



YOUNG URBAN WOMEN

Exploring Interlinkages:
Bodily Integrity,
Economic Security and
Equitable Distribution
of Unpaid Care Work

A Research Study in
Ghana, India and South Africa

November 2015



act:onaid

FEEL AT HOME THE JOINT SPOT



ActionAid's Young Urban Women's (YUW) Programme addresses young women's economic rights and sexual and reproductive health and rights (SRHR). Using a human rights based approach to development, the project places a commitment to building the active agency of young women living in poverty at its centre. This lays the foundation for addressing young women's access to decent work and sexual and reproductive services simultaneously in three key ways: empowerment, campaigning and solidarity.

This publication has been produced with the support from Norwegian Agency for Development Cooperation (Norad) and the Human Dignity Foundation (HDF). The contents of this publication are the sole responsibility of ActionAid International and do not necessarily reflect the ideas, opinions or policies of Norad or HDF.

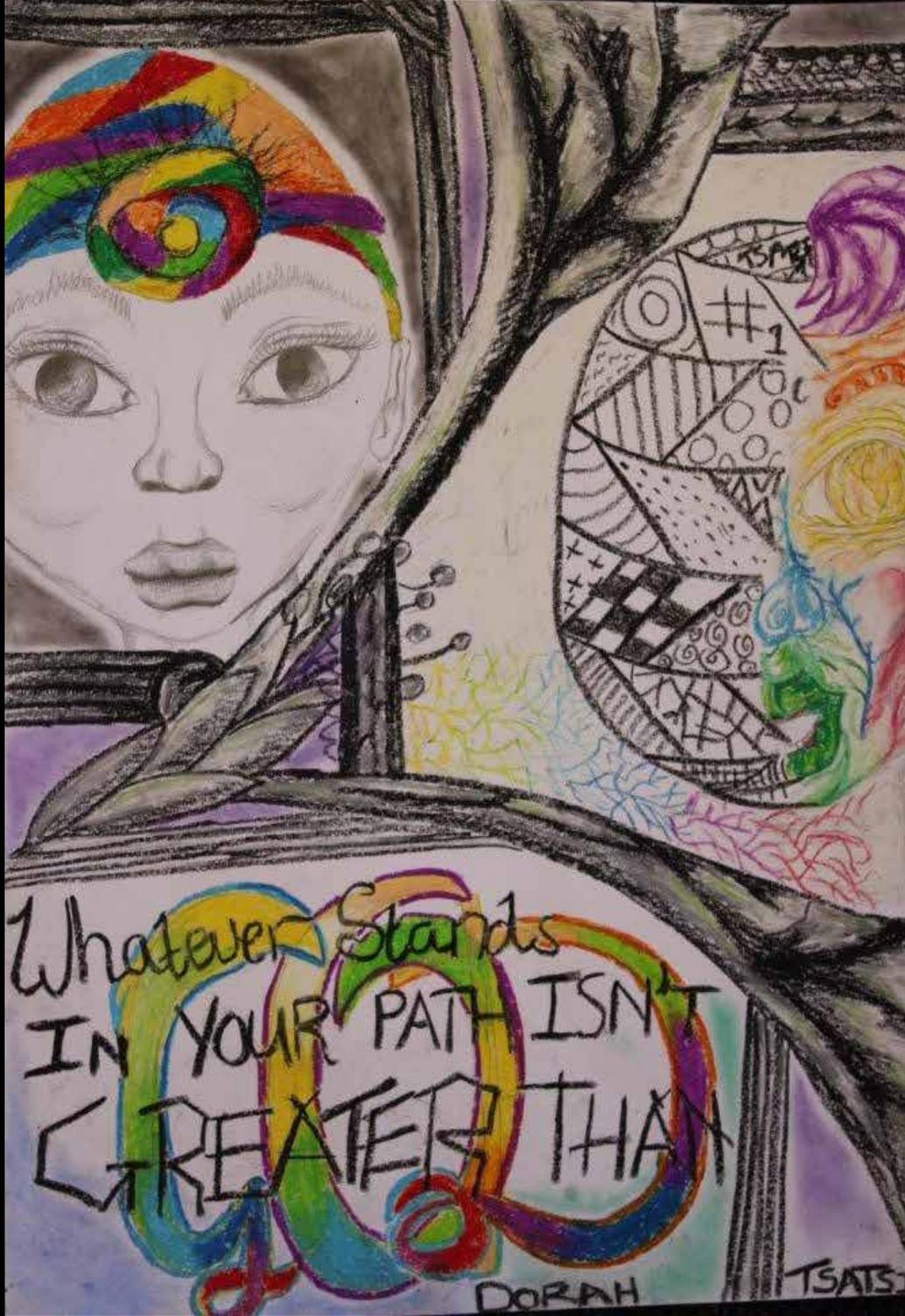
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When ActionAid began the Young Urban Woman programme in 2013, we set out to work with our partners in Ghana, India and South Africa to support young women to be powerful and critical agents of change in their lives and the worlds around them. Our goal was to empower 5,800 young urban women living in poverty through increased economic independence and control over their bodies and by ensuring that their voices are heard and recognised in local, national and international forums.

We felt the need for this programme given the particular vulnerabilities, exclusion and marginalisation that we know confront young women on a daily basis. Young women enjoy fewer rights to political and economic participation than do boys and young men and they perform essential work for which they are frequently neither paid nor fully recognised. In all the spheres in which young women move, they are more vulnerable to the realities of violence. This includes forced and early marriage, not only a blatant violation of women's rights to make decisions that affect their lives, bodies and sexuality, but one that poses risks including limited control over decisions regarding sex, exposure to HIV/AIDS and reduced school attendance.

This report comes in the last year of the first phase of our Young Urban Women programme. We have reached many milestones since the project's inception – witnessed the genuine empowerment of these young women claiming their rights and standing up against rights violations, seen the value of solidarity between these young women across cities and countries, and the impact of investing in young women's capacity as leaders.

At the same time, this report allows us to reflect on the on-going and deep vulnerabilities facing young women at a particular moment in their lives. This is a time when young women are trying to enhance their education and vocational skills to access decent and sustainable opportunities in the workforce. It is a moment when adult identities are defined, when young women seek greater financial independence, perhaps as they move outside the family home. Our findings help us to understand what it means to be a young person in today's society, what it means to be a young woman in particular and the impact of being an urban dweller. We also see the indisputable significance of the many different and intersecting identities of these women – among others, their race, class, marital status and sexual identity.

The barriers women face to economic security, enjoyment of bodily integrity and a more equitable distribution of unpaid care work are made clear in our findings. We call on readers to stand alongside the young women involved in our programme in their demands for greater control over their lives, livelihoods and life-choices.

One final note: We know too well that young women's voices are stifled by cultures that silence them, by political spaces that exclude them and burdens of care work that deny them the time to participate. We hope that the very process of undertaking this research has helped amplify the voices of the young women with whom we work and their demands for change.

Dr Ramona Vijayarasa

International Programme Manager – Women's Rights

November 2015

Acknowledgements

ActionAid is grateful to the young women in Ghana, India and South Africa who participated in the research study. This report would not be possible without their candid responses and input.

We would like to acknowledge the support and cooperation of the following implementing partners in this study: The Ark Foundation in Accra, Ghana, Shaheen Women's Resource and Welfare Association in Hyderabad in India, and Afrikka Tikkun in Johannesburg in South Africa.

This work was led by Susana Fried, independent consultant with support from Baishali Chatterjee, International Project Manager, Young Urban Women: Life Choices and Livelihoods Project. ActionAid is grateful to the national consultants (Miriam Iddrisu from Ghana, Rita Mishra from India and Kodwa Tyiso from South Africa), national project managers (Henrietta Lamptey in Ghana, Nirupama Sarathy in India and Lindelwe Nxumalo in South Africa) and the YUW project management teams across the three countries for their timely support in completing the research report.

We would also like to thank the following organizations for their support and contribution towards this research:

- The Asia Pacific Resource and Research Centre for Women (ARROW)
- Youth Coalition
- International Planned Parenthood Federation (IPPF)
- Women in Informal Employment: Globalizing and Organizing (WIEGO)
- International Trade Union Confederation (ITUC)

Finally we would like to thank Ramona Vijeyarasa, Wangari Kinoti and Christy Abraham from the ActionAid International Secretariat for their support, technical advice and guidance in organising the research and preparing the report.

Abbreviations

MDGs	Millennium Development Goals
SRHR	Sexual and Reproductive Health Rights
ILO	International Labour Organization
KPVU	Confederation of Free Trade Unions of Ukraine
YUW	Young Urban Women
NGOs	Non Governmental Organization
ULB	Urban Local Bodies
HRBS	Human Rights Based Approach
PDS	Public Distribution System
BPL	Below Poverty Line
ICDS	Integrated Child Development Services
ECD	Early Childhood Development
DSD	Department of Social Development
NPOs	Non Profit Organization
GWCL	Ghana Water Company Limited
STEP	Support to Training and Employment Programme
NGP	New Growth Path
NDP	National Development Programme
MoGCSP	Ghana Ministry of Gender, Children and Social Protection
GSGDA	Ghana's Shared Growth and Development Agenda
NSSO	National Sample Survey Organization
NHI	National Health Insurance
BCEA	Basic Conditions of Employment Act
UIF	Unemployment Insurance Act
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population Development
DOH	Department of Health
RCH	Reproductive and Child Health
STIs	Sexually Transmitted Infections
M&E	Monitoring and Evaluation

Foreword

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1.1 Purpose of this Report

This report captures the findings of a research commissioned by ActionAid to understand the linkages between sexual and reproductive health and rights (SRHR) and economic rights (including the right to decent work and the burden of care responsibilities) in the lives of young urban women, and provide recommendations for civil society actors, multilateral donors and governments to address these issues in a comprehensive manner. ActionAid recognises that young women in these poor urban areas are most vulnerable particularly with regard to access to employment and also SRH services. We are particularly preoccupied with the barriers that face young women, especially the greater societal exploitation that results from discrimination and inequality because of their sex and the cultural, political and economic values and norms of the societies in which we live.

The research is situated within the existing Young Urban Women: Life Choices and Livelihoods (YUW) programmes in Ghana, India and South Africa. The research was conducted between May and August 2015 in three of the seven cities of Ghana, India and South Africa where the programme is currently being implemented.

1.2. ActionAid's Young Urban Women Programme

ActionAid's "Young Urban Women: Life Choices and Livelihoods" programme, (henceforth

called Young Urban Women Programme) supported by two donors — NORAD and the Human Dignity Foundation, was initiated in July 2013 to address young women's autonomy and security, using a human rights based approach to development. The programme is being implemented across seven cities in three countries — Accra and Tamale in Ghana; Cape Town and Johannesburg in South Africa; and Mumbai, Chennai and Hyderabad in India. It aims at empowering 5,800 young urban women between the age of 15 to 25 years living in poverty in these programme locations, through increased economic independence and control over their bodies, and by ensuring that their voices are heard and recognised in local, national and international forums. The programme focus is on young women's sexual and reproductive health and rights, their economic rights and the development of young women's leadership.

The programme notes that young women's lack of sexual and reproductive health and rights and the disproportionate burden of unpaid care work impinges on their agency and well-being and impedes their access to decent paid work. Similarly women's engagement in paid employment has not necessarily resulted in a significant change with regard to their disproportionate responsibility for care work and household chores. However the inter-linkages between young women's access to decent work, sexual and reproductive health and rights, and relief from unpaid care work have remained largely unexplored and unaddressed. Development interventions with young women have chosen to focus either

on livelihoods or SRHR issues in isolation from each other. The Young Urban Women Programme is unique since it attempts to bring together two key areas of a woman's life (economic rights and sexual and reproductive health and rights). Rather than addressing young women's sexual and reproductive health and rights (SRHR) or opportunities for decent work and livelihoods separately, the rights' framework conceived for this programme is 'inclusive' of young women's economic, social and sexual empowerment. For example, young women concentrated in the informal economy in precarious conditions of work that ActionAid and its partners are working with are also often denied access to education and sexual and reproductive health services, and they are overburdened with unpaid care responsibilities. While moving them into formal jobs may help increase their economic independence, it will not, by itself, increase their ability to secure their bodily integrity, nor will it decrease their burden of unpaid care work. Thus, action in one area will not be ultimately successful without action in all areas.

The Young Urban Women's programme framework proposes that the combination of these factors and gaining a political voice are necessary for young women's empowerment. The framework uses the three key pillars of Action Aid's Human Rights Based Approach (HRBA): empowerment, campaigning and solidarity. The programme is centred on supporting and advancing the active 'agency' of young women living in resource poor urban neighbourhoods and informal settlements — thus strengthening young women's voices and choices in terms of sexuality, reproduction, economic opportunities and care responsibilities.

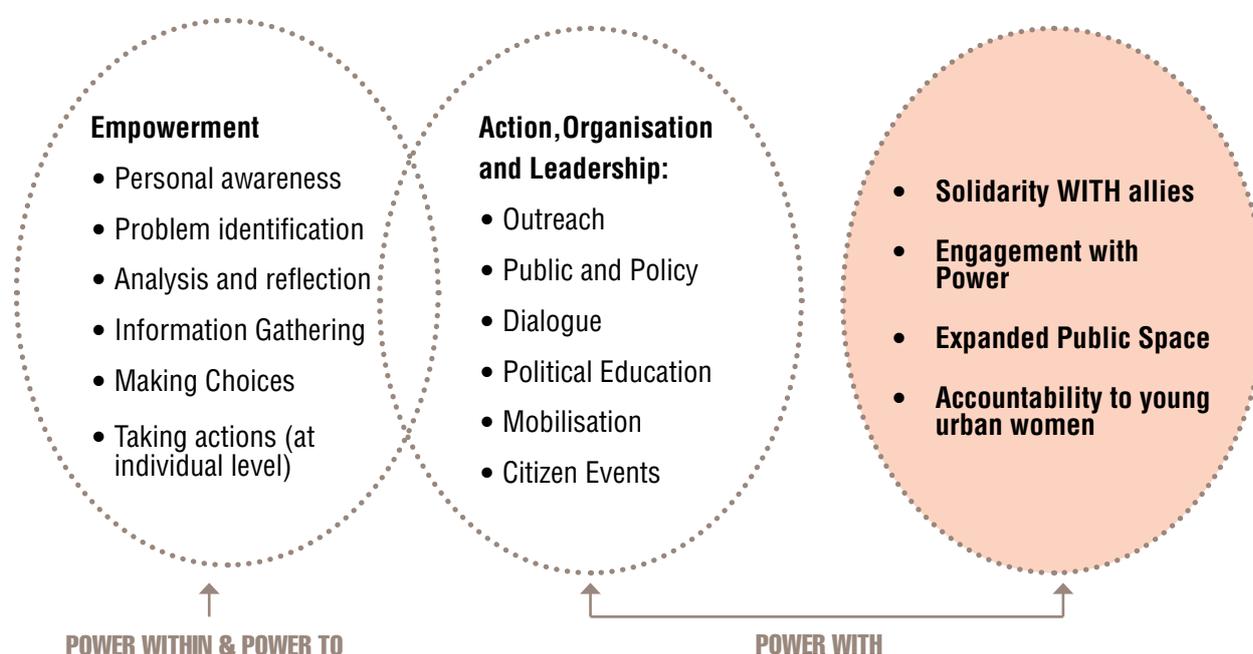
1.3. Key Findings from Young Urban Women Programme Baseline Studies

This research proposition was based on the findings of ActionAid's 2014 Global Baseline Study (covering a total sample of 1428 young urban women) which drew attention to the lack of inter-linkages across these concerns and helped ActionAid recognise the need to better understand young urban women's struggles to secure bodily integrity, establish economic security and negotiate more equitable unpaid care responsibilities within their families and based on this understanding, to adjust or reformulate its programming and advocacy on young urban women's issues.

