THE ROLE OF VOLUNTARY ORGANIZATIONS INTHE PROMOTION OF HEALTH AMONG THE UNDERPRIVILEGED WOMEN: A CASE STUDY OFSECUNDERABAD AND HYDERABAD

A THESIS SUBMITTED DURING 2021 TO THE UNIVERSITYOF HYDERABAD

IN PARTIAL FULFILMENT OF THE AWARD OF A Ph. D

DEGREE

IN

GENDER STUDIES

BY

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CERTIFICATE

This is to Certify that the thesis entitled **"The Role of Voluntary Organizations in the Promotion of Health among the Underprivileged Women: A Case Study of Secunderabad and Hyderabad"** submitted by **Chayadevi G.S.** bearing registration number **11CWPG04** in partial fulfilment of the requirements for the award of Doctor of Philosophy in Gender Studies, Centre for Women's Studies, School of Social Sciences is a bonafide work carried out by her under my supervision and guidance.

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Parts of this thesis have been:

A. Published in the following publications

1. G.S. Chayadevi and Bambah, Bindu A. (2017). AIDS Awareness Interventions for Women: The Role of Voluntary Organizations in the Secunderabad and Hyderabad Region of South-western India. *Journal of International Women's Studies*, 18(2), 233-246. ISSN Number 1539-8706, Chapter 5, https://vc.bridgew.edu/jiws/vol18/iss2/16.(International).

2. G.S.Chayadevi and Bindu. A. Bambah.(2016), "Health Education for Adolescent Girls: The Role of Voluntary Organizations", *Indian Journal of Women and Development*, Centre for Women Studies, SVU, Tirupati, ISSN 2231-3974.

3. G.S. Chayadevi, Bambah Bindu A., and Niumai A., (2021). Health Education for Adolescent Girls: The Role of Voluntary Organizations (in progress)

B. Presented in the following conferences:

1. Oral Paper presentation on "AIDS Awareness Interventions for Women: The Role of Voluntary Organizations in the Secunderabad and Hyderabad Region of South-western India" in the Second World Conference on Women's Studies, Colombo, Sri Lanka, 5-6 May 2015. **(International)**

2. Oral Paper presentation on "Role of VOs in the Promotion of Health among Underprivileged women; A Case study of Secunderabad." Women's Worlds Congress at University of Hyderabad, 2014. **(National)**

3. Poster Presentation: "The Role of Voluntary Organizations in the Promotion of Health among Underprivileged Women; A Case Study of Secunderabad and Hyderabad." Indian Association for the Study of Population XXXVI Annual Conference 7-9 November 2014, University of Kerala, 2014.

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6. Oral Presentation of "Health Education in a Gender perspective," at National Conference on 'Child abuse: Gender Disparity in the protection of girl children on 15-16 September 2015 at Bharathidasan University, Madurai.

7. Oral Presentation on "Health Education of Girls: the Role of Voluntary Organizations" at Conference on Empowering Adolescent Girls", RGNIYD, Prembadur, India.2016.

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Course Code	Name	Credits	Pass/Fail
GS801	Feminist Theories Research Methodologies	4	PASS
GS802	Pedagogy of Gender Studies	4	PASS
GS829	The Role of VOs in the Health among Women.	4	PASS

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Declaration

I hereby declare that this thesis entitled **"The Role of Voluntary Organisations in the Promotion of Health among the Underprivileged Women: A Case Study of Secunderabad and Hyderabad."** Submitted by me under the guidance and supervision of Prof. Bindu A. Bambah and co-supervisor, Prof. Ajailiu Niumai, is a bonafied research work that is also free from plagiarism. I also declare that it has not been submitted previously in part or entirely to this university or any other university or institution to award any degree or diploma.

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I Dedicate my thesis

To my Adorable Father

(Late) Shri Golconda Santosh Kumar

&

My Inspiring Mother

Smt Golconda Susheela

ACKNOWLEDGEMENTS

With heartfelt gratitude to my mentors, guides, and the driving force, I take the opportunity to acknowledge them. Everyone supported me in presenting this thesis. Primarily, my supervisor, Prof. Bindu A. Bambah, Ex-Dean, School of Physics, University of Hyderabad, empowered me under her esteem guidance for more than a decade. Despite various preoccupations, her dynamic perseverance and interdisciplinary approach to science and women's studies greatly influenced me as a researcher. This year collated with her retirement, and I am privileged to be the last PhD scholar of her lifetime intellectual experiences. I bow down to her precision and persistent conviction to achieve the highest degree in my thesis.

With her meticulous support, I could safely navigate research methods through my co-supervisor, Prof. Ajailiu Niumai, Head, Centre for Study of Social Exclusion and Inclusive Policy, University of Hyderabad. My sincere regards to her for teaching me in connecting the subtleties that made a strong point of research practice, intersectionality feminist theory and analyses. Her contribution is the lifeline to the investigation of women's health. My sincere regards to Prof. Rekha Pande, Faculty, Center for Women's Studies, University of Hyderabad, and presently the Director of 'Society for Empowerment Through Environment' Hyderabad. I convey my gratitude for inspiring me to visualize myself as a scholar and feminist. I take her blessings, and thanking heris an insufficient gesture.

Prof. K. Suneetha Rani, Head, Center for Women Studies, University of Hyderabad, had faith in my hard work and heartfelt thanks for supporting ideas and organizing. Next in line are the doctoral committee members of the Center for Women's Studies. Prof. Anitha Jagota, Head, Department of Animal Biology, University of Hyderabad, suggestions prompted my article publications and

conference presentations visible in the thesis, my regards to her. Prof. Deepa Srinivas, Faculty, Center for Women's Studies, University of Hyderabad, I am grateful for her support and re-trailing of my work. My thanks to administrative staff and academic fraternity globally and locally for motivating me, who were invisible unfailing sources of strength in shaping the research I completed.

I am indebted to the Voluntary organization's directors, staff, and respondents of Indian Red Cross Society, Telangana Branch, Hyderabad, Hopes of HIV Positives Efficiency Society, Hyderabad, Hyderabad Leprosy Control Health Society, and Manavatha Parivarthan Society for sparing their valuable time and team energies in sharing their life experiences in conceptualizing the study on women's health issues. I owe my regards to female sex workers, people living with HIV/AIDS, women in the reproductive phase, and school adolescents. 'Patient listening and 'meticulous interpretations' of their narratives were not just the words but the knowledge that pragmatically established the spine and structure of the less privileged women's health research. My heartfelt gratitude to the Interviewed and interactive sessions patient participation shown in gathering their daily life stories grappling with health issues.

I humbly acknowledge the efforts of Anveshi and Andhra Mahila Sabha, Deccan Development Society, Lepra India, APSACS, and other voluntary organizations that worked for women at the grass-root level have framed the hypothesis of the study at the initial stages of my research. I convey my special thanks to all the women and men who contributed to the core analyses of women's health concerns of Secunderabad and Hyderabad. I extend my sense of appreciation to the ethical committee of the University of Hyderabad, Prof. Geetha Vemuganti, School of Medical Sciences, the University of Hyderabad, for providing concerns and

consent in dealing with the living experiences of the research subjects because of the sensitive respondent's participation and investigation. I am also grateful to Mrs Shailaja, office staff, School of Physics, UoH, a trustworthy associate, for all the academic and timely support extended throughout my stay. My special thanks to Mr Prasad, office staff CWS, UoH, for technical support.

I was reborn at the library of the University of Hyderabad; staff and the source material are knowledge gamut aided me in connecting the fine dots for multidisciplinary approached study. I acknowledge the support of the University of Hyderabad I received throughout my M.Phil and Ph.D studies.

Here comes my family, the team leader Dr Satyanarayana Nadagoundla; my husband, a medical doctor, trickled out his knowledge, supporting my ambitious task in pursuing a Ph.D. Thank you for all the support in this regard, especially the endpoint re- reading and re-listening to my thesis drafts and making them presentable. Finally, gender consciousness-raising resonates with my daughter Dr Chitra Dasari and son-in- law Dr Chandrashekhar Dasari. From the bottom of my heart, I thank them for being with me in the ups and downs of the research period. My son Sushain Nadagoundla, daughter-in-law, Dr Kinnera Nadagoundla's cooperation is applaudable. Thanks to my mother, Smt. Golconda Susheela's constant support throughout my academic pursuits. My brother Dr Golconda Veda Kumar from Scotland, UK flying calls appreciated the timely reminder of my thesis completion. It's unjust if I don't mention my extended family and friends who kept the zeal flaring and kept me going; otherwise, it could have been an unmet task.

I am grateful for all the robust support and information I got at a click from GOOGLE, and digital technology was a boon in disguise for anything and everything I sort for clarity. It's incomplete if I don't acknowledge myself because I was born and identified as a woman. It's a motivation beyond my identity. Thus, the question emerged to explore the universe: Why should we live with a gendered lens that divides everyone, everywhere, and mistakes the core sense of our gendered lives.

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ABBREVIATIONS

AHSB	Adolescent Health Services Barriers
AIDS	Acquired Immunodeficiency syndrome
AIIMS	All India Institute of Medical Sciences
ANMs	Auxiliary Nurse and Midwives
ARSH	Adolescent Reproductive Sexual Health Programme
ART	Ant-Retro Viral Treatment
ASHA's	Accredited Social Health Activists
CS	Caesareans Sections
CSDH	Commission of Social Determinants of Health
CSE	Comprehensive Sexuality Education
CSE	Comprehensive Sexuality Education
FGDs	Focused Group Discussions
FLE	Family Life Education
GHMC	Greater Hyderabad Municipal Corporation in Telangana
HIV	Human immunodeficiency Virus
HLCHS	Hyderabad Leprosy Control Health Society
HOPE	Hopes for HIV/AIDS Positive People Efficiency
HRG	High-Risk Group
ICDC	Integrated Child Development Care
ICTC	Integrated Counseling Testing Centers
IRCS	Indian Red Cross Society
J SY	Janani Suraksha Yojana
MDGs	Millennium Development Goals
MEPMA	Mission for Poverty Elimination in Municipal Areas

NACO	National AIDS Control Organization
NGOs	Non- government Organization
NICU	Neonatal Intensive Care Units
NRHM	National Rural Health Mission
OBC	Other Backward Caste
RCHP	Reproduction Child Health Project
RMSA	Rashtriya Madhyamika Siksha Abhiyan
SC	Scheduled Caste Other Backward Caste
ST	Scheduled Tribe
STD	Sexually Transmitted Disease
STI	Sexually transmitted Infections
STRC	State Training and Resource Center
TSACS	Telangana State AIDS Control Society
TSRCS	Telangana State Red Cross Society
UN PF	United Nations Population Fund
UNAIDS	United Nations Programme on HIV / AIDS
UNESCO	United Nations Education, Scientific, and Cultural Organization
UPHC	Urban Primary Health Center
VOs	Voluntary Organizations
WHO	World Health Organization

GLOSSARY

Act. The term 'Act' refers to a bill that has been passed through various legislative stepsto become an enforced law.

Adolescent Phase. Adolescence is the phase of life between childhood andadulthood, from ages 10 to 19 years.

Agriculture Bonded Labour. Bonded labour is cultural, social, physical, psychological, and systematic exploitation against natural justice—their services for less pay or no pay in repaying the agriculture debts.

Biological determinism. Biological determinants can be all the individual characteristics of a person that have the natural background, including genetics, family predisposition, pathology, health status,

Caste. A caste is a social stratification characterized by hereditary lifestyle, occupation, and social status.

Case Study. A case study is an intensive investigation of one particular individual, group,organization, community, or setting.

Census. A census is a social survey of the total population of a given area that collects primary social data about the members of that population.

Characters. A distinctive feature or quality belonging typically to a person, place, or a thing and serving to identify them. The specifications are revealing and recognizable.

Class. Social science divides a society based on social and economic status, also referredto as a social class.

Class Inequities. Class inequity in sociological context focuses on a person's background defined by their parent's social class or economic status influence opportunities.

Commercialization. To organize activity around making a profit

Commodification. The exchange of goods and services that were once given through primary group ties through the market economy

Concepts. Concepts in the research process are the building blocks, formally and logically developed ideas such as formulating questions, hypotheses, and the applied theory for analyses.

Demographic dividend. A demographic dividend is an economic growth brought on bya change in the structure of a countries population.

Disadvantaged Sections. Disadvantaged sections are the communities and individuals who are socially marginalized, economically poor, and politically deprived who succumbto ill effects.

Disciplines. Disciplines are the various academic inquiries of different pursuits such as economics, philosophy, psychology, and linguistics.

Discrimination. Discrimination denies equal access to social resources to people based on group membership.

Double marginalization. Double marginalization is the effect of bias, prejudice at more than one level, such as socio-economically marginalized.

Empirical. Social data of facts that are based on systematic observation or measurement.

Endemic disease. An endemic disease is found regularly in specific regions and particular groups.

Epidemic. An epidemic is a disease that affects a large community of people in an area or various areas.

Epidemiology. Epidemiology is the study of biological, social, and economic factors associated with disease and health.

Epistemological perspective. Epistemological perspective is the framework in predicting, empowering, and deconstructing the issues related to restructured and reframed.

Ethnography. Ethnography is the detailed direct study of small groups of people or communities.

Feminism. Advocacy of social equality of sexes.

Feminist Point of View. Feminist point of is the feminist perspective aims to understandgender issues in terms of equality and prejudice.

Feminist Approach. The feminist approach is the dimension to access the existing knowledge from a different location of the situated study.

Focus Group Discussion. Focus Group Discussion involves gathering people from similar backgrounds or sharing their experiences on a similar situation and topics.

Foeticide. Foeticide is the destruction of the abortion of the fetus.

Formal Health System. The Formal health system is services provided by the health care providers, organizations, government institutions, policies, and finance mechanisms.

Gender. Socially defined behaviour is regarded as appropriate for the members of each sex.

Gender Equality. Gender equality is also known as gender egalitarianism, sexual equality condition to parity regardless of the individual gender. Gender equality addressesdifferent roles and statuses to individuals based on gender.

Gender gap. A political term refers to the gap between men and women on political attitudes and behavior.

Gender Issues. Gender Issues are issues related to gender as the main component in question.

Geo-political. Geopolitical is related to the political issues motivated in the realm of geography

Generalization. Generalization claims that a specific observation will apply to the broader population.

Globalization. Globalization is the development of extensive worldwide economic, social, or political relationships between nations.

Health Education. Health Education comprises consciously constructed opportunities for learning involving some sort of communication designed to health literacy. Including improving knowledge and developing life skills conducive to individual or community health.

Healthy Sex Life. Healthy Sex Life interacts with physical, emotional, mental health, and overall well-being.

Hegemony. Hegemony practices domination, supremacy, and power on the weaker or less privileged.

High-Risk Group. High-Risk groups or communities are essential in understanding the epidemic epicentres communities. They can provide avenues for infected and non- infected populations.

HIV. Human Immunodeficiency Virus is a virus that attacks the body's immune system.

Hypothesis. The hypothesis is a tentative statement about a given state of affairs that predicts a relationship between the variables usually put forward as the basis of empiricaltesting.

Inclusion Policy. The inclusive policy is drafted to keep every aspect of development unbiased caste, creed, law, justice, education, economy, etc.

Indian Trust Act. Indian Trust Act is the law India related to private trust and trustees. Indian law defines them.

Indicator of Development. Indicators measure the development in education, health, economy, employment, or any other element for analyzing how developed a country or asystem is.

Infanticide. Infanticide kills or eliminates an infant for various health and other reasons.

Institutionalization. Institutionalization is the process of locating a person, a social group, an event, or an academic subject within an institutional context.

Intersectional lens. The intersectionality lens acknowledges that everyone has unique experiences of discrimination and oppression—considering anything and everything that discriminates.

Intersectional Theory. Intersectionality theory is an analytical framework in understanding how aspects of persons social, economic, and political identities combinedto create discrimination and privilege.

Inter-subjectivity. Inter-subjectivity is the knowledge of the empirical sources that are shared and agreed upon.

Jogini system. Jogini system is sexual exploitation of young girls to sexual slavery as a custom and ritual in Telangana and Andhra Pradesh.

Liberal Feminism. Liberal in the context of feminism is mainstream feminism defined by a focus on achieving gender equality through political and social reform in a liberal democratic way.

Lifestyle changes. Often called for when chronic treating disease. Rather than curing the disease, the patient makes changes in lifestyle (nutrition, exercise, weight reduction, elevating stress, adapt present moving fashion).

Marginalized. A group of people who are treated insignificantly and even alienated

Migration. Migration is the movement of people from one region to another to live or search for livelihood.

Migrant Population. The migrant population is one crucial study of people. Migration is due to social, economic, and political reasons.

Minority group. The minority is a group of people defined based on their ethnicity or race, because of their distinct physical and cultural characteristics, is singled out for unequal treatment in society.

Mortality Rate. Mortality Rate is the number of deaths accrued in a given period and related issues.

Muslim. Muslim is a religious minority community in Hyderabad and India, holding 10.9% of the world's population.

Need-Based Intervention. Need-based interventions are the activities set by the VO for the benefit of locals, and the requirement demanded in the context and situation.

Neoliberal globalization. Neo-liberal globalization restated new policies imply political and economic relaxations to the effect of global trends. It leads to limit government spending and interference in financial issues of individuals and society—growing interdependence of economies, cultures, and populations globally.

Oppression. Oppression is power exercised by an authority that controls the less potent in burdensome, cruel, unjust, or unfair ways.

Parda Nishin. Parda Nishin in the Urdu language means the one who abides by exposingthemselves in public. Women who observed rigid rules of seclusion.

Paradigm shift. The term paradigm means exemplar: it has been used in the philosophy of science to refer to a particular thesis about the nature and development of scientific knowledge and linguistics to refer to relationships between signs.

Power. Power shows in its social and political manifestation. Management refers to influencing, directing, or controlling people's behavior.

Primary data. Primary research involves the researcher's first-hand collection or generating new (preliminary) data.

Pro-sex Feminist. Pro-sex feminist is similar to liberal ideology accepting sex work as labour work and expecting remuneration in return.

Psycho-cultural. Psycho- cultural is related to the interaction of an individual's psychological and cultural perspectives.

Psychology. Psychology studies the human mind and its various implications in doing original and natural aspects.

Purposive sampling. Purposive sampling is a form of non-probability sampling in whichresearchers rely on their judgment when choosing members of the population to participate in the survey.

Qualitative. Qualitative research primarily relies on gathering detailed evidence of social processes, activities, and events rather than measuring or enumerating social phenomena.

Questionnaire. A questionnaire is a structured means of posing a standardized set of consistent predetermined questions in a given order to respondents.

Radical Feminism. Radical Feminism is part of the feminist approach that calls for a radical reordering of society in which male supremacy is eliminated in all social and economic contexts.

Rationality. Rationality is based on logic and reasoning. A mental state characterized by the coherent thought process is goal-oriented and based on the cost-benefit evaluation.

Religious impositions. Religious impositions are the obligations related to the religion

Reproduction Health Care. Reproductive health care deals with the issues related to reproduction, contraception, and immunization.

Research design. Research design with the overall logic and strategy of the research methods of a particular study

Research methods. Diverse strategies are used to gather empirical material systematically.

Scheduled Caste & Scheduled Tribe. SC&STs are depressed and also oppressed socially, economically, and politically. They are officially designated and recognized groups of people by the constitution of India.

Secondary Data. Secondary data (sometimes referred to as sensitive data) is not directly collected by the researcher but is initially collected or produced for other purposes.

Sex. The biological categories of females and males.

Sex ratio. Sex Ratio is the ratio of males and females in a population. World population estimates 101 males to 100 females (2021 est.)

Socio-economic. Socio-economic states the social representation and economic class apply to understanding living standards.

Stereotype. The stereotype is a rigid and flexible image that characterizes a group. Stereotypes attribute these characters to all individuals belonging to that group.

Stigma. A symbol of disgrace that affects a person's social identity. A negative social label.

Stratification. The existence of structured inequalities in life chances between groups in society.

Sampling. Sampling is the process of selecting several items or individuals from a widergroup or population (via the sampling frame).

Semi-structured. Semi-structured is a questionnaire that can be remade, adding or deleted based on the living situations and their responses**.** It is always done in the initial stage of the particular study.

Sexual Health care. Sexual health care takes care of the health-related to sexuality, activity, and socio-psychological implications for overall well-being.

Sexual Education. Sexual Education is always taught in a programmed intervention or curriculum based in educational institutions.

Sharia Law. Sharia Law is an Islamic legal system derived from Quran.

Socialistic Pattern of Surplus. The socialistic Pattern of the surplus is that comprehensive economic plan accepted by the community in the developmental pattern—not for private profit but social gain. The abundance in the process is notsustainable.

Structure. The structure is a complex set of interrelated elements.

Subjectivity. Subjective is due to the consciousness or thinking of a subject to be perceived.

Subjugation. Subjugation is to suppress or deprive by imposing power by all means.

Surveillance. Surveillance is monitoring the activities of others to ensure compliance behavior. Modern surveillance techniques include cameras and microphones, and a whole range of computer surveillance is available.

Telangana. Telangana was the 23rd newly formed State in 2014 and the 11th largest state in India. It has 33 districts, and Hyderabad is the state's capital.

Underprivileged. Underprivileged are deprived or less privileged in social, economic, and political status.

Unsafe Sex. Unsafe sex involves sex without protection for further consequences like pregnancy or sexually transmitted disease**.**

Women Empowerment. Women empowerment is gaining autonomy in exercising her rights uninterruptedly or not influenced by others such as family, government, or anythingthat curtails her progress.

Zenana Hospital. Zenana hospital is the first exclusive women's hospital in the region of Hyderabad, and it's now a heritage structure as old as the history and formation of Hyderabad.

The Role of Voluntary Organizations in the Promotion of Health among the Underprivileged Women: A Case Study of Secunderabad and Hyderabad

Chapter 1

1. Introduction

1.1 Background and Scope of Study

From a global developmental perspective, the health of women and girls is a critical indicator of development (WHO 2015). We investigate these growth indicators from an Indian perspective with a similar lens. Although public health is primarily a governmental issue, voluntary organizations play a crucial role in shaping and implementing social-economic inclusion policies. This thesis aims to identify the part played and the success of voluntary organizations in rendering health services to the underprivileged women in the twin cities of Secunderabad and Hyderabad in the Telangana state of India. We aim to study and gauge their efficacy in disseminating bias-free consultation in three areas: **Reproductive health care, Adolescent health, and Sexual health education and disease prevention (in particular, HIVAIDS).**

The UN General Assembly recognized the respect for the significant role of the voluntary organizations in its 52nd session, which proclaimed 2001 as the year of volunteers (UN, 2001). In the same year (2001), the Millennium Development Goals for the decade 2005-2015 were proposed to address world hunger, gender equality, and reducing child mortality. After the MDGs expiry period, the focus was to build a sustainable world with equally valued social inclusion and economic development. Thus, this led to 17

Sustainable Development Goals (SDGs 2015-2030). **Goal 3 was "to ensure healthy lives and promote wellbeing for all at all ages" Goal 4 "To ensure inclusive, equitable quality education and promote lifelong learning opportunities for all." Goal 5 was "to achieve gender equality and empower all women and girls."**

According to the WHO Report, 2018, sexual and reproductive health problems are responsible for one-third of the health issues for women between the ages of 15 to 44 years. Unsafe sex is a significant risk factor, particularly among women and girls in developing countries (WHO2018).

Voluntary organizations in the health movement have been instrumental in caring for disadvantaged sections for whom governmental efforts are also marginal. Voluntary organizations have actively promoted sensitivity to gender-related issues among underprivileged women. This area was not adequately addressed by governmental public health initiatives in the 20th century (Sharma, 1996). In the last two decades, voluntary agencies and Non-Government Organizations (NGOs) in welfare and developmental activities have increased, especially in India. However, information on voluntary and community organizations regarding women's health interventions receives minimal attention in Telangana State. Governmental efforts alone are not enough to achieve overall development, particularly in a social setting where most people are poverty-stricken or underprivileged by economic or social norms or stereotyped gender roles. The constitutional obligations of establishing the socialistic society with planned economic growth steers to a more significant intervention of the state's health care system. Women's development

is now becoming a strategy for redefining development locally and nationally.

In this research work, we study the role of Voluntary Organizations(VOs) in disseminating health awareness to underprivileged groups in the Hyderabad and Secunderabad regions. We focus on maternity and reproductive health, adolescent health, and sexual health to prevent AIDS/ HIV among sex workers. We do a three-pronged study in our research. The three prongs, which use an intersectional feminist approach and measure the impacts of VOs interventions, are:

1. To understand how the voluntary sector implements the SDGs regarding women's health. To examine how the voluntary sector reaches out to women left out of the formal health system (such as the Government). We also seek to understand how women contribute to the volunteer sector in convergence with governments existing activities.
2. To understand how the unorganized sex workers sector can avail voluntary organizations for information and prevention of Sexually Transmitted Diseases. To know how thriving the voluntary sector has been in AIDS prevention and theproblems faced are.
3. To understand how sex education classes sponsored by the voluntary sector supplement government initiatives empower young girls to view their health and know about the care of their bodies.

India's tradition of voluntary action is deep-rooted in its culture and value systems. Eventually, charity and sharing the surplus with others are institutionalized as social service, often engulfed with religious institutions. The Independence and the post-independence era required a paradigm shift in social

mobilization. Multidisciplinary multi-sectoral participation recognized the shared vision of public, private, and voluntary partnership. A crucial role is played by voluntary organizations in the emancipator activities involving community participation in implementing government policies and general welfare activities. Health and women are the most sought-after interventions in the realm of the voluntary sector. Despite diversified names, forms, and characters, India acknowledges the organizations and societies registered under the societies registration act of 1860, followed by the Indian trust act 1882. Under section 25 of the company act, 1956, any charitable association is considered a Voluntary Organization or a Non-Government Organizations.

In her paper 'The History of Feminism and Doing Gender in India,' Pande R. points out that in post-independence India's twentieth century, "Gender issues subsumed in poverty-related concerns, and there were no such specific programs aimed at women" (Pande R., 2018). However, in the twenty-first century, the growth of the women's movement, through VOs and NGO's interventions, has taken up many "women-centric" issues such as dowry, women's work, women's health, and Dalit women and marginalized women's rights.

While NGOs were initially a gesture of philanthropy, volunteerism has evolved into a multifaceted domain. The policy, programs, and assistance are designed by the Voluntary Health Association of India (VHAI 2001), 'The Volunteerism and Government' Manoranjan Mohanty and Anil. K. Singh provides detailed insights into India's volunteerism, the changing trends and roles of VOs, diversities in their nature, and the constraints they face (Mohanty,

Singh,2001). The book also focuses on the Government's role in the voluntary efforts, VOs - government relationships, government policies towards the VOs, programs, and the assistance provided to them by various departments and ministries of India. International, national and local agencies, Government and non-government, and other groups, institutions, and individuals deal with social action in volunteerism and further research and provide progressive recommendations. The book has changed the research dynamics of VOs knowledge in the research context.

In a seminal empirical study of public health initiatives through the philanthropy of the Indian diaspora of the United States of America, Niumai A maps NGOs that promote public health in India and America (Niumai A., 2014). She uses intersectionality theory to untangle the invisible relationships between philanthropy and the beneficiaries. She discusses and analyses the trends by which diaspora give back to their villages and towns, looking back to the traditional concerns of family, kinship, castes, and religious sentiments. Eventually, projects were implemented to serve India's needy and the most underprivileged communities. The intersectional lens through which Niumai A examines this philanthropy of the Indian American diaspora serves as a guideline for our study.

1.2 Setting the Scene for our study

In the context of this work, we look at the voluntary organizations that disseminate health services to the underprivileged women in the Hyderabad – Secunderabad twin cities. For this work, the disadvantaged category is defined

as the economic status of the poor in June 2011, placed provincially at Rs 965 (Rs 32 per day) per month in urban areas.

According to the national census, in the research context, by socially underprivileged, we mean marginalized people of the scheduled caste and scheduled tribes. Underprivileged culturally refers to minority Muslim women from the old city of Hyderabad, where Sharia[1] laws are prevailing. Telangana is part of the erstwhile Hyderabad state of Nizam, where the feudal system impacted the ordinary people's lives through religious imposition, language adaptation, and agriculture bonded labour. Even though the demography indicates Muslim rulers were minority rulers, Hindus generated a unique niche among socio-political and economic turmoil. Thus, both Hindus and Muslims are doubly and triply affected by the patriarchal system. These effects epitomize the present structural, material, and psychological domains. The underprivileged sample studied and examined in this work are the slum dwellers whose income is below Rs.3000 per month. According to economic reports and policies, the definition of the disadvantaged is discussed further.

1 . Sharia law is an Islamic law depicted in Quran

Women's health is miserable in the underprivileged section because they are marginalized economically and socio-politically. They are also deprived because of the religious implications. The research demography includes beneficiaries, project implementers, and donors with a sample size of 30 in each voluntary organization examined. School children, staff, and the voluntary organization and their target interventions moulded sample size for health data.

Research analysis tools included statistical analyses, case studies, and secondary data to assess the connection between class inequities, gender relations, and social inequalities. Empirical sources such as questionnaires are the most supportive preliminary knowledge in understanding women's health. We framed and structured questions relevant to the particular voluntary organization for a purposive questionnaire. Analyzing the problem from an intersectional perspective is relevant in understanding the challenges and finding remedial measures. There are limitations of the quantitative and qualitative methods adopted. However, using primary and secondary sources and case studies gave a practical knowledge of how voluntary organizations play a significant role in implementing welfare programs to less privileged women.

1.3 Women's Health Issues from a Feminist Intersectionality Perspective

To achieve an efficient study, we combine a feminist approach concerned with equity and an intersectional viewpoint. Feminist epistemology explores how gender does and ought to influence our conceptions of knowledge.

Intersectionality theory shows how social and political discrimination aspects, such as caste, class, and exclusion, overlap (intersect) with gender. The feminist approach examines women's health and the connections between genders, health, and health inequalities. Kimberly Crenshaw introduced intersectionality theory in 1989. As she explains it, the way we imagine discrimination or disempowerment is often more complicated for people subjected to multiple forms of exclusion(Crenshaw1989).

Gender equality refers to equal chances or opportunities for women and men to access and control social, economic, and political resources. It means good visibility, empowerment, responsibility, and participation for women and men in all spheres of public and private life. Health Inequalities are the disparities in the health care context given to the people who may differ in gender, caste, and class. Health inequity is an experience about justice, politics, and health issues. Health in a broader spectrum involves awareness, prevention, and implementation of policies designed to deal with public health and the welfare of the people. The core functional aspects of health are categorized as promoting health, monitoring health situations, planning and implementing the designed policies, prevention, and reducing emergencies on health issues. Health inequity and gender equity have a symbiotic relationship illuminated in the discussion and the analyses of each health issue represented in further chapters.

1.4 Situating the Study

The study concentrates on the Hyderabad / Secunderabad area in India. According to the world population review 2021, Hyderabad district urban 2021 population is estimated at 10,268,653. The twin cities Secunderabad and Hyderabad are located in the Deccan Terrain in Telangana. Comprising a sex ratio of 988 females per 1000 males, overall, 6.03% of the district population belongs to Scheduled Castes[1] (SC), and 1.02% belongs to Scheduled Tribes[2] (ST). Hyderabad has a district hospital, eight community centres, three area hospitals, 85 PHCs, 53 health sub-centres, and a few private medical institutions (World population review 2021).

According to the state-based ministry of health statistics, there is a floating population in and around the twin cities, making them vulnerable and prone to HIV/AIDS (India Heath Action Trust 2010). 13% of the people of Hyderabad live below the poverty line. There are 1,476 slums in Hyderabad, with at least 1.7 million. Nearly one-quarter of the slum-dwellers came from other parts of India in the 1990s, with at least 63% living in slums for at least a decade. Around 30% of the slums have essential services, while others depend on general public benefits from the Government. (Census,2011).

1&2. SC/ST –Scheduled Caste and Scheduled tribes are the categories represented in the constitution of India. Articles 341 and 342 of the Constitution of India define who be scheduled castes and scheduled tribes concerning any state or Union Territory the groups considered to be emancipated and enhance their economic and social standard, providing all means of support towards equality. "The state will promote with special care the educational and economic interests of the weaker section and, in particular of the scheduled caste and scheduled tribes shall protect them from social injustice and all forms of exploitation." It is one of the Directive Principles of the state policy in the Constitution of India.
The State government provides caste, income, profession, and education column recognized pro forma in the records of the urban primary health centers.

Our data is obtained from voluntary organizations, administrative centres, clinics, and health centres. The VOs in this area are explained in detail while applying a purposive/ criterion sampling method. The focal points are maternity health, vaccination, antenatal & neonatal care, nutrition, child care, immunization, hygiene, and preventive medicine for sex workers provided by the voluntary organizations to the underprivileged. In addition to these, we study voluntary organizations involved in disseminating knowledge and services in awareness and prevention of sexually transmitted diseases HIV/AIDS. One of the VOs giving health education to girls in the adolescent phase is also included. The questionnaires are unstructured, where open-ended questions are used related to the health issues, and semi-structured open-ended and close-ended questions are used based on the selected groups focused on discussions and interviews. Secondary sources are annual reports, records, registers, and monthly reviews. We then carry out an empirical study, analyses, and critical inferences to theorize the women's health issues and see the implications of promotion, prevention, and medication imparted by the VOs and their impact. The voluntary organizations working on women's health chosen are the **Indian Red Cross Society (IRCS), Hopes of HIV positive People Efficiency Society (HOPES), Hyderabad Leprosy Control Health Society (HLCHS), and Manavatha Parivarthan Society.** These voluntary organizations are outsourced by government organizations such as Andhra Pradesh State AIDS Control Society(APSACS) presently Telangana State AIDS Control Society (TSACS) to carry out welfare activities designed for the advantage of the underprivileged communities.

A brief description of each of these voluntary organizations considered for the study is given.

