was organised by the LGBTQI community in Surat along with Swalambi Chuwal Mandal and Chuwal Gram Vikas Trust based in Ahmedabad. According to organisers, more than 350 LGBTQIs were to participate in the parade; however, the police granted permission for just 200 members. GLGBTPF was the brain Child of a Gay Activist from Surat, who is also a member of the Board of Directors at International Gender and Sexuality Alliance (IGSA). The parade's slogan was 'Leaders who will give us equal rights will get our votes'.

"Apart from conducting the march for the pride of the LGBTQI community, this event was to mark the community's presence and the power to make or break the future of many politicians in the 2014 general elections. This march also aimed at mainstreaming of the LGBTQI community."

Similar walk was subsequently held in Ahmedabad that year[4- 5].

In November 2014, Vadodara witnessed a 'a two-day gay pride festival' that included Kashish film festival organized by Kashish Mumbai International Queer Film Festival (KMIQFF) featuring some of the prominent films on LGBTQI issues from across the world. It was followed by musical performances and the LGBTQI pride march. Their slogan was "We Pay Taxes, We do our Duties; Why Don't we have Equal Rights?"

In December 2015 in Ahmedabad around 500 people took part in one of the biggest LGBTQI Pride March. The march was meant to sensitise people on HIV-related issues, Section 377 and the rights of the community. It was organised by the Swavlambi Chuval Mandal.

In February 2018 the streets of Ahmedabad wore the vibrant colours of the rainbow as the queer pride parade took over the city. The parade marked the last day of Gujarat's first queer conference – Sambandh. The conference, which was spread across two days, touched upon issues of queer orientation in culture and its representations in literature and cinema. Politics around sexual identity, as well as queer relationships, were also discussed at length. Around 200 people attended the event, while many others joined along the way.

The 3rd edition of Vadodara Pride March-- "Vodadara LGBTQI + Sanman Yatra 2018'--was held on July 1 and organised by 'Foram Foundation', a Vadodara based organisation for empowering Gay, Bisexual, Transgender and Hijra community[6].

Health issues of LGBTQI

There is very little published on the health issues of LGBTQI populations in India (let alone Gujarat) and their experiences with the health systems. Whatever little has been published is in the context of the HIV AIDS programme, in the 1990s and early 2000s, limited largely to sexual health.

A recent systematic review of studies indicates that LGBTQI people are more susceptible to health problems, such as abuse of alcohol, tobacco and illicit drugs, obesity, unprotected sex, mental disorders, Sexually Transmitted Diseases (STDs) as HIV/AIDS, bullying, and cervical and breast cancer, as well as violent behaviour (Alencar Albuquerque et al 2016)7. The review also points out that the situation is further complicated because of the poor access to health care and the discriminatory practices of health care providers stemming from homophobia. Studies in South Africa (Lynch et al. 2016)[8] confirm some of the underlying drivers of discrimination against sexual and gender minorities, and denial of their SRHR. In addition to the discriminatory and heterosexist attitudes internalised by health care providers because of the prevailing patriarchal norms, the design, management and provision of health services are all structured through a heteronormative lens which act as a deterrent for LGBQTI persons seeking SRH care. The intimate partner – and sometimes even public - violence (including sexual violence) that LGBTQI persons experience, remains unacknowledged by the health systems, which do not have specific protocols to address these issues, thereby adding another layer of violence and compounding its effects. The study identifies a fourth factor in denial of SRHR as that of silences around transgender and sexual minority women's health.

The box below further exemplifies the ways in which health systems are blind to the needs of sexual minorities. This is an excerpt from a policy brief from India and illustrates the range of SRH needs of sexual minorities that health programmes in India overlook.

SRH needs of sexual minorities (Chakrapani 2011)[9]

The two government programmes – Reproductive and Child Health (RCH) -II and the National Rural Health Mission (NRHM) are silent about the needs of sexual minorities. Nowhere in the RCH-II/NRHM documents and training modules one can find terms related to sexual minorities such as MSM or Hijras or transgender people.

a) **Health needs of MSM, Hijra and transgender populations are not articulated:** These populations may be at risk of STIs and HIV if they have unprotected sex with men and women. While any type of STI can be contracted, certain STIs are more likely to be contracted through certain unprotected sexual practices. For example, the risk of getting hepatitis B virus infection is high with unprotected anal sex and that for hepatitis A virus infection with unprotected oral-anal sex (anilingus). Hepatitis B infection may later evolve into a chronic disease affecting the liver and also may lead to liver cancer. Similarly, some strains of the human papilloma virus that cause anal-genital warts may lead to anal cancer. Also, societal prejudice and discrimination have been linked to increased prevalence of mental health disorders among sexual minorities.

b) **Health needs of lesbian/bisexual women and female-to-male transgender people are nowhere addressed:** Lesbian and bisexual women face the same health issues as that of other women but also have specific health information and service needs. These include: Information on the health risks associated with certain sexual practices with women and men (STIs and HIV); information on cancer screening such as mammography (breast cancer screening) and pap smear (identification of precancerous lesions in the cervix); support for problematic use of alcohol, drug use, and smoking/tobacco use; support for mental health issues; and support services for intimate partner (same-sex or other-sex partner) violence. Some of the health needs related to female-to-male transgender people include: Information and services in relation to gender transition – masculinising procedures and sex change operation; pre- and post-gender transition counselling and support; and support for mental health issues.