The baseline findings highlighted that information and services on adolescent-friendly sexual and reproductive health were often difficult to access or not available. It also foregrounded the importance of a "decent work agenda" for young women with a focus on their economic independence, ensuring that they are able to make independent choices and take control of their lives. And indeed, as ActionAid has noted "women and girls living in poverty sometimes have to forego their basic human rights to an education, healthcare, decent work and leisure time in order to balance all these many activities. This perpetuates gender inequality, reinforces inequitable gender norms and keeps women and girls in poverty."(ActionAid, ND)

1.4. Research Agenda and Process

ActionAid undertook this research to focus intentionally and explicitly on the inter-linkages among three domains of young urban women's experiences (bodily integrity, economic security and unpaid care work); and also to define and refine young urban women's advocacy

Figure 1: Young Urban Women's Programme Approach

agenda. One of the key understandings of this process has been to identify multiple forms of oppression faced by young women. The research aimed to explore further how the combination of gender discrimination and the lack of opportunities impact on young urban women's sexual and economic rights. The urban context here is also a critical component of the research given rising urbanisation rates across Africa and Asia. Where urban areas can provide opportunities for greater access to employment and public services, they can also be sites of exploitation, particularly for young women living in poor urban areas.

ActionAid intends to use the results of the research to link young women's experiences and aspirations along with their analysis of barriers, to specific advocacy action for better service delivery, economic opportunities, and care support, including at the municipal, national, regional and global levels.

1.4.i Research Objectives

- To establish the linkages between access to economic security, bodily integrity, and equitable distribution of unpaid care work, highlighting young women's own articulation of these linkages and relationships.
- To use the research findings to advocate for greater cross-movement linkages and consensus building between organizations working on SRHR and women's economic rights with a particular focus on young women.
- To facilitate the development of a small informal alliance of agencies working on youth rights, SRHR, women's rights, labour rights and economic rights in order to conduct targeted advocacy aimed at relevant global and national political actors.

The total number of young women who participated in the baseline across the seven cities in Ghana, India and South Africa was 1428. Women between 15 and 25 years of age were asked to complete an 'intake form' which featured questions on their Demographics; Participation and leadership in women's groups; Work and working conditions; Unpaid care work; Access to information on SRHR; and Community support.

Many young women in the baseline study reported 'inaccessibility' to sexual and reproductive health services due to unfriendly staff, distance to services, lack of privacy, high cost, and family restrictions. In Ghana, the baseline found that only 38% of respondents knew about a health centre within walking distance from their homes. In India, 8% of the respondents said they were able to access treatment for sexually transmitted infections (STIs) and prevention of STIs. Eighty five percent of respondents in South Africa said they had access to family planning and contraception services, while the statistic was only 28% for Ghana and 31% for India.

65% of the respondents in India, 47% in Ghana and 90% in South Africa reported that they were not working. Some of these young women (the ones whose families could afford it) were in school – 40.2% of the respondents from South Africa, 31% in India and 27% in Ghana. Many were self-employed like in Ghana (61%) or working on piece-rate basis from their homes (41%) like in India and in South Africa, the majority of employed respondents worked in traditional occupations associated with women. Across the three countries, 53% of the young women were earning less than the minimum wage in the informal economy. For all working women, conditions tended to be much less than a decent work standard – 40% of the respondents from India, 33% from Ghana and 27% from South Africa reported experiences of exploitation, but virtually none of them had reported these to the authorities in their countries. Moreover, only 1% of the respondents from India, 3% from Ghana and 2% from South Africa were affiliated with some kind of workers' association. *For more information, see (ActionAid, 2015) and (ActionAid, 2014).*

The baseline found that many women, from a young age (as young as 10) had to juggle between various paid and unpaid care activities. In some cases, i.e. domestic workers, this care work was remunerated. The women carried a significant load of their families' care needs – cleaning, cooking, fetching water, weeding, sweeping compounds, and caring for children and the elderly and this amounted to several hours (between 31 and 52 hours per week) of unpaid work every day. Most of the young women surveyed in the baseline reported that their access to both running water and electricity depends on their ability to buy these utilities. In India, 50% of the respondents said that they had to use a shared bathroom to bathe or wash clothes and 13% had to use a shack outside of their home for these purposes. Only 61% of the South African women reported that they had an indoor toilet. Only 20% of respondents in Ghana had running water in their homes, compared to 75% in India and South Africa.

The conceptual framework of the research was built around three aspects – “bodily integrity”, “economic security” and “equitable burden of care” in order to frame young women’s stories¹.

1.4.ii Research Methodology

The methodology of research aimed at creating a narrative space for young women to articulate their understanding of, and aspirations for the key themes – SRHR, Decent Work and Unpaid Care and based on those, share the “SRHR-decent work-care responsibility” linkages in their lives. However this was not intended to be an evaluation of the multi-country YUW programme itself.

A peer-to-peer research process was followed for creating the ‘space’ to share their personal reflections, build their capacity in understanding the research concepts in-depth

as well as develop interviewing and listening skills. The research aimed at building on young women’s knowledge and experience by training and engaging a select number of young women who were already part of the “Young Urban Women” programme to conduct the interviews. The purpose of using a qualitative research methodology was to create the opportunity for young women to tell their stories and then translate these into advocacy demands. It was envisaged that the participatory research would enhance the skills and leadership potential of the young women interviewers. The young women interviewed in this research were not considered ‘respondents’, but ‘peer/community researchers’. The research was thus not seen as an end process, rather as a tool to build the capacity of young women to analyse their lives, hone their leadership skills and enable them to voice their concerns.



Young urban women in Hyderabad carry out a role play as part of the research

The research team included one lead international researcher, three national consultant teams, national programme staff, national partners and peer researchers. They conducted over 120 interviewsⁱⁱ, including 100 interviews with young women, 20 key informant interviews, and five to six role plays/ case studies in each country.

The research involved both primary and secondary modes of data collection. In consultation with the peer researchers, some variations were developed in the interview and case study methodologies for each city. (See *Annexure 1 and 2 for details*)

- Primary data collection: Primary data was collected using qualitative and participatory tools. The research team developed structured interview guidelines which were then contextualised to the local situations in collaboration with national programme staff, national consultants and the YUW programme participants/peer researchers. Key informant interviews (KIIs) were conducted in order to get a macro picture on the issues selected for research. People with an in-depth understanding of each community, region and issues were identified purposively for the interviews. Case studies were developed on different themes and inter-linkages, with a focus on sensitive issues that might be more easily addressed in the form of role plays rather than as interview questions. These were facilitated by peer researchers and the national consultant.
- Secondary data collection: This included an extensive literature review of global studies related to young urban women's lives including the ActionAid Young Urban Women baseline, scoping and project

reports, budgetary data at the municipal/provincial/regional/state and national level, and state policies and programmes with relevance to young urban women.

1.4 iii Limitations and Challenges of the Research

- a. The research closely adhered to ethical guidelines for human subjects' research, ensuring written commitments to confidentiality by the researchers and informed consent by the respondents.
- b. Qualitative research carries benefits (allowing for a better understanding of people's lived experiences) but also carries a range of limitations: the results are neither comparable nor quantifiable. Although the research was conducted across three countries, the research team did not attempt to quantify differences; rather it focused on trends and similarities in the narratives, and on the gaps between service needs and service provision.
- c. There were a number of distinct differences, including in language, among the programme participants across the three countries that had to be dealt with to ensure a proper articulation of the women's relevant experiences.
- d. The number of interviewees varied across the three countries: 45 in Ghana, 25 in India and 26 in South Africa. While this was a limited research sample, it allowed for a multiplicity of stories to be told, from which to draw issue based trends, to be translated into policy advocacy. However, the research sample was taken from the young urban women already part of the multi-country YUW programme except for South Africa. This is because specific

challenges were faced with the peer-to-peer research process in South Africa. As a result, the first sets of interviews (adhering to the criteria) were insufficient and a second round had to be conducted. Time constraints during the second set of interviews meant that some of the criteria were relaxed: some of the interviewees were over 25 years and most of them were not part of the South Africa YUW programme.

- e. In all three countries, some of the criteria were unable to be met: for example, while the research intended 50% of the research sample to be less than 20 years and 50% more, it was not possible to strictly maintain this nor the criteria that 50% of the young women were married and 50% unmarried.



A young urban woman sharing her experience with peers on contraceptive use, Accra, GHANA

1.5 Research Context and Sample

Accra, Ghana: The research was carried out in one of the main project locations within the two Local Rights Programme (LRP) sites of ActionAid Ghana, Accra (Greater Accra Region) in Ghana. The research respondents aged between 15 and 25 years were mobilised from Kpobiman and its environs in the Ga West municipality of the Greater Accra Regionⁱⁱⁱ.

A total of 45 young women were selected for interviews to generate primary data for the research. Of them, about 60% were in the age group of 20-25 years, with approximately 40% between the ages of 15-19 years. Most were not married (70%) and 90% of the young women were literate.

The vast majority (82%) were not in school and 60% were not working (although sometimes it is not clear whether this means they are earning income by selling food and other goods out of their homes). In terms of employment status, 24% of the women were involved in petty trade, 13% were sales girls, 7% were artisans or craft workers and 7% were factory hands.

Hyderabad, India^{iv}: This research was conducted in the Old City of Hyderabad^v. Its population mainly constitutes Muslims and Hindus, along with people of diverse castes, including dalits^{vi} and others^{vii}.

The research was conducted in 10 bastis (slums) of the Old City of Hyderabad, including: Patel Nagar; Aman Nagar (A); Aman Nagar (B);

Valmiki Nagar; Siddiqui Nagar (A); Siddiqui Nagar (B); Bhavani Nagar (A); Bhavani Nagar (B); Nasheman Nagar (A); and Nasheman Nagar (B).

A total of 25 young women were (purposively) selected for primary data collection (from the above slums) as part of this research. Of these, 20 were from the Muslim community, belonging however to various sub-sects. The 5 others were from the Dalit community^{viii}. Seventeen of them were working, while eight were currently not in paid work. Of the young women in paid work, nine make bangles, four work in tailoring, two are involved in the application of *mehendi*^{ix} and two women are in construction work. Five of the young women were married, one was divorced and nineteen were unmarried^{xi}.

Johannesburg, South Africa^{xii}: All the young women included in this research lived in the province of Gauteng which is a magnet for migratory populations (both from South Africa and other countries) searching for work^{xiii}. The city of Johannesburg is situated in the Gauteng province and covers an area of 1645 km. Also known as Jozi or Jo'burg, it is the largest city in South Africa and the provincial capital of Gauteng, the wealthiest province in the country. According to Census 2011, the total population of Johannesburg was 4,434,827 with young people (0-14) accounting for 23.2% of the population^{xiv}.

The research drew 26 young women from four areas of Johannesburg: Diepsloot, Alexandra, Orange Farm and Inner City - Braamfontein^{xv}.

Of this research sample, 9% of the women had never been employed – they had looked for jobs and had not been able to find them. About 12% of the women who had worked in the past were unemployed during this data collection – they reported that at the time that their jobs ended, they were working in food retail shops and had to look for other jobs or explore other ways of making a living. The reasons for the end of their jobs included: Pregnancy (18%); Owners of business changed (37%); Employer expecting more working hours than initially agreed (9%); Contract ended (18%); Sexual harassment (9%); No contract provided (9%). About 62% percent of the women were employed, a high figure in comparison to the national employment status of young women. Of these women, four were facilitators at community centres, two were domestic workers, two cleaners, two food retail workers, two were self-employed, three of them were in the 'learnership' programme and one was a clothing retail worker. Only 8% of the study participants were married.

All of the young women who participated in the research had completed primary school education. All of them indicated that their reading and writing abilities and numeracy levels are beyond basic. Many had also completed secondary school. The vast majority of those who did not complete secondary education cited pregnancy as the primary reason for dropping out (87%), followed by lack of finances (13%).

Conceptual Framework

In order to better understand how sexual and reproductive health and rights, decent work and reduced burden of care responsibilities intersect in young women's lives, this research offers three composite concepts that enable a clear articulation

of their understanding and aspirations. The narrative analysis thus uses the concepts of "bodily integrity", "economic security", and "equitable distribution of unpaid care work" – as concepts that may proximally reflect the aspirations of the respondents.

- **Bodily Integrity** is a broader concept than sexual and reproductive health and rights and/or freedom from violence. It encompasses freedom from violence, access to affordable, youth-friendly and quality sexual and reproductive health programs and services, control over decisions relating to one's body (including fully informed consent to medical procedures), health care and services, contraceptive and family planning choice, knowledge about sexuality, and the ability to make decisions over when, where and with whom to engage in sexual activities. Securing bodily integrity requires being treated with dignity and with the capacity for autonomous decision-making.
- **Economic Security** encompasses sufficient and reliable income, control over use of resources/assets and income, freedom from violence, decent working conditions (including the ability to take breaks and access to sanitary facilities/toilets), freedom to participate in collective action (including unions), ability to lodge complaints, rights at work, social protection (such as basic income and child support grants, pension, health care), etc. It is dependent on other factors such as quality primary and secondary education (tertiary), job/skills training, transportation, social protection, especially those that recognise women's unpaid care responsibilities – such as social security assistance for teenage mothers (such as in Ghana and South Africa).
- **Equitable Burden of Care** is achieved when care responsibilities are shared equitably by both women and men, through re-visiting of gender norms and roles, with the state providing adequate quality gender responsive public infrastructure and services including social protection to support such care. Examples of services that promote an equitable burden of care include community crèches for child care, drinking water and sanitation at household level, free or subsidised disability care and old age care.

For the young women who participated in this research, the aspiration for bodily integrity is articulated in a number of ways:

- by the young women who leave their jobs because of poor treatment,
- by the young women who refuse sex when they do not want it, and
- by the young women who ensure that they can control their fertility with or without their sexual partners' agreement.

They struggle against conditions that hamper their bodily integrity: forced marriages, intimate partner violence, lack of privacy, inadequate access to toilets and washrooms, restricted movement and sexual harassment on the streets and at their workplaces. Even when they have little ability to secure their bodily integrity, they believe in and articulate their rights to it. The full realisation of a young woman's bodily integrity depends upon adequate education, basic infrastructure, social protection and human rights measures at work-place enabling young women to access health care, legal support and other related services, child care and sharing of unpaid care work, among others.

Government policies may also support privatisation of service delivery, which, in many cases, increases the cost of sexual and reproductive health services, education and infrastructure (such as water, electricity and transportation). In this way, economic, health and social policies hamper young urban women's access to the highest attainable standard of health. This standard, known as 3AQ^{xvi}, requires that all health facilities, goods and services be "accessible, available, acceptable and quality" (See Annexure 4 for General Comment 14, ICESCR).

Economic security is a primary struggle in the lives of the young women who participated in this research as they juggle income-generating activities with household care responsibilities and health challenges. Many of them are employed in the informal sector with little or no rights at work-place. This is accentuated by the lack of access to child care and education facilities. In India there is a lack of access to quality government schools for children. Very few of the respondents from Ghana had access to free or low-cost child care. While young women in India may acknowledge the existence of child care, they mostly do not use them because they feel it is not culturally appropriate to do so. As a result, many of the young women bring their pre-school age children to work with them. Across all cities where this research was conducted, young women miss days from work because of illness and injury (including debilitating menstrual cramps and pervasive headaches), yet few seek health care from clinics or hospitals.

However, despite struggles to secure sufficient economic resources, it would be a mistake to assume that young women simply succumb to poor treatment and sexual harassment at work. Yet, rather than lodging complaints, they leave jobs and generate income from other sources like selling food, soap, etc. In this context, their ability to achieve greater economic security would be greatly enhanced if the state provided better infrastructure and quality services especially in the sphere of child and health care – in other words, gender-responsive public services.