1.5 Indian Red Cross Society, Telangana State Branch, (IRCS, TSB)

International Red Cross Society is the first International Voluntary humanitarian organization initiated universally for mitigating war injuries in the 18th century by Henry Durant (Henry Durant 1828-1910). Indian Red Cross Society has 700 branches throughout India. IRCS AP (Indian Red Cross Society of Andhra Pradesh) was officially established in the 1950s, though their activities were initiated much earlier in the 1920s before the formation of Andhra Pradesh. DR. Paul Doss, Red Cross Maternity and Family Welfare Center, Ranigunj, Secunderabad, was a parallel organization initiated. We focus on this centre for this research study from among the IRCS four functioning health centres in Hyderabad and Secunderabad. This health centre was established in the 1920s in an 80+ year heritage building with few renovations made in 1982 and 1995. This centre effectively rendered services for approximately 70 years. It is an "Urban Primary Health Center and Maternity Center" covering 5 to 8 km from the centre. Primary services have expanded to encompass maternal and child health, family welfare, and nutrition.

1.6 Hyderabad Leprosy Control Health Society (HLCHS)

The erstwhile HLCHS (Hyderabad Leprosy Control Health Society) has been outsourced by APSACS (Andhra Pradesh State AIDS Control Society), philanthropists in the old city of Hyderabad were a few started HLCHS. The initial focus was Leprosy interventions in the coordination of Lepra India in 1989 when various diseases like leprosy, tuberculosis, and infectious virus were

at their peak. A recorded decrease in the leprosy disease rate made them shift the interventions to HIV/AIDS with a catchment area of 35000 migrant population. APSAC and TSACS provide a list of sites at risk, vulnerable HRG's (High-Risk Groups), who are 3000 female sex workers(FSW) registered under HLCHS.

1.7 Hopes of HIV Positive People Efficiency Society (HOPES)

HOPES is an organization started by a group of seven HIV/AIDS positive members, with a mission to spread awareness of the virus, educate people to lead a healthy sex life, advocacy and prevent the spread of HIV/AIDS in Hyderabad District.

1.8 Manavatha Parivarthan Society

This voluntary organization was initiated in 2002 to serve underprivileged women's health and girls' health education. Its interventions are need-based. It conducts training sessions, facilitates lectures, and focuses group discussions on health education. Schoolgirls and women in colleges are the target groups. These help girls and women to gain knowledge of their bodies. It also does psychological counselling to understand the behaviour patterns of adolescent females.

1.9 STRUCTURE OF THE THESIS

The thesis is designed into seven chapters. Chapter 1 **Introduction**, Chapter 2 **Research Methodology,** Chapter 3 **Reproductive Health Care, A Case Study of Hyderabad and Secunderabad,** and Chapter 4 **Adolescent Health Care and the Impact of Health Education Interventions.** Chapter 5 **Sexual Health Care and HIV/AIDS Awareness of Female Sex Care Workers** Finally, we **Conclude** in Chapter 6, followed by the **Bibliography and Annexures**.

1.10 Conclusion

Can we survive without organizational skills in the present era of technological advancements? It is a question universally addressed in all walks of life. We organize every phase in groups, communities, and societies in institutional or voluntary associations. The role of voluntary organizations thrusts various attributes such as socio-economic development, geopolitical administration, and psycho-cultural ethos in local, national, and international perspectives. Hyderabad and Secunderabad face an influx of immense floating population growth. This growth proportionately impacts the Government and private sectors, which have insufficient resources in coping with the requirements of these cosmopolitan twin cities. The need for third sector intervention is inevitable and pertinent to the growing needs of society and the Government to address issues such as health, education, unemployment, poverty, migration, and overpopulation. Liberal, flexible, and democratic attitudes promote sustainable solutions to India's urban and rural populations

and the need-based emergencies. Therefore, voluntary organizations are the dynamic force initiating the unexplored avenues of progress among less privileged women and girls' health, with viable means and successful approaches. The present research is motivated with a specific purpose to study the health of underprivileged women through the motivated participation of voluntary organizations.

Public health departments thrive on voluntary organizations that can also make the language of social activism more relevant and understandable at the grassroots level. Voluntary organizations play a crucial role in implementing health interventions by placing persistent issues in easy-to-understand and finding real-world solutions, definitely relating to the adversities. To make the services reach the least fortunate, we need the support of the people. One of the most active people here are the staff and the peer educators, who live in the same communities. All community-based programs need volunteers to support their ideas, spread out the activities, and engage in result-oriented activities. Volunteering for a social cause can help reduce alienation and powerlessness among individuals from varying cultures and socioeconomic backgrounds, particularly women. In the process, strengthen social cohesion within the local communities.

Health awareness is essential to all age groups; vulnerability is prevalent in all age groups. According to the statistical data, women are more prone to disease in many ways. Reproductive disorders apart, many other health

issues affect women throughout their life. 80% of adolescent girl children are frail and susceptible to sexually transmitted disease due to lack of awareness, health education, and poor sanitation. Therefore, there is ample scope for women's health concerns to be addressed systematically as any other epidemic and endemic disease. The three health issues examined in this thesis are interrelated and connected to the life cycle approach.

In summary, the objectives of the study are;

1. To understand how the voluntary sector implements the UN SDGs regarding women's health and gender equality.
2. To see how the voluntary sector reaches out to women left out of the formal health system (such as the Government)
3. To know and understand how women contribute to the volunteer sector in convergence with governments existing activities.
4. To understand how young girls view their health and how much they know about the care of their bodies.
5. To see how the voluntary organizations provide AIDS awareness, information, and preventive measures to the marginalized sex workers community.

Chapter 2

Research Methodology

2.1 Introduction

The study's primary focus is to examine the women's health issues provided by the Voluntary Organizations(VOs). Therefore, interventions of VOs are discussed in this study. This study employs focus group discussions, case studies, and individual interviews with the selected respondents. It's observed that women's health issues have taken a paradigm shift from reproduction health to holistic health care with gender inclusiveness. The four VOs included in the study are Telangana Red Cross Society (TRCS), Hyderabad Leprosy Control Society (HLCHS), Hopes of HIV Positive People Efficiency Society (HOPES), and Manavatha Parivarthan Society.

Though this study emphasizes the qualitative method, quantitative methods are also employed. Intersectionality theory (Kimberley Crenshaw 1989) also acted as a device or an instrument to understand the matrices of the relationship between the women as marginalized and VOs as the facilitators to empower women. The intersection of the marginalized women with gender, caste, class, and religion concerning health care is examined in chapters 3,4 and 5.

2.2 Sources of the Data Collection

This study has used secondary and primary sources. The primary sources include observation, Focus Group Discussion, interviews, and case studies with

the selected voluntary organization's staff, founders/ presidents/ chairpersons, and the beneficiaries. In most cases, meetings with the VOs team and the recipients were concluded in 45 minutes. Additionally, we completed the Focus Group Discussion with the respondents in two hours. The case studies of 30 beneficiaries were unwavering and took around six months. Secondary sources comprise unpublished documents from the VOs, newspapers, websites, internet sources, articles, books, anecdotal information, and census reports. **Field sites are situated in Himayat Nagar (Hyderabad), Ranigunj (Secunderabad), Bowenpally (Secunderabad), Zamistanpur (Secunderabad), Masab Tank (Hyderabad), Gaddiannaram (Hyderabad), Padmarao Nagar (Secunderabad), Charminar (Hyderabad). Abids (Hyderabad), Panjagutta (Hyderabad), Begumpet (Hyderabad), Marredpally (Secunderabad), OsmaniaGeneral Hospital (Hyderabad), Gandhi Hospital (Secunderabad)**

2.3 Tools of Research

Mixed methods have been used in the study since we attempt both qualitative and quantitative analyses to understand the VOs and their interventions in women's health care. The ethnographic method is a qualitative analysis adopted in the study. Ethnographic approaches focus on the respondents' 'lived experiences' and understand the colloquial words and their implications. I employed the following procedure:

1. I observed the respondents and the selected VOs for around one month. Then I have chosen the four VOs based on the criteria that focus on underprivileged women and girls, education, and poor socioeconomic conditions. These four VOs are categorized into local, national, and international VOs. By disadvantaged, we mean they either live under the poverty line or are marginalized by minority religion, caste, and class. It is detailed in the discussion of the specific chapters.
2. The case studies with their health issues have highlighted the experiences the stories of their experiences of the marginalized. The confidentiality of conducting academic research was conveyed to all the respondents to express their opinions to the researcher. VOs staff initially interviewed because they have been working on women's health.
3. Eventually, the ethnographic approach provided the researcher with a new way of generating knowledge of ordinary women's health issues.

2.4 Pilot Study

In Aug 2015, I prepared content based on the hypotheses, research questions. A pilot study was conducted in June 2016 in Hyderabad and Secunderabad among 25 respondents. After testing the questionnaire in the pilot study, I made the changes and revised the questionnaire in consultation with my supervisor and co-supervisor. Finally, I interviewed respondents who could not speak English or Hindi fluently. I used a field notebook to write my observations and responses from people as an ethnographer. I also used a digital camera to capture the visuals of my respondents' everyday lives in Hyderabad and Secunderabad. I did not use a voice recorder during the fieldwork. This pilot study exposed women's reproductive and sexual health and vulnerabilities.

2.5 Sampling Method

Underprivileged women are the target population of the study. Purposively selected VOs and their beneficiaries as the sample of the research study. The sample methods applied are purposive sampling with non-probability sampling, where the respondents were chosen according to the specific VOs instructions. The VOs selected criteria for rendering their services for three particular women's health issues. The sample for the study was done according to the purpose of the study.

In ethnography, the primary strategy is a purposive sampling of vital informants most knowledgeable about the subjects. A practical model developed detailed information of the participants/sample to find the appropriate solutions. The purposive selection allows us to understand the social life, relationships, and side-lining in the local settings. The rapport with the target groups is most necessary. The most commonly used data collection methods are participant observation, face-to-face in-depth interviews, and focus group discussions.

The essence of ethnography is different narrative findings, a detailed description of the lived experiences, and a specific summary description. Purposive sampling gives us information from small samples which depend on the characteristics of the setting for instant access. Further, the study model is appropriately supplemented by a statistical representation of the collected data.

I got access to interview the respondent through the selected VOs for the focus group discussion. VOs have helped me organize beneficiaries ranging from 20 people. Based on the response of the beneficiaries, I have conducted 9 FGD. The moderator has written down a field note to understand the target women's voices, experiences, and challenges. The researcher interacted with the respondents in the ethnographic method and attempted to understand their everyday lives and environment. The technique followed by participant observation and individual interviews among the respondents is understanding how they treat their bodies and perceive reproductive and sexual health.

2.6 The Sample Size of the Study

Three broad respondents were interviewed in selected localities Raniginj, Peerzadeguda, Warasiguda, Bowinpally, Gaddiannaram, MasabTank, Charminar, Bansilalpet, Padmaraonagar, Gandhi Hospital, Osmania Hospital in Hyderabad and Secunderabad from August 2015- till Feb 2017.

At the beginning of the study, no fixed sample size was decided. Igradually interviewed 67 VOs staff, 95 women (sex workers, pregnant women, women with sexual health problems, women for birth control, people living with HIV/AIDS, and adolescents). One hundred sixty-two interviews were collected from the respondents spanning two years from Oct 2015 to Feb 2017.

2.7 Unit of Analyses

The units of analyses in this study are 286, out of which 90 comprised sex workers & women in the reproductive phase, VOs staff and people living with HIV, 185 students and 11teachers from 25 schools in the age group of 12 to 55 years old, including boys and men, girls and women, residing in Hyderabad and Secunderabad.

The selected VOs are Telangana Red Cross Society, Hyderabad Leprosy Control Society (HLCHS), Hopes of HIV Positive People Efficiency Society (HOPES), and Manavatha Parivarthan Society. And the selected 25 schools are Secunderabad Girls and Boys High Schools (6), Picket Girls High School, Bhavans Sri Ramakrishna Vidyalaya, Masab Tank Red Cross Girls High School, Mahaboob College School, Centenary Govt School, St. Mary's School, St. Francis Girls High School and College, St. Anna's High School, Govt. Boys and Girls High School, Station Road, Govt High School, Gun rock, Bansilalpet Govt. Girls High School, Govt boys, Girls High School, Station Road, Keys High school, St. Marks High School, Govt Boys High School, Kawadiguda, Govt Girls High school, Kawadiguda, Girls High School, Market street. These schools comprise both private and Government schools for underprivileged children. Adolescent children and the disadvantaged community are the main focus of the study. Accordingly, I have selected these schools since most are adolescents from underprivileged backgrounds.

The respondents have been selected based on the purposive sampling method, focus group discussion with students, teacher interviews, and case studies. I conducted a focus group discussion in 15 schools. Discussions focused on the students' awareness of adolescent health issues. Similarly, I asked the teachers whether they teach health-related matters in the classroom. Similarly, after the 4 FDGs in other organizations, I collected the respondents' and staff interviews. While interviewing, I wrote down all the respondents' responses, compiled my field notes and observation, and then transcribed it. I used the excel sheet and manually fed the data collected from 286 respondents, which we tabulated and reported in percentages and analyzed. The voices, observations, and viewpoints of the respondents were my dependent variable. The data was from a feminist inter sectionalist theoretical framework of six case studies of the sex workers, reproductive health issues, HIV/AIDS positives. Group interviews and discussions supplemented this. The identity of my respondents is protected by using synonyms. The data collected from 286 respondents have been analyzed by considering their experiences and viewpoints during interviews.

2.8 Field Work Experience

Firstly, I obtained information about various VOs in the twin cities working on women's reproductive health care, adolescent health care, and sexual health care. I shortlisted three VOs rigorously working on the earlier

issues and have a track record. I contacted the VOs through phone and email, communicating my study's objective and arranging to interview them. I also consulted the websites and read the reviews of these VOs Scheduling the time and date to interview the VOs staff, and the women respondents were complicated because some did not respond promptly. Some were preoccupied with their duty and could not give me time to meet them. Therefore, I had to reschedule the date and times of the interview often rescheduled due to their tight schedules. When I reached the VOs staff and the women beneficiaries, I highlighted the objective of my study, stating that the study is to fulfill the thesis submitted for the Doctor of philosophy award requirement in the Centre forWomen's Study of the University of Hyderabad.

I informed the VOs staff about conducting the interviews, and they provided the selective respondents in a limited time frame. I did an individual meeting with the help of the structured questionnaire. The first interview was held from October 15, 2015, to January 16, 2016, in which I interviewed 12 VO staff of the International Red Cross Society in Secunderabad. I interviewed the next VO was HLCHS (Hyderabad Leprosy Control Health Society). Eight staff were interviewed from January 20, 2016, to October 15, 2016, and the third VO viz HOPES (Hopes of HIV positive People Efficiency Society) 20 staff from Nov 2016 to Feb 2017. Twenty schools visited were Secunderabad Girls and Boys High Schools (6), Picket Girls High School, Bhavans Sri Ramakrishna

Vidyalaya, Masab Tank Red Cross Girls High School, Mahaboob College High School, Centenary Govt School for boys and girls, St. Mary's School, St. Francis Girls High School and College, St. Anna's High School, Govt. Boys and Girls High School, Station Road, Govt High School, Gun rock, Bansilalpet Govt. Girls High School, Govt boys, Girls High School, Station Road, Keys High school, St. Marks High School. Five colleges were Siddhanti co-ed College of Education, St Francis College for Girls, Bharathi College, Kasturba Gandhi College, Bhavan's Intermediate College visited in obtaining the appointment to conduct focus group discussions and the pilot intervention of the Manavatha Parivarthan Society from Mar 2017 to Nov 2017. Locations visited are situated at a range of 5kms to 30kms in twin cities.

These three VOs staff identified 97 beneficiaries (women) for me to interview. Accordingly, I conducted individual interviews using a structured questionnaire and 30 case studies from Oct 2015 to Nov 2017. During the fieldwork, I could comfortably interview the respondents because of the language (Telugu); secondly, I have been volunteering with the International Red Cross Society for the past 25 years, quickly accessing the staff and beneficiaries. Thirdly I distributed monetary honorarium, especially to the sex workers, as advised by the VOs team.

During the fieldwork, the women respondents used slang words in Telugu, which I cannot understand its implications, and I often asked them to clarify it. Secondly, while interviewing Dr Paul Doss's Red Cross Urban

Primary Health Centre, the constant response, which means a similar answer repeatedly given to the questions asked to the various participants in the interview sessions. Issues like domination of the husband and mother-in-law in the family, issues of education, and the food they consumed daily make me feel handicapped to proceed with further questions. Thirdly while interviewing the sex workers in the old city of Hyderabad, their clients asked me questions which was uncomfortable. Most of the individual interviews were conducted within 45 minutes in one sitting. The discussions are through face-to-face interaction in which information is gathered through questioning, conversing, and responding. The structured questionnaire was not distributed to the respondents, but I filled the questionnaires and noted the responses. The women respondents narrated their life experiences, health issues, and challenges through the interviews. There are three categories of women respondents. Firstly, the women (women in the reproduction phase) in the urban health centres expressed their suffering from subjugation and suppression in their patriarchal family. The second category comprises women (sex workers). Before interviewing them, I assumed that they would be sad and vulnerable. However, I found them contented and satisfied with their profession as sex workers. The third category consists of schoolboys and girls who cooperated in executing the experimental intervention on adolescent health care.

Interestingly, most sex workers demanded respect, dignity, and legalizing their profession with their specific identity cards issued by the Telangana government. Through the interviews with VOs staff, I came to know

the hot spots of sex workers in the by lanes of Charminar. The VOs staff also revealed that the primary health centres' locations were the pregnant, sterilized women (selective family planning), and HIV/AIDS positive women access to health services.

During the interview with the VOs staff, I learned the number of women beneficiaries, their specific health programs, and the medical services rendered to the recipients. The VOs staff also expressed the program's execution, strategies, and VOs action plan. Some of the VOs distribute condoms to the sex workers as part of their intervention program. Interestingly, VOs demanded the sex workers update their daily life activities. At the end of the fieldwork, field notes and observations were transcribed.

2.9 Limitation of the study

The scanty literature on sexual health, reproductive health, and adolescent health issues in Telangana are challenging to understand these social concern issues' background. Secondly, this study focuses on a sensitive issue revolving around sex and sexuality, and therefore the researcher explained that we would protect the respondent's identity. Thirdly, to find the VOs in Telangana who focus on women's health was a challenge, except for the Indian Red Cross Society and Manavatha Parivarthan Society which were part of voluntary activities of the researcher. It took around six months for the other two VOs to learn about them and select these VOs through the internet and

known individuals. To find the VOs and schools (govt and private schools for underprivileged children) and to take prior appointments for individual interviews was time-consuming and difficult. This study's research should not be generalized as the social reality of sexual health, reproductive health, and adolescent health in Telangana because of the sample size of 286 respondents out of 7 million people (per Census Report of 2011). The work is not 100% accurate as the study was not conducted inside the laboratory. We also excluded the survey's smoking, alcohol intake, education, and material deprivation experience. We considered the registered respondents from a particular voluntary organization and not others affected by the health issues are included.

CHAPTER 3

The Women's Reproduction Health, A Case Study of Secunderabad and Hyderabad

Introduction

In this chapter, we examine how biological, socioeconomic factors interact and affect the reproductive health care of underprivileged women and how various NGOs address the need for intervention. The World Health Organization(WHO) defines "reproductive health as a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes." Though reproductive health is a gender-oriented phenomenon, social, economic, and education are inclusive by specific geographic locations. When women's ability to exercise control over reproduction issues is enhanced, their empowerment is more quickly and fully realized and reorganized. Women across the globe face barriers in autonomy in the reproductive intentions influenced by gender relations. Have enormous direct and indirect consequences on women's health, wellbeing, and life options (McCleary-Sills et al.,2012).

This study focuses primarily on underprivileged communities' reproductive health issues. Reproduction in healthcare is standardized as part of primary health care. Family planning starts before birth and continues to complete the life cycle. The intent here is to capture the reproductive women's

health experience and understand reproductive care functionality from a feminist lens. As we progress in the 2nd-millennium, women's health is attributed explicitly to women's fertility and population growth, leading to demographic evaluation. Significantly, SDGs incorporated sexual health care into reproductive health and rights. By 2030 it aims to enhance people's lives and personal relations in preventing HIV/ADS and sexually transmitted diseases.

Hence, reproductive health care is an issue of global concern, with women being birth control agents. Reproductive health is no longer a mere health issue but has attained a human rights position. Systematic research on a rights-based approach to sexual and reproduction health includes maternity, gender-based violence, and sexual health, suggesting more evidence is needed across the diverse population (McGranahan et al., 2021). Much reproductive health care has been comprehensively documented and assessed over several decades through a monochromatic lens. Moreover, by ascribing reproductive health to population explosion and environment, women become agents in reducing population and poverty. Analyzing standardized reproductive health care requires a multi-pronged and multi-dimensional approach.

The MDGs and SDGs have deepened the need for inquiries into women's health strategies for global development. The target was 'Health for All,' and 'to leave no one behind', which seems an ambitious global aim of everyone's wellbeing and everywhere. Following these developmental guidelines, the conceptual framework of the underprivileged women's health

issues in Hyderabad and Secunderabad, Telangana, India, the present research is planned and developed. We wish to examine how intensified voluntary interventions and policies addressing women's health issues show consistent evidence of fast-evolving debatable discourse between economic inequities, gender implications, literacy rates, and overall executions of interventions. Women, and more significantly underprivileged women, are deterred from mainstream health privileges due to lack of awareness, nutrition, hygienic environment, and unequal distribution of resources. All these factors intersect and disadvantage the dissemination of quality health care.

3.2 Health Inequalities in Reproduction Health Care

There has been an active discussion on inequities in reproductive health care in literature. These inequities are directly linked with unfair distribution in a social structure and social justice. Microcosmically examining and understanding the inequalities is important as ethnography, and the empirical study reconciles interconnection and intra-relation in social stratification. A systematic and scientific study understood that the neglect of women who encounter reproductive health issues could not be analyzed in isolation from their individual experiences in a specific socio-cultural context. Instead, every aspect is driven by a socially stratifying systematic force that reinforces inequalities and resources inaccessibility due to caste division of labour.

Women's health and reproductive problems are never understood and perceived in the women-centric need-based outlook (Cleland, 1982). India's

reproductive situation remains mediocre in ensuring quality care and effective functioning of the health system. However, some argue that the causes of women's reproductive choices are attributed to the cultural beliefs based on gender roles and inequalities of household and local labour markets (Sonalde Desai 1994). Executive director Poonam Muttreja of the population foundation of India cited the need for a life cycle approach to integrating the specific requirements for singled out family planning, maternal health, reproductive health, and sexual health (Poonam Muttreja 2013). Health inequities are parallel obligations of gender and social inequalities in the Indian context.

The female gender is still considered a liability that adversely affects the economic status, social condition, and cultural aspect of an integral part of the society. Our ethnographic study reveals that a girl born in a first-pregnancy family is considered an unwelcome gesture. A second child again, a girl child, is a curse and delinquent to the delivered mother and the child. This reluctance to accept the girl child enroot the gender inequity drastically reflects health inequities. Gender discrimination disadvantages of girls, sex-selection abortion of female fetuses, and female infanticide are severe gender detriments.

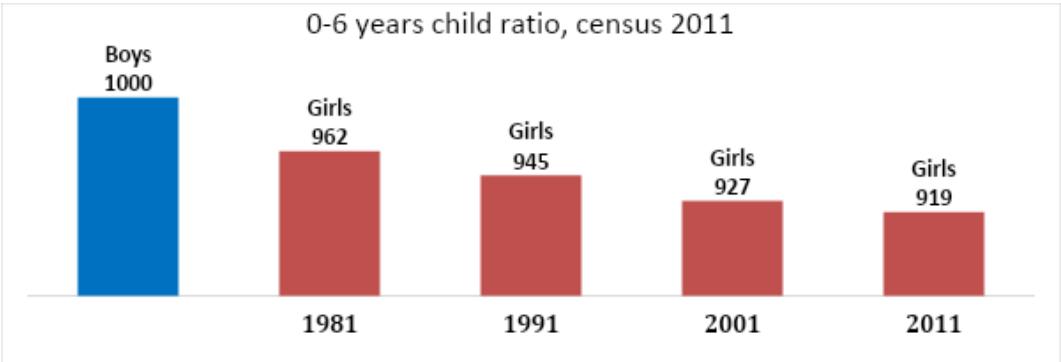

Figure 1: Boys and girl's child ratio from 1981 to 2011, Census 2011, India

The above fig 1 describes the gender ratio of the girls and boys from 1981 to 2011 approximately for three decades. The social and cultural practices such as dowry are economical and politically patriarchal in practice. In this context, young women are disadvantaged, and stereotypical norms reinforce powerlessness in many ways. The most prominent of these are inaccessibility, submissive, and prudence, which have severe repercussions in supplementing women's control as sheer fate and assuming reproductive health as a safe, effective, and informed choice (Jejeebhoy 1994). It strengthens male domination in decision-making and emotional aspects of childbearing and child-rearing attributed to females, economically controlled by males. However, the physical efforts are made by the female counterpart in the family system. The women's subservient role in society is complaisant on the barriers and promotion of health among women. The image of marginalized identities is a tentacle of various branches such as religion, culture, geographic location, regional, and, per se, individual and sexual identities. Kasturi, in an article, presents challenges to health care in the Indian perspective in the five A's, awareness of health issues, access to health care, absence of equitable health care, affordability of quality health care costs, and accountability of the responsibility (Kasturi A 2018). Health inequities are more prevalent in the lower strata of the caste system. Women are at a disadvantage in every instance compared to men and women of the other castes. Significantly hamper the implementation of progressive policies and operational challenges in mitigating women's health issues.

The second strong reason reiterates that the girl child's social upbringing contributes to illiteracy and lack of awareness of health concepts. Most women are illiterate or less educated to understand the minimum hygiene to lead a healthy life. They contribute to undernourishment and malnutrition, and both the ill effects continue to the mother and the child. Poor sanitation and minimum health awareness again lead to health inequities. More than 50% of the couples still believe that investing in the girl's education is non-remunerative because the girls get married and are assets to the husband's family. (Sonalde Desai 1994) further details that educating a girl is more expensive because getting married is higher in demanding high dowry.

3.3 Brief History of the Health Care System in Hyderabad-Secunderabad

The report of the Commission of Social Determinants of Health (CSDH 2005), while examining the history of Hyderabad and Secunderabad, under the Nizam's rule to its evolution as a city in the republic, notes that the vast cultural and economic diversity demanded vital administrative policies at the grass-root levels since the formation of these cities. When the Nizam's of Hyderabad were the rulers, the area was officially not a British province and, therefore, not subjected to direct rule. Western medicine (Care 1948) was dominant in urban areas, and dispensaries and hospitals in Hyderabad city were established. The rural population was still dependent on traditional medicine by local practitioners, Hakims, and vaids.

Women's role was neither a participatory nor a beneficiary one, and therefore the recording of women's health is specifically ignored. Kadambi Ganguly and Anandi Joshi were the first women medical practitioners trained in western medicine in 1886. Women in India were reluctant to get medical treatment from male physicians. Such that resulted in the concept of 'Zenana Hospitals.' It is recorded that the noblewomen of Nizam's of Hyderabad, who was called 'Purda Nishin,' were treated in 'Zenana Hospitals.' The more impoverished communities are being deprived of admission to these hospitals and treated as outpatients. In 1953 Niloufer Hospital, specifically for poor women and child was established in the act of philanthropy of Prince Niloufer of Nizam's family. Health inequities and disparities were shaped during Nizam's era and expanded into a socio-politically influenced later century. In 1928, the Secunderabad military hospital was established. The military medical department of the Nizam's Government of Hyderabad state reorganized service providers such as doctors and nursing staff. Subsequently, Christian missionary interventions played a significant role in the twin cities of Hyderabad and Secunderabad education and health services in the public health arena.

With this backdrop of western medical care, Nizam's Hyderabad state had over 100 health centres in hospitals and dispensaries initially with a 'military-centric approach.' A century ago, in a pre-independence era, on August 17, 1846, the Nizams established a medical school, the first vernacular medical school in India. To conclude, though western medical care was institutionalized

under Nizam's domain centuries ahead, it was utilized by the nobles, army, and their families, British and elite classes of native Hyderabad residents. General hospitals were open to civil society, where 50% of the beneficiaries were Muslim communities, 45% were men, and hardly 20% were women patients. Most of the population depends on the local practitioner's parallel to western medicine. However, the literature on women's health for marginalized communities is minimal and sparse, and access to medication was from Unani and Ayurveda doctors.

3.4 An Empirical Study on Reproductive Health Care

There are few empirical studies on the potentials of family planning programs in an array of socioeconomic development on women's reproductive rights. Sources have discussed reproductive health from a public health perspective. Reproductive health issues have merged into a 'feminist principle' linking reproductive health, general health, and the socioeconomic spectrum (I. Qudeer 1998). The notion of a woman's life cycle is fragmented into widespread illness and gynaecological suffering throughout her life. The word 'Gyneco' means women, and 'logic' means knowledge all taken together. 'Gynaecology' remains a women's issue in creating the universe. Reproductive health remains a women's question instead of being a shared choice of the male and female. It has become the reason for the biological vulnerability of a woman.

Many women's health issues have now evolved and shaped into all-inclusive health care. By the 21st century, India's Government initiated women-centred family planning programs, and India became the first country to introduce such a welfare policy. (UNPF 2018) also states that young people are vulnerable, facing sexual and reproductive health care and awareness hurdles. Due to the knowledge gaps and other socio-economic reasons, girls are exposed to unsafe sex, unwanted pregnancies, unsafe abortions, and school dropouts. The girl child grows to an adult mother leading to a mother and child health issues and a family with low and unequal health status, thus creating an underprivileged community. All the health issues evolve as a gender-based phenomenon.

An international conference on population and development lobbied the countries worldwide to establish the 'health watch team' through voluntary organizations, activists, researchers, and civil society (Cairo 1994). The target-free approach to family planning to a reproductive child health program was discussed by (Jejeebhoy 1999). However, the concept of reproductive health emerged in the 1980s. Women's fertility is centred mainly on social and economic perspectives. The concerns on reproductive issues were interdependence of reproduction health, general health, and socioeconomic context. This study's scope is restricted to voluntary services delivered to the less privileged community.

3.5 The Role of Voluntary Participation in Reproductive Health Care

The growing number of Voluntary organizations (VOs) have supplemented community participation in reproductive health with primary health care with a need-based approach. The public's engagement with the private partnership became functional in the late 1980s. Around this time, VOs seized a significant role in developmental activities and reached their pinnacle as a third sector among the public and private sectors. Despite all the policymaking and implementation efforts, reproductive health care emphasized mainly contraception and sterilization services. It is perceived that population growth is the leading cause of poverty, and health interventions were framed to address population reduction and poverty eradication.

Ironically, the Government has many policies to advantage women and children, but implementation is always arduous. Because of the technical reasons of outsourcing, human resources from various non –government organizations may not monitor the requirement. There is always a gap between formation and execution. Due to fewer female representatives involved in the discussion, designing and deploying the targeted programs favouring women may not solve health inequity.

The Indian family planning program has been renamed a family welfare program that counts women as beneficiaries. When the outsourcing staff is not adequately trained and motivated, reaching the target area is always an

unmet and unresolved task. The programs meant to benefit the poor and the marginalized do not impact these communities and are unaccountable. Family planning is done mainly by sterilization, with 70 per cent of the methods implemented being sterilization. However, (Ravindran 1993) has cited that only 8% of male sterilizations are recorded, and only 5% of couples used condoms in 1989-90, according to a 1988 survey done by operations research group. Thus, the family welfare program is exclusively generated in venerating contraceptives mainly to women and sterilization as a complete end of fertility for women's lives. Men never take the responsibility of contraception, reproductive and sexual wellbeing. Thus, both from a developmental and a research perspective, active involvement of community-based voluntary organizations is necessary for maternal and reproductive health care. The voluntary organizations' selection criteria are based on organizations that render services to the low socioeconomic group considered underprivileged in maternity health, vaccination, antenatal, neonatal care, nutrition, child care, and hygiene. Voluntary organizations that assist in the awareness and prevention of sexually transmitted diseases, HIV/AIDS, are also included. VOs promoting health education among girls' adolescent phases are also studied later.

3.6 Indian Red Cross Society, Telangana State Branch, (IRCS, TSB), Promotion of Reproductive Health Care

The Telangana Red Cross Society (TRCS) is a voluntary organization identified in Hyderabad and Secunderabad. Ethnography enabled me to collect data from all the units of IRCS to understand the services provided in Hyderabad and Secunderabad region. The centres studied were the IRCS mother and child health centres (UPHC'S) and the Dr Paul Doss Maternity Health Center, Ranigunj, Secunderabad. IRCS has a robust voluntary base; its principles and objectives adopt a humanitarian approach. Red Cross society interfaces with the community and the government's public health schemes. IRCS reaches remote communities and less fortunate women. They address health inequalities and economic and social disparities. The Dr Paul Doss Maternity health centre is identified because it suits the research criteria. Another reason is the researcher's access to the IRCS for two decades volunteering in various activities. Among functioning health centres in Hyderabad and Secunderabad, the Dr Paul Doss maternity centre, founded in the 1920s, is housed in an 80+ year heritage building. It is an 'Urban Primary Health Center and Maternity Center' covering 5 to 8 km from the centre. The underprivileged sample studied and examined are the slum dwellers whose income is below Rs.3000 per month. Young and older adults visit for various ailments like backache, knee pain, general weakness, diabetes, and hypertension referred to government hospitals such as Gandhi Hospital, Osmania General

Hospital, and Cancer Hospital in Hyderabad. Health care is provided free of cost and comes under the various government schemes beneficiaries mentioned in the discussion later. Bowenpally Mishrilal IRCS Maternity health centre, Secunderabad, Mohammad guda Maternity Center, Secunderabad, Gaddiannaram Maternity Center, Hyderabad are other not included in the study.