c) **SRH needs of same-sex attracted and transgender adolescents are not addressed:** As same-sex attracted males grow up, some proportion of them may exhibit mannerisms and behaviours that would be labelled by the society as 'feminine'. Thus, they face ridicule and teasing from their neighbours, school friends and relatives. Similar issues may be faced by other sexual minorities as they grow up. Currently there is a complete lack of correct and supportive information about same-sex sexuality or transgender issues in popular media or even from health care providers.

d) **Need for standards of care for gender transition procedures (including sex change operation) for transgender people:** Only one state in India, Tamil Nadu, has initiated free sexual reassignment surgery (SRS) in government hospitals – that too, only for Hijras and male-to- female TG people. No support from the government is available for feminising procedures (such as female hormonal treatment and electrolysis for facial hair removal). The government is silent on providing services such as free SRS and masculinising procedures for female-to-male transgender people.

e) **Lack of legal recognition of same-sex marriage and marriage between transgender persons and men/women:** All citizens including sexual minorities have the right to marry their partner of choice and to have legal recognition of that marriage. Even in the absence of legal recognition, some same-sex attracted people are getting 'married' to same-sex partners and some proportion of Hijras and TG persons get 'married' to their regular Panthi partners.

f) **Ambiguity in legal recognition of gender identity of transgender people and Hijras and its relation to access to health services:** Lack of legal recognition of the gender identity of transgender people (male-to-female and female-to-male) is a key barrier to exercising their rights related to marriage with a man/woman (where their 'trans' gender identity and not biological sex is primary), child adoption, inheritance, wills and trusts, employment, and access to public and private health services, and access to and use of social welfare and health insurance schemes.

Studies have documented that the Hijras felt humiliated on having to stand in a queue for males at hospitals and were laughed at by the co-patients in the queue. Also, Hijras have no say in deciding in which ward – male or female – they can stay as in-patients in hospitals. These experiences prevent Hijras from ever visiting government hospitals or repeating visits.

g) **Marital counselling issues of couples in mixed sexual orientation marriages are not addressed:** There is a huge unmet need for counselling support that should address a range of SRH-related topics of sexual minorities. Sometimes, same-sex or both-sex attracted men and TG persons may get married to women attributing family compulsions and other reasons for getting married to a woman. Some proportion of these married same-sex attracted men and TG persons may complain of sexual dysfunction with their wife and may not know how to deal with the issues they face. Men with a bisexual orientation and MSM or TG persons living with HIV may have a dilemma with regard to whether or not to get married and whether or how to disclose their sexuality and/or HIV status before marriage. Some proportion of lesbians and bisexual women may be compelled or expected by their family members to get married to a man. Heterosexual spouses of sexual minority individuals may also require support in terms of how to deal with their situation, and take informed decisions.

h) **Need to impart adequate knowledge on family planning options for married MSM and TG persons:** Many married MSM and TG persons are largely unaware of the wide range of family planning options available for them and their spouses. Similar to heterosexual males, married MSM and TG persons do not want to undergo vasectomy due to a variety of reasons. Thus, it is important to educate married MSM and TG persons, just like heterosexual married men, about the need to take responsibility for family planning as well as remove any misconceptions about vasectomy.

In conclusion, very little disaggregated data is available on migrants, Dalit women, women with disabilities and the LGBTQI community in the public domain. Nevertheless, the available data highlights the lack of facilities and services for them and the rampant discrimination against these vulnerable communities.

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ANNEXURE

SDG-3 Indicators

3.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Indicator 3.1.1: Maternal mortality ratio

Indicator 3.1.2: Proportion of births attended by skilled health personnel

3.2. By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

Indicator 3.2.1: Under-five mortality rate

Indicator 3.2.2: Neonatal mortality rate

3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

Indicator 3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations

Indicator 3.3.2: Tuberculosis incidence per 1,000 population

Indicator 3.3.3: Malaria incidence per 1,000 population

Indicator 3.3.4: Hepatitis B incidence per 100,000 population

Indicator 3.3.5: Number of people requiring interventions against neglected tropical diseases

3.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

Indicator 3.4.2: Suicide mortality rate

3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders

Indicator 3.5.2: Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

3.6. By 2020, halve the number of global deaths and injuries from road traffic accidents

Indicator 3.6.1: Death rate due to road traffic injuries

3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs

Indicator 3.7.1: Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

Indicator 3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group

3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

Indicator 3.8.2: Number of people covered by health insurance or a public health system per 1,000 population

3.9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Indicator 3.9.1: Mortality rate attributed to household and ambient air pollution

Indicator 3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)

Indicator 3.9.3: Mortality rate attributed to unintentional poisoning

Data Driven Dialogues for Gender Equality and SDGs

Through this project, SAHAJ and EM2030 are set out to generate a policy dialogue for more encompassing, holistic and realistic state and national level plans for better implementation towards achieving the selected targets for girls and women. This work is going on in six selected states, viz., Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Punjab and at the national level.

One of the important objectives of the project is to increase political will and dialogue amongst key stakeholders, particularly government, on the importance of data and evidence-based implementation around selected targets from- Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 5 (Achieve gender equality and empower all women and girls).

Sahaj

towards alternatives in health and development

EQUAL MEASURES 2030