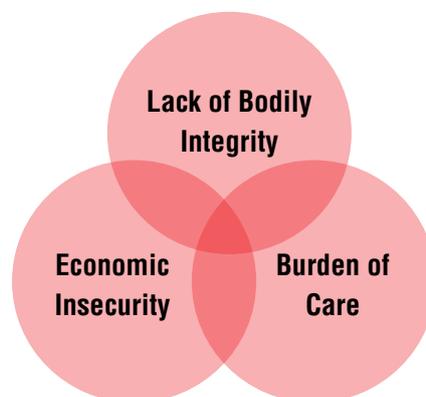
It must be kept in mind that the lives and struggles of these young women to assert their bodily integrity and economic security are situated within their wider social, economic

and political contexts. Therefore, simply having access to quality and affordable sexual and reproductive health care and services may not necessarily result in either bodily integrity or economic security^{xvii}. This is particularly true when government policies encourage businesses to use contractual employment, in which case employment does not guarantee decent working conditions and can in turn have an adverse effect on YUW's claims to bodily integrity, through the lack of provisioning for maternity leave, lack of dispute resolution especially around sexual harassment at work-place or social protection more generally. Moreover, in the case of home-based workers^{xviii}, the question of a decent working environment or equitable care responsibilities may be difficult to negotiate. In fact, young women's definitions of "economic security" may or may not encompass the broader concept of "decent work" as defined by the ILO^{xix} (including access to income, a living wage, opportunities for organising, social protection and insurance), because they are piece-workers, home-based workers, domestic workers, etc. – the idea of "decent work"

appears too remote for their current aspirations or carries the connotation of formal sector employment. While the ILO vision of decent work articulates crucial principles to aspire for, they may not translate readily into young women's realities nor evoke their narratives. In contrast, the idea of "economic security" may better match the current scope of their economic objectives^{xx}. It is therefore important to focus on the more accessible concept of economic security, without setting aside the broader aspiration of decent work for young women.

Inequitable care burden which falls largely on women, especially young women is also exacerbated by the growing tendency of the state to privatise basic services. As this has now come to be globally recognised^{xxi}, the lack of gender-responsive public services creates significant barriers to women's participation in decent work opportunities, in accessing higher education among others. The research findings also support the global trends. This is particularly true in case of child care services in the community. As our research findings

Figure No. 2: Multiple Intersections of Economic Insecurity, Burden of Care and Lack of Bodily Integrity



showed us, there are hardly any quality child care services available which are publicly provided, are of good quality and subsidised. In communities (such as the countries of our research) where women start child bearing at a relatively young age, the disproportionate responsibility on the young women for child care, in addition to other household responsibilities have a detrimental effect on young women being able to exercise their economic rights, and even having time and resources to obtain quality sexual and reproductive health services.

While many of the young women who participated in this research do not assert their claims to bodily integrity, economic security and to meet the burden of unpaid care for which they are responsible on an individual basis, they do express their belief in these rights when given the chance to speak and articulate their issues – as they did in the case studies/role plays conducted during the research. They may not explicitly use the language of “rights” and “inter-linkages”, however they express these while discussing the challenges in daily life and the hopes and dreams for their own future.

Country Contexts

This chapter discusses the impact of some global trends in the specific contexts of the countries where this research was conducted and how they affect the experiences of young urban women in resource poor settings. These include the patterns of **urbanisation; youth bulge** and **persistent gender inequality** (in terms of gender irresponsible public services and unpaid care burdens). The responses of the state in Ghana, India and South Africa vis-à-vis gender equality and justice are also explored through a descriptive understanding of their legal and policy frameworks – to identify the spaces of empowerment, campaigning and solidarity that young urban women in these regions can reclaim and explore.

3.1 Urbanisation

Today's urban explosion is accompanied by greater income inequality. Urbanisation reflects transformations in national economies, with growing numbers of people moving out of agriculture and into industry and the services' sector, including an increasing number of women and young people. This growth is uneven, and as a result, urbanisation and economic growth are frequently accompanied by a parallel growth in inequality. "The sharpest increases in income inequality have occurred in those developing countries that were especially successful in pursuing vigorous growth and managed, as a result, to graduate into higher income brackets. Economic progress in these

countries has not alleviated disparities, but rather exacerbated them." (UNDP, 2013).

The three cities of ActionAid's current research – Accra, Ghana^{xxii}; Hyderabad, India; and Johannesburg, South Africa – are in the midst of such explosive development. Ghana's population has grown from four million in 1950 to more than 25 million in 2011, with the projection of reaching 50 or even 60 million people by 2050. (Vidal J, 2011). Ghana's economy has grown at a very rapid pace in recent years – 7.3% in 2013 and a slightly lower but still robust rate of 4.2% in 2014 (Okudzeto E, 2015). Indeed, Ghana's rate of economic growth from 2000-2013 is believed to have been one of the fastest in the world. At the same time, economic growth has not resulted in reduced inequality. India's 2015 growth rate is a huge 7.46% and while South Africa's growth is somewhat slower, it has been strong and steady since apartheid, and until the recent global economic recession in 2008 (World Bank, 2014). South Africa "remains a dual economy with one of the highest inequality rates in the world, perpetuating inequality and exclusion." (World Bank, 2014). The World Bank reports that India's economy has become the world's third largest in purchasing power parity terms (Ayres A, 2015). India is said to house the world's third largest number of billionaires, and "at the same time harbours within its borders, a third of the world's poor and hungry." The enormous increase in the

number of billionaires in India since the mid-1990s is contrasted with the very large number of people in India who fall below the median developing country poverty line of two dollars a day: 80% of rural inhabitants and just below 70% urban inhabitants in India continue to be poor (Mander H, 2015).

3.2 Youth Bulge

Another major trend in this period is the expansion of the “youth bulge” in which a large share of the population is comprised of children and young adults. In Ghana, according to 2012 data, a significant majority of the population is under the age of 25: 38.9% are 14 and under, and 18.9% are between 15-25 years of age. UNFPA notes that globally, 1.8 billion young people are alive today, but national, regional and global health and development strategies rarely address the specific needs and concerns of young people (UNFPA, 2014). Their employment prospects are dismal and “upto 60%of young people in developing regions are not working nor in school, or only have irregular jobs” (UNFPA, 2014).

3.3 Persistent Gender Inequality

In all these countries, the nature and extent of gender inequality in terms of unpaid care work burdens, lack of access to economic resources and public services puts women at the greatest disadvantage in terms of protecting and promoting their rights.

Unequal burden of unpaid care work:

Women’s disproportionate responsibility for household chores is pervasive – indeed even in Sweden, one of the most gender equal countries in the world, women are still responsible for more household chores than their male partners. And this in turn,

has a negative impact on their health (Eek F, 2015). The lack of gender-responsive public services means that daily domestic and care activities take up disproportionate amounts of time and energy of women and girls. These duties generally fall on women and girls, and often carry with them a huge extra burden of work. Most poor urban women also engage in activities to boost household incomes often at a very young age. As a result, women’s workload, including paid and non-paid activities, is generally much higher than men.

However, despite women’s disproportionate burden of care and household chores (including collecting water and fuel, cooking and cleaning, child and elder care, etc.) they are rarely consulted about access to water and sanitation. As the UN Special Rapporteur on the Right to Water and Sanitation notes, “in many cases women may not be consulted about the placement of water points and sanitation facilities, about their daily needs or the type of facility that is best suited to their needs, even though women are the ones who use and maintain the services and face the greatest dangers when accessing these facilities if they are not fit for use” (Albuquerque, 2012). Moreover, even when countries invest in safe drinking water and sanitation, the benefits do not necessarily accrue to the most marginalised urban residents among whom the young urban women are located. For example, a recent WHO/UNICEF progress report on sanitation and drinking water noted the importance of attention to marginalised groups, without which in-country inequality is unlikely to improve and may even worsen (WHO and UNICEF, 2014).

The ‘gender’ factor is also critical for young people, with “one in three girls in developing countries married before the age of 18,

threatening their health, education and future prospects. Up to half of the sexual assaults committed are against girls below the age of 16” (UNFPA, 2014). Moreover, many employment statistics mask the difference between young and older women’s employment trends. The combination of discrimination against (or ignorance about) young people and discrimination against women results in an arduous journey for young women to achieve health, employment and rights. This is exacerbated by the disproportionate burden of unpaid care placed on young women (UNICEF, 2010). At times, the combined burden of income generation and unpaid household responsibilities can be quite extreme.

Growing gaps in access to ‘economic’ resources:

The gender disparity is repeated from country to country, community to community and household to household. In a report covering 43 countries, the International Trade Union Congress (ITUC) found that while women now have greater access to income-earning opportunities, they still face unequal access to the same employment as men. As a result, women are disproportionately found in part-time work and are over-represented in informal economies. Occupational segregation has a negative impact on women: more women are found in jobs of inferior status and fewer women fill managerial and high-status roles. In its 2008 Millennium Development Goals Report, the United Nations reported that “job opportunities open up, but women remain trapped in insecure, low-paid positions’ based on data compiled on the types of work women are found in across the globe” (Warberg A, 2010).

As the ILO reports, differences in gender and wage structures are significant factors in generating and sustaining inequality. A

recent review on low wage work and low wage workers describes the relationship between national systems, wage and gender inequality. First, differences in national employment systems explain much of the variety in cross-national patterns of low-wage work; factors include institutions of collective bargaining, minimum wages and skill formation systems, as well as welfare policies that shape incentives of people to accept low-wage work. Second, gender segmentation and the resulting over-representation of women in low-wage work is not the result of women’s under-investment in human capital, but reflects four key conditions present to a greater or lesser extent in all labour markets: undervaluation of women’s work; women’s lower reservation wage; gendered wage setting institutions; and discriminatory workplace effects (Grimshaw D, 2011).

Lack of Access to Public Services:

Among the key public services that are lacking is the access to health care and education. ActionAid’s baseline survey of young urban women in Hyderabad had found that only 14% and 7% respondents reported the presence of a health centre and a maternity hospital respectively near where they lived. Furthermore, only 6% of the survey respondents reported that they had access to counselling services; only 3% found information about family planning and contraception, and 3% received information of sexually transmitted diseases and treatment through the available services (Actionaid India, 2014). Even though a large number of respondents reported some form of sexually transmitted or vaginal infection few had sought specific care for it.

Lack of access to public services stands as another important barrier to bodily integrity and economic security for many women. The

relationship between adequate access to public services (electricity, potable water and sanitation facilities), the gender-responsiveness of these services, and the ability to secure economic independence is evident.

3.4 Legal and Policy Frameworks in Ghana, India and South Africa

Ghana: Ghana has a robust series of laws, policies and programmes covering issues related to bodily integrity, economic security and care responsibilities of young urban women. Ghana's legal and policy framework for promoting adolescent reproductive health and rights is underpinned by the general framework of International Human Rights Laws and Conventions to which Ghana is a signatory or has committed to ratify them. International frameworks on decent work, including the right to safe and health working conditions have been captured adequately by the Constitution of Ghana, 1992, Labour Act, 2003 (Act 651), Children's Act, 1998 (Act 560), Human Trafficking Act 2005 (Act 694), National Education, Vocational Guidance and Training 1970 (Act No. 351), National Youth Policy 2010, and The National Gender and Children's Policy. Key legislative and policy instruments include the Criminal Code Amendment Act (1998) which has increased the sentence for sexual offences to between 7 and 25 years; the National Population Policy which gives recognition to the need for information on reproductive health services to both the young and the old (but not very comprehensively); the Ghana Strategic Plan for the Health and Development of Adolescents and Young People which seeks to enhance adolescent friendly services at all levels.

In 2002, the Government of Ghana instituted a National Health Insurance Scheme (NHIS)

following the passage of the Act of Parliament, Act 650 of 2003 and Legislative Instrument 1809, 2004 to improve access to health care in the country. It replaced the "cash-and-carry" system which operated prior to 2002 and required immediate payment for all health services. The District Mutual Health Insurance scheme, which is operational in every district in Ghana is a public/non-commercial scheme and anyone resident in Ghana can register under this scheme. With the creation of this scheme, homeless people, those above 70 years, children under 18 years, pensioners, and social security contributors were exempted from payment of the premium but had to register to obtain the scheme's benefits. In addition, starting in July 2008, pregnant women were also exempted from paying the premium (Witter S, 2004). For people in the informal sector, the premium payable per person per annum ranges between \$1.80 to \$11.97, depending on income and ability to pay (Gobah FKF, 2011). The average premium paid by the informal sector (which constitutes the majority of the Ghanaian population) is around \$2.49, which is around 2.5 percent of the annual per capita income estimated from the last Ghana Living Standards Survey (GSS 2008). On paper, there is no limit on what NHIS pay in medical bills as long as the care is within the provision of the benefits package. However, it does not cover issues like optical, hearing and orthopaedic aids, dentures, beautification surgery, supply of AIDS drugs, treatment of chronic renal failure, heart and brain surgery, etc. This is mainly because of the high expenses associated with those diseases and therefore other arrangements are being considered to enable people get these treated. A report by Oxfam International found that even though Ghana's NHIS had been labelled as a success, it covered just 36% of Ghanaians, while the remaining 64% continued to make out-of-

pocket payments to access health care (Oxfam International, 2013). It is no surprise that despite Ghana's seemingly accessible system, the vast majority of young women interviewed in this research either had registrations that had expired, or had no registration. Some did not even know about it other than in the vaguest way. Only two of the young women use the NHIS, and one of these is from a relatively well-off family.

India: A wide range of laws, policies and programmes ostensibly designed to support sexual and reproductive health, women workers, child care, self-employment and more exist to support young women's lives in India. The National Population Policy 2000 (NPP: 2000) first recognised "adolescents" as a group with special sexual and health needs and advocated special programmes to address their needs. While "stabilising population" was recognised as an essential requirement, the NPP promised to bring in gender sensitivity to these policies with a 'target free' approach to family planning services, and voluntary and informed consent as basic conditions for use of such services. The emphasis on decentralised planning and implementation was also advocated. Health being a state subject in the Indian federal context, while some state governments continued with their own policies, other states pursued restrictive measures to achieve targets (Narayanan 2011:45). The fallout of the target driven approach is well-captured while analysing the 2014 incident where 11 young women lost their lives and 34 became critically ill during "faulty" sterilisation surgeries at a government-organised family planning camp in Bilaspur district, Chhattisgarh^{xxiii}.

Legislative protection for workers to receive a minimum wage is one of the fundamental

premises of decent work. In India, the Minimum Wages Act, 1948 provides for fixation and enforcement of minimum wages in respect of scheduled employments. With effect from April 1, 2011 the National Floor Level of Minimum Wage was raised to Rs 115.00 per day. The Act also requires the appropriate government (both at the Centre and States) to fix minimum rates of wages in respect of employments specified in the schedule and to review and revise the same at intervals not exceeding five years. However, informal home-based workers in India function in a legal grey area, with no legal status, no minimum wage, no occupation and health standards, etc. Yet, as of 2011-12, home-based workers represented 14% of the total urban employment and 32% of women's urban employment (Chen and Raveendran 2014). It has been estimated that over half of all manufacturing units in India are home-based (Chen MA, 2014). While some social protection schemes have been developed for home-based workers in India, for example worker welfare funds (Chen MA, 2014), none of the young women who participated in this research made reference to receiving benefits from such a fund.