I have collected the information from four health centres to understand the structured implementation, which suits our research analyses of local health issues and requirements. Subsequently, I focused on getting the details on how the volunteer staff enables gender equality and health services in equal distribution of health resources. All the health units were visited, where interactive sessions and interviews of volunteers, health workers, and the medical officers of the UPHC'S (Urban Primary Health Centers) were conducted. Observation and witnessing of the awareness campaigns were conducted over the weekdays and door-to-door visits to collect data on women's health issues, pregnancy, deliveries, and immunizations. The ongoing activities such as immunization camps and the neonatal care carried out by the health workers, health visitors like ANMs (Auxiliary Nurse and Midwives), ASHA's (Accredited social health activists) in the catchment areas IRCS Health Centers was monitored and emphasized in the methodology chapter.

Purposive/criterion sampling methods are used. Selected VOs have been observed, and an intensive observation study is done for six months. The interviewer got acquainted with the staff and the IRCS health units' beneficiaries in Secunderabad and Hyderabad. Collected data is from the pre-recorded monthly registers. Purposive sampling simplifies and facilitates qualitative research. Random selection of the beneficiaries is made with the medical officer's prior reference and the staff of the health units of IRCS. The survey area where one-to-one interviews are conducted is in the catchment area of the UPHC (details are given in the form of charts). Case studies are the beneficiaries who visit the centres with various health issues related to pregnancy, antenatal, neonatal care, immunization, sterilization, and nutrition. (other than reproduction health issues). Case studies are discussed and analyzed at the end of the chapter.

The picture below depicts the women of three generations who benefited from the IRCS, Telangana. The twin baby girls are seen carried by the mothers who delivered their babies in the maternity centre.

Picture 1: UPHC, IRCS Maternity Center, Ranigunj, Secunderabad.

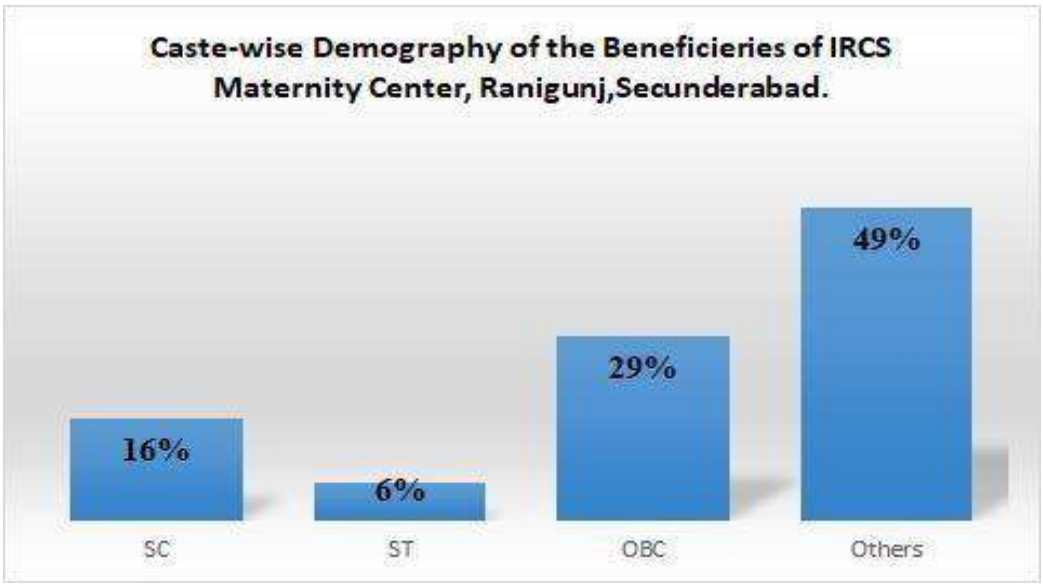

Figure 2: Demography of the beneficiaries at IRCS Maternity Center

The education status of the Dr Paul Doss Community Centre beneficiaries is shown in figure 2. Socially disadvantaged SCs and STs are 16%, and 6% benefited and registered in the IRCS maternity centre records. Muslim and Christian women included in the data clubbed as BCs are 29%. They are doubly affected by the underprivileged class and discriminated gender. India's globalization has produced an uneven distribution of resources along caste, gender, and the overall economy (Pande R. 2007). With industrialization and globalization, people around Hyderabad moved into sub- urban, massive migrant influx driven most women searching for jobs. Agricultural labourers, weavers, and semi-skilled workers took unorganized jobs as maidservants or workers in commercial outlets, added to the expansion of the urban slums population in Hyderabad. They have unequal access to the existing resources of health care services and education too.

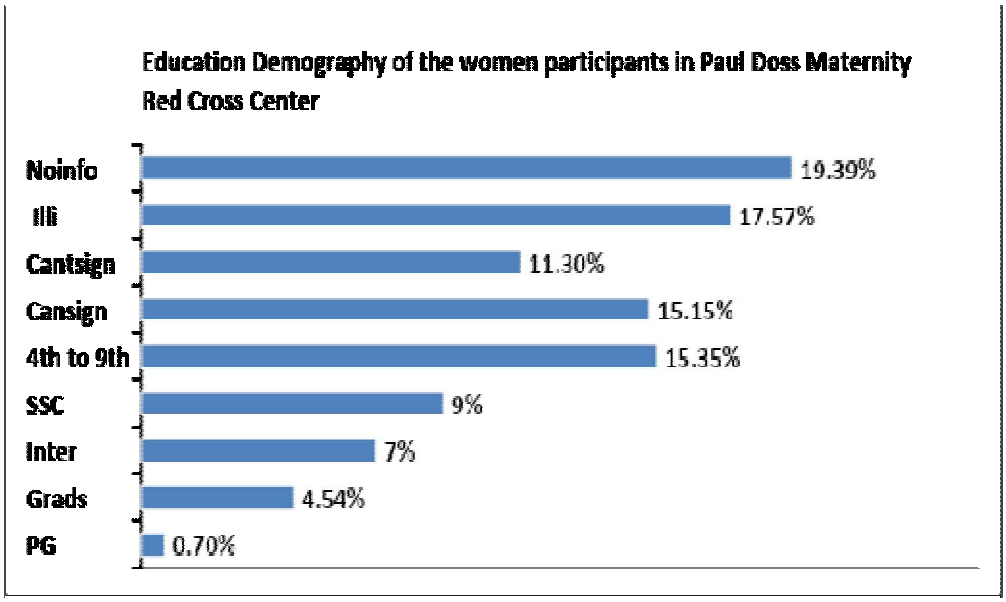

Figure 3: Education status of the IRCS Maternity Center.

Literacy standards of the beneficiaries are illustrated in figure 3. 20% registered in UPHC can't say their status. 60% are illiterates, 30% had school-level education (4th to 10th class), 9% are intermediate-level, 5% are graduates, and less than 1% are postgraduate-level education. Both literates and illiterates are at the advantage of using health facilities. They benefit from the welfare programs, who are equally aware of the maternity centre's services. However, education on health and hygiene are considered determinants of the reproductive health perspective. The mothers' and child's health awareness and education levels are interrelated, and several studies identified the pathways and influential factors affecting them. Plenty of evidence reports the risk factors for maternal mortality, infant mortality, and nutritional status (Cleland, 1982) assessed various mechanisms and intervening factors that influence maternal

education. His findings emphasized that educated mothers value children's health and make greater decision-making power than philosophical notions. Educated mothers are more aware of the prevalent disease and sort for innovative remedies applying appropriate knowledge and adaptability.

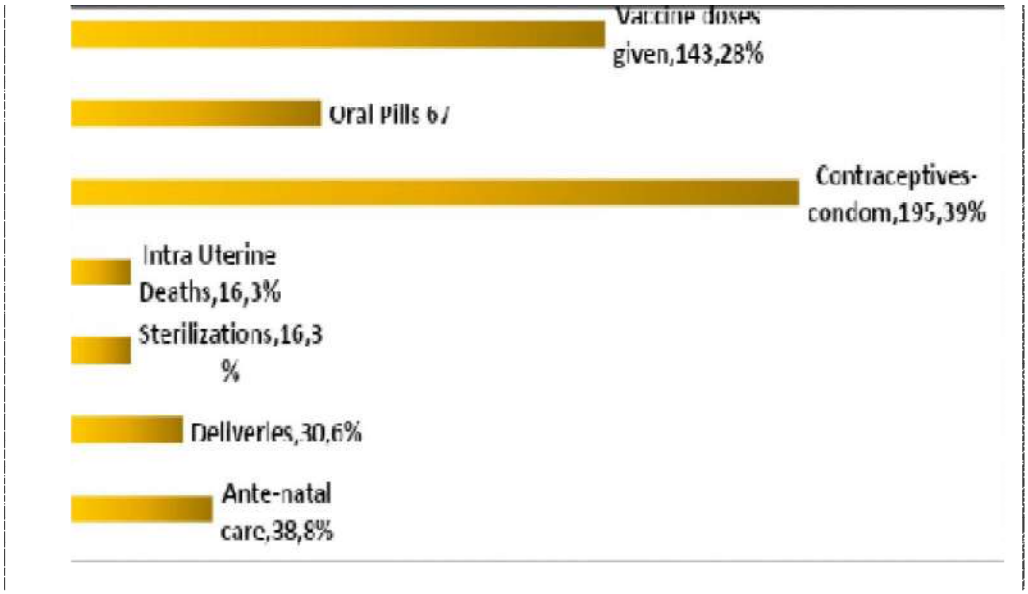

Figure 4: Various monthly activities are done at the IRCS Maternity Centre.

Another issue is sterilization, a perfect birth control tool in both perspectives; reducing the population and controlling the family dynamics. Various modern and conventional methods limit and regulate women's conception and pregnancy as only women's related problems. A report stated that 35 to 55 million pregnancies(worldwide) are terminated yearly through induced abortion, even though it may spare the women's lives but affect their fertility and future health. This health-related situation and illness appear to be

true irrespective of socioeconomic or invisible and unorganized, whether working and non-working women. Another reports that although India has legal abortion status unobtainable due to lack of access to the facilities, it succumbs to plant-based virginal applications for ending unwanted pregnancies, increasing health risks (Meleis 1997). The various UPHC medical officers have records of such cases in urban metro cities like Hyderabad and Secunderabad. Yet another issue is intra-uterine deaths. In other words, the 'stillbirth rate' had decreased from 22.1 in 1995 to 18.9 stillbirths per 1000 births in 2009. Lack of adequate anti-natal care is the most critical problem that needs attention, and 70% of stillbirth occurs because they did not receive proper anti-natal care due to anaemia and accidental haemorrhage. A study on stillbirths as preventable by educating mothers at the early stage of pregnancy and preparedness for family and making referral hospital deliveries presented (Patel. S 2014).

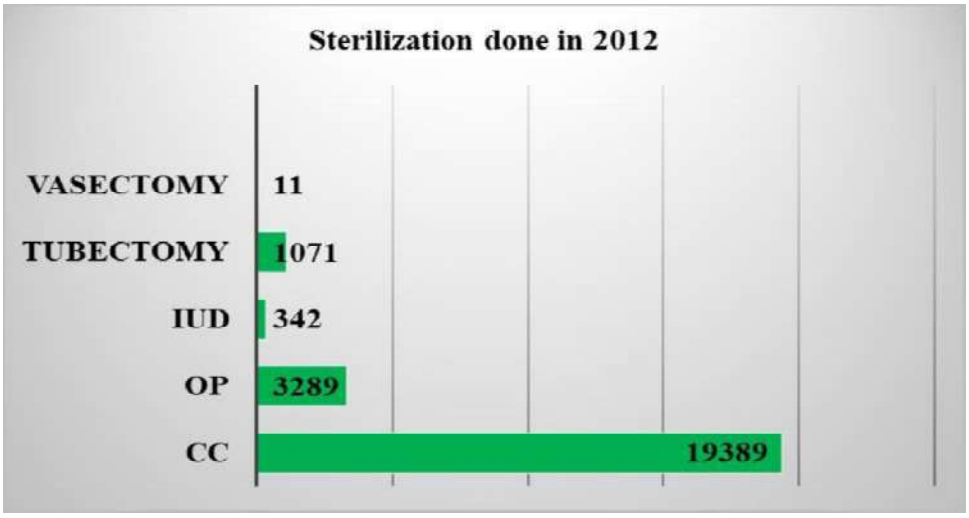

Figure 5: Elective Sterilisation done at IRCS Maternity Centre.

Elective C Sections are done in the most alarming numbers by choosing the beneficiary because the tendency towards normal labour is debatable by youngest mothers. The pain threshold is low, and they are reluctant to go through labour pain duration in standard delivery. Caesareans have become new normal and perceived 'easy way out and ignore the relative risks associated with the surgery. Common known risks are postpartum haemorrhage, bleeding, fever and sepsis, wound infection, hysterectomy, blood clots, and most risk-oriented complications for a baby born. We see in fig.5 that 19 389 cesarean sections were referred to government hospitals by the UPHC medical officer. However, maternity centres' infrastructure facilities such as toilets, drinking water, clean labour rooms for delivery, and regular electricity are inadequate and depleted. (Paul Doss maternity centre,18th century established). Another concept frequently cited in the literature is the maternal mother's influence, further influenced by family and friends.

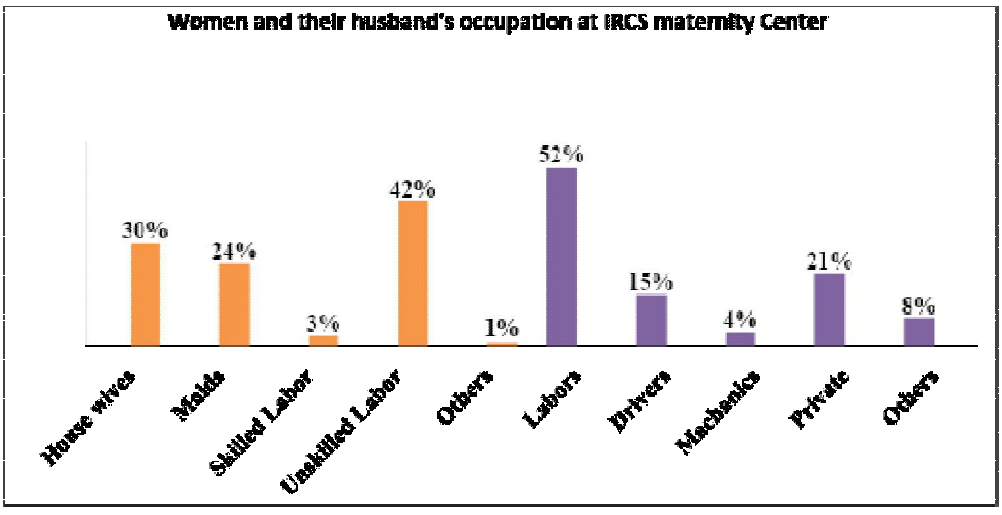

Figure 6: Occupation of the beneficiaries of the IRCS Maternity Center

Low income of these unorganized marginalized workers perpetuates income inequality and contributes to inadequate health care to the underserved communities. Lower education and standards of living both affect the quality of living. Apart from reproductive health issues, women had backache, bronchitis, asthma, tuberculosis, and chronic illness due to their occupation hazards. No government welfare programs have comprehensive coverage addressing these issues directly linked with housing, sanitation, water supply, hygiene, nutrition, and deficiencies. Population-specific health care needs to draw attention to address health inequities in suitable improvement programs. Fig 6 shows the beneficiaries' occupation, 52% of men whose family members attended the centre's facility identified as labourers, 42% of women work as unskilled who support their families financially. Others remain housewives, 30% of them, skilled labourers are 3%. Men/ husbands are primary drivers, mechanics, and others who work for private firms. Rural to internal urban migration contributes to overcrowded urban slums attributing to the urbanization of poverty. Migrant populations impact fertility, immunization, demographics, and socioeconomic development of the situated locations, for instance, Hyderabad and Secunderabad. However, health care is one of the crucial issues unable to address to the fullest. Fieldwork and interviews are evidence to substantiate the attendance of the beneficiaries. It is also reiterated by the health workers and the medical officer's experience in a few case studies.

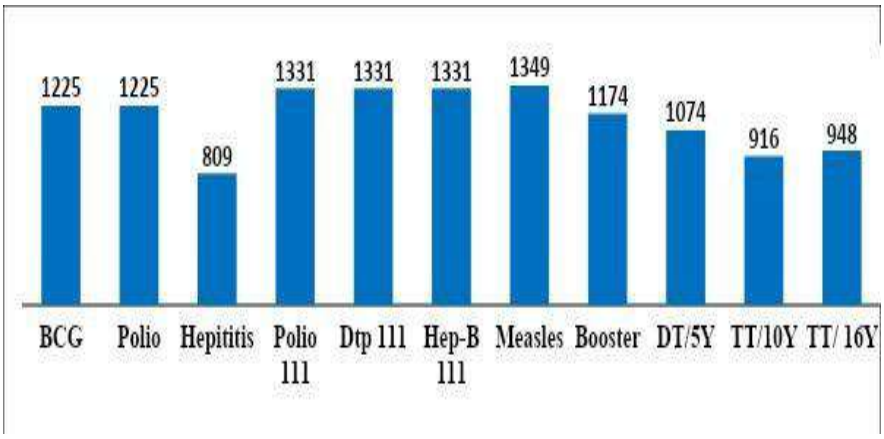

Figure 7: Immunisation is done at the IRCS Maternity Centre

Immunization is the critical element of primary health and currently prevents two to three million deaths every year. World Health Organization defines 'immunization as a process whereby a person is made immune or resistant to an infectious disease, typically by administering a vaccine. The vaccine stimulates the body's immune system to protect against subsequent infection or disease. However, vaccines save millions of preventable deaths and improve health outcomes throughout life. India became smallpox-free in 1977 though the preventive efforts against the disease in India were reluctantly opposed and were slow in accepting the vaccine at first instance. According to Sample Registration System 2014, Infant Mortality Rate in 2013 was reported as 40 per 1000 live births in India and varied across the other geographic locations. Immunization programs associated with immunization coverage inequity in the Indian scenario are discussed (Geddem J.B 2018). Total Hyderabad immunization is 71.3%, whereas immunization among the underprivileged communities is lowered by 66.5%.

Immunization has become an essential component of the National Reproductive and Child Health Program since 2005. It provides vaccination to prevent seven vaccine-preventable diseases; Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of childhood Tuberculosis, Hepatitis, Haemophilus Influenza type b (Hib), and Diarrhoea. Fig 7 shows the vaccines provided by UPHC for the centre's catchment area, which mainly has a migrant population. They keep shifting places, spreading infectious diseases beyond control. Reproduction care is even more difficult for the UPHC's to promptly make a continual follow-up during pregnancies, deliveries, and immunization. Prenatal, postnatal, anti-natal and maternal mothers are vital recipients of successful Immunisation interventions, yet keeping track of child vaccination is an unmet task to a most considerable extent. The immunization dropout rate is high due to mothers' age, education, gender, caste, religion, migration period, and present geographic location. (Laheriya C 2014) exemplifies that vaccination received slow acceptance, and reluctance is an identified challenge for inequitable immunization coverage.

Telangana state government has a list of health schemes such as National Rural Health Mission-NRHM, Reproduction, and Child Health Project-RCHP, Janani Suraksha Yojana-JSY, Integrated Child Development Care-ICDC, Neonatal Intensive care units –NICU, Emergency Health Transport Scheme, Free Bus Pass Facility to Pregnant women, Untied Funds, Arogya Shree, Arogya Lakshmi, Bangarutalli/KCR kits. Anganwadi and ASHA-Accredited Social Health Activists play a significant role in successfully

administering all the schemes in the urban and rural health centres of Secunderabad and Hyderabad. Health interventions are mainly deliveries, sterilization, immunization, prenatal, postnatal care, and anti-natal counselling. Added activities are health awareness in schools to adolescent children, free medicines and immunization vaccines, health camps in the catchment areas. Awareness, health, and hygiene are inclusive programs.

Basthi Dawakhana's was started in April 2018 by (GHMC)The Greater Hyderabad Municipal Corporation in Telangana is the first urban local body-led community clinic in India. Basthi Dawakhana brings the state health department, the Mission for Poverty Elimination in Municipal Areas (MEPMA), and the urban local body to deliver health care. In convergence amongst multiple agencies and improved urban health governance to improve the existing urban PHC services in Telangana State.

3.7 Women's Health Issues from a Feminist Intersectionality Perspective

The notion which makes forgoing or retaining the autonomy on reproduction is closely linked with the sensitivity of motherhood. The contribution to the feminist literature on reproductive health issues in a larger field of approaches, arguments, and perspectives makes it impossible to give a complete account of the development. The content and features of feminist discourse on reproduction, conception, and contraception we investigate specifically among the less privileged, focusing on a particular dimension of feminist discourse.

The analyses and discussion run not only between the male and female genders. It extends to intra-gendered power relations between the young daughter and her mother-in-law in the autonomy of reproduction issues. The concept of choice is central to liberal feminist thinking, which envisages complete independence to choose reproductive choices such as getting pregnant, choosing to space the pregnancies, expressing the abortion and termination in one's terms in unrestricted individual agency. Though the section of medical interventions of contraception is locally controlled by methods such as IUD, MTP, oral contraceptive pills, tubectomy, vasectomy, and condom usage, medical professionals advise. Focusing on individual choice towards gender equality reproductive health has a scope in being judgmental in maintaining women's health and their children's life better.

Some radical feminists saw reproduction as enforced motherhood (de Beauvoir 1953) in her work 'The Second Sex.' In her book 'The Dialect of Sex,' Shulamith viewed reproduction as the centre for all oppressions, exploitations, and inequalities. Feminism at a broader range analyzed that women depend on men for their life necessities such as food, shelter which excluded them from the other social functions, thus creating inequalities. ‘Males are producers and females are reproducers’ (Firestone 1970) is a saying that shows the oppression of women, visibility, and participation and transacts female disadvantage at social, economic, and political overlapped in layers. Visibility and participation are the fiercer social determinants in lower-income groups. Our reading of

feminist literature defined discrimination and suppression as the roots of patriarchy and the need to uproot by dismissing patriarchy at all levels. Health and women's health care disengage from other economic, language, political, and other sciences. Certain vital factors reflect the process for any development and provide a wide range based on individual countries. A developing country ike India has a unique tradition of social work or community welfare activities committed to a people-centred approach, focusing on target groups that spread across the traditional boundaries of caste and marginalized groups. A stereotypical phenomenon prevails in all stages of a woman from infancy till the end of her life.

The line of the thought process itself fostered curiosity to the edges of social and cultural norms. Essentially, a personal debate is extended to a universal notion that instrumentally conceptualizes the present study. Without exploring the root cause of inequalities and lapses, ignoring women's history and health would further misappropriation. Why is hegemony so, and what made it be so? Who were the participants equally responsible for the systematic subjugation of reproduction and general health issues? Is this voluminous topic worthy of study as an entity? O'Neill and his team illustrated the differences that disadvantage needs re-thinking the interventions to implement and evaluate them. Marginalization is always focused on understanding the vulnerability but not the dynamics of layered exclusion groups (O'Neill 2014). We understand and introspect the research questions under mentioned appropriately in a feminist intersectional analytical framework.

3.8 Discussion and analysis

The study raised various questions:

In convergence, health and women's gendered health issues evolved significantly into newer learning. For instance, the health and wellbeing of women's health have been neglected for centuries to receive attention in recent decades only. Newly generated attention in a tunnel view escalated to the peaks of less attended issues. For example, sexually transmitted health is purely attitudinal, behavioral, and lifestyle. The present study aims to understand, analyze, and find solutions to women's reproductive health care in poor living conditions. The women's reproductive and sexual health are centred and examined with a feminist intersectional lens. Our efforts are fruitful in understanding the functionalities and lacunae in accessing the existing health care among the underprivileged women in Hyderabad and Secunderabad.

1. Whether women's health issues are addressed adequately?
2. Are they discussed in the domain of the voluntary sector?
3. Although women are vulnerable and susceptible to various diseases atall stages,how do these conditions affect them?
4. Women's Health is always limited to the reproduction, and where otherdiseases are increasing at an alarming rate, are these issues attended?
5. To examine health as gender-inclusive, how women contribute to thevoluntary sector in the voluntary sector's present scenario.
6. Do the women's social status, income, and caste affect access to health careandtreatment at the health care centres?

7. Do all sections of women get family support?

These are the answers

1. Yes, to some extent related to reproduction, family planning, immunization. But, issues regarding health education and overall holistic health are neglected. The patriarchal family role within the family is stereotyped, which means women are to produce children and plan to support their upbringing. UN Human Rights Committee on the Elimination of Discrimination Against Women(CEDAW) Article 10 specifies that women's right to education includes access to specific educational information to ensure the families' healthand the wellbeing of the families, including information and advice on family planning. Though reproductive and sexual health is a fundamental right related to multiple human rights, it is less addressed and understood in the health care system.
2. VOs are the bridging gap in executing the development policies with many shortcomings like financial assistance, the programs' sustainability, and limited access area for further expansion. The voluntary organizations identifiedfor the investigation positively impacted the underprivileged women. Traditional philanthropy is successful for the fixed health issues, for a small population, and the need for increasing voluntary services is foreseen. 2019 is the year of transforming advocacy, policy-making, and innovative interventions in addressing COVID19 and upcoming viral infections. In recent 2021, a team of young advocacy researchers adopted was different from the previous generations. Online advocacy and digital

organizing were essential tools for translating monitoring efforts to recommendations representing next- generation public health leaders (Huffsteller et al., 2021). They also referred to the rising attacks on marginalized women's contraception and abortions during the pandemic.

3. Mostly, women's health issues are related to reproduction, sterilization, and immunization, not other diseases like HIV/AIDS positives. Comprehensive reproductive health care, including infectious disease and other associated implications, needs vigorous advocacy, as we have realized in the ongoing pandemic COVID19.
4. Health issues are not whole, gender-inclusive, and need a paradigm shift from women's reproductive health to holistic health. The promotion of health issues has a conventional approach that is not gender-oriented in addressing the health inequities that still impact higher multitudes attributed to gender inequalities and health inequities.
5. Women play a significant role and are catalysts to women's health promotion and far more increase in the contemporary local and global perspective. In a feminist critical analytical view, we found that the social construct of gender disproportionately affects marginalized communities. As observed, a case study implied that well-informed health workers are the front- line health workers who can educate the less privileged at urban primary health centres. These interventions were for the poor and illiterate women marginalized by caste and served by the doctors, ANMs, and health visitors whoare also women. Gender and human rights are incorporated in the teaching modules designed by the state, and the local voluntary interventions need appropriate

capacity building.

6. Caste, class, and social status impact health benefits. It is understoodthat the lower the caste, education, and income, the lesser the access to health care. Minimum education and a better financial status have better access to the health centre and health entitlements. 40% of the beneficiaries, for instance, are upper-caste. These women are informed and gain knowledge of the various schemes at proper availability intervals. Data depicts that less than 20% of SC and STs visit the UPHC while other caste women beneficiaries are more than 40% among the Red Cross Maternity Centre beneficiaries.
7. It is observed that most women are accompanied by their family members, mothers-in-law, mothers, and sisters, who are the sources of psychological and other assistance provided by the government welfare schemes such as 'Arogya Lakshmi/ KCR kits' in Hyderabad and Secunderabad. Very few women are financially supported by their husbands, and psychological is less or unavailable. Due to the fluctuation in migratory population, unorganized, unemployed, caste identities interchange and intersect in accessing reproductive health care, immunization, and sterilization. They are not adequately addressed miss out on treatment and access to the entitlements provided by the UPHC.

Contextually, women and the child focus on three reasons in three dimensions. Firstly, women are more likely to face health inequities because of physical demands like pregnancy and child care with greater risk. The second women are the access to improving an entire population's health, starting with the whole family. The third and the important is the burden of caring for the

entire family, which leads to time off work and loss of pay and, in turn, leads to poverty and cuts resources to good health. It contributes to poor treatment and ill health. A vicious downward spiral begins that moves to the next generation.

Contrariwise, women still lack in supporting the girls' upbringing; they risk their lives favouring boy child, which leads to infanticide and foeticide of the girls. Thus contributing to the gender gaps, disparities and inequalities are uncontrollable and unreachable for elimination. Instead, we need to understand how these oppressions are different and unique in their contexts. Contemporary discourse and analyses can appropriate the inquiry to address women's health contextually. It's not about recording the conversation of their vulnerability but also about evaluating the intensity of the bias, oppression, and discrimination, which is partly visible, and most of it is under-covered. The layered subjugation identified the different health issues with a difference in finding a solution to our research question through the intersectionality theory. However, voluntary organizations significantly determine the vulnerable population among Hyderabad and Secunderabad high-risk-prone locations. Despite their certain limitations, such as budget, staff, and outsourcing, the projects' sustainability is the contributory factor of implementing awareness, diagnoses, and consistent treatment of our reproduction health study.

The reproduction of health care is potential for further knowledge; there is a need to understand intersectionality's theoretical representation.

Association for Women's Rights in Development appraisal noted intersectionality is an analytical tool for studying, understanding, andresponding to how gender intersects with other identities and how these intersections contribute to unique oppression experiences and privilege. The study's various identities are diversified, ranging from different age groups of women (menarche, pre-menarche and menopausal), marginalized communities with low economic status, working-class mostly unorganized sectors. These groups are studied and analyzed following women's health issues related to reproduction sexual health.

To achieve an efficient study, we intend to apply a feminist approach concerned with equity. The intersectional approach, concerned with oppression and asymmetry, contributes to women's constant illness. Feminist epistemology studies how gender does and ought to influence our conceptions of knowledge. Intersectionality theory shows how social and political discrimination aspects, such as caste, class, overlap and navigate gender bias. The feminist approach examines reproduction health and the connections between gender roles due to pregnancies and related health inequalities. Dr Kimberly Crenshaw introduced intersectionality theory. She explains how we deal with discrimination and disempowerment subjected to multiple forms of exclusion.

A case study illustrates an example of how upper-caste women could access health care and take advantage of the health centre and the government interventions. She had two daughters who availed all the eligible entitlements,

such as ‘Bangaruthalli’ and ‘Arogya Lakshmi scheme.’ Though she is qualified, and her social status is upper-caste, she belongs to an underprivileged community by her financial position. In a family background, women's role is always influenced by patriarchal domination, which intersects with socio-cultural norms contributing to the less privileged communities. These women who are economically less fortunate may not belong to marginalized communities. Here economic class plays a crucial role in preventing these women from accessing health care for various reasons and social contexts. A case study illustrated a situation where women from the upper caste married at 25 years. She is a postgraduate married to a daily wage labourer who is a school dropout, surviving on contract income. She was 3rd among the five female siblings; she was forced to marry to favour the younger sister's settlement in life. She maintains her maternity health care with limited resources she delivered in Red Cross Urban Health Centre. She accepted all theincentives provided by the government welfare schemes. She is currently educating her daughters (2) in TRCS school in Masab tank (voluntarily run by Telangana Red Cross Society) and mitigates the effects of oppression and gender discrimination through her proactive attitude toward her family's welfare. She is a success story as a beneficiary of the Voluntary interventions and government welfare policies in Hyderabad.

The amiable perspective is that intersectionality provides a lens of subtle variation scoped to gauge women's experiences in different situations and intensities. Women's reproductive health issues seem similar to any other

mundane problems in every household. Specifically, underprivileged women are ignorant of exercising the power of decision-making to bear the child or terminate the pregnancy. The husbands always control them as the family's breadwinner, and the mothers-in-law decide the reproduction phase. The other family members also determine the couple's immunization and family planning, primarily not pregnant women. Women's mothering produced and reproduced the generations due to the sexual division of labour and sexual inequality inside and outside the family (Chodorow, N.1978).

This kind of situation hampers the implementation of the policies and depletes the overall development of society. The growing disease represents a significant health threat to women worldwide. Gender inequities derived from traditional social roles and economic status structured from patriarchal ideology failed in articulating the linkages and the strengths in these linkages. Reproductive health care around sexual practices and general illness are still reasons for the disease's feminization are the core factors from a feminist perspective. Here are a few selected case studies that make a landscape of the women bearing future generations.

3.9 Case study: 1

A senior ANM narrated a case demonstrating a stringent hold of patriarchy on the prevailing socio-cultural scenario system. A woman was admitted for the fourth delivery, anticipating a male child since she already had

three female babies. She and her family were displeased and distressed and exploded with a huge cry in the centre at the fourth female child's delivery. The burden of sex determination was placed on her by the family. A Senior Medical Officer intervened in the situation and explained in a simple local language to make them understand fertilization and how the husband's XY chromosomes are responsible for the birth of a female child. The Medical officer gave an insight into the fact that the women who get pregnant and give birth to a girl or a boy child are not blameable. However, women are abused for giving birth to a female child. Research shows that voluntary health workers and the medical fraternity help the communities be educated in sex determination biology, making it more acceptable to have girls in a patriarchal society.

3.10 Case study: 2

A girl married at 16 was not considered child marriage; Saida[1] is the youngest in a Muslim family of 14 members from Hyderabad's old city, married to a mechanic. Lives in the slums of the Begumpet area close to the UPHC. The family benefits and have good regards. The grand old lady got her grandchild Saida for the medical follow-up. Having questioned why they got married at the age of 15 is offensive and punishable. The elderly lady answered that based on the risk, vulnerability, and religious norms, they get their girls married at 15. Such gender bias and discrimination are just accepted as their social and religious identity. We find such marriages common in the socio-economically underprivileged communities. Despite the changing attitudes and trends in behaviour patterns, women and girls are vulnerable to risky reproductive health issues.

Note: 1. The actual names and identities of the respondents in the case studies are not disclosed in the thesis. The words used are fictitious.

3.11 Limitations of the study

Due to the coverage area of the activities of the NGOs being massive, and ethnographically it's challenging to get their co-operation. Technicalitiesin reaching the beneficiaries and staff always limit their availability. Interaction in a group may not fetch the feedback effectively, and each interview is recorded in the field notes because most of them are illiterates. Awareness is limited, and their understanding of health is limited in mother and child care. Hospital delivery and vaccination are the two health issues known and practised. Most of the beneficiaries are happy with the services rendered by the Dr Paul Doss Maternity Center. Since decades passed, they utilized the interventions from three generations of reproductive issues and their follow-up. Not even a single woman spoke about the other health issues other than knee and back-related pain. The research process faced a challenge in getting the same answers for the questions asked in one-to-one interaction with the visitors. This mode of repetitive responses continued for three months of the ethnographic phase. Eventually, with the advice of the supervisor's researcher, I changed the perspective and the question dynamics. Interpretation of the responses also changed according to the relevance.

3.12 Conclusion

In conclusion, women and reproduction are parallel in understanding equality, equity, and a woman's life cycle. Telangana's geographical and cultural history shows evidence of a girl child favoured as an honour to the family culturally. Still, ironically it necessitated discrimination in property, marriage by choice, personal space in the family itself is still challenging. Such overwhelming situations build a platform to ponder the problems from an epistemological perspective. Most studies about women's health neglect health in a broader sense and least consider caregiver roles in reproductive health. Perhaps women are acknowledged agents of birth control and not individual autonomy rights. Multiple questions are unaddressed, which seems vague till looked upon as mainstream gender and women studies as persuasive knowledge to be studied and analyzed with the feminist intersectional lens. This introspection and gaining knowledge unravelled the facts and plunged due to various factors discussed—a few strong reasons to fall back on women's health as a broader research area.

For two decades' researcher self-motivated in establishing a voluntary organization to address women's health and education, specifically among the underprivileged communities, limited organizational activities to school's colleges and the slums Secunderabad and Hyderabad region, activities conducted for over two decades catalyzed further into mainstreaming women's health needs in multiple dimensions. These programs were just the tip of the

iceberg for women's health. Women's knowledge about common infections, sexual health, and adolescent health education is abysmally low.

A systematic study over specified perspectives heave light upon the new subtleties regarding women's reproductive health care: the study demands an outlook of the present scenario in an existing range of occurrence, vulnerabilities, and the prevailing concerns of women's health. Geographical, economic, and political reasons are also major contributing factors in the study. Family, society, and culture are the three main factors that motivated me to draw attention to this academic research. Reproductive health issues and their complexities are multi-layered, and health is specifically internalized to be gendered. It is an issue of girls and women who bear the pregnancy and motherhood and are never treated as equally responsible activity-based as family.

Moreover, women evolved from docile, submissive to active, outgoing participants in various dimensions. Along with the present status, women are experiencing the repercussions of globalization. Reproduction health care is also changing with women's choices to incorporate in their lifestyles and behaviour patterns. Understanding women's health and wellbeing are fast developing, as the issues are considered corrections, dreadful new decease is catching up. This particular dimension gave a vital point to take up the present health issues. The reasons could be how far the existing interventions successfully reach the vulnerable population.

Examining the role of women headed for women at large, by all means, are they aware of their bodies? The following reason, in general, any woman or a girl is neither said to know of the adolescent phase, physical and psychological implications, and significance of adult women in bearing a child and the wellbeing of the mother and child educative and scientifically. Even though it is mandatory for all the schools included in the curriculum, they are either skipped while taught or asked to read independently for the sake of academic results. By the time they reach adulthood, they continue to understand such doubt and despair among the underprivileged women.

Moreover, all the levels of women and girls, including the elite with varying understanding and intensity. A thorough investigation in reading and collecting statistical data and analyzing the facts sheets were the only way to find the bottom line and the root cause for lack of awareness, inequalities, and discrimination. Gender roles are interconnected and structured, intricate in practice having substantial implications socio-culturally and politically motivated. Reasons for sustainability in such thinking and practices are the questions needed to analyze and emulate the cause and solution. What isgender equality? Availing equal opportunities by men and women in controlling socioeconomic and political resources is the abstract of gender equality.

The female gender is still considered a liability that adversely affects the economic status, social condition, and cultural aspect, an integral part of the society. Primarily reproduction health is limited to pregnancy and delivering the baby. In general, upper-caste people have better exposure to several life cycle issues, including reproductive and sexual health matters, than less privileged

caste such as scheduled caste and scheduled tribes. This status can be mainly due to the upper caste's high socio-cultural and economic levels. An attempt is made to know the influence of caste on marginalized and underprivileged women's reproductive and sexual health concerns. The first pregnancy bearing a girl child is considered an unwelcome gesture. A second girl child is a curse and a problem to the delivered mother and the child in the family. This notion of reluctance in accepting the girl child itself enroots gender equity reflecting on the health inequities drastically—social and cultural practices like dowry, which economically and politically attribute to the conventional patriarchy.

It strengthens the male supremacy in decision making and opting for childbearing and child-rearing, controlled by males economically. The physical efforts are made by the female counterpart in the family system. The women's subservient role in society, in fact, complaisant barriers and promotion of health among the women. Particularly health inequities are more prevalent in the lower strata women who are socio-economically disadvantaged.

CHAPTER 4

Adolescent Health Care and the Impact of Health Education Intervention

4.1 Introduction

This chapter discusses the status of voluntary and government organizations in promoting health education among adolescents, an often neglected area of public health research. Adolescent health care is a cluster of human physiology, nutrition, disease prevention, and sex education. The Lancet Adolescent Health Series reported that adolescents are more exposed to substance abuse, sexually transmitted infections, and other risks than in the past because of the emerging challenges of social media. However, despite recognizing its importance, especially for adolescent girls, the health education imparted is highly skewed in actual practice. Attempts to introduce a sex education component of health education in Indian schools have been met with hostility and prejudice, which has resulted in newspaper headlines (Jha, 2014). The research study justified probing the adolescent girls' health education in government schools (where the less privileged are enrolled) and found that most schools do not sanction or provide information on sex education. The second focused point is how avoidance has increased school victimization and dropout rates. Thirdly, voluntary organizations that foster health education programs at large intend to understand how voluntary organizations impact adolescents' health. We also examine the attempts being made by voluntary organizations to

promote health education programs for development in the broadest sense by hearing the silent adolescent's unheard voice. We also aim to understand how voluntary organizations impact adolescent health education.

4.2 Health Care for Adolescent Girls

Although it is recognized that girls' health education is imperative to the development process, poverty and gender bias negatively influence gender-equal access to education and health care. It has been widely acknowledged that education does not necessarily ensure better knowledge and grasp of gender issues. Awareness of gender issues among the school's growing population comes during the adolescent years. Health education for girls has three different facets. 1) Knowledge about nutrition and health 2) Knowledge about the body and diseases 3) Sex education. In recent years, World Health Organization (WHO), United Nations Population Fund (UNPF), United Nations Education, Scientific, and Cultural Organization (UNESCO), and various researchers and practitioners have, as part of their programs promoting Family Life Education, specified the operational guidance for Comprehensive Sexuality Education (CSE).

National surveys have recognized Indian adolescents as one of the most under-served population groups for imparting health education. It is well established that the relationship between education, health, and economy is interconnected, reshaping each other. This chapter explores the fraction of the

adolescent population from underprivileged slum areas, which is rarely addressed and documented. The role of voluntary organizations promoting health awareness among adolescent girls is instrumental in generating knowledge and information gaps. A study on anaemia in adolescent girls conducted in the urban slums says that nearly 50 % of the girls suffered from anaemia in Hyderabad (Naidu 2014). His findings suggested that health education on the causation and prevention of anaemia be given to the girls. There was a large gap between the prevalence of anaemia in literate versus illiterate.

The study also showed that NGOs intervening in health education programs in these slums lead to folic and iron supplements to prevent anaemia. Such studies give more impetus to extending the reach of NGOs to programs beyond reproductive health only. An effort to tap into adolescents' unique perspectives and experiences contribute to better understanding their needs for better solutions are discussed in this chapter. According to (WHO 2000), fundamental biological changes from childhood to early adolescence are established, leading to stress on health at puberty. An essential transition from adolescence to adulthood is the process of understanding oneself, others, and relationships. Understanding causal relationships develop in early adolescence, and problem-solving becomes more sophisticated. At this stage, an individual's social interactions change drastically from childhood, as more time is spent with peers leading to increased interaction with opposite-sex peers. Moral development also occurs as adolescents internalize different opinions and

messages they receive from various sources. Specific need-based interventions endorse various complexities that situate sex education as crucial at the adolescent level. Added the intensity, juvenile sex activities are challenging to measure, and the available data is minimal or unavailable. The training and the awareness programs are intended to begin at early adolescents.

Core knowledge of human rights concerning gender norms, consent and decision-making, sexual oppression, gender-based violence, and sexual diversity should be mandatory in early adolescence. One of the tools to disseminate health information among adolescent youth is CSE (Comprehensive Sexuality Education). Reproductive issues are often standalone topics introduced from a gender perspective. Moreover, such gender content dovetails to keep girls in school and promote a democratic learning environment. A safe and healthy learning environment administers a practical participatory teaching approach, helping the learners personalize information and better skills. The youth affairs and adolescent development policy highlighted health, nutrition, reproductive, sexual, and mental health (Youth Policy 2012). Nearly 253 million adolescents in India are between the ages of 10 and 19 and constitute almost 20 % of the world's adolescent population.

In a seminal study on the modern-day stress on adolescent girls in India, Kiran Malik argued that adolescence in India, especially for girls, often leads to the curtailment of opportunities and personal freedom. She suggests that India can reap adolescent girls' demographic dividend by giving appropriate education and being equipped with skills and a healthy lifestyle (Malik 2015).

The present chapter mainly emphasizes one aspect of this challenge, educating girls at the adolescent stage about human physiology, sex-determining factors, nutrition requirements, sexuality, and impact. Gender bias affects the educational framework in the Indian context, no matter how much resistance is against it. The male child will always favour getting educated in a family where resources are limited due to income, caste, orreligion. The seeds of secondary status are planted in the girl child, making it challenging for her to be a confident woman capable of withstanding the abuse.

A growing research community has found gender, economic status, and caste work together, forming health inequities. The adolescent health care and mainstream health care system has several gaps that need to be channelized. School admission data, state policies, and the available interventions all combined provide some insight. Feminism tells us that sex is biological, but gender is a social construct. However, feminism is not recognized as a necessary part of an educational curriculum. The difference between sex and gender is not clear and unknown, and youngsters are made aware of this difference at an elementary level for a more balanced view of the world. Many social scientists, Mark, observed that although feminist research has provided the foundation for the most understanding of gender equity in education, the politics of knowledge has excluded the woman's perspective in mainstream scholarship (Mark 1996).

Gender research, which has its goal of "equality, equity, and empowerment," has gained legitimacy. This type of research has, in many cases, served to reinforce traditional and firmly believed ideas of gender differences. Questions about these traditional assumptions and why they exist

have not been addressed yet. For example, one can take the conventional policy assumptions about sex education. The right feminist questions could be who /what was silenced in removing sex education from the education policy and how this affects voluntary organizations? Such feminist reforming is often necessary to uproot gender bias. Using a gender lens, examining such prejudices sheds light on some Secunderabad and Hyderabad schools' practical health education programs to see how voluntary organizations provide health education material to underprivileged adolescents.

4.3 The Demographics of the Adolescent Population of Hyderabad

The study is geographically limited to the Hyderabad and Secunderabad area; the population distribution of Hyderabad/Secunderabad demographics are given in table 1. According to the 2011 census, Hyderabad's population is 7,674,869, and total Adolescents(11-19years) are 18.5%, and girls are 48.5% of it.

Population of details	**India**	**Hyderabad**
Population,2011censes	1,210,569573	7,674,689
Males	623,12184	51%
Females	587,477,030	48.8%
Present literacy rate	73% Males 56.9% Females 43%	83.96% Males 86.99% Females 79.35%
Adolescent 11-19 year	22% of the total	18.5% of the total
	Males 53%	Boys 51.5%
	Females 46%	Girls 48.5%

Table: 1 Demographics of Hyderabad population distribution

Hyderabad's portals show the distribution of govt Aided and non-govt Aided schools in the Secunderabad- Hyderabad area. Six hundred sixty-eight schools are unaided, and 181are government— (AP Online Portal, 2015, DEO Hyderabad portal 2015). I am applying purposive sampling, which is selective and relies on the researcher's judgment. When researching gender issues, especially in health education, the feminist approach offers methodological insights. The relativity of both qualitative and quantitative necessitates the research objective—an attempt for research, theory, and practice together in an intersectional feminist approach.

4.4 Adolescent Health Intervention

Purposive sampling is adopted to gather information about adolescents' prevailing trends for adolescent health intervention. Tools applied are ethnographic interviews, narratives, focus group discussions. Empirical data are the prime sources, and interpretation is made with the adolescent participants' specific responses. Further details are done in the methodology chapter and identified 25 schools in Secunderabad and Hyderabad. Ten were exclusive girls' schools, 5 were exclusive boys' schools, and 10 were co-educational schools. Schools identified are for students of the underprivileged section, both in caste and economic status. They fall under the benefit schemes of the government like Sarva Siksha Abhiyan and Rashtriya Madhyamika Siksha Abhiyan(RMSA), Rajiv Vidya Mission, Mid-Day-Meal, and Attainment of Basic Competence (ABC) program (Rao, Rena, and Nair, 2008).

For the study on adolescent health education, sources adopted as per the (WHO 2015) issued guidelines by setting eight global standards of quality health care services for adolescents. The adolescents' health literacy, community support, the appropriate package of services, provider's competencies, facility characteristics, equity with non-discrimination, data and quality improvement, and adolescent participation. The sourcebook for applying a specific method is similar to the (WHO 2019) 'Handbook for conducting an Adolescent Health Services Barriers Assessment' (AHSB). The particular forms of obtaining information consisted of three stages on school site visits—Focus group discussion with students and interviews with the teachers. About 180 students participated in the Focus Group Discussion (see the notes). I interviewed eleven teachers in the schools. The moderator conducted an orientation briefing on body, sexuality, behaviour patterns. After an hour of the session, time is set for the question hour for students and teachers.

First, we set up focus group discussions in the three schools identified in table 2. discussed the level of awareness and knowledge the students had on health issues. The teachers were also asked about the method followed in teaching health-related matters in the curriculum. Students responded positively to general health issues such as body ache, obesity and hair loss, and infectious diseases, but they did not link these with nutrition and lifestyle. They were concerned with memory, forgetfulness, and personality development. However, such health issues are not addressed in the curriculum. Mental health disorders

are entirely neglected due to their stigma in the mainstream health system. To understand health care and health education among adolescent girls and boys was conducted.

Focus Group Discussion involves the group of participants in an informal debate among selected individuals about a specific health issue. The issue considered for the study is adolescent sexual health care. It's a focus group interview or a group depth interview involving the moderator and the researcher in collecting interactive data. The Focus group is the unit of analyses based on notes analyzed from the focus groups while debriefing from each session.

In five government schools' focus groups, the discussion was held to collect their opinions and perspectives on general health and sex education. We considered all the government schools because they have interventions of voluntary organizations. The schools that participated in focus group discussions are givenin Table:

Name of the School	Students	Staff
Govt. Girls High School, Picket, Secunderabad	60	5
Centenary Govt. School, Mahaboob College, Secunderabad.	Boys 45 Girls 35	5
Govt. High School, Masab Tank, Hyderabad. IRCS, Telangana.	45	5

Table 2 Schools participated in the FGDs

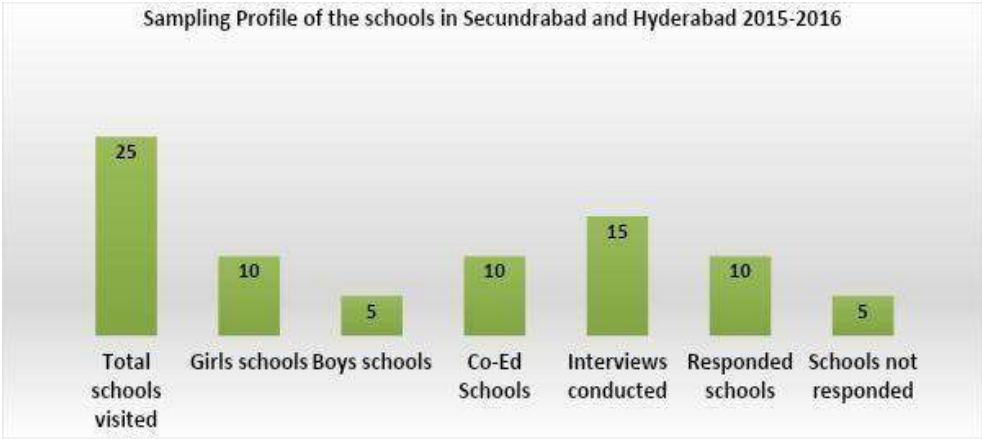

Figure: 1 The sampling profile of the schools

The sampling profile of the schools visited was 25, and the interviews conducted in 15 schools are shown in fig 1. Ten co-education schools and five exclusive boys and ten exclusive girls are examined. We also had a negative response from five schools. However, ten schools that responded positively could make a pilot study in the research context.

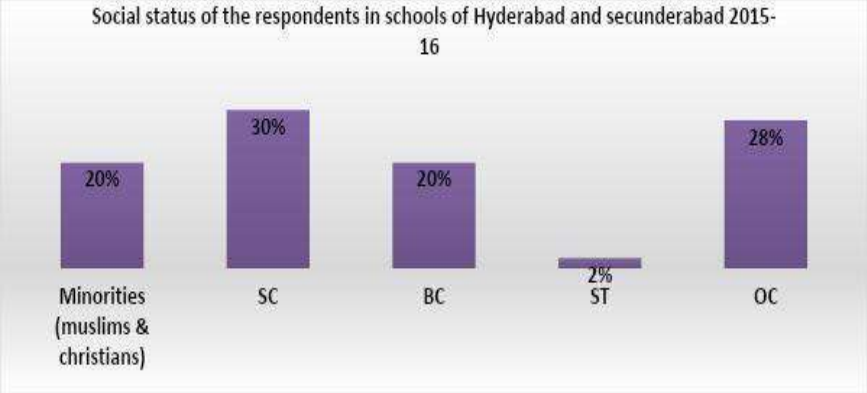

Figure: 2 Social status of the respondents.

Demographics of social position are mentioned in figure 2. Muslims and Christian religious minorities were 20%, SCs and BCs were 30% and 20%. STs were 2%, and other caste school boys and girls belong to different castes, not considered for the study. Based on fieldwork conducted in the school, information on various organizations' participation and participation is collected and shown in the list. The following are the voluntary organizations and the services rendered. See table 3

Indian Red Cross Society	Women volunteers contribute time,money, and other services required.
Lions Club	Health camps conducted & distributionof medicines, spectaclesare done
Rotary Club	Health camps, Eye Camps, and otherdonations like books, benches, and pens
Sarojini Devi EyeHospital	Eye Check-up Teams
Dental Clinics	By leading practitioners/trainees
Team India	Teaching language and other subjectsrequired
Senior Citizen Forum	Books and school uniforms, lecturesonhealth and hygiene
Society for aged and women(SAW)	Lectures and training programs onhealth, distribution of sanitary napkinsto girls
Manavatha Parivarthan	Health education
Sweekar Upkar	Medical Camp

Table: 3 The list of VOs and their services

4.5 Results and Discussion

The ten organizations mentioned above executed their services' such as health camps and donations of various materials like books, school uniforms, and sanitary napkins. Understanding the perceived needs of these wards is the only criterion. Some organizations focused exclusively on medical centres

distributing vitamin supplements and supplying free spectacles in the eye camps. Health care training, as such, is unheard of in schools. For instance, May be an adolescent boy or girl who is aware of substance abuse and understands the element of exploitation is known to some extent. Still, they miss out on proper training to face the situation. Global Monitoring Report 2015 (UNESCO, 2015) insisted that training should be designed to be relevant to local contexts and include comprehensive sexuality education. Teachers need teaching and learning materials that question gender stereotypes and promote equitable behaviour, and we couldn't find them in the school's schedule.

There was a lack of information concerning specific issues like menstruation, reproductive system, contraception, prevention of sexually transmitted disease, and associated these things with uncleanliness. There is a question of morality and values to openly discuss the issues related to sex and sex-related myths among the students and the teachers. Teachers accepted limitations and embarrassment in teaching the sex-related lessons, and therefore they either ignored them or used plant and animal examples to illustrate while teaching. The students did not identify with this approach and were left to know about these issues independently.

Urbanization without basic amenities and health care is a fundamental problem in the Indian health system. At this level, students are left wayward in assumptions gathered from their friends, social media like the internet, what's app, television, and movies. And if the knowledge about the body, physiology, sex organs, and their functions in detail were not addressed adequately, it leads to risk behaviour patterns in the adolescent.

The next step was to examine the voluntary organizations addressing some of the health education issues for adolescent girls. Manavatha Parivarthan Society has been conducting awareness programs focused on juvenile health issues, general health, and hygiene for boys and girls in government and private sectors. Targeted intervention to the low-income and marginalized sections are also the focus. Community-based programs such as blood donation camps, complete health profiles, and need-based intervention among the underprivileged are Table: 4, which gives the health issues that are part of the girl's curriculum and how the VOs address them. List various health issues in the schools managed and services rendered by multiple VOs. The dialogue engaged students and teachers on adolescent health care. The discussion included human physiology, the origin of species, the history of human beings' evolution, gender construct and the physical, emotional relationship of a male and the female, the incidence of sexually transmitted diseases, and consequences.

Awareness on Health andHygiene	Manavatha, Lions Club, Rotary Club
Sex Education	School curriculum, Manavatha, IRCS volunteers
HIV/AIDS	Govt. org such as UPHCGandhi Hospital

Table 4: List various health issues and the voluntary and government organizations.

4.6 Adolescent Health Issues from a Feminist Intersectionality Perspective

We got an overall picture from an Indian perspective promising potential projects to show no shortage of adolescent health education interventions through government and VO interventions. None of the services is reported and documented. Consistency in disseminating knowledge and continuous training is always an issue and concern of the VO and the govt welfare programs. Gender inequality has profound repercussions in everyone's life, damaging physical and mental abilities. Even though partially visible and mostly silenced, the impact needs correction at the down-up level. Feminism enables us to analyze discrimination in all grades and intensities. Understanding the gender roles and implications are the lessons taught and practised in the family and society. 'If you see inequality as their problem or unfortunate other problem, that is a problem,' says Kimberly Crenshaw (Women U N 2020).

The gender roles stereotypically reaffirm the next generation from a very young age. Some examined adolescent health access concerning gender, age, location, and poverty with a similar lens of intersectionality in Ethiopia. The key factors influencing the inequalities are addressed by informed interventions (Jones 2020). In attending the SDGs, mainstreaming gender equality as a feminist research concern is also a crucial objective emphasizing the structural disparities. In accessing adolescents' health care, we intend to draw adolescents' information and perspectives in specific school interventions of Secunderabad and Hyderabad.

However, the execution of interventions is a severe moral and financial problem. Since the government schools provide strategies to improve gender-equal educational access, they must address the social factors that impact the family decided to send girls to school and impart sex education to the students. Sex education is considered a western concept that is not tolerated in modern Indian society. Neeru Garg's paper stated that sex education in the Indian context is a phenomenon of Western practices, child marriage, and teenage pregnancies that indulge in legal authenticated sexual activity at a very young age (Neeru Garg, 2015). There is confusion between sex education and education about sex. It is misconstrued that this leads to sexual promiscuity. The study explicitly described adolescent girls' need to know and discuss pregnancy. Kurapathi emphasized the first documented adolescents living with AIDS from the All India Institute of Medical Sciences(AIIMS) (Kurapathi S. 2012). All that is learned in misassumptions and misguide about sex is shrouded in secret, and it reinforces unequal gendered views, which victimize, emphasize women, and empower men. Sex is viewed as something done to women. None of the educational programs addresses this issue with the required intensity in empowerment.

4.7 Adolescents Participation in Shaping the New Perspective

Subsequently, the next step was to ask the students and teachers. After the awareness session, many students asked various questions about sexuality, sexism, abusive patterns, and considerable doubts regarding family life education. The consciousness-raising session of the adolescent group voiced their silence in multiple questions.

1. Why is sex required in our lives?
2. When sex is for progeny, why do they have sex after producing kids?
3. How can we overcome the attraction towards the opposite sex?
4. What is the meaning of sex, and how is it?
5. Why do parents get us married at a very young age? Can you help us toavoid it?
6. Why do we feel abusive and shameful to raise questions on sex?
7. Can we overcome the influence of social media?
8. How to tackle peer and parent pressure?

Manavatha Parivarthan Society illustrates the new questions generated by the young students on adolescent sex education intervention. A dimension that others have not sought out and drastically ignored caused a challenge in answering such questions in the listed educational institutions mentioned in the table: 3. It is important to note that the study material is appropriately researched and compiled in response to questions raised by the adolescents of this intervention. It was prepared while planning the interventions considering the interactive responses of reproductive and sexual health care case studies.

1. Sex is an integral part of our creation, and it is the process of producing similar species and applicable to all living creatures. An evolutionary process that keepsmoving from birth to death is a cycle within itself.
2. Yes, sex produces children and sexual acts, but it is also a biological need and physical desire. It is also related to the emotional aspect of sharing love, affection, and compassion with certain limitations. Present living conditions are

more curious about sex because of the change in the attitudes and agency towards sex. People have become more expressive with fewer inhibitions, and executing individual freedom is the primary concern.

3. Yes, males and females of any species have certain hormones that provoke each other in physical attraction, leading to a sexual act called intercourse and resulting in pregnancy and delivery of the babies. This process occurs among allthe universal species, such as animals, plants, and other living millions ofspecies around us. This law of attraction is also applicable to the human species.If you look back on the timeline of millions of years, the evidence of fossils and excavations, we see disappearances and the human race's extinction many times to date. The causes are many instances that are unknown and are still a mystery. Pieces of evidence show medically and scientifically that children born to the same blood group parents are deemed to accept the children with congenital abnormalities, deformities. On most occasions, they die prematurely. Scientifically explained proof is one reason for not encouraging sex with the same blood group. Eventually, the system has evolved and established into a social and moral norm. Taboos and values are created around the essential involvement of sex among the siblings and the same group of individuals as a sensitive and value-based issue.

4. Such values are incorporated into our daily lives' cultural and religious disciplines. Henceforth the humans are protected and encouraged for healthy living and extend the longevity of the entire civilization. It is explained from a marginalized scientific perspective. In1994, few researchers found 4.4% excess mortality with inbreeding among first cousins (Brittles, Niel,1994). Progeny of parent-child or sibling are at increased risk. Studies suggest 20-36% of these leads to death or disability. Another study on similar lines (William.H.,2004) examined 29 offspring found that 20 had congenital abnormalities and four autosomal recessive alleles (Baird, McGillivray 1982).
5. Sex involves the two physical features or bodies as male and female. They come closer and physically get involved in the act. The body receives the changes internally to get into the action called intercourse, as you all observe in other species like birds, animals in nature, and explained in your textbooks as part of your curriculum. This action releases feel-good hormones in the body and relieves stress levels. When this happens at the right time with the right person in the right way and at the right age is the most critical factor to be considered. The right age for marriage in the Indian context and tradition is 20 for females and 25 for males. This age indicates the preparedness of the physical and mental ability to start a family life. However, it can be considered the right time to get involved in sex. The right person is the person you are married to, and the sexual act is healthy, legitimate to lead a healthy relationship.

Interaction between the students and the interviewer/research scholar in the focus group discussion was an insightful tool to frame a further action plan in promoting adolescent health issues among voluntary services. Intersectional lens and feminist approach examine the girls in the sessions, found were curious but hesitant to raise the questions. Boys were better participants, and they raised many questions as they were outgoing and outspoken. Gendered roles are reflected in their day-to-day lives as part of the culture and traditional norms making young girls less informed than boys. The same age group of gendered behaviour patterns was overwhelmingly visible. One of the interactive sessions gave insights into family and society's behaviour patterns against the girl child. When asked - do you find any gendered discrimination between the male and female siblings in resource distribution like food, clothing, and the other requirements? The most stirring fact was that the underprivileged communities still believe that the boys have to be fed more, and milk is provided. Instead, girls are given diluted leftover tea. When girls raise their voices against, they are confronted and silenced by telling them that boys are the future breadwinners and take care of all the privileges. Whereas girls tend to get married and leave their parents and make their own families, they are denied equality and equitable resources in personal spaces. Subsequently, girls and boys are trained in specific patterns in reinforcing the patriarchal norms from their childhood. Infancy claims an unbreakable circle leads to girls' undernourished future generations who are made to prove weak physically and

less confident in their accomplishments. In brief, it explains adolescent healthcare systems interact, insect, and interconnect sociocultural norms, economic resources, and education structure.

4.8 Limitations and Research Needs

We find limited information and awareness on adolescent health care; no specific health issue is discussed and documented for finding substantiated references. No traces of independent research data sets are available. Even sources such as voluntary organizations and government organizations have limited interventions on the effect of adolescent health education requirements. As we have analyzed, the lack of information skewed knowledge of the younger generation's health care system. Present-day academics acknowledge the paucity and knowledge gaps as a pressing issue of concern and focus.

4.9 Conclusion

The scientific sex education of adolescents shapes their minds and thinking towards a healthy gendered attitude, which helps avoid health-related risks. The earlier, the better incorporating the knowledge building from the family, community, and the best is schooling. If the health system fails for girls, it fails its whole developmental process. 'Health for all' is hampered at the beginning in adolescents. Vulnerable to various changes associated with physical, emotional, and psychological transition, adolescents/ youth must have

proper knowledge of sex education that, in the process, empower them into healthy, productive. As aptly studied, Sunandamma says discrimination has become a tradition in the society where right from the basic needs of food, clothing, shelter, and education, any work level girl children have become victim to discrimination (Sunandamma 2004). Adolescent girls in the developing world need to acquire remunerative and marketable skills not taught at home, such as computers, fluency in an internationally spoken language, financial skills, and social systems knowledge. Technological growth enhances the choices towards gender justification and a balanced society. Where gender is a construct, deconstruction of it seems proper using suitable strategic perspectives.

The parliamentary committee recently recommended against sex education in schools. Adversely, the committee suggests deleting physical and mental development in adolescents. AIDS and sexually transmitted diseases are deleted from the mainstream structure. Instead, they want these topics to be included in the biology syllabus, which further disadvantages marginalized section students who are hindered in gaining health knowledge. Moreover, these students who belong to marginalized communities selectively opt for vocational training courses for their early financial support are more susceptible to diseases and infections like HIV/AIDS and other infectious diseases. It further puts the adolescents in a more critical situation than before. However, proactive policies and activities are a dire need for innovative coordination with skills to enhance critical thinking and decision making. Furthering a habit of continuous learning capabilities facilitates girls in the fast, ever-changing dynamics.

Additionally, parents do not have proper and scientific information about sexual and reproductive health-related matters. (Mahajan and Sharma 2005) also support the argument that the silence in adolescence and clarified doubts expressed in the study are testing indicators. However, neither the parents nor teachers clearly understand the implications of sexuality and rather discourage open and healthy discussions. Such fear and inhibition imposed on a girl's health education are at a more significant barrier for her future socio-psychological development and the individual's wellbeing of the society as a whole.

In conclusion, more intervention is needed to tap into adolescents' unique perspectives, knowledge, and experiences, contributing to a better understanding of their needs for better school solutions. Training sessions need to be conducted to educators to impart sex and gender education, shaping the learning enforce and reinforce contextually. The study reiterates that VOs are instrumental in bringing this about systematically and scientifically. Based on the practical and critical examination, we find gender consciousness and gender-inclusive perspective that VOs facilitate an interface between the local government and the community regarding health education among adolescent girls.

For implementing government welfare schemes, voluntary organizations serve as a bridge between educators and teenage students. However, government schemes like (SABLA 2013) have been introduced in all the states

of India to empower adolescent girls in various related health issues and lifestyle skills. Lack of trained teachers, shortage of funds, and budgetary constraints slowed down the scheme in action. There are many healthcare programs under various ministries to address adolescents' problems: Kishori Shakti Yojana, Balika Samridhi Yojana, Rajiv Gandhi Scheme for Empowerment Adolescent Girls is known as "SABLA" scheme, Rashtriya Kishor Swasthya Karyakram, and Adolescent Reproductive Sexual Health Programme (ARSH). It was only fruitful to some extent, coordinating the local voluntary interventions. Even the teachers and the school heads of management expressed their opinion and suggested that voluntary organization interventions play a vital role in imparting sex education. Instead of avoiding topics like sex education, a scientific adolescent-centred objective is needed. This subject should be a part of Family Life Education as a standalone FLE subject/program.

The national survey findings of the department of women and child development say one or more forms of sexual abuse faced by children are 53.2%, and at least half are known offenders of the family and the child. Therefore, sex education might help the vulnerable young population be aware of their sexual rights and protect themselves from undesired violence and sexual abuse molestation. At this stance, we can relate to the implications of sexual health care workers that female sex workers get into sex work at a very young age for supporting their families financially. Because adolescents are particularly vulnerable to specific health issues, educators, research scholars,

communicators, and other concerned citizens are appealed to 'be adolescent competent,' invest their knowledge and experience pragmatically for the advantage of most fragile adolescents.

The hour's need is to communicate clearly and encourage adolescents to talk openly and instead respect their privacy and confidentiality. Voluntary organizations are progressively working with government agencies to promote health awareness is limited and skewed by various reasons, as highlighted and discussed. And much more strategic programs to impact and improve attitudes towards gender equality and eradicate discrimination.

CHAPTER 5

Sexual Health Care and HIV/AIDS Awareness of Female Sex Care Workers

5.1 Introduction

This chapter is dedicated to the role of voluntary organizations in promoting awareness of sexual health care and HIV/ AIDS awareness in sex workers in Hyderabad Secunderabad. Sexual health care is embracing sexuality physically and emotionally in a healthy environment. Although the need for sexual health care is universal, it is crucial for sex care workers as they are the most vulnerable to sexually transmitted diseases. Awareness programs and education in sexual health are often unavailable to them as they are a marginalized section of society. Specifically, in this chapter, sexual health is categorized as awareness of the sexually transmitted disease (in particular AIDS) among female sex workers.