Minimum wages are mandatorily required to be provided to all categories of workers, but the majority of the informal/unorganised workers are not aware of it and are made to work far beyond the statutory hours without overtime. The India National Baseline Report (NBR) found that about 80% of young women who participated in the survey were not aware of the per day minimum wage of under \$4.00 for a skilled worker and only 9% are aware (11% did not respond to this question). As per this report, the 15-18 age groups are unaware and more vulnerable considering their new entry into the labour market and lacking bargaining strength (ActionAid India, 2014).

Overall, it can be said that there are numerous laws and policies related to work (such as Social Security for the organised sector and the Unorganised Workers' Social Security Act 2008) in India. Other programmes include: the National Urban Livelihoods Mission^{xxiv}; Working Women's Hostels^{xxv}; STEP (Support to Training and Employment Programme)^{xxvi}. While they appear comprehensive in the letter, they leave much to be desired in implementation and do not cover unorganised groups and women in particular.

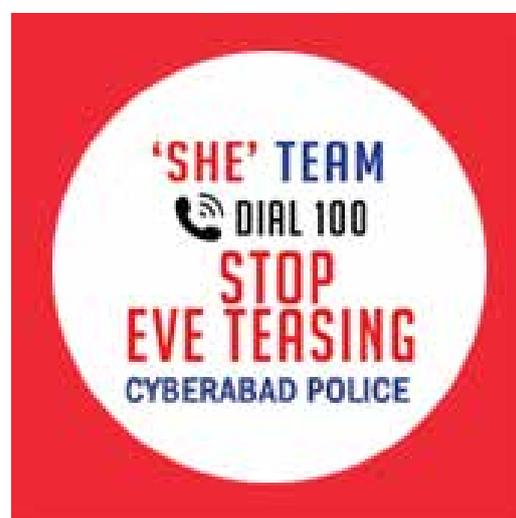
The National Rural Health Mission (NRHM), a flagship initiative of the central government, aimed at strengthening public health care facilities around the country by increasing public health care spending. Until the National Urban Health Mission (NUHM) was announced (in May 2013) as a sub-mission, the NRHM services were also extended to the poorer sections in urban areas. The key component of NRHM was the establishment of an army of health care workers – Accredited Social Health Activists (ASHA) to help with outreach of primary health care services especially in case of maternal care and child birth.

In addition to the above, there are a number of key laws aimed at ensuring sexual and reproductive rights for young women.

- Criminal Law (Amendment) Act, 2013 known as Anti-rape Act
- Prohibition of Child Marriage Act 2006
- Protection of Women from Domestic Violence Act 2005
- Medical Termination of Pregnancy Act (MTP) 1971 and Amendment of 2002.

A series of municipal schemes and programmes^{xxvii} exist that could assist young urban women in Hyderabad, including: Kalyana Lakshmi/Shaadi Mubarak Scheme^{xxviii};

Arogya Lakshmi^{xxix}; rice distribution^{xxx}; and Bangarutalli^{xxxi}. One municipal initiative that deserves special attention is the '*She*' Team: *An initiative for women's safety and security*. Keeping in mind the rising rates of crimes against women, the Telangana government constituted a seven member committee headed by IAS officer Poonam Malakondaiah to advise it on the measures to be taken for the safety and security of women and girls. The committee submitted its report with 77 recommendations – forming "She" teams was one of them. One hundred special teams were set up in October 2014 to check the harassment of women in public places (IANS, 2014). The 'She' teams (comprising five police officers) patrol places where sexual harassment is common^{xxxii}, work under the direct supervision of the Additional Commissioner and are expected to act swiftly on the complaints of harassment of women in public places.



A number of other central government programmes and schemes are designed to provide support for girls and young women: Integrated Child Development Services (ICDS) Scheme^{xxxiii}; Kishori Shakti Yojana (KSY)^{xxxiv}; Sabla or The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)

^{xxxv}; Rajiv Gandhi National Crèche Scheme^{xxxvi}; Jan Dhan Yojana^{xxxvii}; and the Sukanya Samridhi Yojana Account^{xxxviii}, along with a variety of other schemes.

South Africa: South Africa has a strong legal and policy architecture that should provide a safety net of support for young urban women as much as is expected from Ghana and India. The National Youth Policy seeks to *“enhance the capacities of young people through addressing their needs promoting positive outcomes, and providing an integrated, coordinated package of services, opportunities, choices, relationships and support necessary for the holistic development of all young people, particularly those outside the social, political and economic mainstream.”* The draft 2015-2019 policy focuses on placing the economy on a “labour-absorbing growth path” and supporting “youth absorption into employment.”

The Constitution enshrines a wide variety of labour rights, which are further realised through a variety of laws and policies: Labour Relations Act; the Basic Conditions of Employment Act; the Employment Equity Act; the Skills Development Act; the Unemployment Insurance Act; the Occupational Health and Safety Act; and the Compensation for Occupational Injuries and Diseases Act. In theory, these provide a progressive safety net for workers like the young women who participated in this research. However, virtually none of the respondents were aware of the availability of these protections. South African law stipulates that employers are required to give an employee a host of prescribed employment details in writing when they start work with that employer, whether or not there is a signed contract. However, even

when they signed contracts, respondents of this study generally had very little knowledge of the details of their employment agreement. Among the entitlements due are maternity leave (though the employer is not mandated to pay for the leave), payment into the Unemployment Insurance Fund and sick leave, among others. While there are remedies for failure to provide these entitlements, the institutions that adjudicate such cases are often placed in areas far from communities, presenting a serious barrier to accessibility. Young women may also lack knowledge on how to access these institutions.

Adding to the policy scaffold, in January 2014, the South African government passed the Employment Tax Incentive Act, seen as measure to help young people to be absorbed into the formal sector. In a key informant interview, a municipal worker explained, *“The city of Johannesburg aims to achieve the government’s goal of increased youth employment through programmes such as Jozi@Work. This programme employs only young people and a lot of money has been invested on it to ensure that many young people in the city benefit. It was also launched by the Mayor.”*

Section 27 (1) of the Constitution^{xxxix} provides that every citizen must access social security and social assistance if they are unable to support themselves and their dependents, and this includes social protection. Within this, the Constitution guarantees to everyone the right to access health care services including reproductive health care, sufficient food and water, and social security, and if they are unable to support themselves and their dependents, appropriate social assistance.

Social assistance continues to form an important part of government’s strategy to fight

the triple challenge of poverty, inequality and unemployment. More than half of all households in South Africa benefit from the government's social assistance programme. According to the National Treasury, for 22% of the households, social grants are the main source of income. Comprehensive social security alleviates and reduces poverty, vulnerability, social exclusion and inequality through a comprehensive social protection system.

In keeping with the above policy, the municipal government is to provide a basket of basic services to families in need. For example, poor and needy households in the municipality of Gautang are eligible to receive a 'free' allocation of 50 kWh or equivalent energy where no electricity network exists, provided that the monthly usage is less than 150 kWh per month. This allocation is made with the first purchase each month.

Access to sexual and reproductive health care is another element of the government's strategy to address teen pregnancy. An array of laws and policies provide support for legal, social (including care for children) and health services, including a liberal abortion law^{xl}, and an extensive structure of community health clinics.

The Constitution calls for equality, equal protection and benefit before the law and non-discrimination. The National Policy Framework on Gender Equality saw the establishment of a National Gender Machinery. A range of laws and policies prohibit discrimination and promote women's rights, including: the Employment Equity Act; PEPUDA; Domestic Violence Act; Recognition of Customary Marriages Act; Prevention and Combating of Trafficking in Persons Act; Criminal Law (Sexual Offences Act and Related Matters) Act and the establishment of Equality Courts.

Research Findings, Analysis and Implications

Across all three cities included in this research, young urban women struggle to secure bodily integrity and economic independence and this manifests in terms of unequal care burdens in their life. There is uneven, uncertain and inadequate access to sexual and reproductive health information and services; inadequate opportunities for decent work; and a high burden of unpaid care work carried by young urban women – all of which are interlinked and result in a vicious circle of gender inequity, poverty and social marginalisation.

This chapter presents the findings from the research with relevant analysis and comment on young urban women's lives and rights in Ghana, India and South Africa. The available research data is grouped in three subsections according to emerging issues which may sometimes overlap due to the complexities of each spatial and social context as well as the lived realities of the women who participated in the research.

4.1: Negotiating Work, incomes, Sexual Health care and Education

Economic Security or Lack Thereof:

Most of the young women who participated in the research in Accra and the Old city of Hyderabad had started working at a young age – the average age is about 15 years. Several started earlier, at the age of 10 or 11 years. In over 50% of the cases, the young women decided to work on their own, while

in some cases, the parents forced them into work. The young women who had been forced expressed being upset about being pulled out of school without having a say or choice in the matter. Thereafter this reality became a part of their life and as they started paid work at home or outside, they had to shoulder the responsibilities at home, with increased workloads throughout.

Both in India and Ghana, the vast majority of the young women included in the research work in the informal economy, giving them little access to job security, healthy and safe workplaces, social protection, child care, maternity benefits, not to mention easy access to water and sanitation in their homes and workplaces. Along with long hours of work for insufficient pay, they are surrounded by health hazards and sexual harassment. Indeed, in both these countries, the view that workplaces are not safe for young women influences their decisions to work from home or take other jobs.

In South Africa, the large majority are either unemployed or in school. Those who work tend to have somewhat informal jobs, but often in formal businesses. This is a challenge in South Africa, with relatively progressive labour protection that is often bypassed by businesses^{xi}.

The economics of marriage has a strong bearing on the way girls are perceived and treated in the Old city of Hyderabad. In all

cases, marriages of young women have been fraught with expenses and many problems for families. No marriage is complete without the payment of dowry – there is a cash component of about US\$ 770-1,060, along with 30-40 sets of finery and clothes for the women of the household, and utensils for the kitchen.

Income and Decision-making: Most of the young women who participated in this research value paid work as they perceive that it has brought them material access, and increased decision-making roles in their families. They emphasised that their earnings have paved the way for a greater say and participation in family matters.

“Aaj meri baat ko sunte hain” (They listen to me now). (A young woman in the Old city of Hyderabad)

A significant number of young women in Johannesburg (92%) reported to have control over their income and a final say over how their income is spent. This was however not the case with married women. Control over income seems to depend more on marital status than educational levels. Young women are exposed to families where women are the heads of the household and decision makers: 69% of young women in this study come from female headed households. Another contributing factor is that 42% of the young women are recipients of child support grant. They reported that this money is ‘considered their money’; and they spent it on their children as they deem fit.

The young women perceive links between economic security and having control over their own incomes even though they are not the financial decision-makers in their households – only 8% of the respondents in Ghana were either the primary or significant partner such

decisions; parents, in-laws, husbands or boyfriends accounted for 92% of the financial decisions.

Compromising individual needs and accommodating others’ is valued in families and communities, whether that means taking a job at the age of 11, or feeding one’s drunken brother first. These values were strongly articulated by the young women – many are working in order to support the education of their siblings; medical treatment of parents; supplement family income etc. and for many these imply great and unending costs and debts. What is significant to mention here is that many times families extend support to these women not because they “value” their work or freedom but because the young women are “supporting” their families financially. In trying to understand the inter-linkages between economic security, bodily integrity and equitable distribution of unpaid care work, the research finds that these young women have to negotiate for their rights at various levels.

Some of the women believe that paid work has brought them more respect and better food to eat. Others are able to spend money on buying appliances to make their household work more manageable, and even save some money.

I can spend on myself. I bought a cooler and refrigerator for the house. (A young woman in the Old city of Hyderabad)

In fact in all the research sites, earning money implies being able to purchase appliances, a key aspect in reducing the burden of unpaid care responsibilities. A young woman (in the Old city of Hyderabad) shared that she had all the basic appliances required in an Indian household such as a grinder, an iron and a refrigerator, as a result of which her workload

at home had lessened. She further explained that she had bought some of these appliances with her earned money; another young woman emphasised that the “*grinder and gas hasten cooking*”; and a third added that cooking with gas is a cleaner way to cook and makes it less stressful. In Johannesburg, young women reported to have access to electric stoves, fridge and microwaves as assistance to their cooking responsibilities. Fewer women (23%) indicated using washing machine for laundry. One young woman shared that “*having a washing machine reduces time spent on doing laundry on weekends so I can go out and spend time with friends.*”

However in these cities, married young women (with some exception) report that they play a limited role in household decision-making, have limited mobility and limited access to resources in their marital homes. They are often subjected to both emotional and physical violence and controlling behaviour by their husbands, families and employers. However, there is a clear relationship between financial independence and earning an income, as many of the young women perceive that they have control over the money that they earn, even if they are not the final decision-maker in their households.

We both take decisions but when it comes to money issues my husband decides. He always consults me but because he's the man I allow him to make the final decision on our finances in the home like building and the schools the children attend. I generate some income. I also decide on how to spend my own income. I decide on how to use my money personally but as a woman at times I give money for food if there is none for him to provide. At times I lend him money of which he pays me back when he gets money. *(A young woman in Accra)*

Discussions with young women in Ghana on their livelihood activities revealed that they face many challenges, including inadequate returns and limited access to financial support (for those who were self-employed). However, they were conscious of the positive impact of being economically empowered and found different ways of coping with their economic realities. For example, working in lower paying jobs or being self-employed due to the flexibility it allows; engaging in activities that gave them a sense of worth, even though they provided low economic returns.

Some of the Ghanaian young women reported working up to 19 hours on their job daily, others stated 14 hours of work daily. Self-employed women spent relatively less time at work and this explains why a majority of the young urban women prefer to work for themselves. About 46% of those who were unemployed expressed no interest in working for other people; 84% had been on their current job for less than 12 months and one woman each indicated being on their current jobs for more than two and seven years respectively. Even though income levels were low across the board, those who worked for others earned much lower with some earning far below the minimum wage. Research data from Ghana shows that 64% of their families were dissatisfied with their current jobs due to reasons such as the risky nature of their jobs, less income and health implications.

There are examples of women who had to quit or change jobs when they became pregnant. Others engaged in seasonal work. Despite high levels of unemployment, some women left jobs in which they felt they were under-paid, faced health risks, worked long hours, or faced family pressure to seek a better source of income.

I worked with a woman in a chop bar. I

stopped because the pay was not good; she exploited me by giving me US\$13 at the end of four years. So I didn't take the money and my husband asked me not to work for anybody again. My husband does not like the work I am doing but he agrees I need to save money to learn a trade. My husband thinks that I am exposed to risk and so should stop selling the eggs and look for another job. He thinks it's too stressful. (*A young woman in Accra*)

Linking Education, Economic Security and Bodily Integrity:

The young women interviewed in Ghana and India generally had very low levels of schooling. In Ghana, this was primarily due to lack of school fees, while in India it was a combination of fees and the need to work to help support the family. Some of the women from the Old city of Hyderabad have never gone to school as the family only prioritised finances to educate the boys; still others went to school until a point when financial difficulties took precedence. There are also examples of women who have experienced exclusion and discrimination: one explained that she and her sister would be made to clean and do household chores for the teacher while the boys studied; they would be scared and thus obeyed. In fact a number of Indian women who participated in the research and were out of school are still trying to pass exams so that they can return to school. On the other hand, in Ghana, though many of the young women expressed a desire to go back to school, none were attempting to do so. The educational status of the interviewees in Johannesburg was significantly higher than of the women in Accra and the Old city of Hyderabad with almost all of the young women either in school, having completed secondary school, or in post-secondary programmes. However, the level of schooling does not equate with having jobs - particularly in Ghana,

where many of the young women were self-employed or work in small shops; or in India, where the young women primarily worked at home (bangle and pin-making) or in small factories. This is to do with the phenomenon of jobless economic growth being observed worldwide^{xiii}.

Since most of the young women start working at an early age they are seasoned workers by the time they reach their twenties, however their health suffers as a result. Many of these women also get married and bear children during this time, and their health is further affected by the pressures of family and children to care for. This creates challenges to getting paid work; moreover, there are few opportunities to improve their work status and skills.