Women's health, empowerment, and AIDS eradication are all global concerns incorporated in the seven Millennium Development Goals (MDGs) focused on sexual health and reproductive rights proposed by the United Nations. Later, Sustainable Development Goals(SDGs), specifically in SDG3 and SDG5, address Health and well-being and gender issues of women's marginalization globally. However, gender prejudice prevails in every corner of

society in multiple variants. There is a shortage of awareness programs targeted explicitly towards women sex workers, which constitute one of the highest risk groups. As discussed in earlier chapters, female sex workers from the underprivileged sector are of low socioeconomic status. But, in the Indian context, they are marginalized in hierarchical socio-cultural settings by caste, religion, and gender-oppressed at multiple levels.

Gilligan argues that “Voice is the foundation, and radical listening is the only access” while discussing that many voices are excluded in a patriarchal culture (Gilligan 1998). A study on sexual health care of sexual victims' real-life situations gives a voice to the victims. Understanding their experiences from a new perspective is our research criteria. Sexual health issues are looked at from a woman-centred perspective through which discrimination is scrutinized and also evaluated. Female Sex Workers (FSW), according to (UNAIDS 2012), are those workers who have monetary benefits acquired through sex regularly or occasionally. In addition, there are informal sex workers such as those in the “Jogini” system used to victimize young girls. It is prevalent in Hyderabad, especially in the Telangana region. Mishra emphasizes that the Jogini system gradually converted young girls recruited from scheduled castes into concubines to obtain womanhood. The mechanism for induction was that religious superstitions, lack of economic assets make young SC women a marketable commodity in concubine trade, and social weakness as female increases her vulnerability to coercion. (Mishra,2011).

Literary sources provide an insight that women cannot prevent sexual disease in a public health domain because they are victims of men's sexual power and privilege. Sexual health issues are always addressed from a women's susceptibility paradigm, and female sex work legitimizes trajectories of HIV/AIDS. Suniti Solomon, a physician microbiologist, first documented and talked about HIV/AIDS in India. Eventually, it played a crucial role in educating about the threats of the epidemic. One of the first patients tested among a group of sex workers was an adolescent girl of 13 years' old who was forced into sex work (Solomon.S.2006). India has the second-highest population of HIV/AIDS after South Africa.

The sexually transmitted disease is a hurdle to human development due to its infectious nature, leading to public health and human rights crises. The epidemic is high in its prevalence and covers 1% of the population out of 7 billion of India's total population. Though India registered its first HIV case over three decades ago in 1986, presently, it exists in 29 states of India. Identifying and targeting the HIG (high-risk groups) is essential in averting sexually transmitted diseases in India. National AIDS control organization (NACO 2006) estimates 0.6% to 0.7% of the adult female urban population is engaged in transactional sex. The female sex worker's health issues are crucial to the fifth five-year plan of the national agenda. The National AIDS control program aims at 100% coverage through community mobilization target intervention.

5.2 Sexual Health Awareness among Female Sex Workers and People Living with HIV/AIDS in Hyderabad - Secunderabad.

Ethnographic methods with added empirical knowledge are applied to learn about the sexual health of FSW and HIV-positive individuals. Hyderabad is the fifth-largest metropolitan city in India, bearing the historical and cultural heritage of five centuries, has experienced the HIV/AIDS epidemic extensively. Due to globalization, migrant populations are the leading cause of sexually transmitted diseases. For three decades, Hyderabad has developed into a Hi-Tech city, a techno hub for many multinational companies worldwide. The universal techno growth has influenced social and cultural lifestyles, and significant behaviour patterns have drastically impacted the public health domain. Pande speaks about 'globalization and commercial sexual exploitation of women's bodies in India,' concluding a threat to human life and dignity. She says they are trapped due to illiteracy, ignorance, and poverty, hoping for a better life. Henceforth, sex work, slavery, bonded labour, and forced labour on domestic and commercial domains are pathways to disease and violation of human rights (Pande.R. 2021). Cultural shifts paved an avenue for spreading infectious diseases like HIV/AIDS and other sexually transmitted infections. Increased job opportunities and improved living standards gave rise to a steep increase in purchasing power. Buyers took over the sex work in commercializing and expanded Hyderabad's unorganized sector.

Preventive measures undertaken by the government are insufficient against the alarming spread of sexual infectious diseases. The interventions of

the third sector are compelled at this juncture. VO's interventions into local health concerns at the grassroots level are appropriate to establish a conducive environment economically and socially at the community level. The preventive measures of VOs assess the socio-behavioral factors at the primary levelspread of HIV sexual contact, mother to child transmission, infection by blood transfusions, and through infected needles used by the drug users.

The voluntary organization strives to create awareness, safe sexual practices, and condoms distribution. According to Hyderabad's data, 80-85% are infected through sexual contact, 15% through blood transfusion. Behavioural interventions thrust negotiation skills such as condom use and lifestyle changes. Community engagement is targeted among the underprivileged or socio-economically marginalized FSWs. Degrees of stigma and discrimination are most experienced among disadvantaged communities. The study explores HIV/AIDS issues through VOs and the beneficiaries' viewpoint. Intersectionality theoretically offers a framework to understand the diversity within the women's community. It gives us a tool for analysis that addresses discrimination at various levels. It is instrumental in the context of sex workers as they are ostracized by society and often eliminated from access to public health. They are often marginalized by gender, caste/religion, and profession. A discussion on how ‘planned social transformation' through women, culture, and development' seeks to consider multiple perspectives of women's experiences. Oppression of women cannot be understood locally, and

feminists need to step out of their specificities connecting national and global spheres (Bhavnani K.K 2003). The policies of neoliberal globalization are perpetuating intolerance and discrimination against women. They justify excluding those left behind by the global economy and aggravating poverty, inequality, and human rights violations. Globalization and economic change are impacting different people in different ways. Multiple identities are addressed by an intersectional analysis that exposes the different types of disadvantage that occurs due to the combination of identities.

Empirical studies and ethnographic knowledge positioned the survey of sexual health issues of female sex workers and HIV positives among high-risk groups(HRG). High-Risk Groups refer to female sex workers, high-risk men who have sex with men, transgender, and injecting drugs.

5.3 Voluntary Services on Sexual Health Peer-driven Intervention

VOs actively involved in HIV awareness work were identified after visiting several websites and visiting VOs in Hyderabad and Secunderabad. I accessed these organizations through telephonic and electronic mails. Contacted the managers and requested staff and peer educators to approach the participants. Executed fieldwork under their guidance to reach target groups of female sex workers. Focused group discussions with the selected samples were held at regular intervals at the VOs office premises. Home visits, pickup areas, and catchment areas such as marketplaces, cinema halls, and labour pickup

points were the areas suggested by the VO's staff. Though the approach was difficult initially to interact with the sex workers, the main hurdle was a personal stigma, inhibitions, secrecy, and confidentiality, mainly due to their take on sex work and infectious disease. Despite these limitations, the researcher pursued being non-judgmental towards the participants and encouraged them to interact freely. University of Hyderabad's ethical committee approved consent procedures for the researcher and the participants to interact and examine the narratives of the research domain.

After investigating thousands of voluntary organizations in the region, the study involves three voluntary organizations. Numerous welfare interventions are carried out actively in various economic, social, educational, religious, and voluntary psychological activities. However, the specific health interventions are outsourced by the government and international agencies such as WHO, UN AIDS, UNESCO, and IRCS. The VO's identified were the Hyderabad Leprosy Control Health Society (HLCHS), HIV Positives People Efficiency Society (HOPES), and Manavatha Parivarthan Society. The mentioned VO's activities to improve FSWs in preventing sexually transmitted diseases strive to support HIV positives and avoid the spread of sexually transmitted infections through awareness, advocacy, and support.

According to the staff's functional hierarchy and the target groups, a questionnaire was distributed to the voluntary organizations. For qualitative or case studies, conducted interviews and focused group discussions. In the

analysis, we present case studies from HLCHS, HOPES, and Manavatha Parivarthan Society, as examples of the larger sample. Two different sets of questions are used for the staff and the beneficiaries. Outreach workers, peer educators, and councillors were interviewed to assess the target groups' services. Beneficiaries are peer educators, FSW, and HIV positives questioned to know their personal, social, and economic status. Methods and tools are further described in detail, and the methodology adopted is mixed methods in the realm of intersectionality theory with a feminist lens.

A qualitative, quantitative study and ethnography are the core tools in collecting data. Secondary sources are consistently acquired from the documents of the voluntary organizations. Reports and reviews were essential sources, and without empirical study, it could have been incomplete, incompetent, and unauthentic research work. Two case studies were illustrated from each of the voluntary organizations. Though data collected from these VO's is comparatively a tiny portion against female sex workers' total HIV/AIDS positives living in Hyderabad and Secunderabad. HLCHS female sex workers have been selected to explore the VO's role in disseminating the designed interventions that suit the living conditions. The rapidly increasing formal and informal research ethics considers human subjects' research ethical procedures. Specifically, in work with indigenous and human populations, ethics and purposive sampling are suggested for the study's reliability. It examines traditional ethical considerations on empirical and ethnographic and

how the research environment has changed to mandate new procedures for compiling the nuances in research work. The proposal was submitted to the University of Hyderabad's ethics committee to get approval to conduct ethnography on human sampling. The ethics committee looked into the code of conduct matters are mandatory. Informed consent of those studied is required from the VO, the researcher, and the respondent is considered stringently.

5.4 Demographics of the Hyderabad Leprosy Health Control Society, Hyderabad, Telangana, India.

For HLHCS, the FSWs' demography in figure (1) has 3000 registered female sex workers. Among these, 2720 FSWs make regular visits to the HLCHS clinic. Condoms were distributed to 2,796 FSWs, and 537 were clinic attendees. Integrated Counselling Testing Centres(ICTC) tests 1760 FSWs, and 300 tested positive for syphilis, and they also found 54 people HIV positive. And the details also illustrated in percentages in table 1.

HRG’s contacted	97.6%
Contacts regular	92%
Condom distribution	93.2%
Clinic attendees	17.90%
Treated for STI	4%
Referred as HRG’s	11%
Tested at ICTC	92%
HRG’s syphilis tested	10%
HRG’s found positive	1.81%

Table 1 statistics of 3000 registered female sex workers

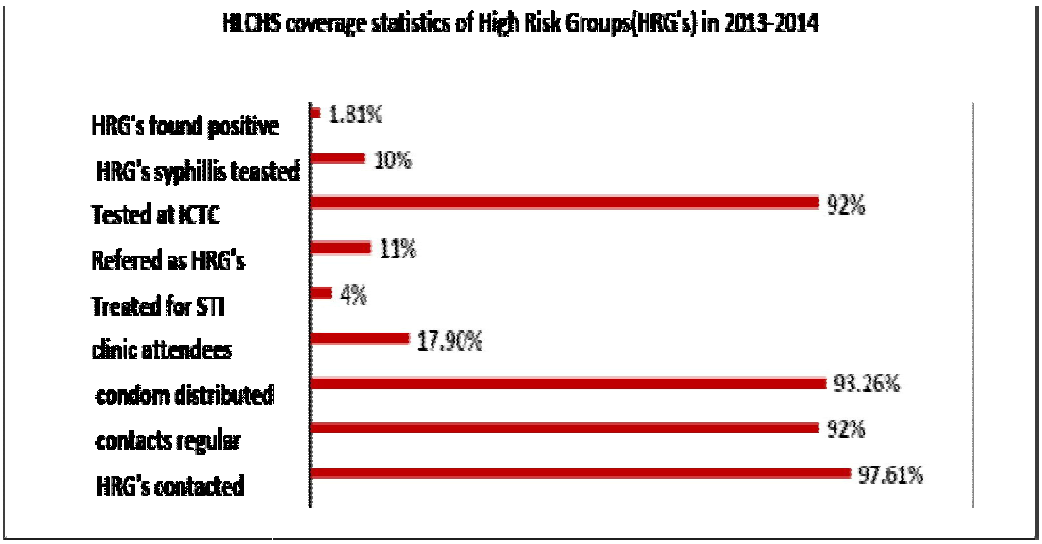

Figure 1 HLCHS statistics of HRGs in 2013-2014

Among 3000 registered FSWs, 1.81% are HIV positive, and 11% are HRGs. The peer educators and counsellors contact 97.6%, 92 % have regular contact with the clinic HLCHS, and each is tested at ICTC. 93.2% were informed about condoms, which is a significant indicator of the planned intervention. We find 4% of them were treated for STD.

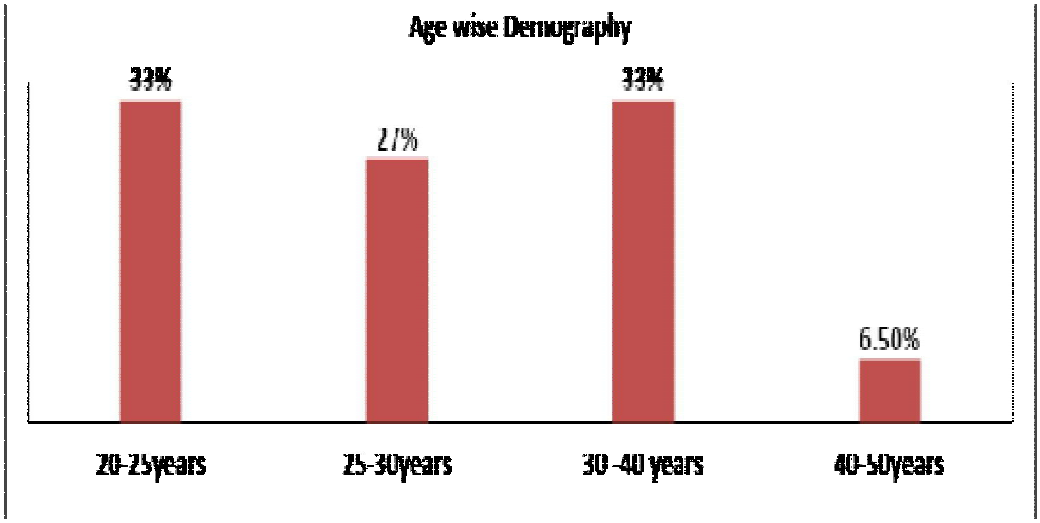

Figure 2 The Age-wise Demography of the Female Sex Work

As the data shows in figure 2, registered FSWs, 90% of the HRGs are 20- 40 years, and 10% of them are above 40 to 50years of age.

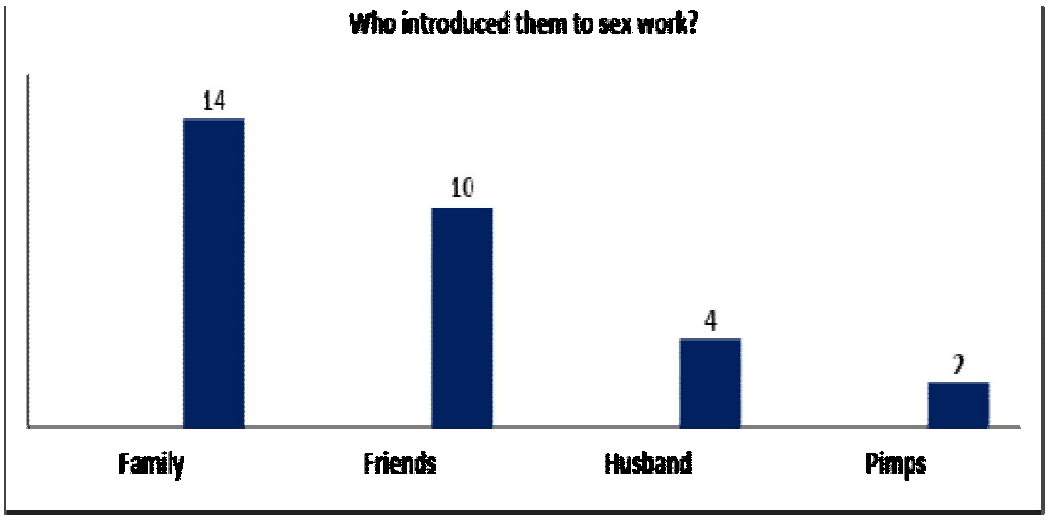

Figure 3 People who have introduced FSWs into sex work

A detailed description of the people who pushed the sex workers into sex work was undertaken. Fourteen said their family members involved them. Ten of them had friends that caused them, and the husbands fetched four, and two pointed towards the pimps in the commercial sex.

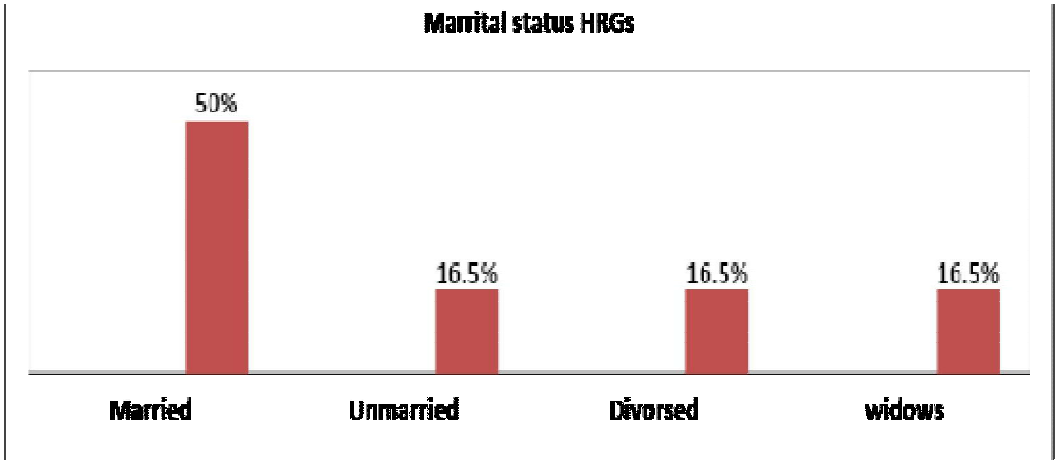

Figure 4 The Marital Status of FSWs

The statistics in figure 4 give the female sex workers' marital status; 50% of the HRGs are married and unmarried, divorced and widows are 16.5% each.

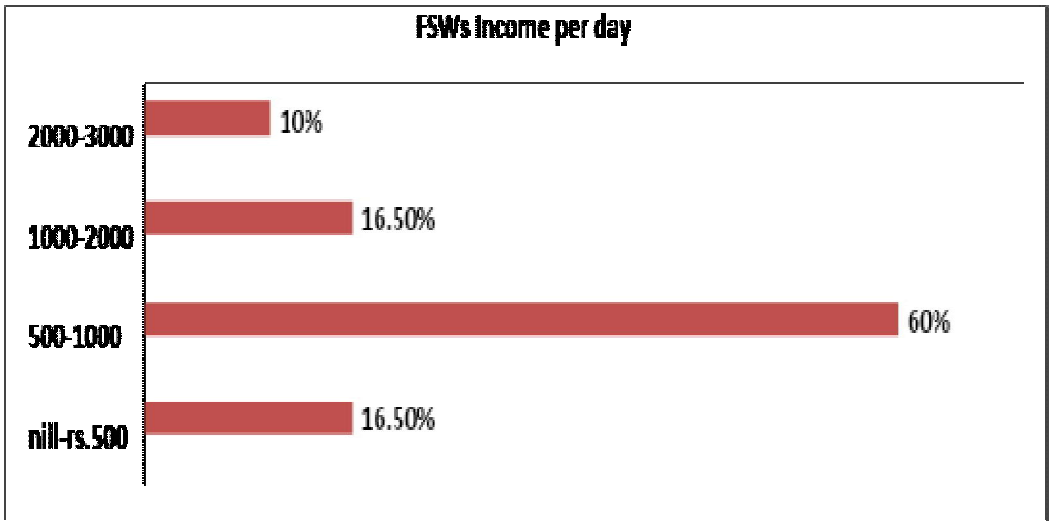

Figure 5 FSWs distribution of income per day

Figure 5 shows that 60% of the females earn between Rs 500-1000, and more than 16% earn less than 2000rs and less than 500 Rs per day. The remaining 10% of them make Rs 2000-3000 per day.

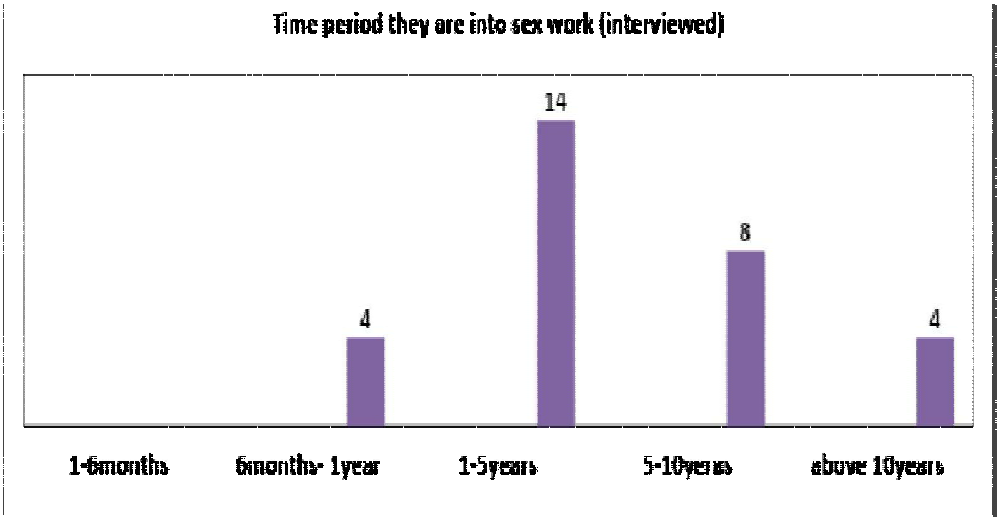

Figure 6 Duration FSWs are into the sex work

Here the data belong to the sex workers interviewed and not the total 3000 workers registered in the HLCHS. Among the 30 interviews taken, 14 of them worked for five years, eight were for sex work for ten years, and four were working from one year to six months.

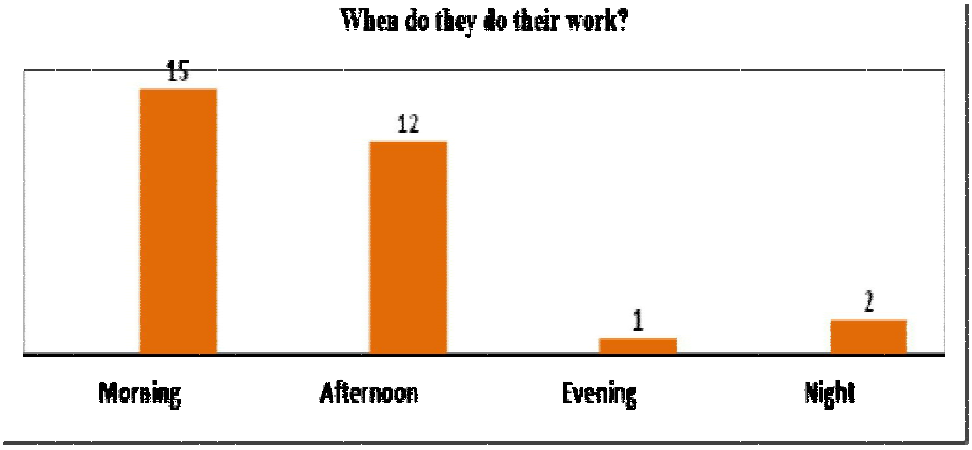

Figure 7 The work time of the FSWs

The data shows in figure 7 that fifteen of them worked in the morning hours, and twelve of them said that people expect them in the afternoons and one in the evening, and the two of them preferred them in the nights. It revealed that the clients expect sex workers' availability in the early hours of the day is to disguise with the working hours.

The data in figure 8 shows that they can accept an average of three clients in a day. Two of them said that it depends on the pimps the providers.

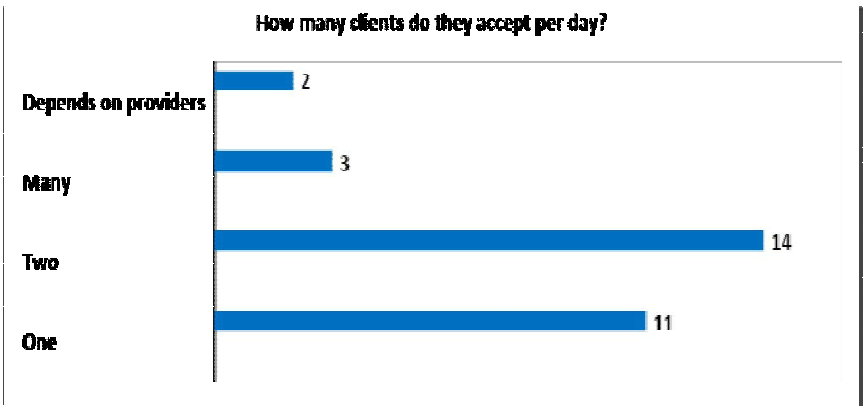

Figure 8 Clients use alcohol during sex with FSW

This question of alcohol is a health concern to female sex workers. Only one respondent out of 30 said that the client never expected to drink during sex. Thirteen sex workers were not insisted on imbibing alcohol, and ten of them experienced the demand to take alcohol. In contrast, six of them consistently had abusive alcoholic sex work with their clients. The impact of alcohol was altogether a saga of negative effect on the health of the FSW. The inappropriate gestures were rude and beyond control, and problematic.

5.5 Case studies of a purposive sample of Female sex workers of HLCHS

5.6 Case Study 1

Mother of a young boy 45 years working as an office assistant in the old city of Hyderabad. She earned respect and good relationships with the community people. Son is 19 years old. After finding that she was a sex worker started abusing and disrespecting her. Son expected her to be a 'good mother.' She faced all the challenges as a single mother because she divorced her husband. He was HIV positive, and she faced domestic violence. Some rich contacts gave her financial stability and education to her son in reputed schools and colleges. She maintained her health and the relationships to date, but her son moved away. She was pained with no hope in her life because she is now tested HIV positive.

5.7 Case Study 2

Most of the registered Female sex workers at HLCHS are trained and counselled by the trainers in using preventive measures like condoms, hygiene, personal grooming, and maintaining their homes pleasant to a healthy environment. Regular door-to-door visits in the identified area accommodate the sex workers' health with all the methods taught through behaviour pattern awareness programs. The peer educators trained her to deal with illiterate clients, adamant and macho men reluctant to the terms and conditions of the sex workers. One 25-year-old FSW was the victim of such behaviour, and she underwent mastectomy due to the client's unusual behaviour. She was treated under a referral centre for further medication.

5.8 HIV Positive People Efficiency Society (HOPES), Padma Rao Secunderabad.

The second voluntary organization identified is HOPES, which is committed to implementing the interventions designed for and by the people living with sexually transmitted diseases and the other government organizations. HIV/AIDS positives run this VO in coordination with the outsourcing to APSACS, NACO, and (AVAHAN), a Melinda Bill Gates-funded AIDS intervention. Ethnography was conducted on 30 HIV positives at Padmarao Nagar HOPES office, Gandhi Hospital. Its activities are implementing workers training programs through critical selections of peer educators by STRC (State Training and Resource Center). They, in turn, identify the HRG (High-Risk Group) population in the areas suggested by

APSACS. HOPES and APSACS take care of the registrations from the underprivileged society, such as scheduled castes, other backward communities who interchange their identity in many instances. Due to the migrant category population, their work mode is constantly wavering, and difficult to standardize their income and employment status. They talk about HIV, identifying them, how they get infected, and types of contamination. Prevention and precautions are discussed, and therefore staff is guided and trained. Most importantly, the training is given to all the councillors and the other team to track the HRG's and get them into the low-risk group and prevent HIV & AIDS. Condoms are distributed at regular intervals to the HRG's.

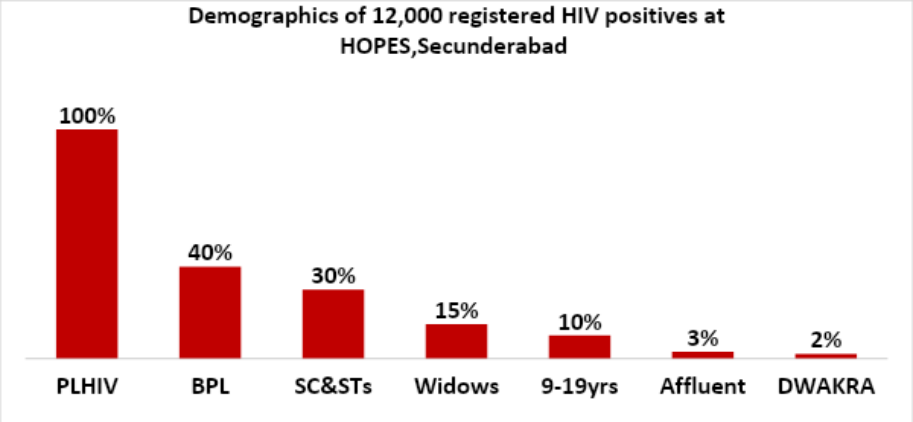

Figure 9 Demographic profile of 12000 registered HIV positives in HOPES.

The demography of the HIV/AIDS positives in HOPES is given in Figure (10). Twelve thousand persons living with HIV are registered with HOPES. Of these, 4,800 from underprivileged communities are the sample studied. 25 HIV/AIDS positives were selected at random for interviews to avoid bias in sampling. SC and ST category by caste are three thousand six hundred, another 1200 adolescent positives of 9 to 19 years, 360 are affluent and upper-class, and 240 are from self-help groups (SHGs).

While researching feminist social work practice, gathering information, a sourcebook has entailed analyzing documents of various kinds and interviewing men and women (Collins, B. G. (1986). For documenting the research experience, I will switch to a first-person narrative. I have interviewed 30 women. I chose these practitioners because they had particular expertise in working with the issues I wished to examine. The beneficiaries are invited to be interviewed and recommended by HOPES staff and peer educators to articulate their own experiences. The interviewees have been willing to have me retell their stories to others but did not wish to be identified. Hence, I quote them anonymously to avoid and mask their identities. Refer to their case materials where it seems appropriate by using fictitious names. This criterion is that their words convey their views more implicatively. I do not have produced valuable findings or these in empirical notes.

I adopt this stance for inquiry with feminist participative research principles. It enables me to listen carefully to the respondents' experiences as they tell them, try to understand what they are saying, reflect more closely on their lives as they lead them, and theories from that (Reinhartz, 1992). That theorization represents my interpretation of their accounts (Stanley and Wise, 1993). Each narrative highlights the relationship between the personal and social environment. The belief that the 'personal is political' provides an 'inter subjective' framework of their life stories and fortifies the researcher's relationship with the participants (Lengermann, P., & Niebrugge, J. 1995). A

Feminist inter subjective posits that the subjugation of women is conscious exploitation in multi-dimensions in the ongoing everyday world

5.9 The Case Studies from HOPES

5.10 Case Study 1

Lakshmi (fictitious name), 35 years old, has been HIV positive since her husband succumbed to the lung infection. She was married at the age of 15, hailing from a rural area in the Telangana region. These people migrated from the rural area of Orissa, one of the states with a more underprivileged population. Most men and women migrate as daily wage labourers to the other states. She was forced to marry a co-worker while she was in dire need of financial stability. Unaware of his health condition, her parents married an HIV cheerful man. She gave birth to two boys, and they were born HIV positives. None of the family members got the blood work done and were unaware of the infectious disease. When the husband expired with a severe lung infection, the UPHC advised the wife and the family members to get tested, and all the three were positive, living with HIV registered with HOPES.

5.11 Case Study 2

Thirty-eight years female, married to an auto driver from an underprivileged community. She tested positive in 2003 after her husband was diagnosed as HIV positive. Her husband infected her. None of the family members was informed about the incident. She is suffering from TB, and all the family members believe that her lungs are damaged. The kids are now 17 and eighteen, and she has been on medication since the second child was born. One of the children is diagnosed as positive, and presently she takes care of her kids and aims to make the world free of HIV and other sexually transmitted diseases. When questioned, what are the advantages of the VO, and are the services rendered decreasing the burden of illness? She answered, “Yes, they are alwaysprepared to address infected people's needs. Sometimes provide food rich in vitamins, leafy vegetables, and sprouts if there are regular government supplies.”

Counseling is done by the outreach workers who are also optimistic and proactive with friendly behavior, and relevant advice is provided according to the HIV-infected people's expectations. They are trained to live with medication; they succumb to the disease and have many psychological effects if they skip or get demotivated using the ART and proper diet.

5.12 Manavatha Parivarthan Society

The Manavatha Parivarthan society's third organization was initiated a decade ago to serve underprivileged women's and girls' health education.

Prioritize training sessions, lectures, and focused group discussions about their bodies andfunctionality. Young women and girls receive health education, and psychological counselling provides an opportunity to understand and change behaviour patterns. However, awareness of target intervention is designed to make them familiar with sexual health-related diseases and their prevention. Emphasis is primarily on the outcomes of unsafe sexual behaviour patterns resulting in HIV/AIDS.

The demography of the target interventions of the Manavatha Parivarthan Society is detailed in figure 11. The adolescent education and awareness program was conducted in 25 schools. Health education courses are given in fifteen colleges on sexual health care. Lectures and workshops were conducted to focus groups on HIV awareness and prevention of HIV in five various sessions. General health issues were also programmed to address the general population consisting of groups of vulnerable women and kids in the slums of Hyderabad and Secunderabad. Other five lectures were addressed in various institutions like the Indian Red Cross Society, All India Radio, National Institute of Macro, Small and Micro Enterprises (NI MSME), etc.