The reality is that, in all three countries, young women struggle with economic security and most rely on their combined incomes with other family members or husbands in order to make ends meet.

At the same time, in all the research sites the capacity of young women to earn independent incomes has improved their ability to afford contraceptives or household and personal goods. Earning money has the added implication of being able to access health care, as reported by 16 of the 25 women in India. This financial status has further empowered them to engage in independent or consultative decision-making on their sexual and reproductive health, or to contest violence.

Since I started working I have the money to buy the contraceptive because I am self-employed. I can now refuse my husband when he demands sex if I am not in the mood. My husband has never advised me to use

contraceptives but I haven't told him that I have been using it already. I haven't told my parents either. *(A young woman in Accra)*

Some of the young women perceive this connection between earning an income and bodily integrity – including the ability to say 'no' to sex with partners when they are not in the mood for it. But they also find it challenging at times to deal with male partner's control over their bodies.

I am not able to refuse my partner sex. He is always persuasive and sometime angry, so I try to satisfy him. There are days I tell him I'm not interested to have sex and he understands. *(A young woman in Accra)*

Young women in India, too, found that earning an income gave them greater freedom. For one young married woman, working and earning has changed her situation and the power dynamics between her and her husband to a certain extent. Her income is needed to buy essentials for the house and the family like clothes, utensils, appliances etc. She spends her own and her husband's salary very carefully and needs to tell him about all expenditure. She pays the house rent, so that gives her some control. What she earns she controls and is hence able to spend on important things, such as education for her children and health care for her. When she is ill, she can go to the health centre, after informing her husband. She goes alone and pays out of the money she earns. Research evidence from Ghana also suggests that young women are also able to spend the money that they earn on buying food.

General Health and Wellbeing: Many of the young women in the three research sites suffer from work-related health problems. In

Ghana, 48% reported body pains, headaches, and stomach pains, while 24% of the young women mentioned other sickness like, ulcer, flu, cold etc. Ninety percent of the young women from the research in India pointed at weakness, tiredness and menstrual troubles as the foremost health issues, with aches and pains in the back, legs, hands and decreasing eyesight also common. Many of these problems are directly attributed to the work the women do, both at home and in the (paid) work arena. Equally, these health problems have a direct impact on their paid and unpaid work and the vicious cycle continues.

I have pain in my eyes which gives me headache all the time. I used to use lens but the glasses are broken and the new one I have is missing. Sometimes I get menstrual pains and I can't go to work for a couple of days but I still do my house chores because I am the only one responsible for that. When it happens like that, I use my health insurance for medical care. *(A young woman in Accra)*

These health hazards and accompanying costs as well as lost incomes are accepted by most women as unavoidable, although several of have looked for alternative job opportunities to avoid such health hazards.

In the past when I use to sell tea and salad, the gas burnt my hand and I could not go to work for a whole week and my employer did not pay me for that week. After that incident, she gave me oil to put on it and I went to the drug store for medicine. I don't go to the hospital because of money. The hospital is also not in my area so the distance is also a challenge. I know about the adolescent friendly facility because some of their staff are elders in my area. *(A young woman in Accra)*

4.2: Negotiating Choices, Health and Violence Concerns

The young women interviewed during this research face significant barriers at every turn, from completing school, to finding work, and securing their physical and psychological health and safety. These life challenges take their toll on the health and well-being of the young women: a large number of the interviewees reported having debilitating headaches, discomfort from STIs, work-related injuries and painful menstrual cramps. Many rely on traditional remedies – including for abortion^{xliii} as they report distrust or dislike for health providers.

Sexual and Reproductive Health

Knowledge: The research clearly shows the vulnerability of young women's bodily integrity and their lack of information and access to appropriate services, particularly to address STIs and unwanted pregnancy.

Among the young women who participated in the research in India, the majority were unmarried and few were sexually active; and their levels of knowledge and understanding about sexual and reproductive health was very low (out of 25 young women only 11 reported having the knowledge of contraceptive methods such as pills, condom and Copper T). One woman who was about to get married told a story that was repeated in nearly all the other interviews – that she had no experience with sexual matters or what that means – she was unaware of contraception, STIs, HIV and other such terms. Her menstrual cycle was normal but she had a lot of white discharge. When asked about having visited a doctor, she had not as she did not think it was serious issue. Moreover, since her mother was speech impaired, she was unable to discuss

such personal issues with anyone, and found it difficult to discuss such matters with her father.

In Ghana, most young women stated that they had some knowledge about birth control, however the majority of sexually active young women do not use modern forms of contraception (49% of the interviewees). Rather, many rely on natural methods of contraception. The relative lack of contraceptive use results in early pregnancy: two of the young women had become pregnant at age 14 and 15, with many more having their first child at 18 or 19 years. Of the women who participated in the research, six of them had one (1) child; two of them had three (3) children and one woman each had four (4) and five (5) children. The consequences of not having children can be grave for many of the women in this region. A married woman in Ghana shared that she faces ill-treatment and the threat of being thrown out of her marital home for not giving birth. This situation is a normal occurrence in Ghana where women are blamed for childlessness.

My first pregnancy was unplanned at the age of 18 years. I have tested for HIV. I have been pregnant twice but given birth once. I had an abortion once because I didn't know about the family planning procedures and things were difficult financially for me. My partner and I did it at home by taking in some local herbs to terminate it. But now I have learnt how to prevent pregnancy from the Young Urban Women (YUW) centre.

As the above narrative reveals, many women have had complications with pregnancy, often attributed to the lack of accessible or acceptable care options. Some have opted for traditional herbal treatments for abortion because they were unable to pay the cost of a clinic-based abortion despite Ghana's relatively progressive abortion laws.



Body mapping underway in Hyderabad to gather information on bodily integrity

The research in Ghana found that most young women do not discuss sexual and reproductive health matters and limited couple communication on these topics further undermines married young women's ability to adopt protective actions. And yet, they take the appropriate contraceptive decisions based on available knowledge, even though some fear and insecurities of usage remain.

I know about protecting yourself from pregnancy by using a condom. However, I have contracted candidiasis before. I don't want to get pregnant so I use my menstrual cycle to prevent this. I have obtained contraceptives before and the day I used the condom I couldn't remove it. I was scared so I don't use it again. I have never talked to my mom about contraceptives but my boyfriend was

okay when I spoke to him about it. My guy is the one who normally puts on the condoms. I don't put on a condom because I am afraid it will get stuck.

In Johannesburg, 25% of the young women reported to have the ability to buy contraception of their choice from the pharmacy. Twenty three percent of the young women revealed awareness around Sexually Transmitted Diseases (STIs) through media and TV programmes in particular - they watch programmes that discuss sexual and reproductive health in the afternoons on their return from school or on their free afternoons (for those who work in shifts). Community health talks also ranked high as a source of information about STIs. Since they are often attended by people of different

ages, the educators are often not explicit and use euphemisms while talking about sex. Thus, although these talks are useful to raise awareness on certain health issues, young women cannot rely on them to access comprehensive information on sexual and reproductive health or rights. Schools are a possible source of scientific information on sexual and reproductive health. However it was beyond the scope of the research to look at the role played by schools in providing comprehensive sexuality education to the young women.

Access to Sexual and Reproductive Healthcare Providers:

The young women in Accra, Johannesburg and the Old City of Hyderabad consider pharmacies or chemists to be far more accessible than clinics or doctors for a range of health care needs, including contraception. They find them less judgemental and allowing for more privacy than nurses and doctors in hospitals and clinics. This is not surprising in light of the many stories of disregard or mistreatment that the young women experience at the hands of health practitioners. In Johannesburg for example, young women find that there is insufficient information on contraception in the clinics. One woman shared that the pharmacy staff provided information as well as the commodity and she *“is able to ask questions in an environment that is non-threatening.”* In India, only 10 young women reported that they have access to contraception and that they can get it from the chemist shop. One married young woman shared that her husband buys the contraception. They feel that nurses coerce them to use a particular contraception and this experience has been specifically seen in the forced acceptance of the “implant” method of contraception (as it will stay for many years and the women will not have to go back to the clinic

soon). More than 11% of the young women in Johannesburg shared that the rude behaviour of the nurses deters them from attending health services, as also that they are given sermons about not focusing on their studies or future. One young woman recounted that she observed a nurse saying to a pregnant young woman, *“When you are dirty during pregnancy, how will you look after your child.”*

Accessibility to pharmacies was also easier for most women in the research sites as it did not usually require travel outside the neighbourhood and many of them did not get time from their work schedules to visit the local clinics where these services were provided for free. Shift workers reported that they were able to take out time to go to the clinics during weekdays to access contraception and some women also shared that condoms were freely available at their workplaces and they did not need to buy or get them from a clinic. Apart from the time factor, this access depends on the type of contraception. For example, hormonal contraceptive injections require that the woman goes to a clinic and that makes it potentially quite difficult especially for young women who are in school or are working – often clinic hours are not compatible with the time that young women are free to go to a clinic. Clearly, the availability of free clinics does not necessarily translate to accessibility of free contraception for young women. However, it can be said that even with variations in the nature and extent of access to contraception, the fact that such access is even possible implies that some young women feel more able to control their fertility and can negotiate other decisions in their life.

I am not ready, I feel other men at work put pressure on him because he does not have a child yet, I ask him to tell them he is not ready.

I negotiated that I finish my studies first so that when the child arrives, I am better ready and have a qualification.

Let's follow a common standard for naming the quotes – either we name where they are from everywhere or we don't.

In India, the young women who participated in the study confirmed the relative lack of information about the availability of services and poor communication by health providers – 18% of the young women wanted better communication skills by the staff such that women are not embarrassed to access information. 21% of women from the age group of 19-25 claimed that this was essential. Around 17% of the women believed that there should be clear physical space ensuring privacy; multiple points for getting information; availability of female service providers and age/gender sensitive availability of information. Age appropriate information was reported mostly by women in the age group of 15-18 years (24%) whereas privacy was reported by women in the age group of 19-25 years (21%). Thirteen percent of women also wanted conducive timings to encourage the use of services by all.

Clearly, the overall lack of quality services, young women friendly services and discriminatory practices compound young women's challenge manifold.

Safety and Security: Perceptions of safety and security seem to influence the life choices that young women make. While young women in Accra generally report feeling safe travelling to and from home and/or school, they also adjust their schedules to avoid danger. One young woman shared that she felt safe and secure at work, on her way home and in her home and yet she does not stay out late “/

make sure I get home early. These criminals usually roam at night”. In other words, safety is conditioned on young women anticipating where and how they might face danger, and the lack of safety is an unremarkable fact of life. However, organising one's schedule to avoid danger does not really equate with safety or lack of danger. Overall, safety and security are conditional while interpersonal violence is understood in the narrowest sense by the young women who participated in the study: name calling, deprivation of food, and severe restrictions on mobility were, for the most part are considered “normal”.

Freedom of movement for the young women who participated in the research varies significantly from one city to the next. While young women in Accra (84%)^{xiv} and Johannesburg report a relative lack of restriction on their freedom of movement, the situation in Old city of Hyderabad is quite different. High levels of violence and sexual harassment has led many of the young women's families to place severe limitations on their ability to leave the house. Many are not allowed to go out alone, or if so, with clear parameters. Hence buying provisions – vegetables, meat, pulses, rice, etc. or caring for their personal needs – buying sanitary napkins, medicines or personal hygiene products are reported to be very difficult. Some young women go out with close women relatives (mother, sister, sister-in-law or sisters) but friendships are not encouraged. Almost all the young women have experienced “eve teasing”^{xiv} as well as threats of violence or sexual coercion. Some of the women even faced restrictions on attending sessions at the resource centre run by Shaheen, the women's organization that they are associated with. Thus, most of the young women who work do so from the confines of their homes in this area.

Violence, Deprivation and

Discrimination: Violence against women and girls is as commonplace in Johannesburg as it is in the Old city of Hyderabad and, to a lesser extent, in Accra. Almost 50% of the young women who participated in the Johannesburg research report that they have experienced violence either from a family member or a sexual partner, and this takes different forms.

Many of the young women in India reported serving food to a male figure first, in line with their religious and social norms. This male figure could be a father, brother or a grandfather. There is a societal expectation of putting men first: one of the respondents shared a story of her brother who is always drunk and is unemployed. Still, she is forced to serve him food first when she cooks in the evenings after a long day at work. The mother encourages her to respect her brother.

Even while young women are primarily responsible for cooking food, economic circumstances and gender-based abuse often leaves them without food (81% of the women interviewed in Ghana) and requisite nutrition. In such cases, many of them borrow money or food from family or neighbours or buy it on credit. One woman disclosed that her family withholds food from her – a form of deprivation that, in human rights terms constitutes cruel, inhuman and degrading treatment.

When I was living with my brother he used to starve me a lot. Even my husband sometimes decides not to give me money to cook, he would buy food and come and eat with our son. So sometimes I sleep on an empty stomach. *(A young woman in Accra)*

Young women do not however turn to hospitals to treat the results of violence. In India, 44% of

the young women have experienced violence at home; in most cases inflicted either by the father or husband. Young women narrated instances of beating, torture, sexual abuse and domestic violence at home. Three young women said they used to be beaten up by their husbands; however, they rarely seek help. The reasons for not availing medical care varies: some women did not go to the hospital after getting hurt because family members would not allow it, others did not seek medical help due to social stigma and some women did not seek help as the injury was not too serious.

Many young women also face harassment at work, as shared by a young woman from Orange Farms in Johannesburg.

I experienced mistreatment and favouritism and threats at work. No, I didn't report. I feel like the executives have a bond and my complaints would just be brushed off. *(A young woman in Johannesburg)*

On such experiences of sexual harassment at the workplace, another young woman in Johannesburg described how she lost her job when she refused to have sex with her boss. In this sense, her effort to protect her bodily integrity was directly at odds with achieving economic security. Young women's bodies are often seen as commodities that provide more than paid labour at the workplace. This is also evidenced by several young women in Accra and Johannesburg who lost their jobs when they became pregnant.

In India, while many of the young women interviewed worked from home, others worked in *karkhanas* (factories) and each had some violence story to tell. Conditions in the *karkhanas* tend to be extremely poor: they are not separate buildings in most cases, but rooms or sections of residential buildings (usually a small 100 sq.ft.

The HIV experience in Johannesburg

Half of the research participants in Johannesburg disclosed their experiences of violence especially due to their HIV status. Among the women living with HIV, a majority of them have experienced violence from intimate partners. The youngest of these women is 19 years old and has two children. One woman stated that her boyfriend insults her about her HIV positive status when he beats her up. Most of the young women living with HIV learnt of their status during ante-natal care, as routine HIV testing is done at the clinics during pregnancy. However as 8% of them reported, they were not informed of the results: *“Nurses do some tests and they never explain those tests – if you do not ask they will not tell you”*. Most women revealed that they had never taken a HIV test voluntarily, as they found it scary; others felt standing in a queue for a HIV test is symbolic of social exclusion and stigma and nurses or other hospital staff do not follow any discretion in making such cases publicly visible at the clinics. Fortunately, a number of the young women living with HIV are supported by an NGO (Positive Women’s Network) and participate in support groups for young women living with HIV. These groups provide support and advice for young women, including those who feel they are not ready to disclose their HIV status to a sexual partner *“I just tell the person who wants to have sex with me that we should use a condom because we don’t know each other’s HIV status. I am not going to tell someone I hardly know that I am HIV positive”*. Due to stigma from society, some respondents feel that they are only able to disclose positive HIV status to those very close to them: one young woman said that she has only disclosed her HIV positive status to her mother and to the researcher conducting this study.

room where over 25 women work). The lighting is insufficient; there is rarely drinking water or clean toilets for women.

We go to the neighbour’s house for water. Also for changing pads during menstruation.

Young women also spoke of concerns around molestation by men, especially in the absence of toilets and having to use corners for defecation where they were susceptible to such violence^{xvii}. Of the 25 young women who participated in the research in India, 22 had faced gender based violence while travelling to and from work/home and this was one of the reasons for choosing to work from home or to discontinue jobs.

However, the research found that working from home does not spare young women from harassment.

Men who come to give us orders or pay money try to hold our hands. They try to touch us when we get up, bend over when we are working and ask for sexual favours in return for additional money. (A young woman in the Old city of Hyderabad)

They reported that such incidents are avoided if a brother or uncle is in charge of the money and order exchanges; in which case the women do not get the entire money and the family member/ middlemen take a “cut” out of their earnings.

Despite the extent of violence faced by women across the research sites, there is an overall sense that reporting the violence will not be useful, as in the case of a young woman about her boyfriend beating her.

We would argue for small things like partying or money. He used to slap me in the streets at night or at his place. I didn't report anything I just let things be. Anyway what's the point of reporting someone who is feeding you? I really don't see the point. *(A young woman in Accra)*

What is heartening in these scenarios are the examples of community support, as one woman in the Old city of Hyderabad reported about her neighbours *"intervene when my husband hits."* While this causes the husband to prevent the woman from going out, it also helps her to survive. Another young woman said that she was *"safe at my workplace because the women there help me and care for my wounds."*

4.3: Negotiating Living Conditions and Unpaid Care Burdens

Space and Overcrowding: In Ghana and India, most of the interviewees live in very crowded spaces – resulting in very little privacy. In India, only two young women interviewed had a private room to sleep in. All the rest live with families – parents and siblings or in-laws and children, and share sleeping quarters. The typical family size ranges from five to ten members per house. While the houses comprise of one or two rooms, the number of members in the family far exceed its capacity. Only five women had their own house, which belonged to their ancestors, and was not bought by the parents.

The situation is similar in Ghana and, though slightly less extreme, in South Africa too. In Accra, more than two-fifth (46.3%) of all

dwelling units in the municipality are compound houses and 28.8% are separate houses. About 40% of the dwelling units are owned by a household member; 43.6% are owned by other private individuals, and relatives who are not household members own 12.1% of the dwelling units. Indeed, one room constitutes the highest percentage (88.9%) of sleeping rooms occupied by single households in the housing units in the municipality (GSS, 2010), and this reality is shared by several women interviewed in the research. Most of the young urban women either live with their parents or husband/partner in rented or owned houses that are inadequate for most families. More so, space for household chores such as cooking, washing and bathing is unavailable, and many resort to doing these chores outside the house.

I live with my mum and my son with my two siblings. My house is a single room. We are five in the family and we all sleep in the same room. Only one bedroom and I don't have my own room. The house has no kitchen, bathroom or running water. We cook outside. *(A young woman in Accra)*

Access to Essential Services: While 85.5% of the women interviewed in the Accra research (like the women in the Old city of Hyderabad and in Johannesburg) have access to electricity in their homes, they complain about the frequent and unpredictable electricity power outages and load shedding. With respect to cooking fuel, potable water and toilets, however, the young women face a lot of access issues in Accra^{xlvii} and the Old city of Hyderabad. The most significant burdens are associated with the access to water, both in terms of time and energy. Barring a few women who have access to "borehole" water, wells and the use of water storage facilities (in Accra) and common tap water in their neighbourhood (for a few hours in the Old city of Hyderabad),

most young women end up spending a sizable number of hours in collecting water from distant sources and completing all the work associated with it afterwards. Whether near or far, fetching water has an impact on young women's responsibilities, requiring attention, planning and usually a significant amount of time.

Access to toilets and water for washing also constitutes a challenge for many of the young women (84% women in Ghana) relying on public toilet facilities and/or sharing a washroom with neighbouring houses. As a result, one young woman in Accra explained *"the queue is too much, one has to join a long queue before I can bathe or I must wake up early"*, while women in India spoke of *"washing clothes and utensils from 11:00 pm to 1:00 am"*. In Johannesburg, such queues are longer in the mornings and early afternoon when most people are back from work. The average waiting time in the communal tap is 7 minutes. There are also exceptions to the rule like a woman in India whose life had become easier since she got a pump installed in her house that makes water available at her home and some women in Johannesburg who have access to piped running water.

Unlike in Accra and Hyderabad, childcare is often provided by crèches in Johannesburg and they use child support grants to pay crèche fees. Moreover, 21% of the young women who are mothers do not live with their children. These children live with family members in the rural areas. The young women who were interviewed find this arrangement easier as it provides a stable living and educational arrangements to the children rather than the uncertainties of life in informal settlements in Johannesburg.

Employment Choices: Care responsibilities at home are major barriers to women continuing their studies or taking up paid work. Thus

Supporting each other in India

In spite of scarce resources, the idea of the "neighbourhood" is very strong, and families support each other. Food though scarce, is shared between family members and in cases when it is lacking, a neighbour helps out. Likewise is the case with water, wherein about 50% women shared that they take water from a neighbour's house.

women (and their families) choose self-employment (Ghana), home-based work or informal arrangements (South Africa) which do not meet decent work standards but provide crucial additional income for the family. For these young women, gender-responsive public services would have an enormous impact on reducing their burden of care, supporting their struggles for economic security and building their capacity to ensure their own bodily integrity. A number of organizations in each country have such a focus but the voices of diverse young people (especially young women) are not always heard loud and clear.

Fulfilling Unpaid Care Work Roles:

Unpaid care responsibilities fall quite heavily on most of the young urban women (accounting for several hours a day). Only in rare cases is unpaid care work shared equitably within their families. They manage this by waking early, taking time off from work, or working late into the night.

Since I started working, my responsibilities have been the same. I wake up as early as 4:30 am and do most of my house chores and come back home in the evening after work

to complete the rest. My schedule is fixed so I just manage my time well. *(A young woman in Accra)*

Added to the household burdens and the unequal access to essential services is the lack of cooking space and facilities in most young women's homes. As mentioned earlier, only a few of them live in houses which have kitchen space, most of them either create their own wooden structure to use or use their porch for cooking. This means hauling pots and other cooking utensils back and forth, and this makes cleaning up after meals a significant amount of work, for which the young women are generally responsible.

"Managing" seems to be the operative word: young women manage their families, manage their time and the work manages to have control over their bodies and their lives. They do so with many barriers to bodily integrity and economic security: unsafe schools, harassment and violence on the streets; high levels of unemployment; and a severe lack of privacy and non-work time. And yet, many of these young women interviewed have solid (economic) aspirations for the future: to own their own businesses and have people working for them; become hairdressers, tailors and *mehendi* (henna) designers; to take on social and development work and the like.

Multi-tasking in Ghana

79% of the women interviewed in Ghana engage in sweeping cleaning, fetching water and cooking daily for the household. Every young woman who participated in the research is engaged in one of the above responsibilities. In addition, most of them (82%) also weed, remove cobwebs, and scrub bathrooms on a weekly basis. Significantly all the women wash clothes on a weekly basis for their household members. One woman shared that she stopped working to take care of her sick father. Only 21% of the women indicated that they use any childcare facility, rather they bring their pre-school age children to work with them.

Long hours for women in Johannesburg

Those who are employed do the household chores after work; and for those at home the chores begin at day break.

"I wake up at 6h00am everyday (weekdays and during school term) and prepare for the children. I start with the eldest and monitor her in dressing up and preparing for lunch. I walk her half-way to school because she complained that I walk others not her. I do this so she feels special as well. I come back and wake up the second child – monitors her in bathing, dressing up and eating breakfast. While I take the second one to school; the youngest watches TV. I come back and prepare the 3rd one who goes to crèche. When all kids are gone, I have my cup of tea so I can relax. My husband wakes up when kids are gone, but sometimes children wake him up."

Future Forward: Addressing Challenges and Aspirations

Accra, Hyderabad and Johannesburg are three very different cities in three diverse countries. Yet they share some important characteristics: each is undergoing rapid economic development and social change; experiencing a “youth bulge”^{xlviii} matched with high levels of unemployment among young people (especially young women).

The research findings align with available information on the lives of adolescents and young women in resource poor communities – being able to earn an income has a major impact on young women's lives in terms of their ability to engage in household decision-making, whether around health care, contraceptive use, and (this comes through very powerfully in India) their ability to buy appliances/utilities that help enormously in saving time (on unpaid care work) and also in providing access to entertainment. Across the three countries, unpaid care responsibilities often take time away from paid work; lack of education results from lack of money in the family and boys' education is given priority (more distinctly in Ghana and India). The lack of education has a powerful impact on young women's ability to find work (in economies which are not creating new jobs, it gets harder for young women with little or no education to access decent work opportunities), but it does not stifle their hopes and dreams. Violence is pervasive across all three cities, but the form is different and as a result, has a different

impact on bodily integrity and economic security.

The differing contexts of each of the cities in three diverse countries imply that the issues that the young women face, in the most immediate sense, are somewhat different^{xlix}. But similarities also show through, both in terms of challenges and the ability to exercise ‘agency’^{xlx}. A WIEGO study about the informal economy raises a significant point for all three cities: “there are important class divisions between women workers in the informal economy, which means it is extremely difficult to articulate their experiences in a unitary manner.” (Alfers L, 2014). We might add to this an understanding of recent patterns of rural to urban migration and, in the case of Ghana and South Africa, international migration.

Reduced Burdens, High Expectations:

Across the three research sites, employment does sometimes reduce the burden of unpaid care work to a certain extent for young women. There are examples of family members sharing in the responsibilities of fetching water and cooking in some of these working women's lives - however this has not resulted in redistribution of the gendered nature of unpaid care work itself since in most cases these are other female members in the household. Despite the relief, young women indicate that many of the family expectations from them remain and most women are

engaged in fulfilling these while negotiating personal costs and claiming spaces for themselves.

Increased Health Problems, Available

Resources: The burden of care work and occupational hazards and poor conditions of paid work has resulted in various health problems but the means to address them are still limited. However, access to income means better access to appliances that reduce a woman's home based workload even though it does not ensure equitable distribution of care responsibilities. There is a pressing need for greater attention to regulate and act to address (existing) workplace health and safety regulations, such as ensuring adequate potable water and sanitation facilities in formal and informal workplaces, and ensuring that employers abide by minimum wage and leave policies.

Normalised Violence, Independent

Decisions: Across the research sites, young women are subjected to various forms of harassment on the streets like eve teasing, stalking, molestation, abuse, and most of the time they are blamed for it. Indeed, some of the respondents disclosed harrowing experiences of violence amounting to torture. Both within and outside the home, violence pervades the lives of young women to the extent that it is accepted as 'normal' and the response is in the form of 'stay at home for safety' or 'this is part and parcel of intimate partner relationships'. The idea that men have a right over women's bodies is consistent from one city to the other. Some of the violence is extreme, from being starved for food (as revealed by some women in Accra) to being beaten and physically abused severely. Very few women have reported violence to the police and where they have, it has not

lead to any positive results for the women - instead support has come from peers. In fact the continuum of violence persists from the workplace (often exacerbated by the lack of sanitary facilities) to the home for self-employed women who are subject to harassment by the men who come to give them orders especially when they are alone. Yet, the research finds that the young women negotiate economic decisions that may undermine bodily integrity in the immediate, however, in the long run economic security provides them with the opportunities to make some independent decisions for their families and themselves.

Discriminatory Practices, Accessible

Services: As mentioned earlier, a significant barrier to accessing healthcare stems from the fact that in many places (such as Hyderabad) women are not allowed to go out alone, thereby linking mobility issues with issues of access. In some households, women are prevented from going to a medical centre. The other reason is due to having so much of work to do (both paid and unpaid), that they are not able to gather time for the same. Long distances to the clinics, lack of adolescent-friendly services and inaccessible hours all combine to make clinic or hospital visits exceptional for most of the young women. Lack of young women friendly and quality services as well as discriminatory practices compound young women's challenges manifold. Young women who are employed find it difficult to access health services, due to lack of time to do so; some work in jobs where there is a "no work, no pay" principle. Employers only waiver that principle when there is bereavement in the family or something serious happens. They either do not get leave from their workplaces or are busy with the housework and care

of the household people. These lead to over-the-counter drugs and home remedies becoming the easy solution - common and popular treatment methods. While these work for some, there are many times when the condition becomes very urgent and severe before it is treated.

With respect to access, the preference for private clinics rather than government run hospitals came through across the entire research sample. For young women who work, accessing public health services during working hours is a concern as the clinics have fixed hours and may remain closed over weekends when young women are free from work. Issues of quality of care and confidentiality also influence young women's decisions to visit a paying, private clinic over free public ones. Buying drugs over the counter for headaches, fever and colds was normal, as also taking medicines prescribed by the pharmacist as if given by a doctor. The outcome of such practices is that most often the symptoms are treated and the actual (bigger) cause of the medical problem is ignored. More women are however now turning towards formal health care systems for treatment, especially the women who are educated, earn money and are otherwise aware because of intervention programs prefer to visit a doctor. However, this education does not extend to sexual and reproductive health. Some of the lack of access also results from discrimination, marginalisation and gender inequality, which can only be addressed by substantive work with families, religious leaders, elders and the women so that they can better negotiate these social barriers. Regardless of income, work or marital status, young women face severe restrictions in finding sexual and reproductive health care that enhances their rights and is

accessible, available, affordable and of high quality.

Social Taboos, Available Choices: The issues that affect bodily integrity are deep rooted in the society and long-held religious beliefs, and require engagement with the larger community and other stakeholders who exert control over women's lives, especially on their sexuality. Topics of sexuality, sexual health, reproductive health and sexual and reproductive rights are still taboo and not discussed in the households or communities and knowledge on sex, contraception etc. before marriage is low (at least not discussed openly). However, with increasing awareness and exposure among young women, the age of sexual interactions is reducing and there is a need for conversations around safe sex, healthy relationships, control and consent, etc.

Mental health of young women is a largely neglected area though there was clearly a need to address the same considering the tremendous pressures and stresses young women face, without a space for catharsis or sharing. Health care in general, and sexual and reproductive health information and services in particular, are woefully lacking or simply unavailable to most young women when they need them. Additional alternative schemes to provide medical support and assistance to the young women have had limited reach so far and need to be intensified. However, women engaged in paid work are better able to access health facilities and those who are aspiring to take up paid work in future feel they will be in a better position to access facilities once they earn an income and have greater mobility. With access to income, the tendency is to move towards private health facilities even if more expensive as public facilities are either non-existent or perceived to be of poor quality.

The research finds that each country has a wide variety of policies and programmes designed to support young women's sexual and reproductive health and promote their rights. However, major gaps remain in knowledge, information, and accessibility of services. For example, despite the fact that sexual and reproductive health programming is supposed to include attention to HIV, it is clear from the study that many young women lack information about HIV prevention as well as treatment, care and support. Yet, in all three countries, young women are amongst the most vulnerable to contracting HIV. These barriers could be overcome helping make linkages across different kinds of civil society groups – ensuring that organizations for young women include HIV prevention, treatment, care and support information in their SRHR and invite experienced HIV community workers to present or join a workshop. Expanded programming would facilitate diverse young women's access to quality, adolescent-friendly services and care.