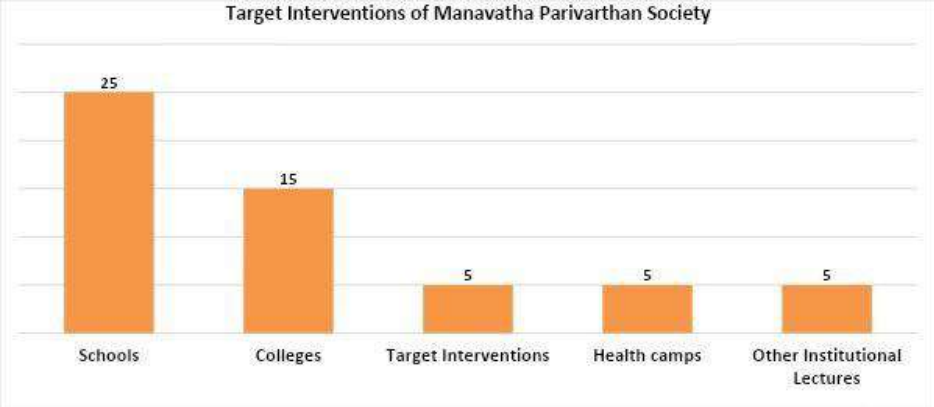

Figure 10: Target interventions of Manavatha Parivarthan Society 2015-2016, Secunderabad.

Society takes cognizance that if sexual health awareness is not discussed, general health and tools such as condom usage and access are ignored. Then young girls might be led into unsafe sexual behaviour. Early sexual debut has been trendy in social settings where social media played a prominent role in the past few decades. Adolescents are exposed to sexually transmitted diseases before the age of 15 years, (Idele 2014) elaborates in details of African sub-Saharan countries, 13% of boys and 9% of the girls had sex before the age of 15 years, and this trend is observed in almost all the regions around the globe. Lack of parental guidance and peer misinterpretation on sexual issues is the primary culprit in grappling with sexual health issues among the adolescent population reflecting their adult lives. The HIV/AIDS epidemic and its control are related to socio-cultural and socioeconomic situations persistent to sex work. Each individual has a personal and socially shared understanding of sexual health based on their cultures, sub-cultures, and standards, shaping the infections and virus's heterogeneity beyond sexual health care. Due to the lack of and failed social, financial support and minimum education. They lack the skills to get formal jobs. The option left is sex work to earn their livelihood. This VO examined the adolescent group among female sex workers, identified them, counselled them, and taught them condom usages and follow-up visits systematically and technically.

5.13 Sexual Health Care from an Intersectional Feminist Perspective

Multiple factors affected female sex workers, HIV positives, and adolescents' sexual health care in Hyderabad and Secunderabad. An intersectional feminist lens is used to understand the vulnerability, cause of discrimination, and stigma towards sexual health. SDG 3 and SDG 5 ensured health to all age groups, including the prevention of HIV/AIDS, and aimed at gender inclusivity. It is understood and assumed that HIV/AIDS is considered dead with the disease once infected and can never be healthy again. Today, we see people living with AIDS in communities and rehabilitation centres and employed anonymously residing for a decade. Case studies in ethnography cited female sex workers leading moderately healthy lives with ART, a healthy diet, and a hygienic environment. However, taboos and stigma are still haunting them. Their concealed identity is sometimes rescued with regulated aided services of the VOs, but it is a question of survival to many of the beneficiaries.

The study suggests that intersectional dynamics play a unique role in Indian socio-cultural and ethnic settings (Nivedita.M 2015). Moreover, we seek an intersectional feminist perspective while analyzing the study's qualitative data. Supported by similar views from the similar geographical topography and lower-middle-income profile, countries like Bangladesh, Pakistan, Afghanistan, Nepal, Singapore, Maldives, Bhutan. (Jejeebhoy 2001) reiterates the inconsistent influences of religion, nationality, and north-south cultural differences in shaping women's autonomy. Regions play a significant role in the

Indian sub-continent in accessing and experiencing social resources such as power, prestige, knowledge, and health entitlement.

HIV programs in Bangladesh, as pointed out (Sultana 2015), have ignored the fact that the sex workers' choices are due to the social and gender norms highly related to notions of bodily purity implications of sexually transmitted disease. An added dimension in studying VOs' interventions from a feminist perspective is establishing the feminist conceptualization of sexually transmitted infections among high-risk groups such as FSWs and positives living with AIDS. There are two conflicting ideologies. Radical feminism seeks to eliminate patriarchy in all social and economic systems. Most VOs and certain feminists believe that sex workers are the victims of exploitation and the patriarchal system (Carpenter 2000). According to some radical feminists' positions, patriarchy shapes the symbolic representation of sex work in which women are objectified for men's sexual desires (Anderson 2002). Similarly, Sen exemplifies patriarchal supremacy provides a pathway to control sexuality and sexism, intersecting marginalized status of FSWs(Sen 2009). Women sex workers are further shaped by individual socio-economic, cultural, and educational experiences, which are disadvantaged.

The second ideology is that of liberal feminism. Liberal feminism personifies sex work like any other profession for earning a livelihood. Through liberal feminism, women have a choice and the ability to assert their equality through their actions. The liberal viewpoint that was legally prohibiting sex work criminalizes sex work and reflects male domination and control over

women and their bodies. In many studies (Kotiswaran 2011), sex work is similar to other labour, such as domestic labour. Pro-sex work feminists believe that sex workers should have employment rights and better working conditions (Scott, 2005). In a legal context, sex workers' re-positioning allows them to address caste and economy recognition inequalities and entitles them to work-related healthcare benefits. The linkages between theory and practice for sexual health care are part of everyday lives, and this intersectional legal approach validates the ignored individuals, groups, and communities.

5.14 Limitations of the study

Firstly, the study has a small group of underprivileged communities among the overall women population. Data collected from voluntary organizations are limited to analyzing their health issues related to three particular health issues. The limitations are further extended to women's sexual health care. For instance, reproduction health care overlaps and intersects adolescents' sexual health care in a limited arena of schools and colleges. The need-based tools are not provided to these sections. Accommodating contraception to adolescents is a taboo in Indian cultural and social norms. It's a compromised situation as a research analyst who is socially concerned with health issues.

Secondly, female sex workers' data collected is of a small group and cannot represent the overall FSWs of the country. Prostitution is always under-covered and challenging to access. Reliability was appreciated situationally for the study. HIV/AIDS positive partners and sex work infectivity is shared in multiple degrees beyond prevention and control, through training them is

practically insufficient. The researcher and the voluntary organizations ignore such flaws. Prevention and prognoses of the infectious disease are dealt with diligence in the domain of the HIV infected and the general public limited to HRGs. They are the beneficiaries and the benefactors.

Thirdly, due to a large influx of migratory populations, female non-positive sex workers keep moving in and out of the sex work, creating a massive gap in the VO's preventive interventions. Collecting data through these sources is equally the most significant limitation of the study. Interview sessions were complicated and challenging. Some were seasonal, occupational, part-time sex workers, and identity was dangling throughout the research work process.

The fourth is intermingling registered sex workers and the general population, including the men clients, an unknown space, and an enormous risk for infection, transmission care, and prevention.

5.15 Conclusion

Finally, it's arduous to assess FSWs to estimate the burden of sex work in spreading sexually infectious diseases in limited VO's and their services. Female sex work is a significant risk factor for sexually transmitted infections. Preventive measures are essential because there is no vaccine, and access to treatment is the only medical diagnosis. Awareness of using consistent male-female condoms is valuable in the preventive process. Through surveillance, medical care, and preventive strategies improve preventive programs' success, most general populations are at high risk of contamination and are not inclusive.

It instead sounds ironic that despite the inhumane, degrading, and demeaning treatment accounted for sexual subjugation, not one of the case studies or the respondent opted for the release from the clutches of sex work. They, in contrast, preferred economically more secured policies drafted in favour of commercializing instead of criminalizing the clients and beneficiaries. Female sex workers from HLCHS voluntary organizations are liberal and cogent in approach and advocate establishing their situation as any other work and labour. However, one of the respondents used 'Izzat,' meaning the respect and pride in colloquial Urdu of Hyderabad. Pragmatically, her narrative of sex work ended on a satisfactory note in supporting her children highly placed in the European countries. They opted for empowerment in the pursuit of health awareness, counselling, and insured sex work for their continuity as informal and unorganized work. The women studied acquired autonomous decision-making power on physical, economic, and social involvement.

Hence a different compatible lens, feminist intersectionality, allowed us to understand and analyze the layers of discrimination and abuse in fundamental health issues among poor women. Multiple levels of gender bias are critically examined in sexual and adolescent health care. The intersectionality lenses evaluated issues that impact gender, caste, and even the class in they exist. Ironically liberal feminism validates male dominance by consenting freedom of choice and would further experience women's subordination for sexual

demands. Simultaneously they are fixed into poverty and powerlessness due to sexual subjugation. It is further explained female sex workers opting for sex work as a profession and financial support will revisit the abuse, stigma, discrimination, and criminalization in selling their bodies for male pleasures. Marginalized by caste and economy reshape the lives of the female sex worker's agency reproducing sex work showing economic reasons of validation.

CHAPTER 6

CONCLUSION

6.1 Introduction

Taking the Millennium Development Goals (MDG's) and the Sustainable Development Goals (SDG's)as the point of departure, the study aimed to examine the role of voluntary organizations (VO's) in providing awareness and aid for women's health concerns in the underdeveloped sector in the twin cities of Secunderabad and Hyderabad. To this end, interventions of VOs were examined applying ethnographic methods, focused group discussions, case studies, and individual interviews with selected respondents from selected VO's. An informed selection of VO's was made from the few VOs in this region that solely take up women's health interventions. The ones working to aid reproduction and sexual health and women's health care were selected. A portion of the existing urban migrant poor population was chosen to be studied and interviewed. The combined marginality of gender and poverty prompted us to examine the health issues with a feminist intersectionality lens. For a persuasive study, mixed methods, both qualitative and quantitative, estimated the VO's interventions in women's health care. We examined the dynamics of the relationship between women as marginalized and VOs as the enablers to empower women in a stringent patriarchal setting. Thus, the intersection of marginalization and discrimination across gender, caste, class,

and religion are analyzed, revealing that all aspects of women's health are restricted to sexual health rather than holistic health. That reproduction or sterilization is the main feature of health dealt with by the VO's.

The primary study's objective sought answers to the causes for gender discrimination, abuse, and criminalization in access to health care by marginalized women. The respondents were chosen from TSRC (Telangana State Red Cross), Manavatha Parivarthan Society, HLCHS (Hyderabad Leprosy Control Health Society), and HOPES (Health of Positives Efficiency Society). They fulfilled the organization's criterion of providing reproductive and health care assistance to underprivileged women. Though they are interrelated and interconnected, the discriminatory levels vary because their health care problems and access are different in different health issues, and interventions are executed differently. A similar study aimed to assess reproduction health awareness, nutrition, and hygiene among early and late adolescents from marginalized populations in a community-based cross-sectional survey across five Indian zones (Sharma.S et al., 2021).

In this study, non-probability sampling, known as purposive sampling, is used. The main reason is that it allows us to focus on particular characteristics of interest, in our case health of underprivileged women and the interventions of VO's. Purposeful sampling is widely used in qualitative research to identify and select information-rich cases from a broad population. Thus, it suits our purpose well. Purposively chosen beneficiaries of the research study are socio-economically marginalized by caste identities (SC, ST, and BCs) and Muslim

minorities. The interventions considered are the reproductive sector, sex education of adolescents, and AIDS information for female sex workers. In the light of interviews of the population, the life experiences, and the challenges they face. Many reproductive health problems go untreated in developing countries like India and assume not to require medical attention (Bansal.M.2017). Many National policies are functioning towards improving, enhancing, and developing women's reproductive health were interpreted within the intersectional framework. Statistical sampling and Empirical studies were also done to assess the role of interventions in family planning policies.

Additionally, the issues of subjugation and suppression in their patriarchal families are expressed by interviews collected by maternity health centres and VOs. Interviews conducted on sex workers reveal a dichotomy of economic and domestic and social pressure. The female sex workers' response to the stigma associated with sex work was drowned out by the economic benefits as a means of survival. It has given rise to an intense debate between Liberal and Radical feminists. Liberals stress the organization of the sex sector, while radicals stress the abolition of the sex sector.

Feminist intersectionality theory is applicable in interrogating variables of women's health and its interacting factors. The causes for women's suppression and discrimination are deep-rooted in acknowledging the patriarchy as a way of life. They were structured in socio-cultural beliefs. The factors governing gender roles are entrenched in economic position also. Overall, these

have impacted less privileged women's health care which has been hampered, distorted, and even unmet because of the double marginalization of gender and poverty, often exasperated by caste and religion. Feminism is heterogeneous and internally differentiated (Menon. N,2015). The repercussions resulted in the widening of the gender gap, producing undernourished future generations, and finally, sex workers' interpretations demanding dignity and legalization of their profession are revealing.

At the other end of the spectrum, new questions were highlighted from the research in adolescent health education. The pilot study on teenage health intervention showed how the VO's and researchers' participation in sex education contributed to shaping the new perspectives through the questions the schoolboys and girls raised during interventions. New outlooks like reproductive autonomy on pregnancy, childbirth, and birth control were also discussed. The issue that needs immediate attention is awareness about the contraceptive measures to the entire generation of women, be they adolescents, middle-aged or sex workers. Henceforth the study showed that the onus of protection is only on women. Such awareness campaigns are being carried out by distributing condoms to female sex workers in preventing sexual infections with the absence of client (male sex partners) counseling sessions.

This research clearly illustrates that the VOs play a crucial role in giving services to poor women. Some narratives apply to UPHC, schools, sex workers, and HIV positives. These women shared an optimistic note as the beneficiaries

of the voluntary organization. A focus on inequalities and marginalized groups, including humanitarian settings, interventions need to address structural determinants of women's health, reduce inequities in health access (Temmerman et al., 2015). But, it also raises the question of sustainability and continuity of intervention because these are time-bound and fund-driven programs. While the sample studied is limited compared to the total population suffering from these selected health issues, this limits the generalizability of the results inferred. This approach provides new insight and scope for further research. We intend to expand the study and investigate women's leadership roles in garnering capital for women's health intervention. Subsequently, it would entail us to seek the corporate social responsibility of various industrial institutions.

6.2 Future Scope of the study

Health and health care systems are ever-evolving. Some of the health issues identified and discussed during the research study are not the same priority and intensity in focus. Some more new infections and diseases become urgent diagnoses and treatments. New health models emerge in the rescue of the traditional ones. The underprivileged category examined is a small sample initiated to reach a broader spectrum. By collecting real-life experiences in reproductive and sexual health, we established pathways from a feminist

perspective which is just a beginning and has the enormous future expansion of the study. Reproductive rights are now considered human rights, which are fundamental rights that are not situated enough in women's health or from an academic perspective. These are the future markers of perseverance for further research. Voluntary organizations' interventions are very few executed against the prevailing women's health issues need innovative approaches to outreach the grassroots level. Awareness, promotion, and prevention of women's health issues are unmet tasks compared to the alarming situation of underprivileged women.

A broader outlook has to evolve with a whole discourse of female autonomy in terms of health, wealth, and sex transactions from a feminist perspective, including social obligations, patents to a complete paradigm shift, establishing multiple repercussions socially, economically, and politically. The massive impact would have evolved a turnaround the whole discourse of feminism. That may be a beginning to resolve inequality, discrimination, and criminalization of sex work at all levels. However, to sum up, the only solution is empowering girls and women with **appropriate knowledge and preparedness to tackle** the contagious virus and biologically stipulated diseases with the solid support of VOs, states, and civil societies.

6.3 Limitations of the Study

There is no deficiency in policy and concern towards women's health care in Indian and in the Hyderabad cities context. The documentation for

accountability, references, and consistency in implementing the projects by the VOs and the government institutions is lacking. It was arduous to identify the organizations working towards health issues solely for Secunderabad and Hyderabad. Every VOs intervention has few emancipatory activities for women as part of their objectives, time, and specific funded programs. Non-available knowledge and information itself was the primary hurdle in the research progress. Due to the scarcity of research and data on adolescent health issues, voluntary services are also disproportionate in twin cities' vast urban poor population. Similar problems are experienced in sexual health issues. Follow-up programs are insecure because the floating urban migrant population tested reliability and was even ignored to some extent.

6.4 Recommendations

The implications and theoretical perspectives on healthcare education gleaned from this study cannot be considered from isolated physiology or psychological perspectives. Women's health must be diversified to include aspects of sex determination factors, nutrition requirements, enhancing life skills, economic and health inequalities, which play a significant role in girls' and women's health. Therefore, curtailing the hampering effects by unbiased gender sensitization in a practical participatory teaching approach. Interventions and school curriculum inclusive of such a more comprehensive approach should be made viable at the school level and even the community grassroots levels in

long-term sustainable programs. Adolescent health care is fragile and minutely meticulous. If the education system is corrected at its base level, it could deconstruct the systematic subjugate methods that intersect and interconnect socio-cultural norms and economic resources. Such an attitude produces gender-sensitized adolescent girls for future dynamic empowered women equipped to address gender gaps and flaws.

Based on these conclusions, gender consciousness should consider in all spheres for strengthening women. The future scope is towards the role of VOs studied, which is limited by three health issues. Women's health issues are in multiple levels in various intensities and can be addressed with a similar scholarly academic approach.

Recommendations are listed in order of priority for the optimum utility of the study

1. Health education from secondary education levels with appropriate learning material should be initiated as 'Health Promoting' schools, communities, public, private, corporate, industrial, and technological avenues ascomprehensive socialresponsibility.
2. Need-based and individually motivated micro-interventions are essential women's health projects for the VO sector, such as the Manavatha Parivarthan Society pilot study of the research.

3. Long-term multi-disciplinary approach learning material is suggested in implementing the findings of women's health care—parent's and teacher's guidelines with a competency framework for prompt awareness and training health issues.
4. Scientific-Centred Health Education should be adopted at every learning possibility, inclusive of sexual rights to everyone. ‘Science, Solutions, andSolidarity’ are the guidelines. (WHO,2021).
5. Further investigation-based research is suggested in applying the feminist lens and perspective as part of the social responsibility towards the marginalized and less-privileged women's health issues. Consciousness-raising with community- based interventions is the need of the hour.

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Institute Ethics Committee, University of Hyderabad

T.N.C.
Justice R. Rangarajan
Chairperson

Prof. Geeta K. Vemuganti
Member Secretary

Decision Letter of Institute Ethics Committee

IEC No Application No:	UH/IEC/2014/31	Date of review/approval	30.07.2014
Project Title:	Role of Voluntary Organisations in the promotion of health awareness among under privileged women		
Principal Investigator/ Co-PI:	Prof. Bindu Bambah, School of Physics, UoH Dr. Ajailiu Niumai, Ms. G. S. Chaya Devi		
Participating Institutes if any	Durgabai Deshmukh Hospital&Indian Red Cross Society--	Approval from Participating Institute	Yes
Documents received and reviewed	Protocol, ICF, Questionnaire		
In case of renewal, submission of update	--		
Decision of the IEC:	Approved Duration of Approval: One year from date of approval		
Any other Comments Requirements for conditional Approval	--		
Members Present	Sri Justice Rangarajan, Dr. B. Sesikeran, Prof. Aparna Dutta Gupta, Prof. Meena Hariharan, Dr. Purendra Prasad, Ms. M. Varalakshmi		

Please note:

a. Any amendments in the protocol must be informed to the Ethics committee and fresh approval taken.
b. Any serious adverse event must be reported to the Ethics Committee within 24 hours in writing (mentioning the protocol No. or the study ID)
c. Any advertisement placed in the newspapers, magazines must be submitted for approval.
d. The results of the study should be presented in any of the academic forums of the hospital annually.
e. If the conduct of the study is to be continued beyond the approved period, an application for the same must be forwarded to the Ethics Committee.
f. It is hereby confirmed that neither you nor any of the members of the study team participated in the decision making/voting procedures.

(Justice Rangarajan)
Chairperson

(Prof. Geeta K. Vemuganti)
Member Secretary

Member Secretary
Institutional Ethics Committee (IEC)
School of Medical Sciences
University of Hyderabad
Hyderabad-500046.

Address : School of Medical Sciences, University of Hyderabad, C.R. Rao Road, Gachibowli, Hyderabad - 500 046.
Tel (O) : +91-040-23134781 / 23013279
E-mail : iec_uoh@uohyd.ernet.in, deanmd@uohyd.ernet.in

THROUGH HUMANITY TO PEACE

Indian Red Cross Society

(CONSTITUTED UNDER ACT XV OF 1920)
(A.P.HQRS : RAJ BHAVAN, HYDERABAD)

Tel : 23221748, 23260201,
(RCH)23227693
Fax : 040 2326 1246
E-mail : secretaryaprc@yahoo.co.in
Website : www.indianredcross-ap.org

Admn.Office :
3-6-212, Street No.15,
Himayatnagar,
Hyderabad - 500 029.

No: IRCS/APSB/Misc./2014 /864 **Date: 24th June, 2014**

To

Mrs. G.S.Chaya Devi,
Research Scholar,
University Of Hyderabad,
Central University Post Office,
Hyderabad -500 046

Madam,

Sub: Indian Red Cross Society, Andhra Pradesh Branch, Hyderabad – Permission to Visit Red Cross Hospitals – Reg.

Ref: Your letter dated 23-6-2014.

***

With reference to your letter cited above, you are hereby permitted to visit Red Cross Hospitals in twin cities and obtain the performance statistic of the Red Cross Hospital working in the promotion of health awareness among Underprivileged women and you are also permitted to interact with the staff and beneficiaries.

Please acknowledge the receipt of the letter

Yours faithfully,
Sd/-
GENERAL SECRETARY

// F.O.B. //
MANAGER 24/6/2014

A1.1a

HYDERABAD LEPROSY
CONTROL & HEALTH SOCIETY
National Aids, TB Control and Leprosy Eradication Programme
Regd. by the Govt. of Andhra Pradesh (Reg. No. 317)
: 5-9-209/8/1, Hyderi Plaza, Chirag Ali Lane, Abids, Hyderabad - 500 001.
☎ : 23203991, 32449859, E-mail : hlchs@rediffmail.com

Date...6/1/2015.....

To,

Mrs. Chaya Devi
Ph.D. ,Research Scholar
Centre for Women's studies
University of Hyderabad.
Hyderabad.

Sub: Permission granted for the research studies –Reg.

As you are a Registered student with Reg No 11CWPG04 from the Centre for Women's studies University of Hyderabad, you are permitted to conduct research studies as part of Ph.D. program on "**The Role of Voluntary Organizations in the Promotion of Health Awareness among the Under- privileged women: A Case Study of Secunderabad and Hyderabad**" you will be interacting with the female high risk population and families suffering from HIV and Leprosy in the operational area of old city, Hyderabad . This is very a sensitive matter and associated with stigma and discrimination you will have to follow ethics and maintain confidentiality of the persons. You have to submitted a copy of report

With Regards.

Dr.Mohammed Ilyas
Project Director
H.L.C.H.S.

Hyderabad Leprosy Control & Health Society Govt. Regd. Hyd.

A1.1b

ANDHRA MAHILA SABHA
DURGABAI DESHMUKH HOSPITAL & RESEARCH CENTRE
FOUNDER PRESIDENT LATE (Smt.) Dr.DURGABAI DESHMUKH

AMS/DDHRC/1464/2014 Date: 7.7.2014

To,

Mrs. G.S.Chaya Devi
Research Scholar
Centre for Women's Studies
University of Hyderabad
Gachibowli, Hyderabad. 500 046.

Sir,

Sub: Permission to visit the DD Hospital - Regarding.

Ref: Your letter dated 7th July, 2014.

****

With reference to your letter cited above, you are hereby permitted to visit the hospital to obtain data and also to interact with the staff and the beneficiaries for your Research Work . **"The role of Voluntary Organizations in the Promotion of health awareness among the underprivileged Women. A case study of Secunderabad and Hyderabad."**

Please acknowledge the receipt of the letter

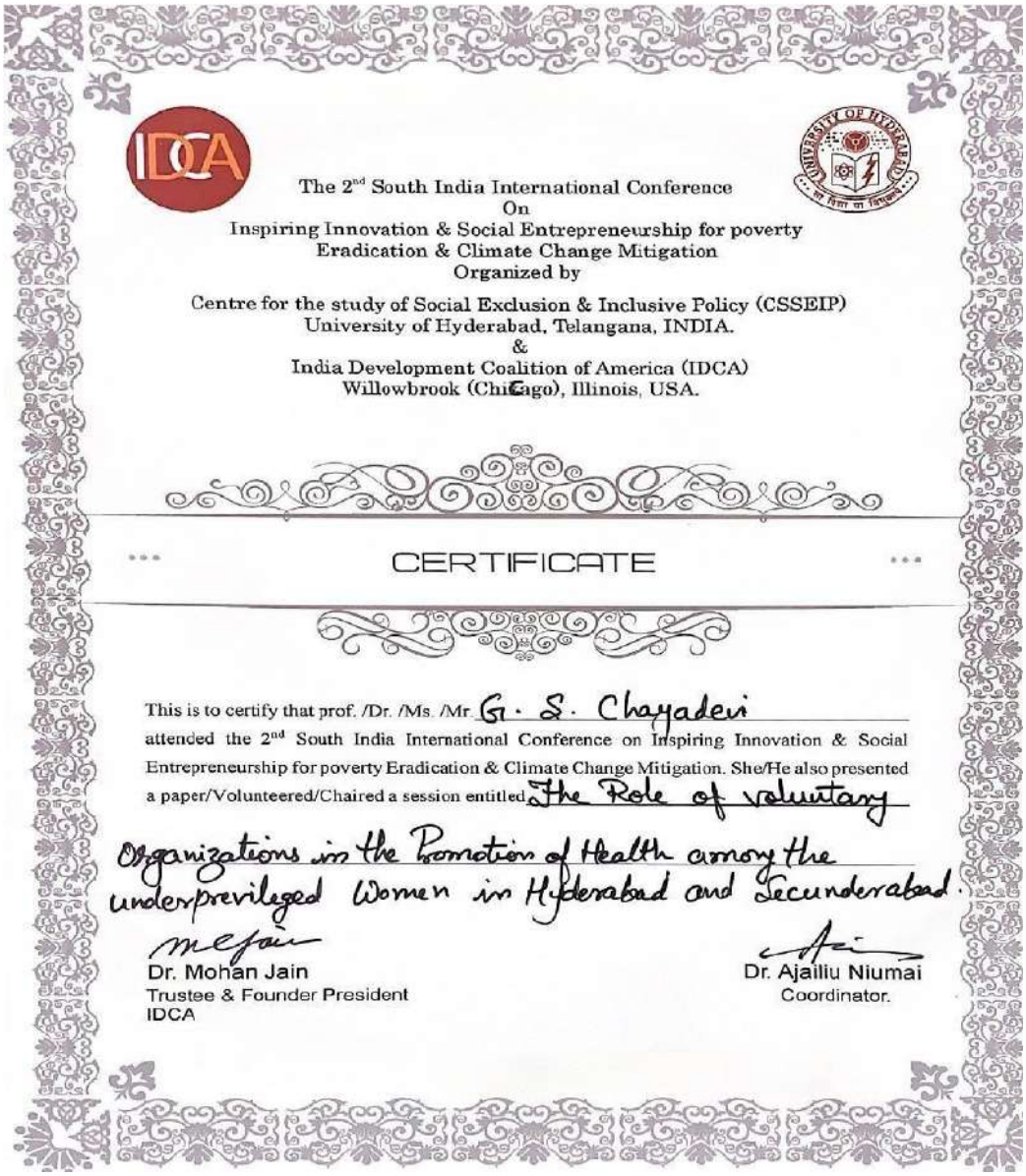
Thanking you,

P.Seeta Ram Reddy
I/c. Secretary

University Road,Vidyanagar, Hyderabad - 500 044. Grams : "MAHILA" Telephone : 040-27681100, 27681500,
Fax.No: 040-27667889, Email :durgabaihospital@gmail.com.

Annexure 2

A1.2



The 2nd South India International Conference
On
Inspiring Innovation & Social Entrepreneurship for poverty
Eradication & Climate Change Mitigation
Organized by

Centre for the study of Social Exclusion & Inclusive Policy (CSSEIP)
University of Hyderabad, Telangana, INDIA.
&
India Development Coalition of America (IDCA)
Willowbrook (Chicago), Illinois, USA.

CERTIFICATE

This is to certify that prof. /Dr. /Ms. /Mr. G. S. Chayadevi attended the 2nd South India International Conference on Inspiring Innovation & Social Entrepreneurship for poverty Eradication & Climate Change Mitigation. She/He also presented a paper/Volunteered/Chaired a session entitled The Role of voluntary Organizations in the Promotion of Health among the underprivileged Women in Hyderabad and Secunderabad.

Dr. Mohan Jain
Trustee & Founder President
IDCA

Dr. Ajailiu Niumai
Coordinator.

Pressing for Progress 2019

An IPA National Conference towards Gender Equity in Physics
19 -21 September 2019, University of Hyderabad, India

CERTIFICATE OF PARTICIPATION

This is to certify that

Chayadevi Golconda

Has participated in

Pressing For Progress 2019

Gender equity in Physics 19 – 21 September 2019

Held inthe University of Hyderabad

Signature:

Date:

Convener
PFP - 2019
University Of Hyderabad

MOTHER TERESA WOMEN'S UNIVERSITY
KODAIKANAL

DEPARTMENT AND CENTRE FOR WOMEN'S STUDIES
SIPCOT Industrial Complex - Pallapatty
&
DHAN Foundation - Madurai

ORGANIZED A TWO DAY NATIONAL CONFERENCE ON

GENDER DISPARITY IN PROTECTION OF GIRL CHILDREN (CHILD ABUSE)

15th and 16th September, 2015

CERTIFICATE

This is to certify that Ms. /Mrs. / Dr. / Prof. G. S. CHAYA DEVI, RESEARCH SCHOLAR, CENTRE FOR WOMEN'S STUDIES, UNIVERSITY OF HYDERABAD has chaired a session/ participated/ delivered a lecture / presented a paper entitled GIRLS' EDUCATION; IN GENDER PERSPECTIVE

in the Two day NATIONAL CONFERENCE ON GENDER DISPARITY IN PROTECTION OF GIRL CHILDREN [CHILD ABUSE] held on 15th & 16th September 2015, organized by the Department and Centre for Women's Studies, Mother Teresa Women's University, Pallapatty and DHAN Foundation, Madurai at Madurai Symposium- 2015.

Prof.S.P.DENISIA
Convener & Director
MTWU, Kodaikanal

Prof.N.KALA
Registrar i/c
MTWU, Kodaikanal

A1.2c

Indian Association for the Study of Population

Certificate of Attendance

This is to certify that Dr./Mr./Ms. G. S. Chayadevi has participated/presented a paper/poster entitled The Role of Voluntary Organizations in the promotion of health among the Underprivileged Women: A Case Study of Secunderabad and Hyderabad. in the National Seminar on Population, Health and Development at the XXXVI Annual Conference of IASP held at University of Kerala, Thiruvananthapuram, Kerala during 07-09 November, 2014.

Organizing Secretary

President

A1.2d

WOMEN'S WORLDS CONGRESS

August 17-22, 2014, University of Hyderabad, India

CERTIFICATE

This is certify that Mr. / Ms. / Dr. G. S. Chayadevi has participated / presented a Paper / Panel / Workshop entitled The role of NGO's in the promotion of health among the underprivileged women: A Case study of in the Women's Worlds Congress on Secunderabad and Hyderabad. *Gender in a Changing World* held on August 17- 22, 2014.

Prof. Ramkrishna Ramaswamy
Chairperson, WWC - 2014
Vice Chancellor
University of Hyderabad

Prof. Rekha Pande
Director, WWC - 2014

Prof. Sita Vanka
Deputy Director, WWC - 2014

A1.2e

Annexure 4

Questionnaire on Reproduction Health care and Sexual Health Care

Dear readers,

The questions are from a gender perspective which is part of our project **"The Role of Voluntary Organizations in Health Awareness among Underprivileged Women: A Case Study of Secunderabad and Hyderabad.** We intend to collect the data from all the Indian Red Cross Units of Hyderabad and Secunderabad. We request the readers to read the questions with the help of the supervisor. Answer and return it after you fill in all the answers. It contains ten questions. We assure to safeguard your identity in all respect and context.

Thank you,

G.S. Chayadevi, (PhD, Gender Studies), University of Hyderabad. Hyderabad.

1A. **Questionnaire: 1**

To the Supervisors

Q1. Name of the Unit and Location-

Q2. What are the activities of the Indian Red Cross Society?

_____

Q3. How much budget is spent on the projects for this unit? a)1Lakh Rupees b) Two Lakh Rupees c). Three Lakh Rupeesd) Four Lakh. e) -(if more).

Q4. How many orientation programs are conducted during the year?

One ....., Two ....., Three ....., Four ....., (more ifany)

Q5. How many counselling sessions are conducted? Name the topics?

Q6 Any equipment purchased, and what is the cost of it?

Amount in rupees .....

Q7. Could you find the progress in the beneficiaries?

Yes ( ) No ( ) cannot say ( ).

Q8. How many days in a month do you allocate for each scheme?

....., ..., ...

Q9. Do you conduct the briefing sessions for the councillors? How often do youwork?

_____

Q10. How many women-oriented programs do you conduct in a year? Name them?

Q11. Data of the beneficiaries and few details in this regard?

Health awareness Questions:

Q1. What are the main identified health problems so far?

1.....

Q2. Did they receive counselling from the supervisor of IRCS?Yes ( ) No ( )

Q3. Did these sessions help them in any way? Yes ( ) No ( ).

Q4. What is the economic status of the supervisor?Salary in rupees

1B. Questionnaire 2

To the Beneficiaries (questionnaire will be made according to the unit we dealwith)

Q1. What initiatives are taken in educating the girls on health issues?

a. .....

Q2. Which organizations have been contacted so far?

a. .....

b .....

Q3. When and where the counselling has taken place?

Q4. What was the feedback they gave?

Q5. What is the difficulty in implementing the project?

Q6. What kind of monitory help do they get from the project? How do they divide?