In Summary

Across the research sites, the research has found linkages between economic security, bodily integrity and an equitable burden of unpaid care work responsibilities. In fact, it is in their daily lived realities that these connections manifest. What we can conclude at this point is that the nature of inter-linkages between bodily integrity, economic security and unpaid care responsibilities are not linear, rather they are multifaceted and complex. Paid work has considerable value for women themselves and could constitute the basis for their attempts to make changes in the future. Keeping jobs is critical to bodily integrity and economic security. Most women are likely to attend medical services when they start to

work. At best, the combination of paid work and access to health care gives women a renewed identity, a sense of achievement and an aspiration to bodily integrity and economic security. Overlaid across the discussions is the pervasiveness of gender-based violence, gender-based discrimination in the form of stereotypes and harmful gender norms about young women's "proper" roles, and the persistent challenge of living and working with inadequate access to water, electricity, child care and health services.

Yet, young women in the research cities continue to dream of more education, better jobs and secure professions in their futures, as pilots, police officers, development practitioners, nurses, doctors, radio broadcasters, and more. They also have demands from the state – support from governments to utilise child care facilities; transport facilities to save travel time; and police security in case of emergencies, etc. They also expect that employers should offer flexible timings, crèches, help during emergencies, sick leave, maternity leave, clean and safe toilets and drinking water. At the same time, they lack connections with trade unions and other worker's associations that can make these demands come true.

Without interventions that are cognizant of the dynamics that such connections create in young women's lives, gender equality remains an illusion; and it is these that organizations working with young women need to focus on going forward.

Still missing the mark: Proposals for Action to Increase Young Urban Women's Voices and Choices

The world has proclaimed its commitment to gender equality and to empowering young people. The recently agreed UN Sustainable Development Goals, for instance, contain a “stand-alone” goal on gender equality that encompasses issues such as ending violence, nurturing women’s leadership, increasing women’s equal access to resources, valuing women’s unpaid care work, ensuring universal access to sexual and reproductive health and reproductive rights, among others. Several of the targets speak specifically to the issues we have focusing upon in this report, agreeing to:

- Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate
- Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life
- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

- Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.

The UN agreement, “Transforming our world: the 2030 agenda for sustainable development,” also takes up a number of issues of particular young people. It highlights the many challenges faced by young urban women: unemployment (para. 14), the need to empower people who are vulnerable, including young people (para. 23), providing inclusive and quality education for all (para. 25), and achieving full and productive employment and decent work for all – including young people (goal 8, target 4). Among the other commitments are those with a significant impact on the young women who participated in this study, such as ending poverty and hunger, ensuring health lives and quality education, reducing inequality and making human settlements safe for all people, and increasing the availability of clean water and sanitation^{liv}.

However, achieving these goals, including at the national level, requires a better understanding of ways development promotes or impedes empowerment of young women. Ultimately, while many actors need to engage in the process, government is the primary

duty bearer. Each country (Ghana, India and South Africa) has a plethora of laws and policies that promote and protect women's rights in all spheres of life. Yet, the gaps between promise and reality are wide. It is clear that governments need to be vigorous in monitoring implementation of these laws, while development partners and advocacy organizations need to keep a close eye on the process starting from awareness, understanding, and access as well as justice issues. Without this, for young women, these laws, policies and programmes are relatively meaningless. In this context, a commitment to addressing the rights of young women should animate all of the work of government programmes and policies at all levels, civil society allies and partners, and the agendas of development partners and ally organizations.

Each country has a strong scaffold of laws and policies to support the rights of young women. However, the promise of these laws and policies is not given effect in young women's lives, in part because of law and policy silos, and in part because of persistent discrimination against women and girls and against young people. This supportive law and policy context gives civil society organizations (local, national and international) an excellent opportunity to link young women to local government spaces that address health issues, provide child care, offer free or low-cost health insurance, deliver employment skills building, or give access to education at reduced cost or at no cost.

Action proposals are organised by the actor to whom the recommendation is directed: government, development partners (UN, donors and INGOs), and local, national and international civil society organizations.

Each section begins with an overall recommendation, followed by a number of country specific recommendations drawn directly from the national reports.

By Government: While some multiple and often overlapping programmes exist that address the needs and rights of young urban women, they are not reaching young women in the communities with whom we worked. Budgets tend to be grossly inadequate and programmes lack integration across the areas of sexual and reproductive health, work and employment and public services. Thus, there is an urgent need for more programming that focuses on the needs and rights of young urban women, as follows:

- » Provide specific guidance on available social protection and youth development programmes, increase budgets allocated to these and ensure that they are accessible to young women
- » Provide more, better quality gender-responsive public services and design them with reducing young women's care work burden in mind; involve young women in designing and monitoring the delivery of such services
- » Expand affordable and quality housing schemes, with units that include indoor toilets and running water.
- » Intensify efforts to make schools safe, secure and more accessible to young women; implement integrated sexual and reproductive health education programmes in schools
- » Reverse macroeconomic policies that encourage the casualisation of labour, removing benefits to employers who rely on outsourcing to the informal economy.

- » Strengthen laws and policies that prohibit sexual harassment and violence in both formal and informal work-places, and ensure that victims have access to legal, social and health services to take action to bring the perpetrators to justice
 - » Intensify implementation and monitoring of workplace health and safety regulations – ensure water and sanitation facilities in both formal and informal work places
 - » Ensure that employers abide by minimum wage and leave policies and take action to deter employers from denying employment benefits. Review and revise maternity and sick leave provisions to ensure that the use of these benefits is accessible, acceptable and does not put women's jobs at risk. Such benefits should not depend on formal employment but rather be part of a generally accessible social protection/ social insurance package
 - » Provide accessible, affordable, acceptable and high quality adolescent-friendly sexual and reproductive health programmes and services, and work in partnership with youth organizations to widely disseminate information and monitor health providers' treatment of young people.
 - » Implement integrated school-based health programmes, including comprehensive sexuality education, in all schools, as well as community-based educational programming for out-of-school young people.
- priorities of a number of donors. In some cases, UN agencies and donors are engaged and supportive of programming to support young women in the study area. However, in a number of cases, donors and the UN are mostly absent from these communities, leaving young women without the full range of programmatic support that they need, and that these agencies are mandated to support. In supporting increased programming that focuses on the needs and rights of young women, development partners should also commit to support young people's advocacy and identify ways to help create spaces for their voices to be heard.
- » Promote an integrated approach to young women's bodily integrity, economic security and burden of unpaid care, in order to tackle harmful gender norms. This should include establishing policies and delivering programmes that support not only the health of women and girls, but also their socio-economic development more broadly, including a strong focus on gender equality and the prevention of sexual and gender-based violence against girls and young women. This might also involve coordination by development partners to ensure such an integrated approach is put in place with adequate budgets for implementation.
 - » Advocate for and support implementation of, a gender-budget analysis of national policies and programmes, including those that focus on GBV, sexual and reproductive health and HIV programmes. The analysis should provide recommendation on how to reduce the vulnerability of young girls and increase their agency, by ensuring they receive adequate information and services –

By Development Partners, UN Agencies and Donors:

The issues that the young women in our study face fall squarely within the ambit of a number of UN agencies, as well as within the funding

particularly in terms of their reproductive health, with a focus on contraception, STIs and HIV.

- » Play a major role in helping girls and young women participate in the public life of their communities, including local and national decision-making processes. For example, development partners can support programming that engages young women in capacity building exercises about how local and national government works.
- » Support governments to ensure access to adolescent-friendly health services and employment/skills training and opportunities. In particular, a concerted effort should be made to support initiatives that strengthen community health systems and invest in activities that help health systems overcome constraints to the achievement of improved sexual and reproductive health outcomes, with specific attention to young people.

By Civil Society Organizations:

Allies and partners working on young women's rights include a wide variety of organizations, ranging from ActionAid's national partners, groups providing adolescent-friendly services (such as Marie Stopes International, IPAS and Planned Parenthood in Ghana), to advocacy and support organizations such as the Positive Women's Association in South Africa or the Self-Employed Women's Association in India, to global research and advocacy groups whose mandates include the issues these young women face, like the International Planned Parenthood Federation, WIEGO (Women in Informal Employment: Globalizing and Organizing), the Youth Coalition for Sexual

and Reproductive Rights, and the International Trade Union Confederation (all of whom are part of this study's Research Working Group). There are a large number of ways in which these allies can help to address the needs and rights of young urban women, strengthen partnerships with youth organizations, and increase the voice and choice available to young urban women, including those in resource-poor settings. This might include: ensuring that information about products and services is widely known; municipal, provincial and national organizing initiatives affirmatively reach out to young women (and in particular, the young urban women who are participating in the ActionAid programme); and ensuring that young women's voices and experiences are part of global advocacy around young people, sexual and reproductive health and rights, decent work, gender-responsive public services and women's rights and gender equality more generally.

- » Support young people to review municipal, provincial and national budgets from a gender lens, using popular economic education tools, and based on the analysis, develop and implement strategy advocacy with municipal, provincial and national governments.
- » Ensure CSO and CBO initiatives link to and leverage municipal programmes, for example linking programming to ensure better safety and security for girls and young women to municipal initiatives such as the SHE initiative in Hyderabad or South Africa's Victim Empowerment Programme.
- » Refocus and engender discussions on economic rights and anti-poverty programming to include young urban women's concerns.

- » Scale up and institutionalise attention to intersectional discrimination, for example, the particular challenges faced by young women with disabilities, young people living with HIV, and people of diverse sexual orientations and gender identities. For example, organizations focusing on the needs and rights of young women and girls should work with groups (for example, Stepping Stones) that pay explicit attention to building gender equality and human rights with traditional leaders, including, but not limited to, addressing gender-based violence and sexual and reproductive health.
- » Strengthen links across sectors, especially anti-poverty, youth organizations and women's rights group with national campaigns on labour issues. Young women's voices need to be heard in national and municipal debates about employment opportunities, worker health and safety issues, and other key worker benefits such as paid sick and parental leave.
- » Ensure that youth organizations are active participants in efforts to strengthen gender-responsive public services, ensuring that young women in each community are able to have a part in determining what and where public services are located so as to ensure that these services meet the specific needs of young women.
- » Pay greater attention to issues of sexual and reproductive health and rights, especially by youth organizations, calling for significantly scaled up attention to helping young women secure their bodily integrity on a more consistent basis.

Take action to make it happen.

Annexure 1: Detailed Research Methodology

International research process:

The lead research team worked closely with ActionAid staff and key informants to define the terminology, scope, scale and methodology of the study, including the parameters of the peer research process. This was supported by a Research Advisory Working Group, composed of colleagues from other NGOs whose work addresses the needs and rights of young urban women.

National research process:

Accra: As noted above, the lead international researcher was unable to travel to Ghana, so the national consultant, ActionAid Ghana staff and one YUW programme participant traveled to South Africa to work together for three days in order to have an orientation, and to revise/contextualise the tools for working in Accra.

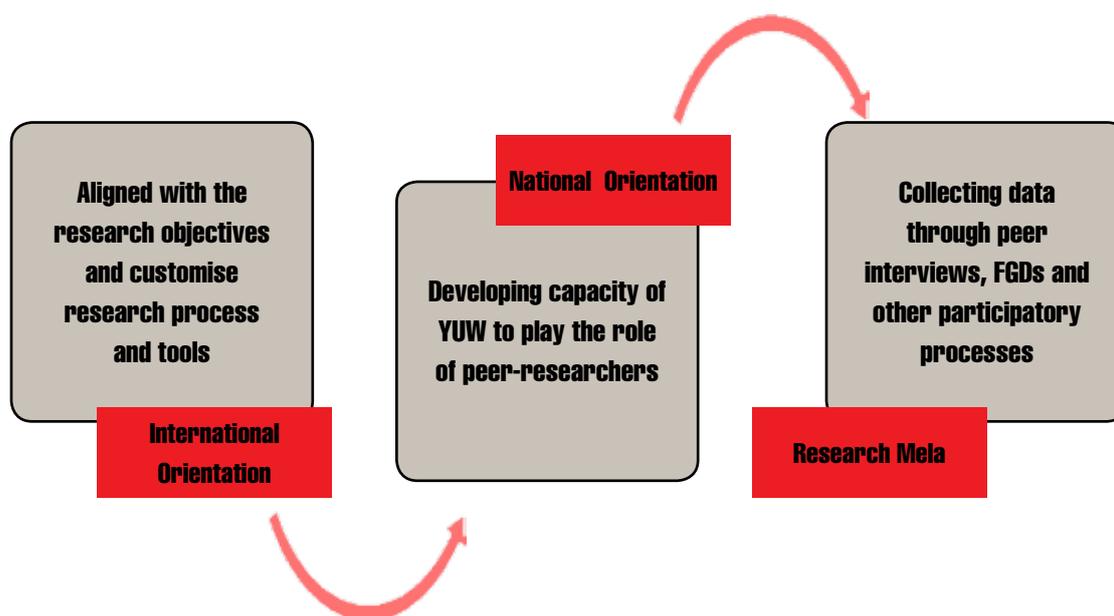
The Ghana national study was carried out in the one of the main project locations within the two Local Rights Programme sites of ActionAid Ghana, Accra (Greater Accra Region) with the target respondents being young urban women aged between 15 and 25. Respondents and peer researchers were mobilised from Kpobiman and its environs in the Ga West Municipality of the Greater Accra Region. Interviews and case studies were conducted over two days at the AAG office. Semi-structured interviews were administered on 45 young urban women as well as key informant interviews and focus group discussions. Five peer interviewers were selected based on literacy and level of comfort interviewing. All five were currently in school. The peer interviewers were supported by a professional note-taker. The main consultant monitored each interview.

Case study/role plays were facilitated by the national consultant. The case study/role plays were held at the AAI youth friendly center to provide as much privacy as possible where participants were comfortable. Participants sat in circle to ensure eye contact with each other and could hear each other speak. The principal researchers served as moderators during the discussions, while a note taker who formed part of the team were present to conduct the focus group discussions.

A total of 12 key informant interviews were conducted with governmental agencies, UN agencies, other donors, non-governmental organizations and community based organizations. The governmental agencies are Ghana Health Service, Ga West Municipal Assembly and Ministry for Gender and Social Protection and non-governmental agencies are Marie Stopes International, Planned Parenthood Association of Ghana (PPAG) and IPAS Ghana. The UN agencies are UNICEF and UNFPA as well as other international donors such as DFID and USAID. The community-based organizations are the Kpobiman Women's Association and No Yawa Community Theater Group.

Old city of Hyderabad: An international orientation session was held in Hyderabad and Johannesburg in order to introduce the research, discuss the process and revise/contextualise the research tools (semi-structured interview tool, case studies, and peer researcher training and support process). The lead international researcher worked separately with the Ghana team (who traveled to South Africa for the meeting). In India, about 25 women from the communities who were part of the young urban women project in the past year joined ActionAid India staff, ActionAid HQ staff, Shaheen staff (national NGO partner), national consultants and the international lead consultant, for the workshop.

Given the particularities of the research sample and the peer researchers, the India team developed a research process designed to provide the maximum level of support to the peer researchers. Most of the peer researchers did not speak English, and many could not read or write. As a result, following the international orientation meeting, the Hyderabad team conducted a 2-day national orientation/training workshop followed by a two-day research "mela" (gathering).



The international orientation included the international consultant, the ActionAid team, Shaheen (local NGO partner) and the National Consultant met to discuss the roles and responsibilities and the activities and timelines of the research project. About 25 women from the communities – who were part of the young urban women project in the past year participated in the workshop.

Following the international orientation session, a 2-day national orientation workshop was convened to build capacity of young women, followed by a 2-day 'research mela' to collect data using participatory tools. In addition, the national researchers conducted 4 key informant interviews, in order to capture the broad context and engagement with the young women.

The two-day orientation workshop was conducted with 29 young women including 5 cluster coordinators from Shaheen (NGO). The goal was to equip these young women with the skills and knowledge to become peer-researchers. In the course of the two days, the young women started to open up and share personal stories. Active participation of young women was one of the high points of the workshop.