Q7. How much remuneration is paid to the guest speaker? In Rupees

Q8. We are interested in improving the measures of IRCS to improve the situation.

a. Few success stories. .....

b.Few failures in empowerment: .....

What are the reasons for the success / Failure?

Q9. Do IRCS enjoy the same reputation and privilege?

Yes ( ) No ( ) cannot say ( ). Reasons:

.....

Q10. Do the beneficiaries get any cooperation from any other organization apartfrom IRCS?

Give names of NGOs.....

These are the re-structured questions after the observation period we restructured in consultation with the consent of the Supervisors, the voluntary organization directors, and the staff.

1C. **<u>Questionnaire 1</u>**

Questions to the Beneficiaries

1.Name..... 2.Age:……3. Sex……..

(a) Male

(b) Female

3. What is your caste?

(a). ST, (b). SC, (c) BC, (d). General

4. Marital status .....

(a) Married

(b) Unmarried

(c) Divorce

(d) Separated

(e) Widower//widow

5. At what age did you get married?

6. Annual family income

(a)Below Rs. 30,000 (b) Rs. 30000-60000 (c) Rs.60000-90000 (d) Rs 90000-120000

(e) Rs120000 & above

9. How many children do you have and their age----------

10. No members in the family? .....

11. Educational Qualification

a) Under matriculation

b) Matriculation

c) Intermediate

d) Graduate

e) Post –Grads

f) Any other

12. Residential details: a. Rural---------- b. Urban ---------- c. Semi-urban d. Remote village----------

13. How did you know about this organization?

14. Is there any other NGO you can mention with similar benefits?

---

15. Can you give me a list of benefits you get from this centre?

Questions on Gender perspective:

---

16. Do you know what ‘gender ‘means?

17. Are you involved in the process of decision-making?(a)Yes (b) No (c) Can’t say

18. Do you face any difficulty in social mobility?

(a) Yes (b) No (c) Can’t say

19. Do you have the liberty to spend from your salary?

(a) Yes (b) No (c) Can’t say

20. Are you aware of Gender discrimination?

(a) Yes (b) No (c) Can’t say

21. Do you face any challenge in patriarchy in your family?

(a) Yes (b) No (c) Can’t say

If Yes explain .....

---

22. Do you have freedom of choice about your children and their future?

(a) Yes (b) No (c) Can’t say

23. Do you go for regular medical check-ups for yourself and your family members?

(a) Yes (b) no (c) Can't say

24. According to your observation, what kind of changes are seen in society today about women;

---

25. Do you encounter?

a. Jealous ---------- in the family

b. Personal conflict ---------- in the family

c. Rivalry ---------- in the family.

26. Can such voluntary organizations give an advantage to the overall public health?

---

27. Can such voluntary organizations benefit women through medical aid, and do you think ancient naturopathy should help many? (Tips for healthy living)

---

28. Does voluntary organizations give you psychological and moral support according to your expectations?

1D. <u>Questionnaire-2</u>

Modified on Reproduction Health Care

Questionnaire to the councilors/ project co-coordinators of the VO (IRCS)

Q.1.Name .....-------.....

Q. 2. Age: ..... Q.3. Sex: Male / Female

Q4. what is your caste?

(a). ST, (b). SC, (c). BC, (d). General

Q5. Marital status.....

(f) Married

(g) Unmarried

(h) Divorce

(i) Separated

(j) Widower//widow

Q6. At what age did you get married?

Q.7.Annual family income

(f) Below Rs. 30,000(g) Rs. 30000-60000 (h) Rs.60000-90000 (i) Rs 90000-120000

(j) Rs 120000 & above

Q. 8. How many children do you have and their age?

Q. 9. No of members in the family?

Q.10. Educational Qualification

a) Under matriculation

b) Matriculation

c) Intermediate

d) Graduate

e) Post –Grads

f) Any other

Q.11. Residential details: a. Rural---------- b. Urban----------

c. Semi-urban d. Remote village----------

Q.12 what is the Name of the Institute?

Q.13. Can you give me details of any other organizations approached?

(a) For donations.....

(b) Any donations in kind .....

(c) Rendering the services with the voluntary organizations ----------

Q. 14. Are you aware of the Millennium Development goals? Y/N

Q15. How many orientation programs are conducted during the year?

(a) One, (b) two, (c) three (d) or more

Give brief information regarding these projects?

Q. 16. How many counselling sessions are conducted? Name the topics?

Q17. Is the orientation program showing a positive impact? (Can give the detailed activity Report)

Q.18. Any equipment purchased, and what is the cost of it? Amount in rupees__.

Q. 19. Could you find the progress in the beneficiaries?

Yes ( ) No ( ) cannot say ( )

Q. 20. How many days in a month do you allocate for each scheme?

Q. 21. Do you conduct the briefing sessions for the councillors? How often do you work? `

Q. 22. Give the data of the beneficiaries and a few details in this regard?

(a) Geographic location.....

(b) Financial status .....

_____

Health awareness Questions:

Q1. What are the main identified health problems so far?

Q2. Did they receive counselling from the supervisor of the voluntary organization?

Yes ( ) No ( )

Q3. Did these sessions help them in any way?

Yes ( ) No ( ).

Q4. What initiatives are taken in educating the girls on health issues?

Q5. Have you identified a few inadequacies in adolescent problems?

Q6. Do you give awareness regarding gender sensitization?

Q7. Do they give any information regarding the observation and attitude of their peer group at home or in society?

Q 8. Which organizations have been contacted so far?

Q 9. When and where the counselling has taken place?

Q 10. What was the feedback they gave?

Q 11 What is the difficulty in implementing the project?

Q 12. What kind of monitory help do they get from the project? How do they divide?

Q 13. How much remuneration is paid to the guest speaker?

In Rupees.....

Q 14. We are interested in improving the measures of the voluntary organization to improve the situation

c. Few success stories. .....

d. Few failures in empowerment: .....

e. What are the reasons for the success / Failure? ----------

Q 15. Does this voluntary organization enjoy the same reputation and privilege?

Yes ( ) No ( ) cannot say ( ).Reasons:

Q 16. Does their social and economic status play a key role in health issues?

(a)Yes---------- (b) No---------- (c) Can't say--------

If yes, explain.....

Q 17. Do you prefer the conventional method of medication?

(a) Yes.....(b) No.....(c) can't say .....

Q. 18 what is the reason for not using the homemade remedies to someextent?

(a) If yes, give the reasons.....

(b) If No explain the reasons .....

Q19. What do you talk about the reproduction system and care?

Q20. What sort of common doubts do they get regarding pre-natal and anti-natal care?

Q21. Do you accompany them throughout their pregnancy?

Q22. Do you council their husbands?

Q23. What is the detailed procedure you talk about contraceptives and the methods to adopt?

Q24. How many visits do you make to all the identified slums in a month?

Q25. Do you give any medical assistance?

(a) Medicines .....

(b) Food supplements and food or energy drinks----------

(c) Any types of equipment to the mother and child ----------

(d) Give the details if the unit provides for the health and well-being of the community .....

Q 26. What kind of treatment do you offer apart from family planning, deliveries sterilization, and vaccination?

1 .....

2 .....

3 .....

4 .....

2. <u>Questionnaire on Sexual Health Care</u>

To the Staff, peer educators, and outreach workers, People living with HI/AIDS Peer Educators

Dear Readers,

The questions are from a gender perspective which is part of our research program "The Role of Voluntary Organizations in Health Promotion among Underprivileged Women: A Case Study of Secunderabad and Hyderabad." We request the readers to read the questions with the help of the supervisor. We assume to safeguard your identity in all respect and context.

Thank you.

(PhD, Gender Studies), University of Hyderabad, Hyderabad.

2A. <u>Questionnaire:1</u>

To the staff and peer educators

Q1. Name .....

Q2. Age .....

Q3. Sex .....

Q4. What is your caste?

Q5. Marital status

Q6. At what age did you get married?

Q7. What is annual family income?

Q8. How many children do you have?

Q9. Number of members in the family

Q10. Education Qualification

Q11.How many counselling sessions do you conduct? Name of the topics?

Q12. Are the orientation programs showing any positive impact? Can you give me a detailed report?

Q13. What are the different safety measures followed by the staff?

Q14. What kind of medical services do you provide?

Q15. Can you give me the geographical purview of these sex workers?

Q16. Are there any legal services provided to the sex workers?

Q17. Are care giving and support given gender-inclusive?

Q18. How much % of SW approach the VOs among the HIV-positive sex workers?

Q19. What are the preventive measures implemented to curtail HIV in this area?

Q20. Are these measures impact the family of sex workers?

Q21. What kind of care do you take towards the children of the HIV-positive sex workers?

Q22. Do you take any orientation programs in schools and colleges regarding HIV, AIDS, and Sexual infectious diseases?

We protect your identity and abide by confidentiality with your consent We are thanking you.

2B <u>Questionnaire: 2</u>

To the Beneficiaries of Sexual Health Care

Sex workers and People Living with HIV/AIDS

Q1. Name..... Q2. Age..... Q3. Sex .....

Q4. What is your caste?

Q5 Marital Status

Q6. At what age are you married?

Q7. Annual Family Income

Q8. How many children do you have and their age?

Q9. The number of members in the family?

Q10. Educational Qualification

Q11. Residential details:

Q12. How do you know about the organization?

Q13. Is there any other NGO that you can mention with similar benefits?

Q14. Can you give me the list of benefits you get from the centre?

Q15. Do you take any help from the organization?

Q16. What kind of help do you take?

Q17. Since how long are you in this work?

Q18. Can you tell me the reason why you are into SW?

Q19. Where do you do your work?

Q20. How much time do you spend, and at what time do you start the day?

Q21. Do you take Alcohol?

Q22. Are you aware of HIV/AIDS, and what is the source of information?

Q23. Since how long are you attached to this organization?

Q24. Do you use condoms regularly?

Q25. From where do you get them?

Q26. How many times do you visit the centre in a year?

Q27. How frequently is the blood work done?

Q28. Did you face any problems such as abuse or violence? And by whom?

Q29. How do you deal with the issues regarding the SW?

Q30. Whom do you approach in crises?

Q31. Do you practice safe sex?

Q32. Which kind of contraception do you adopt?

Q33. Do you face any violence from the clients?

Q34. What kind of protection does do VOs provide?

Q35. What kind of measures do you take on other health issues?

Q36. Do you find any gender bias to access health care?

Q37. Duration and the effected period of HIV?

Q38. Can you explain about the medication and the follow-up?

Q39. Does this VO provide another kind of assistance apart from HIV rehabilitation?

Q40. Do you get any micro-finance for self-reliance?

We protect your identity and abide by confidentiality with your consent. Thanks for your kind co-operation in giving the information, and it will be acknowledged in the thesis submission.

The Role of Voluntary Organizations in the Promotion of Health among the Underprivileged Women: A Case Study of Secunderabad and Hyderabad

by Chayadevi Golconda

Submission date: 30-Nov-2021 05:04PM (UTC+0530)
Submission ID: 1716267776
File name: Chayadevi_Golconda.pdf (1.1M)
Word count: 26937
Character count: 155425

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Journal of International Women's Studies

Volume 18 | Issue 2 Article 16

Jan-2017

AIDS Awareness Interventions for Women: The Role of Voluntary Organizations in the Secunderabad and Hyderabad Region of Southwestern India

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Bindu A. Bambah

AIDS Awareness Interventions for Women: The Role of Voluntary Organizations in the Secunderabad and Hyderabad Region of Southwestern India

By G.S. Chayadevi[1] and Bindu A. Bambah[2]

Abstract

In this paper, we examine the role of Voluntary organizations (VO's) in combating the incidence of HIV/AIDS and Sexually Transmitted Diseases among Female Sex Workers in Hyderabad and Secundrabad. These are twin cities in the newly formed state of Telangana state in the southwestern region of India, called the Deccan Plateau. We trace the evolution of VO's towards becoming agents of information and prevention of AIDS in the region. Our focus is on how VOs' interventions impact the prevention of HIV among female sex workers. The activities that contribute towards this aim are sexual health, counseling, medication and continuous health follow-ups. Using purposive sampling methods, we analyze the data quantitatively and qualitatively with the help of case studies with intersectional feminist theory.

Keywords: Voluntary Organizations, AIDS awareness and prevention, Sex Workers, Intersectional feminist theory

Introduction

Women's health, women's empowerment, and AIDS eradication are all global concerns incorporated among the seven Millennium Development Goals (MDGs) propounded by the United Nations [UN Millennium Report 2005]. Goal six of the eight millennium development goals is "to combat AIDS/HIV, Malaria, and other Diseases" and Goal three is "to promote gender equality and empower women." The MDGs have done much to advance progress on the health of women and girls in developing countries and have been "the most successful anti-poverty push in history" [MDG Report 2011]. However, there is still marginalization of women globally when it comes to AIDS awareness, and there is a dearth of awareness programs specifically targeted towards women sex workers, which constitute one of the highest risk groups. Sex workers from the underprivileged sector are not only socio-economically poor but, in the Indian context, they are marginalized by caste and religion making them doubly or triply marginalized under the patriarchal system.

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[2] Bindu A. Bambah (Ph.D.) is the Dean and Professor of Physics and Joint Professor of Women's Studies at the University of Hyderabad. In addition to scientific contributions, Dr. Bambah has written articles and given seminars to Women's Study groups both in India and abroad to devise methods of inducting and training women to assume leadership roles in the physical sciences. Published work on this topic is Women in Physical Sciences from Followers to Leaders Monograph on Women in Science, ISCA publications. Prof. Bambah has also started undergraduate courses on scientific methodology and given lectures to school students on the importance of scientific thinking in all spheres of life. She is also a joint faculty in the Centre for Women's Studies.

We focus on awareness programs for female sex workers (FSW), which are among the highest risk groups for HIV. Sex workers are "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally" [UNAIDS, 2012].

In India, the first HIV/AIDS case was in Chennai in 1986. Today, HIV is prevalent in 29 of India's 32 states and territories. The epidemic is high (with a prevalence amongst pregnant women attending antenatal clinics being more than 1%) in six states—Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, and Tamil Nadu. The National AIDS Control Organization of India (NACO) and Andhra Pradesh State AIDS Control Society (APSACS) estimate the number of people with HIV in India at 5.1 million in 2004. India has the second highest population of HIV/AIDS in the world after South Africa. HIV/AIDS is a hurdle for human development, a resurgent infectious virus, a public health crisis, and a major human rights issue as health is a fundamental human right.

We situate our study in Hyderabad and Secundrabad (see map in Figure 1). Globalizationand liberalization are the leading causes of the epidemic spread of HIV/AIDS. Hyderabad had an information technology boom in the 90s which resulted in multinational companies mushrooming in the city. Social media in the form of technological innovation influenced the cultural and the social norms drastically and led to the changes in behaviour and lifestyles. This liberalization has shaped dialogue across cultures globally. A major effect of this was on public health and private lives in the major metropolitan cities of India. Hyderabad is the 5th among the cosmopolitan cities in India. Economic and the cultural shift paved a suitable environment for the spread of infectious disease like HIC/AIDS and other sexually transmitted diseases. Increased job opportunities and as well improved standards of living gave rise to a steep increase in the purchasing power of the people. The financial excess and accessibility resulted in commercializing sex as a source of income in many forms, such as casual sex and commercial sex. Economic liberalization has increased the responsibility and the role of the private sector and at the same time has reduced the control of the government on the financial affairs. A huge gap resulted between private and government welfare policies. Interventions by the voluntary sector were the only way out in executing the less addressed issue of the prevention of the spread of sexually transmitted diseases. To establish a conducive environment economically and also at the community level interventions by VOs into local health concerns at the grassroots level is the only compatible approach. These VOs assess the socio-behavioral factors needed for prevention as well as the primary modes of spread of HIV: sexual contact, mother to child transmission, and through infected blood transfusions and intravenous drug use. As stated rightly by [Chong, 2007], "HIV/AIDS represents a growing and significant health threat to women worldwide. Gender inequities in socio-economic status and patriarchal ideology around sexual practices are among the most important, yet often neglected, reasons for the feminization of this disease".

The predominant mode of spread is through sexual contact (80-85%), while the other 15% is through other means such as blood transfusion and infected needles, as per Indian data [Hyderabad, 2010]. Interventions have three dimensions: creating awareness of the disease, safe sexual practices, and distribution of condoms. Stigma and discrimination towards sex work hamper health interventions for sex workers. Behavioural interventions target risk behaviour reduction, negotiation skills, condom use and promotion of community engagement among the underprivileged or socio-economically marginalized FSWs. "Underprivileged"is an umbrella term for social-economic status, caste, and gender and in the present research, these communities are socio-economically disadvantaged [Planning Commission report, 2013].

In this paper, our aim is to explore issues related to HIV/AIDS through the perspective of VOs and the viewpoint of the beneficiaries.

Research Viewpoint

We use an intersectional feminist framework to examine HIV/AIDS awareness programs in the Indian context where it is utilized to distinguish the experiences of women of lower caste or a minority religion from those of upper caste Hindu women [Nivedita, 2015].

In seeking to adopt a feminist viewpoint for this study, we examined the work done in other countries similar to India on HIV and sex work activism. The criterion for "similarity" is geographic and economic. Geographically, Bangladesh, for example, is a country similarly situated to India which has opened its markets globally.

Sultana, in the paper *Sex worker activism, feminist discourse, and HIV in Bangladesh*, [Sultana 2015] pointed out that HIV programs in Bangladesh have ignored the fact that the 'choices' made by sex workers are due to a range of social factors such as gender norms and notions of bodily purity, which have implications for HIV-related risk.

An added dimension in trying to study VOs' interventions from a feminist point of view is the different perspective on sex work in the many forms of feminism. Thus, we have to delve into multiple branches of feminism in demarcating the feminist conceptualization of sex work. There are two conflicting ideologies. The first ideology that seems to be common among most VOs and certain feminists perceives sex worker as victims of situations, such as economic exploitation and patriarchy [Carpenter 2000]. Victimization is the point of view of radical feminism that seeks to eliminate patriarchy in all social and economic systems. According to positions held by some radical feminists, sex work is the symbol of patriarchy [Anderson 2002] in which women are turned into sex objects to satisfy the desire of men. However, the radical feminist viewpoint is often not shared by sex workers themselves. The feminist position that is more in line with the attitudes of sex workers is the pro-sex-work perspective of liberal feminists which sees sex work as an occupation or profession. Liberal feminism is about choice or women's ability to assert their equality through their actions. In many studies [Kotiswaran 2011], it is argued that sex work is similar to other kinds of labor such as domestic labor. Pro-sex work feminists take the position that sex workers should have the employment rights and better working conditions, such as protection against violence that people in other occupations enjoy [Scott, 2005]. Sex work advocates also argue that sex workers separate their core selves from the labor that they perform [Kotiswaran 2011]. This re-positioning of sex workers allows them recognition in legal contexts and entitles them to work-related benefits such as healthcare.

Thus there are different feminist viewpoints, with which we can study the data relating to sex workers and AIDS awareness. We use an intersectional approach combined with a liberal feminist view. According to human rights sources, "Intersectionality is an analytical tool for studying, understanding and responding to the ways in which gender intersects with other identities and how these intersections contribute to unique experiences of oppression and privilege" [Association for Women's Rights, 2004]. The other identity besides gender that we work with is social marginalization due to caste and religion [Weber, 2003].

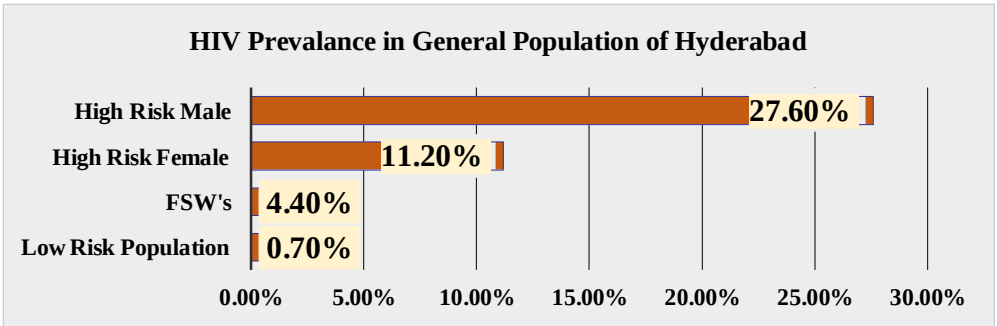
Situating the Study

The study concentrates on the Hyderabad/Secundrabad area in India. Secundrabad and Hyderabad are twin cities geographically located in the Deccan terrain in the Telangana region. Demographically, Hyderabad District has an urban population of 76, 74,689 [Census, 2011]. The sex ratio for Hyderabad District is 955 females per 1000 males. Overall 8.02% of the district population belongs to Scheduled Castes (SC), and 0.90% belongs to Scheduled Tribes (ST). One district hospital, one community health center, and some private medical institutions and VOs serve Hyderabad. Because of globalization there is a floating population in and around the twin cities, making them vulnerable and prone to HIV/AIDS, according to the state-based ministry of health statistics [India Heath Action Trust 2010].

Figure 1: Map Situating Hyderabad (Courtesy Google Maps)

Field work consisted of identifying the VOs actively involved in HIV awareness work. Several visits were done with prior appointment to the project managers of the voluntary agencies. The beneficiaries of the organizations were the female sex workers (FSW) and visits to various categories of sex workers homes, focused (pickup areas) and the catchment areas. Gathering the target group of female sex workers was a difficult task. Stigma, inhibitions, secrecy, and confidentiality were the main hurdles to overcome among the Female Sex Workers and infected women. To overcome these limitations the researcher (Chaya Devi) made several visits to the VOs that advise the sex workers. The counselors in these centers, who held the confidence of the sex workers, introduced them to the researcher. A non-judgmental approach allows the workers could freely exchange their views.

Figure 2: HIV Prevalence rate at Hyderabad in the year 2011



Methodology

Sampling

This study uses purposeful sampling, a technique used in qualitative and quantitative research when the resources are limited [Patton, 2002]. In tune with this type of sampling, we identified individuals who specifically have knowledge or experience related to HIV/AIDS. It is more restrictive than random sampling which allows generality in findings by minimizing the potential for bias in selection [Palinkas, 2013], but useful for many focused studies such as ours. We identified three VOs for the study. The sample for the beneficiaries was taken from the FSWs and the living-with-HIV/AIDS individuals (LHIV) identified by the VOs. Furthermore, we restricted ourselves to the underprivileged women engaged in sex work, who are marginalized by caste and religion.

The three VOs that fitted our sampling criterion were

1. HIV Positive People Efficiency Society (HOPES)
2. Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad which has out-sourced, Hyderabad Leprosy Control Health Society (HLCHS)
3. Manavatha Parivarthan Society

We give a brief description of each of these societies.

1. HIV of Positive People Efficiency Society (HOPES)

HOPES is an organization started by a group of seven members who are HIV/AIDS positive, with a mission to spread the awareness of the virus, to educate people to lead a healthy sex life and to prevent the spread of HIV/AIDS in the Hyderabad District. HOPES works under the umbrella of AVAHAN the project started by the Bill and Melinda Gates Foundation for HIV Prevention.

Objectives of the HOPES are:

a) Fight against discrimination towards the HIV/AIDS positive persons.
b) Fight for the legal rights of HIV/AIDS positive individuals and support them and their children with medication.
c) Family and Marriage Counseling

2. Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad

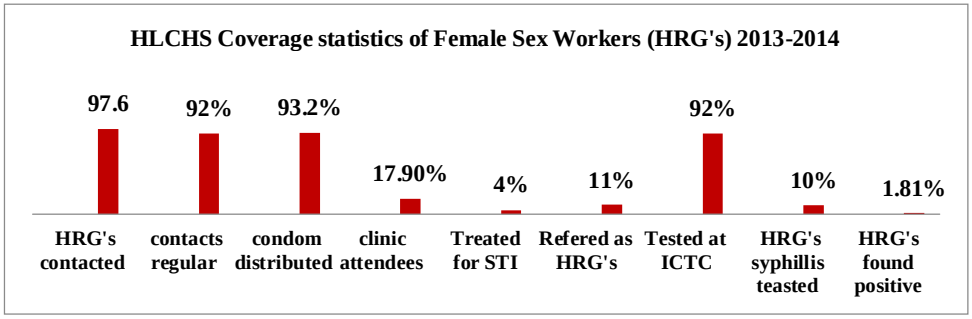
This society is a branch of the Hyderabad Leprosy Control Health Society (HLCHS).A group of philanthropists in the old city of Hyderabad initiated HLCHS. The initial focus was Leprosy interventions in the coordination of Lepra India in 1989 when the incidence of various diseases like leprosy, tuberculosis, and communicable disease was at its highest among the Muslim and underprivileged communities in the old city of Hyderabad. With the lowering of the disease rate it shifted its focus to HIV/AIDS. At present the leprosy rate is low, so the services shifted to HIV/AIDS intervention programs in the slums /underprivileged communities of the old city of Hyderabad. The target interventions are identified and supervised by the project director assisted by project officer and a medical officer. The functionaries are three outreach workers, eight peer educators and two Auxiliary Nurse Midwives. A migrant population of 35,000 is under the catchment area of HLCHS. APSACs provide a list of sectors at risk which are the areas vulnerable to HRG's (High-Risk Groups).

3. Manavatha Parivarthan Society

This VO was initiated a decade ago with the objective of serving the underprivileged society with regards to women's health and girl's health education. It conducts training sessions in the form of lectures and focus group discussions on health issues in girls' schools and women's colleges. These help girls and women to gain knowledge of their own bodies. It also does psychological counseling to understand the behavior patterns of the adolescent females. An awareness dialog is designed to make them familiar with sexually transmitted diseases, and their prevention. The serious implications and the repercussions of having HIV/AIDS are emphasized in these health interventions.The beneficiaries are the target group of the various VOs.

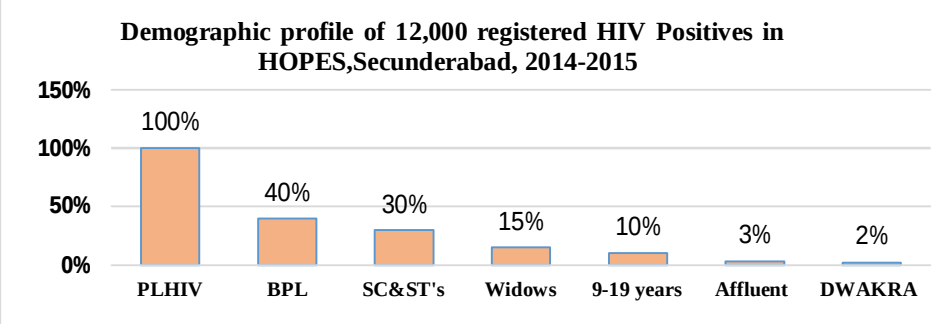
For HLHCS the demography of the FSWs is provided in Figure [3]. The target interventions show that among the 3000 registered, 2,928 high-risk FSW's contacted the HLHCS. 2720 were in regular touch with the HLHCS clinic. Condoms were distributed to 2,796 FSW's and 537 were clinic attendees. 2,760 were tested at an Integrated Counselling Testing Centre (ICTC) and 300 of them tested positive for syphilis, and they also found 54 persons HIV positive.

Figure 3: HLCHS Coverage Statistics of FSWs (HRGs) in 2013-2014



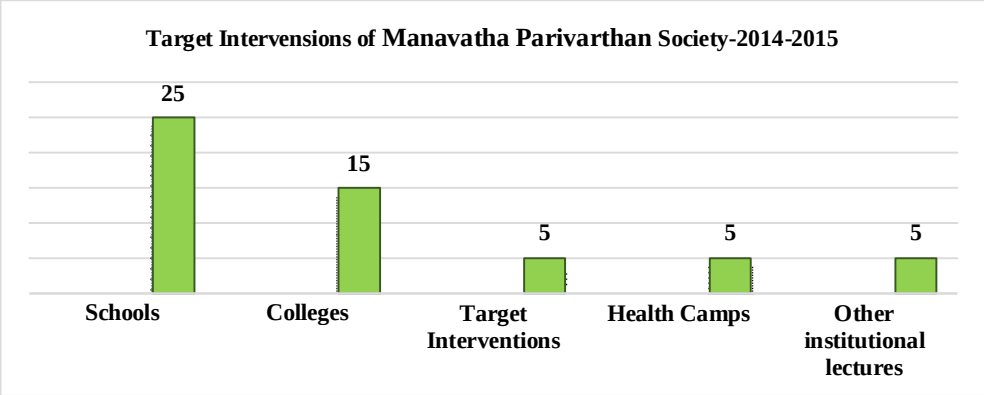
For **HOPES** the demography of the HIV/AIDS positives is given in Figure [4]. 12,000 persons living with HIV are registered with HOPES. Of these, 4,800 were underprivileged categories and were selected for purposive sampling. Among them, we chose 25 persons infected with HIV/AIDS at random for conducting interviews for the study to avoid bias in our sampling. Three thousand, six hundred belong to SC and ST category; 1200 are adolescents of 9 to 19 years of age, 360 are affluent and upper-class, and 240 are from self-help groups (SHGs).

Figure 4: HOPES demographic Profile of registered HIV positives, 2014-2015



For the Manavatha Parivarthan Society, the demography of the Target Interventions is given in Figure 4. Twenty-five schools had adolescent health education courses that include sex education. Fifteen colleges trained in behaviour and attitude changes through lectures and workshops. Five specific target interventions were conducted exclusively to focus on HIV/AIDS awareness programs. Five camps were held for general health issues and awareness among the general population. Added to these, another five lectures addressed in various institutions like Indian Red Cross Society, All India Radio, and NIMSME, etc.

Figure 5: Manavatha Parivarthan Society's Target Interventions 2014-2015



Before getting into the research study, the proposal was submitted to the ethics committee of the University of Hyderabad to get approval to conduct ethnography. The ethics committee framed a code of conduct requiring informed consent of those studied (Female Sex Workers, HIV/AIDS positives) in the research context.

A questionnaire was distributed to the VOs according to the functional hierarchy of the staff and the target groups. For the qualitative or case studies, interviews and focused group discussions were conducted. In the analysis, we present two case studies from HLCHS and two case studies from HOPES, as examples of the larger sample. We used two different set of questions used for the staff and the beneficiaries. Outreach workers, peer educators, and councillors were interviewed to assess the services rendered to the target groups. Beneficiaries who are peer educators, FSW and HIV positives were questioned to know their personal, social and economic status.

Results and Discussion

FSWs between 20-25 years are at high risk of positivity, which correlates with their involvement in more sex work. Prevalence of HIV is 18% more than the older age groups. Among the FSWs, 33% FSWs are between 20-25 years of age and 52% have been in sex work for less than 1-5 years. More than 46% have a client volume less than two per day and 50% are currently married. More than 50% of them reported home based work followed by 20% reported the brothel as the primary place of solicitation. Eighty percent of the FSWs use condoms and peer educators provide these condoms and educate about their usage. More than 50% of them consider sex work as their full-time job for financial support and survival. Fifty percentof the FSWs are married, and

their families supported by their earnings. After the age of 35, these women tend to lose their clients, are left deserted and worn out with disease and infections. Neither government or the VOs nor the family members who depended on them provide support for out of work FSW's. At this stage, they ask for legalization and pension benefits as for any other profession.

Peer Educators (PEs) play a vital role in disseminating the knowledge of the disease, its incidence and also preventive measures under the supervision, training and the guidance of the project co-ordinator. The FSWs get to know the peer educators, who monitor the movements of the other FSWs in the identified areas and streamline the new entry of FSWs for registration with the VOs. Specifically, condom use behaviour is monitored and recorded by FSWs, 85% of the FSWs complained those husbands, and the lovers had never opted for the condom use. Because most of the FSW got into sex work as means of earning at the very young age between 18 to 20 years and continue after they are married, lack of education and have no alternate means of survival, they rely on sex work as their permanent profession.

Case Studies

Case studies have been chosen based on the vulnerability, discrimination and submissive victimization intersecting with poverty, caste, and gender. The "women from scheduled castes and scheduled tribes of India and poor Muslim families are the most vulnerable group for HIV infection. The Scheduled Castes (SCs) and Scheduled Tribes (STs) are various officially designated groups of historically disadvantaged indigenous people in India. The terms are in the Constitution of India, and different low-income groups belong to one or the other of the categories. They belong to families of marginal farmers or landless laborers and must leave the village to make a living. Patriarchal hegemony, sexuality, and sexism intersect with the marginalized socio-economic status of the female sex workers in our study [Sen, 2009]. The traditional work that these castes do was manual labor, and because of globalization, there is not much work for them. Since they mostly work in the unorganized sector, the wages from housework and manual labor are very cheap. The lure of easy money from sex work and their lower status in society make them the victims of confidence tricksters. Hence, they are "triply marginalized" by caste, gender, and poverty. Their experience is very different from the "call girls," who are from an upper caste.

Cased Studies from HOPES

Case Study 1

Monikaisa, 35-year-old HIV-positive woman is a sex worker for ten years. She is married and living in Secundrabad. She and her husband were not aware that they have AIDS, or how they contracted the infectious disease. She financially supports her family through sex work and needs to take care of two primary school kids. She is under the supervision of the Peer Educator of the HOPES clinic. The government, through the VOs, provides free medication and groceries to them. She is doubly affected as an FSW and as AIDS positive. Even though prostitution is illegal in India, the government relaxed the illegality for the AIDS positive cases such as this one. The intervention HOPES provides medical treatment through its intervention programs. Discrimination and psychological trauma have demoralized her, leading into depression. HOPES has rescued her by counseling and strengthened her by recounting success stories of other positives. Thus the voluntary services of HOPES act as a conduit for government interventions, to evade the illegality of the profession. However, such welfare programs do not alleviate the social stigma attached to

the profession. Monika argued that the lucrative nature of the job over others such as housework compels her to stay in business with the supervised use of condoms.

Case Study 2

Shravani is married with two children. She was 25 years old when she tested HIV positive in her second pregnancy. She conjectures that she contracted HIV through the use of infected needles at the hospital. With the intervention of HOPES both her children have been tested and the result is negative. Deserted by her husband and her family and she find taking caring for and raising children difficult tasks to perform. Under the supervision of HOPES, she has access to Anti-Retroviral Treatment (ART). The VO provides a diet consisting of Millet bread (roti), coconut water, and leafy vegetables to keep her immunity levels high and also provides supportive medicines. She is aware of the disease and the severity of its incidence, and the VO helps her in going through the trauma of various stages.

Case Studies of HLCHS

Case Study 1

Our first interviewee was Shantha, the second recorded HIV-positive among the 3000 identified FSWs. She is one the staff and trained as a Peer Educator (PE) at HLCH. She is married with two children and dependent parents to take care of. HLCHS provides her with training, awareness, and medication. In return, she has been monitoring the movements of the sex workers and has registered 120 sex workers into HLCHS. She counsels the other FSWs in implementing safe sex methods such as usage of condoms while teaching the BCC (Behaviour Change Communication). She tracks the condoms used, visits made to the center and blood work of the 120 FSW's that she has registered. She knows that she is infected by the client who visited her. She now prevents the spread of the HIV/AIDS and earns a living. She has turned from a victim to a peer counsellor, thus empowering herself.

Case Study 2

Raabia, 24 years, is an Out Reach Worker (ORW) and a graduate. She belongs to the Dalit caste (lower caste). Acute poverty has led her to sex work. She is self-motivated to protect herself and her family from the infectious disease with the help of HLCHS. She is a regular sex worker as well an efficient ORW who takes the responsibility of 120 sex workers based in the area of Charminar (old city of Hyderabad). She makes door to door visits, talks to them about the hygiene, health and also grooms the young girls who are doing sex work. She motivates them to maintain a clean environment and proper clothing so that they can demand more money from clients. Raabia is well acquainted with many college students and has a huge contact list. She trains them in using the STI prevention methods such as condoms, without which sex is not allowed.

Manavatha Parivarthan Society

The modus operandi of this society is different from the two previous ones. Its main aim is to educate and inform school and college age students, who are between 11 and 20 years old. Motivational programs include health issues related to AIDS awareness and safe sexual practices. The Indian education system introduced sex education into the school curriculum a decade ago, including lessons about changes in body organs, body functions, the reproduction system,

hormonal functions and also psychological implications of sexual changes. When the VO visited the schools, it found that most of the lessons were not taught, but ignored because of "morality" issues: talking about sex is still a taboo in the Indian social context. However, when offered the opportunity, students opened up with various questions related to the body, functions, and sexuality. Myths and mistaken notions about sexuality gleaned through multimedia were clarified. The society sponsored orientation programs, lectures and focus group discussions at the Indian Red Cross Society, at Hyderabad about AIDS/HIV prevention and behaviour change communication.

Theoretical Reflections

Studying AIDS awareness from a radical feminist perspective is often thought of as patronizing to the affected FSW population. In contrast, the liberal feminist framework defends sex work as regular work and posits that FSWs should enjoy all the benefits that regular workers have, such as unions and health care [N Veena 2007]. It is this philosophy, which public health activists and all the VOs that we visited advocated for the decriminalization of the profession and supported the liberal feminist position on sex work [Rogers, 2006]. Hence, in this perspective, sex workers are represented not as victims or vectors, but as fighters or agents and this portrayal relieved them of social stigma.

Discussion

As the result of our study, we find that it is low economic and social status that drives women and girls to depend on sex work for financial support. This notion often means that the use of condoms is not an option when a woman's value is measured by her fertility and her ability to give men pleasure. Focusing on condoms or abstinence as the global response to HIV excludes women whose lives are shaped by these are factors, often beyond their control. Addressing poverty and gender inequality among women is thus an intersectional task [Nivedita, 2015]. There is no recognition in society that women involved in sex work have a human right to education, health, freedom from violence and support. Governmental bodies often treat sex workers as criminals, thus, more often than not; it is VOs that provide support and education to help women sex workers protect themselves from a potentially life-threatening disease.

The data indicates that India has made significant progress in tackling its HIV epidemic, especially in comparison with other countries in the region. For example, while new HIV infections have fallen by more than half since 2001, the number of new HIV cases in neighboring Pakistan has increased eight-fold. The reason for this seems to be two-fold. First, by utilizing the assistance of VOs, the government has avoided the legal aspects of taking on the promotion of awareness of sex workers and high-risk groups, since most of these activities, by law, are illegal [Ahmed, 2011]. Secondly, in most of the AIDS awareness programs for FSWs, the onus of protection against the epidemic lies on the sex worker. Paradoxically, it is the women who are trained and taught about the regular usage of condoms. Moreover, some public health specialists reflecting a liberal feminist perspective, who work for the protection of FSWs in the context of the management and prevention of HIV/AIDS, [Nagaswamy, 2008] argue that sexual labor is not necessarily abusive and violent. [White 1990] has argued "Prostitution is a capitalist social relationship not because capitalism causes prostitution by commoditizing sexual relations but because wage labor is a unique feature of capitalism'.

In conclusion, we find that many HIV preventative measures, such as condom distribution, fail to address what drives people into the vulnerable situation of exposing themselves to unsafe sex in the first place. Ignorance and lack of health awareness are two significant drawbacks in the aspect of public health. The HIV/AIDS epidemic, as well as its control, is socio-economically driven among Indian Sex Workers. Thus, facilitating and training women and girls involved in sex work in the aspects of health and well-being to prevent HIV/AIDS is the only tool which is realistically viable. The VOs that we have explored were able to cater to the requirements of the FSWs; they identified them, counseled them and also taught them condom usages and provided systematic follow-up visits. Decades of seeking to achieve the MDGs and SDGs (2006-2016), resulted local proactive policies of the Indian government and their implementation, in successfully lowering rates of STIs. The positive impact of such strategies adds a glimmer of hope for the eradication of the disease among vulnerable communities. Table 1, substantially gives a statistical global estimate and illustrates the impact of the target interventions and the efforts of the VOs.

Table 1: Figures from UNAIDS 2016 of the Global trends and occurrence of the STDs

People living with HIV in 2015(Global)	36.7 Million
People living with HIV accessing ART in 2015	17 Million
New HIV infections in 2014	2.1 Million
New HIV infections averted in the past 15 years due to scale-up of services	30 Million
AIDS- related deaths in 2015	1.1 Million
AIDS-related deaths prevented in the past 15 years due to scale-up of services	8 Million
Reduction in new HIV infections among children	58%

Conclusion

In conclusion, as above stated, we find that even though awareness drives and condom distribution are preventive measures, these initiatives fail to address what drives people into the vulnerable situation of exposing them to unsafe sex in the first place. Ignorance and lack of health awareness are two significant drawbacks in the aspect of public health. The HIV/AIDS epidemic, as well as its control are related to socio-cultural and socio-economic situations catalyzing a shift to sex work. At this juncture, facilitating and training the women and girls in the aspects of health and well-being in preventing the sexually transmitted disease (HIV/AIDS) is the only tool which is ardently approachable. Voluntary organizations (VO's) examined and analyzed were able to cater to the requirements of the FSW; they identified them, counselled them and also taught them condom usages and follow-up visits systematically and technically.

Also, we have seen from our visits to HOPES and the Manavatha Parivarthan Society that risk behavior patterns are internalized at a very young age, as the adolescent population (22% of the world population) is increasing at an alarming rate. India is home to nearly 225 million adolescents between the ages of 10 and 19 years. Unless we attend these issues at the grassroots level, it will become harder to curtail the epidemic. Unless there is a questioning of the

developmental processes and attention is given to access to healthcare, education and food security for socio-economically vulnerable sections of the population, there is little hope of attacking the roots of the epidemic. A direct emphasis on HIV/AIDS care should be an integral part of healthcare systems that already exist. But in countries that do not ensure primary health care, prioritizing HIV/AIDS care in isolation will not only be met with a lack of success; it may also jeopardize the struggle for basic healthcare by side-lining it and making it appear less relevant. Thus the role played by VOS in bridging the gap between the public health care system and high-risk groups, not only lessens the stigma of HIV but also assists high-risk groups to obtain the preventive measures and information they need, without fear of legal consequences associated with their profession or lifestyle.

These organizations have made the first step in the right direction. Our interaction with the VOs revealed to us that besides prevention and education of high-risk groups, the infected cases have no legal rights and are ineligible for medical insurance. Finally, to have an integrated approach to HIV/AIDS control, it is crucial to adopt a three-point program: Firstly, to control the disease one must create programs that tackle the socio-ecological determinants of health in addition to providing cures and interventions. Secondly, we must strengthen general health services to fill this urgent need. We should provide free access to sexual and reproductive health education, and information has to be increased in various forms, targeted to the different needs of women and men and also to various age categories. And thirdly, we must emphasize the human rights approach and recognize the importance of the context and the complexity of the issue. For long term, effective reform, there are no shortcuts. Minor increases of existing services are not going to solve the problem. What is needed is a radical restructuring of services, placing the people at the center.

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Health Education for Adolescent Girls: The Role of Voluntary Organizations

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Abstract

It is universally accepted that health education should be holistic and touch every aspect of life, including lifestyle skills [WHO, 2003]. Heath education should include human physiology, nutrition, disease prevention and sex education. However, in actual practice, especially for adolescent girls, the health education imparted is highly skewed. Attempts to introduce a sex education component of health education in Indian schools has been met with hostility and prejudice, which has resulted in newspaper headlines [Jha, 2014]. In this paper, firstly, we examine the status of health education of adolescent girls in government schools and find that most schools do not sanction or provide information on sex-education programs. Secondly, we examine how the current practice of avoidance increased experiences of victimization. We find The dropout rates among lower-income underprivileged adolescent girls. Thirdly, we look at voluntary organizations' attempts to foster health education programs for development in the broadest sense. We also aim to understand how voluntary organizations impact adolescent health education.

Keywords:

Health Education, Adolescent Girls, Sex-Education, Voluntary Organizations, Health Interventions.

Introduction

Although it is recognized that girls' education is imperative to a country's development process, poverty and gendered prejudice have a strong negative influence on gender-equal access to education. It has been widely acknowledged that education does not necessarily ensure better knowledge and a grasp of gender issues. Awareness of gender issues among the school growing population comes during the adolescent years. However, national surveys have recognized Indian adolescents as one of the most under-served population groups regarding health education.

Health education for girls has three different facets. 1) Knowledge about nutrition and health 2) Knowledge about the body and diseases 3) Sex education. Health education for girls primarily consists of awareness of nutrition, menstruation and maternity. World Health Organization (WHO), United Nations Population Fund (UNPF), United Nations Education, Scientific and Cultural Organization (UNESCO) specified the operational guidance for Comprehensive Sexuality Education

1. A basis in values and human rights of all individuals as a core component, not an add-on:
2. Thorough and scientifically accurate information about human rights, gender norms, and power in relationships (including consent and decision making, sexual coercion, intimate-partner and gender-based violence, and sexual diversity): the body, puberty, and reproduction: relationships, communication, and decision-making: and sexual health(including STI/HIV and AIDS, unintended pregnancy, condoms and contraception, and how to access health and other support services):
3. A gender focus (gender norms and gender equality) as a standalone topic and also infused across other CSE topics: moreover, such gender content dovetails with efforts to keep girls in school and to promote an egalitarian learning environment:
4. A safe and healthy learning environment:
5. Practical participatory teaching approaches help learners personalize information and strengthen their skills.

Similarly, the youth policy drafts of the Government of India highlight the need for a more focused adolescent health, nutrition, and reproductive, sexual and mental health programme. It also says that [Youth Policy 2012] gives adolescents data as 22% of the world's population. India is home to nearly 225 million adolescents between the ages of 10 and 19 years. The seeds of secondary status are planted in the girl child, making it challenging for her to be a confident woman capable of withstanding abuse. This paper emphasizes the impact of educating girls at the adolescent stage to know about human physiology, sex-determining factors, nutrition requirements, and sexuality.

Further, we look at the role of voluntary organizations that have programs to promote health awareness among adolescent girls. According to the WHO Information Series on school health, "The onset of puberty constitutes a fundamental biological change from childhood to early adolescence. An important component of social cognition in the transition from adolescence to adulthood is the process of understanding oneself, others, and relationships. The ability to

understand causal relationships develop in early adolescence and problem-solving becomes more sophisticated" [WHO, 2003]. At this stage, the social interactions of an individual change drastically from childhood, as more time is spent with peers leading to increased interaction with opposite-sex peers. Moral development also occurs as adolescents begin to internalize different opinions and messages they receive from various sources—why sex education is essential at the adolescent level. As Christina Taylor, the community and bequests officer "Plan International", says **",** Girls education is about so much more than knowledge. By ensuring that a girl has equal access to education, employment and adequate health care, the benefits will be passed on to her children (both boys and girls), community and her country." In the policy on youth affairs and adolescent development of the Govt. of India [Report, 2007], it is stated that adolescence is generally perceived to be a healthy period of life. But this is deceptive since adolescents face several public health challenges that are, of course, different from those they met when they were children. Nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours started during adolescence." Studies have shown that adolescent women are two to five times more likely to die due to causes related to pregnancy and childbirth as compared to women in their twenties.

Gender bias affects our educational framework in an Indian context, no matter how much resistance against it. In a family where resources are limited due to income, caste or religion, if there are both male and female children, the male child will always be favoured to get an education. A growing research community has found gender, economic status, caste and classwork together from childhood create gendered health inequity, i.e.unfair and avoidable differences in health and health service provision. Feminism tells us that sex is biological, but gender is a social construct. However, feminism is not recognized as a necessary part of an educational curriculum.

Most people do not know the difference between sex and gender, and children have to be made aware of this difference at an elementary level for a more balanced view of the world. As observed by many social scientists [Mark 1996], although feminist research has provided the foundation for the most understanding of gender equity in education, however in mainstream scholarship, the politics of knowledge has excluded the woman's perspective. Gender research which has its goal of "equality, equity and empowerment", has gained legitimacy. In many cases, this type of research has served to reinforce traditional and firmly believed ideas of gender differences. Questions about these traditional assumptions and why they exist have not been dealt with. For example, one can take the conventional policy assumptions about sex

education. The right feminist questions could be who /what was silenced in the removal of sex education in education policy and how does this affect the interventions of a voluntary organization? Such feminist reforming is often necessary to uproot gender bias. This paper will examine such prejudices using a gender lens. It will also shed light on the effective health education programs in some of the schools of Secundrabad and Hyderabad to see how voluntary organizations aid them in providing material for health education to underprivileged adolescent girls.

Methodology

Our research methodology comprises of

- Fieldwork – interviews, narratives, focus group discussions.
- Empirical data and sources-Primary and Secondary.
- Tables and charts are used for interpretations.

SAMPLING

Since the study is geographically limited to Hyderabad and Secundrabad area, the population distribution of Hyderabad/Secundrabad is given in table 1.

Population details	**India**	**Hyderabad**
Population (2011 Census)	1,210,569573(India)	7,674,689(Hyderabad/Sec)
Males	623, 12184	51%
Females.	587,477, 030	48.8%
Total literacy rate in the country at present	73%	83.96%
	Males 56.9%	Males:86.99%
	Females 43%	Females: 79.35%
Adolescent 11-19 years	22% of the total	18.5% of the total
	Males53%	Boys 51.5%
	Females46%	Girls 48.5%

Table: 1

We have gone through the portals of Hyderabad online to find the distribution of govt. Aided and non-govt. Aided schools in Secundrabad- Hyderabad area. Six hundred sixty-eight schools are unaided schools, and 181are government schools in Hyderabad[AP Online Portal, 2015, DEO Hyderabad portal 2015].

We have chosen a non-probabilistic sampling technique known as purposive sampling that is selective and relies on the researcher's judgment. Thus, when researching gender issues,

especially in health education, feminist approaches offer methodological insights on the focus of the research, the relativity of both research and the necessity of the statement of the values of the investigation. Therefore, random sampling is not suitable for any gendered study. Historically, in the mainstream scholarship of the politics of knowledge, women's perspectives are excluded, and statistics are the only reliable measures. When selecting the units (e.g., people, cases/organizations, events, pieces of data) that are to be studied for a particular topic, purposive sampling is practical. In this case, using purposive sampling, we identified 25 schools in Secundrabad and Hyderabad. Of these, 10 were exclusive girls' schools, 5 were exclusive boys' schools, and 10 were co-educational schools. Schools identified are for students of the underprivileged section, both in caste and economic status. They fall under the benefit schemes of the government like *Sarva Siksha Abhiyan* and *Rashtriya Madhyamika Siksha Abhiyan(RMSA), Rajiv Vidya Mission, Mid-Day-Meal* and *ABC program*[Rao, Rena and Nair, 2008].

The sampling profile is given in Fig. 1

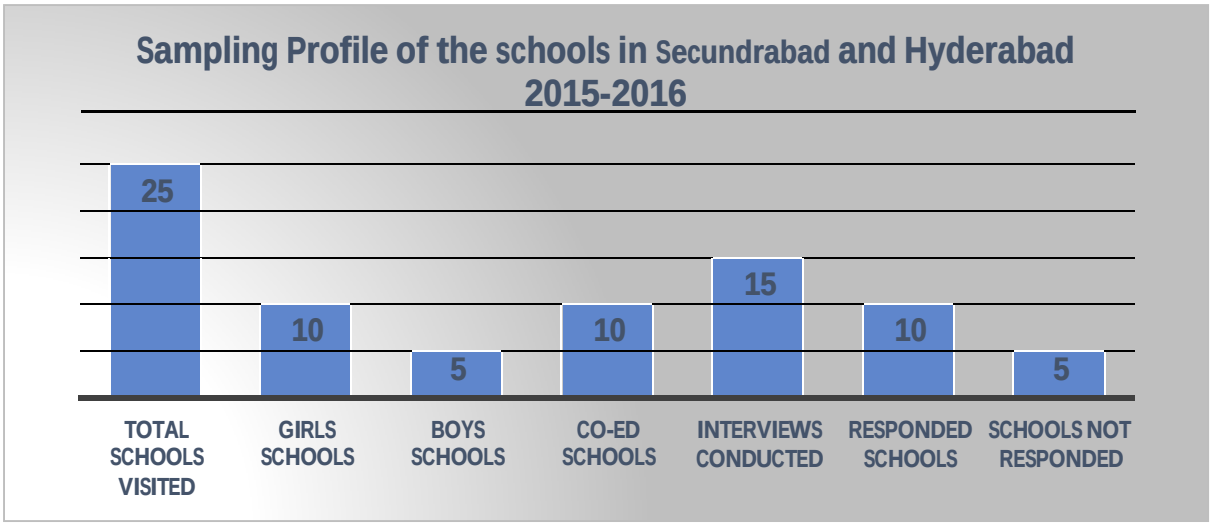

Fig: 1

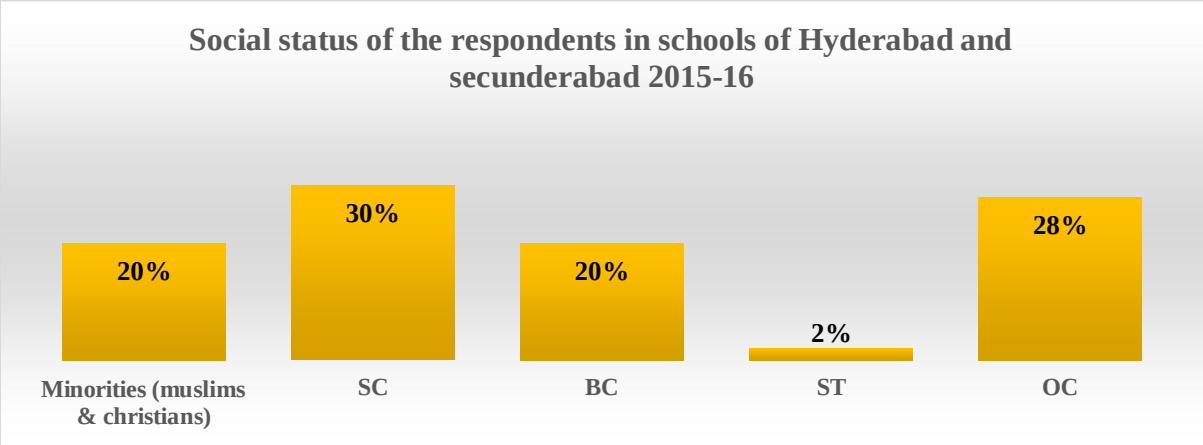

Fig: 2

In five government schools, focus group discussion was held to collect their opinions and perspectives on general health and sex education. All the government schools were chosen because they have interventions of voluntary organizations. The schools that participated in focus group discussions are given in Table: 2

S.No.	Name of the School	No. of Students	No. of Staff
1	Govt. Girls High School, Picket, Secundrabad	60	5
2	Centenary Govt. School, Mahaboob College, Secundrabad.	45 Boys 35 girls	5
3	Govt. High School, Masab Tank, Hyderabad. IRCS, Telangana.	45	1

Table: 2

We explored all the portals available in this area in the electronic media to know about the existing number of Voluntary Organizations, how many are registered and how many are working. Our criterion for selecting the VO's was again purposive and limited to those voluntary organizations that were imparting health services in the schools of Hyderabad and Secundrabad. Based on this, we identified the following Voluntary organizations and the services rendered. This is given in the table. 3.

1.	Indian Red Cross Society	Women Volunteers contribute time, money and other services required.
2.	Lions Club	Health camps, distribution of medicines, spectacles, Health awareness camps.
3.	Rotary Club	Health camps, Eye Camps and other donations like books, benches and pens
4.	Sarojini Devi Eye Hospital	Eye Check-up Teams
5.	Dental Clinics	By leading practitioners/trainees
6.	Team India	Teaching language and other subjects required
7.	Senior Citizen Forum	Books and school uniforms, lectures on health and hygiene
8.	Society for aged and women(SAW)	Lectures and training programs on health, distribution of sanitary napkins to girls
9.	Manavatha Parivarthan	Health education
10.	Sweekar Upkar	Medical Camp
11.	Ramachandra Mission	Health camps and other donations

Table: 3

Situation Analysis.

Our methods of obtaining information consisted of three stages on school site visits.

1. Focus group discussion with students and teachers.
2. Orientation on body, sexuality, behaviour patterns
3. Question hour for students and teachers.

First, we set up focus group discussions in the three schools identified in a table: 2. Discussions on the level of awareness of the students on health issues were assessed. The teachers were also asked the method followed in teaching health-related issues in the curriculum. Students responded positively to general health issues such as body ache, obesity and hair loss, infectious diseases. Still, they did not link these with nutrition and lifestyle. They were concerned with memory loss and personality development. However, such problems are not there in the curriculum. Mental health disorders are wholly neglected due to the stigma attached

to them. This was the generalized understanding about health education among the adolescent girls and boys at the age of 9-16 years from class 6^{th} to 10^{th} class in the schools.

Results and discussion.

Global Monitoring Report 2015*[UNESCO, 2015]*evaluates that "Training should be designed, so it is relevant to local contexts and include comprehensive sexuality education. Teachers should also be supported with teaching and learning materials that question gender stereotypes and promote equitable behaviour." There was a lack of information concerning specific issues like menstruation, reproductive system, contraception, prevention of sexually transmitted disease and associated these things with uncleanliness. There is a question of morality and values to talk openly about the issues related to sex and sex related myths among the students and the teachers. Teachers accepted that there were limitations and embarrassment in teaching the sex-related lessons, and therefore they either ignored them or used plant and animal examples to illustrate while teaching. The students did not identify with this approach and were left to know about these issues independently. Students are left wayward in assumptions gathered from their friends, social media like into the. If the knowledge about the body, physiology, sex organs, and their functions were not addressed adequately, it leads to risk behaviour patterns in the adolescent phase. We engaged the students and teachers in dialogue and expanded with an orientation talk on teenage health. The lecture included human physiology, the origin of species and the history of the evolution of human beings, gender construct and the physical, emotional relationship of a male and the female, the incidence of sexually transmitted diseases and their consequences.

The next step was to examine the attempts made by voluntary organizations to address some of the issues related to health education for adolescent girls. This was done by constituting health camps associated with eye check-ups, dental care, skin care, and nutrition. One such voluntary organization is the ***Manavatha Parivarthan Society,*** initiated in 2000 by like-minded people in public health education interventions. This VO has been conducting awareness programs focused on adolescent health issues, general health, and hygiene for boys and girls in Government and private sectors. Targeted intervention to the low income and also marginalized sections is given. Community-based programs such as blood donation camps, complete health profiles, and need-based intervention among the underprivileged are Table: 4,

which offers the health issues that are part of the girl's curriculum and how they are addressed by the VO's.

List of various health issues in the schools addressed by the VO's, the services rendered by multiple VO's

Health Issues prevalent in Schools	**Names of VO's inactivity**
Awareness about health and hygiene	Manavatha Parivarthan Society, Lions Club, Rotary club,
Sex Education	Included in the curriculum, Manavatha Parivarthan gives lectures, IRCS women volunteers, society for aged and women (SAW), Rotary club.
AIDS/HIV and STD	Govt. organizations like UPHC"s, Gandhi Hospital, Osmania Hospital
Talk and train the students about safety measures and precautions regarding STD.	Red Ribbon clubs

Table: 4

The overall picture we got was the following: From an Indian perspective promising potential projects to show no shortage of adolescent health education interventions through government and VO interventions. However, implementation is a serious problem both from a moral and financial standpoint. Since the Government schools are providing strategies to improve gender-equal educational access, they must address the social factors that impact the family decided to send girls to school and impart sex education to the students. Sex education is considered to be a western concept that is not much tolerated in modern Indian society. Neeru Garg,[2015] that " The experts say that the case of sex education in India is quite different from the west because child marriages here make certain that you do not only indulge in legal sexual activity at a young age, but you also have a teenage pregnancy." There is confusion between sex education and education about

sex, and it is misconstrued that this leads to sexual promiscuity. All that is learnt about sex is shrouded in secret, and it reinforces unequal gendered views, which victimize women and empower men, and sex is viewed as something done to women. None of the educational programs addresses this issue with the required intensity in empowerment. Subsequently, the next step was to take questions from the students and teachers. After the lecture, many students opened up various questions about sexuality, sexism, abusive patterns, and considerable doubts regarding family life education. Some of the questions raised by the students were:

1. Why is sex required in our lives?
2. When sex is for progeny, and why do they have sex after they produce kids?
3. How can we overcome the attraction towards the opposite sex?
4. What is the meaning of sex, and how is it?
5. Why do parents get us married at a very young age? Can you help us to avoid it?
6. Why do we feel abusive and shameful to raise questions on sex?
7. Can we overcome the influence of social media?
8. How to tackle peer and parent's pressure?

Manavatha Parivarthan Society answered all the questions raised by the students to complete Family Life Education intervention in the listed educational institutions' table: 3:

1. Sex is an integral part of our creation, and it is the process of producing similar species and applicable to all living creatures. It is an evolutionary process that keeps moving from birth to death is a cycle in itself.
2. Yes, sex produces children and a sexual act, but it is also a biological need and physical desire. It is also related to the emotional aspect of sharing love, affection, and compassion with certain limitations. Present living conditions are more interested in sex because of the change in the attitudes and agency towards sex. People have become more expressive with fewer inhibitions, and executingividual freedom is the central issue
3. Yes, males and females of any species have certain hormones that provoke each other to be involved in the physical attraction, leading to a sexual act called inter course and resulting in pregnancy and delivery of the babies. This process occurs among all the universal species, such as in animals, plants, and other living millions of species around us. This law of attraction is also applicable to the human species. If you look back at the timeline of millions of years, the evidence of fossils and excavations, we see disappearances and

extinction of the human race many times till date. The causes are many instances unknown and are still a mystery. Shreds of evidence show that children born to the same blood group parents are deemed to bear the children with congenital abnormalities and deformities and die prematurely on most occasions. So this is one of the reasons for not encouraging sex with the same blood group. Eventually, the system has evolved and established into a social and a moral norm. Taboos and values are created around the fundamental involvement of sex among the siblings and the same group of individuals as sensitive and value-based issues.

4. Such values are incorporated into the cultural and religious disciplines of our daily lives. Henceforth the humans are protected and encouraged for healthy living and extend the longevity of the entire civilization. This can be explained from a scientific perspective. "A 1994 study found mean excess mortality with inbreeding among first cousins of 4.4%. [Brittles, Niel,1994]Children of parent-child or sibling-sibling unions are at increased risk compared to cousin-cousin unions. Studies suggest that 20-36% of these children will die or have a major disability due to the inbreeding [Willium.H.,2004)] made "A study of 29 offspring resulting from brother-sister or father-daughter incest found that 20 had congenital abnormalities, including four directly attributable to autosomal recessive alleles. Baird, McGillivray (1982)."
5. Sex is the involvement of the two physical features or bodies as male and female. They come closer physically get involved in the act. The body receives the changes internally to enter the action called intercourse, as you all observe in other species like birds and animals in nature, which is explained in your textbooks as part of your curriculum. This action releases feel-good hormones in the body and relieves stress levels. When this happens at the right time with the right person in the right way and at the right age is an essential factor to be considered. The right age for marriage in the Indian context and tradition is 20 for females and 25 for males. This age indicates the preparedness of the physical and the mental ability to start a family life; however, it can be considered the right time to get involved in sex. The right person is the married person, and the sexual act is healthy, legitimate to lead a healthy relationship.

   Interaction between the students and the interviewer/research scholar in the focus group discussion was an insightful tool to frame a further action plan to promote adolescent health issues among voluntary services. Girls in the sessions were curious but hesitant to raise the questions. Boys were better participants, and they raised many questions. Gendered roles are reflected in their participation as young girls who are less informed and ignorant when

compared to the boys of the same age group. One of the interactive sessions gave an insight into the behaviour patterns and the personal traits of the parents towards the girl child in the family and society. When asked, do you find any discrimination between the male and female siblings in the context of resources like food, clothing, and other requirements? The most exciting fact was that the underprivileged communities still believe that the boys have to be fed more and milk is provided to them. Instead, girls are given diluted leftover tea. When girls raise their voices against, they are confronted and silenced by telling them that boys are the future breadwinners and are taken care of with all the privileges. Whereas girls tend to get married and leave their parents and make their own families, they are also denied equality and equitable resources in personal spaces. Subsequently girls and boys are trained in particular patterns in reinforcing the patriarchal norms from their childhood and even at infancy. This again leads to girl's undernourished future generations who are made to prove to be weak in their physique and also less confident in their accomplishments.

Conclusion:

Scientific sex education of adolescents may help to avoid the number of health-related risks. If the

The Health system fails for girls. Then it fails for the whole developmental process of the country. Being vulnerable to various changes associated with physical, emotional and psychological transition, adolescents/ youth must have proper knowledge of sex education that in the process empower them into healthy, productive and responsible adults, as aptly stated by[Sunandamma, Sreenivasa Moorthy,2004]"Discrimination has become a tradition to the society where right from the basic needs food, clothing, shelter and education any work level girl children have become victim to discrimination". Adolescent girls in the developing world need to acquire remunerative and marketable skills not taught at home, such as computers, fluency in an internationally spoken language, financial skills, and knowledge of social systems.

A *Parliamentary Committee* with a varied political membership recently recommended that there should be no sex education in schools. The committee has recommended that Chapters like physical and mental development in adolescents and AIDS and other sexually transmitted diseases be removed from the mainstream curriculum. Instead, they want these topics to be included in the biology syllabus, which further disadvantages marginalized section students who are hampered in gaining knowledge of health. Moreover, these students who belong to marginalized communities selectively opt for vocational training courses for their early

financial support are more susceptible to diseases and infections like HIV/AIDS and other infectious diseases. It further puts the adolescents in a more critical situation than before. However proactive the policies and activities are; new and innovative methods to promote interactive and collaborative learning can help develop critical thinking and decision-making skills and instil a habit of continuous learning—capacities that will accommodate girls in a fast, ever-changing world. Additionally, parents themselves do not have correct and scientific information about sexual and reproductive health-related matters[Mahajan and Sharma 2005] also support the augment, "The silence in adolescence and clarified doubts are testing Indicators neither the parents nor teachers make a clear understanding about sexuality, frank and healthy discussions are discouraged."Such fear and inhibition imposed on girls' health education are at greater disadvantage for her future socio-psychological development and the individual's wellbeing of the society as a whole.

In conclusion, we find that more intervention is needed in schools and training sessions need to be conducted for educators to impart sex education. VO's can be instrumental in bringing this about. Based on this research study, we find that VO's facilitate an interface between the local government and the community regarding health education among adolescent girls. To implement government welfare schemes, voluntary organizations serve as a bridge between educators and teenage students. Although government scheme like *[SABLA,2013]*has been introduced in all the states of India to empower adolescent girls in various related health issues, lifestyle skills, lack of trained teachers, shortage of funds and budgetary constraints, though slowed down the scheme in action. It was only fruitful to some extent with the coordination of the local VO's interventions. Even the teachers and the school heads of management expressed their opinion and suggested voluntary organization interventions play a vital role in imparting the knowledge of sex education in school. Instead of avoiding topics like sex education, a scientific attitude has to be adopted, and this subject should be a part of Family Life education as a standalone FLE subject/program. A nation-comprehensive study by the *Department of Women and Child Development* says that "53.2% of children have faced one or more forms of sexual abuse and at least half of the perpetrators were known to the child. Therefore sex education might help the vulnerable young population be aware of their sexual rights and empower them to protect themselves from an undesired act of violence, sexual abuse molestation". Because adolescents are particularly vulnerable to specific health issues, educators, research scholars, communicators and other concerned citizens are appealed to 'be

adolescent competent', invest their knowledge and experience pragmatically for the advantage of most vulnerable adolescents.

The need of the hour is to communicate clearly and encourage adolescents to talk openly and instead respect their privacy and confidentiality. Voluntary Organizations are trying to work with governmental agencies to promote health awareness in adolescent girls, but this is very limited. Much more intervention has to be done to impact and improve attitudes towards gender equality and eradicate discrimination.

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