The research mela was a two-day long workshop for collecting data. It was conceived as a participatory process with games, activities and role plays to collect data. It was also envisaged to be a peer-to-peer process with hand holding support from research team. In total, 25 young women participated in the mela: 7 *Karkhana* (small factory) workers, 1 bangle making women, 1 woman not working, 4 tailoring women, 5 students, 2 *mehendi* designers and 2 women engaged in other outdoor activities. To make consent giving process for the research interesting, every young woman signed their names in the list but also walked up to the painting of a plant pinned up and used a lady's finger to add their consent in the form of a flower.

The interviews were conducted in small groups of five: three women, one cluster coordinator from Shaheen and a lead facilitator. To enable participation, all the data forms and questionnaires were translated to Urdu/familiar script for use by the participants. Likewise, note takers were selected on the basis of their skills in reading and writing. Shaheen was requested to form the small groups in order to ensure that peer researchers would have a minimum level of comfort with each other for the conversation to take place.

The researcher facilitated case studies in between interviews and sessions/activities. It was interesting to note that the participants not only played the characters given in the role plays but also improvised the role plays by adding more characters and props. The case study/role play methodology was extremely

useful to elicit diverse points of view. Young women enjoyed playing the different characters and could identify with the characters. As the discussion was around a 'third' person there was no inhibition in putting across viewpoints and no one felt threatened. It was also witnessed that young women were very much involved in performing the role plays and observing the characters by being in the audience. It was helpful in breaking the monotony of the interview schedule.

The women who work in the karkhanas were unable to be part of research mela as the owners of the karkhanas would not allow them to take leave. Shaheen cluster coordinators decided to conduct the interviews in or close to the workers. While two women invited them to take interviews at home, three other interviews took place at the karkhanas. One young woman asked her husband to leave the house during the interview as she was not comfortable talking about the various issues in front of him.

In addition, four KIIs were conducted with: Girija, Nirnaya (an NGO worker, at her office); Mohd. Wajahad Khan, Corporator, GHMC, Hyderabad (local political representative at his residence); Mohd. Imtiaz Khan, District Child Protection Officer (State Govt. Official interviewed at Shaheen's office); and Ms Sandhya, a senior NGO functionary working with Magic Bus, Hyderabad (telephone)

Johannesburg: Data in Johannesburg was collected using face-to-face, semi-structured interviews. Initially, it was planned to have peer interviewers conduct all the interviews, with support from the national consultant. However, inadequate monitoring of the peer-to-peer interviewing process resulted in results that were patchy and seriously lacking in detail. As a result, these interviews could not be used as data for analysis and a second round of interviews were conducted. However, as a result of extremely tight time frames and logistical challenges, the consultant conducted the interviews and the peer researchers conducted the case studies/role plays. Interviews were conducted at the respondent's convenient time. For example, domestic workers were available during the day when the employer was not available, and would give one hour notice for the interview. At that time, the peer interviewers were not around to conduct the interview. This resulted in most interviews conducted by the researcher alone, with a few supported by ActionAid staff, and fewer still conducted by peer interviewers.

Young women participating in each case study/role play were relatively homogenous as far as key background variables for the study are concerned, since different role plays were conducted at the locations of AASA's national partners. The role plays permitted richness in the collection of data that may be difficult to capture in individual interviews. Young women who participated in the role plays added their own creativity in interpreting the case study. Caution was taken to stick to the story, and additional characters were added to the storyline to reflect their own realities.

Role plays were conducted at four Afrika Tikun centers, with one role play conducted at each of the four centers. Case studies for the centers were selected with peer interviewers. Discussions on role plays and case studies were largely led by peer interviewers with the researcher interjecting for clarity and probing when necessary. These sessions were held in the afternoons when more young women were available from school and some from work. Each center used days for the monthly meetings for the role play to ensure availability of young women. The following are case studies that were selected in each center: Alexandra, Case Study 1; Diepsloot, Case Study 6; Orange Farm, Case Study 2; and Uthando (Inner City), Case Study 3.

Key informant interviews were conducted with organizations working on issues relevant to the research and with a national footprint. These organizations were able to discuss their experiences in working with women nationally, not only in Johannesburg. Respondents were young women employed by these organizations. Organizations that participated were Positive Women's Network (an organization that supports HIV positive women) and Southern Africa Youth Project (youth and skills development organization that facilitates community development training). One interview was conducted with a municipal official in Johannesburg, a staff member who works on a leadership program for in-school youth.

Annexure 2: Selection Criteria of Research Participants across sites

Criteria	Remarks
Have participated in ActionAid Project for at least one year	Applies to all women (except ITUC members)
Industry	20-25 of the 30 interviewees should be currently working or have worked in the recent past. The interviewees will be selected from 4-5 industry categories, with at least 5 interviewees from each industry. If necessary/useful, additional interviewees can be identified by ITUC.
Between the age of 15 and 25 years	Applies to all women – ½ of interviewees should be in the younger age group, and ½ in the older age group
Ever Married	Proportionate to the married/unmarried ratio of women in ActionAid's Project, or 50%
Has children	Proportionate to ratio of women in ActionAid's Project by country, or 50%
Works outside the home/or home-based worker	At least 20 of 30 interviewees

Annexure 3: Ethical Research Principles and Guidelines

2.1 WHO Guidelines for research on violence against women

Young women may discuss personal experiences of violence in regard to this and other indicators. The group facilitators should all be women to ensure that young women feel comfortable to discuss issues of violence and sexual exploitation. Drawing on the WHO Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women, we have adapted these for the purpose of this data collection process. The facilitators, partners and ActionAid should abide with the following guidelines while doing the data collection:

- A. The safety of respondents and the research team is paramount, and should guide all project decisions.
- B. Create a safe and familiar space in order to minimise the under-reporting of violence by the young women themselves
- C. Protecting confidentiality is essential to ensure both women's safety and data quality.
- D. All data collection team members should be carefully selected and receive specialized training and on-going support. All facilitators and partners doing the data collection should be women.
- E. The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
- F. Facilitators and staff should be trained to refer women requesting assistance to available local services and sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.

2.2 ActionAid Research standards

1. *People living in poverty are empowered by our research – both, in process and product:* Research priorities were drawn directly from the baseline reports and the experiences of AA Young Urban Women programme staff in consultation with young women project participants. Young Urban Women programme participants participated in designing the questionnaires and role plays, and the data collection process was organised as peer-to-peer interviewing. The research outcomes will be vetted with the young women, and recommendations designed to be used by the young women in their advocacy for better public services, economic opportunities and sexual and reproductive health and rights.

2. *Strong analysis:* The research has a feminist analysis of poverty at its core. The explicit focus of the research is on the interconnectedness of structural challenges faced by young urban women in Accra, Hyderabad and Johannesburg.

3. *Linking our work across levels and adding value as a federation:* The research focuses on creating a context in which young women can articulate their definitions of, and aspirations for rights related to sexual and reproductive health, decent work and equitable unpaid care responsibilities. It links in-country and cross-country research for an analysis built on the narrative voices of young women in ActionAid's Young Urban Women (YUW) programme in Accra, Hyderabad and Johannesburg.

4. *Innovative and engaging:* The research contains a bold message – young women understand and aspire to bodily integrity, economic security and an equitable burden of care responsibilities. As follow up, the research includes information about budgetary spending that young women can analyse and assess, and based on that, develop strategic advocacy with their municipal, provincial and national governments.

5. *Research partnerships:* The Research Advisory Group is made up of key allies with whom ActionAid will seek ongoing collaboration around the issue of young urban women's rights.

* See also <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563398/> for additional considerations about ethical guidelines.

Annexure 4: Selected text of General Comment 14 to the International Covenant on Economic, Social and Cultural Rights

General Comment 14 to the International Covenant on Economic, Social and Cultural Rights (accessed at http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf), definitions of “availability, accessibility, acceptability and quality.” The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) Availability. “Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)”

(b) Accessibility. “Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities. Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.”

(c) Acceptability. “All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”

(d) Quality. “As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”

- ActionAid India. (2014). *Young Urban Women: life choices and livelihoods.. A study on the status of young urban women in Chennai, Hyderabad and Mumbai*. ActionAid India.
- Actionaid India. (2014). *Young Urban Women: life choices and livelihoods. A study on the state of young urban women in three cities in India (Chennai, Hyderabad and Chennai)*. A STUDY ON THE STATUS OF YOUNG URBAN WOMEN.
- Adogla D. (2014, May 14). *General news*. Retrieved from GhanaWeb: <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/3-100-maternal-deaths-in-2013-despite-Ghana-s-progress-309133>
- Albuquerque, C. d. (2012). *On the right track: Good practices in realising the rights to water and sanitation*. Geneva: UN Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation. Retrieved from http://sr-watersanitation.ohchr.org/pdfs/BookonGoodPractices_eng.pdf
- Alfers L. (2014). *The Ghana National Health Insurance Scheme: Barriers to Access for Informal Workers*. WIEGO Working Paper (Social Protection) No 30, WIEGO. Retrieved from <http://wiego.org/publications/ghana-national-health-insurance-scheme-barriers-access-informal-workers>
- Alfers L, R. M. (2014). *Health risks and informal employment in South Africa: does formality protect health?* International Journal of Occupational and Environmental Health, p. DOI 10.1179/2049396714Y.0000000066.
- Ayres A. (2015, August 17). *Economic Growth and India's Global Rise*. Forbes. Retrieved from <http://www.forbes.com/sites/ayssaayres/2015/08/17/economic-growth-and-indias-global-rise/>
- Bhardwaj A. (2014, November 12). *Chhattisgarh sterilisation tragedy: Besides medical negligence, guidelines for operations also violated*. The Indian Express.
- Benzoni S. (2013, January 7). *An unexpected economic boom brings questions about who benefits*. The Rockefeller Foundation's Informal City Dialogues.
- CEDAW, U. (1979). *Convention on the Elimination of All Forms of Discrimination Against Women*. Retrieved from <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article13>.
- Chen MA. (2014). *Informal Economy Monitoring Study Sector Report: Home-Based Workers*. WIEGO.
- Clarke EE. (2003). *Contribution of Occupational Health and Safety Factors to the Brain Drain in the Health Sector*. African Newsletter on Occupational Health and Safety, Vol. 13, No. 2., Vol. 13, No. 2.
- Cohen A. (2013, April 9). *The 70 Percent in Ghana (Hint: It's the Informal Sector)*. The Rockefeller Foundation's Informal City Dialogues.
- Darteh E, D. D.-D. (2014). *Reproductive health decision making among Ghanaian women*. *Reproductive Health*, p. 11:23. Retrieved from <http://www.reproductive-health-journal.com/content/11/1/23>
- Eek F, A. A. (2015). *Gender inequality at home is associated with poorer health for women*. *Scandinavian Journal of Public Health*, V 43 (2): 176-182.
- GSS. (2010). *Population and Housing Census*. Accra: Ghana Statistic Services.
- GhanaWeb. (2015, April 18). *99 percent have sex before marriage - Oye Lithur*. Retrieved from GhanaWeb: <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/99-percent-have-sex-before-marriage-Oye-Lithur-355007>
- Gill K, P. R. (2007). *Women deliver for development*. *The Lancet*, pp. Volume 370, No. 9595, p. 1347-1357.
- Gobah FKF, Z. L. (2011). *The National Health Insurance Scheme in Ghana: Prospects and Challenges: A Cross-Sectional Perspective*. *Global Journal of Health Science*, Vol. 3, No. 2; .
- Grimshaw D. (2011). *What do we know about low-wage work and low-wage workers? Analysing the definitions, patterns, causes and consequences in international perspective*. ILO Conditions of Work and Employment Series No. 28.
- GSS. (2009). *Ghana Demographic and Health Survey*. Accra: Ghana Statistical Service and ICF Macro.
- GSS, G. I. (2009). Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro: *Ghana Demographic and Health Survey 2008*. Accra.
- GSS. (2010). *Population and Housing Census*. Accra: Ghana Statistic Services.
- IANS. (2014, 10 24). *She-Police-Teams-in-Hyderabad-for-Womens-Safety*. Retrieved from [newindianexpress.com: http://www.newindianexpress.com/cities/hyderabad/She-Police-Teams-in-Hyderabad-for-Womens-Safety/2014/10/24/article2491493.ece](http://www.newindianexpress.com/cities/hyderabad/She-Police-Teams-in-Hyderabad-for-Womens-Safety/2014/10/24/article2491493.ece)
- ILO. (1999). International Labour Conference. Geneva: International Labour Organization.
- ILO. (2015). *Global Wage Report 2014/15: Wages and income inequality*. Geneva: International Labour Organization.

- Institute for Policy Alternatives. (2006). *Community Voices II: Quality health services for the poor: Is the NHIS the answer?* Annual Civil Society Assessment of Pro-Poor Policies and Programmes in Ghana, 2005-2006, Institute for Policy Alternatives, Accra.
- IPPF. (2015). *Sexual and reproductive health and rights - the key to gender equality and women's empowerment*. 2015: International Planned Parenthood Federation.
- IUSSP. (2010). International Seminar on the Health, Social and Economic Consequences of Unsafe Abortion. IUSSP Scientific Panel on Abortion and Population Council.
- Mander H. (2015, July 12). *Surging tides of inequality*. The Hindu. Retrieved from http://www.thehindu.com/opinion/columns/Harsh_Mander/harsh-mander-on-the-rising-economic-inequality-in-india/article7407472.ece
- MTF. (2005). *Taking Action: Achieving Gender Equality and Empowering Women*. New York: United Nations Millennium Project Task Force on Gender Equality (MTF).
- Okudzeto E, M. W. (2015). *Ghana 2015. African Economic Outlook*. Retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2015/CN_data/CN_Long_EN/Ghana_GB_2015.pdf
- Osei-Assibey E. (2014). *Inequalities country report: Ghana*. Prepared for the PAN-AFRICAN CONFERENCE ON INEQUALITIES IN THE CONTEXT OF STRUCTURAL TRANSFORMATION. Retrieved from <http://africainequalities.org/wp-content/uploads/2014/05/Ghana.pdf>
- Oxfam International. (2013). *Universal health coverage: why health insurance schemes are leaving the poor behind*. Oxfam briefing paper 176.
- Potgieter C, P. R. (2006). *Women, Development and Transport in Rural Eastern Cape, South Africa*. Pretoria: HSRC Press.
- Quarty L. (2013, July 13). *Ghana revises investment law to safeguard local traders*. *The Africa Report*. Retrieved from <http://www.theafricareport.com/West-Africa/ghana-revises-investment-laws-to-safeguard-local-traders.html>
- UN CRC. (1990). *Convention on the Rights of the Child*. Retrieved from <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.
- UN ICESCR. (1976). *International Covenant on Economic, Social and Cultural Rights*. Retrieved from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.
- UNDP. (2013). *Humanity Divided: Confronting Inequality in Developing Countries*. New York: United Nations Development Programme. Retrieved from http://www.undp.org/content/dam/undp/library/Poverty%20Reduction/Inclusive%20development/Humanity%20Divided/HumanityDivided_overview.pdf
- UNFPA. (2014). *State of the World's Population*. New York: UNFPA.
- UNICEF, U. a. (2010). *Fact Sheet: Girls and Young Women* (prepared for the International Year of Youth, 2010-2011). NY: social.un.org/youthyear.
- Vidal J. (2011, October 21). *Ghana's population explosion*. Retrieved from theguardian.com: <http://www.theguardian.com/global-development/2011/oct/21/ghana-population-explosion>
- Warberg A, W. L. (2010). *Decisions for Work: An examination of the factors influencing women's decisions for work*. London: International Trade Unions Confederation.
- WHO. (2008). *Commission on Social Determinants of Health, Closing the gap in a generation: Health equity through action on the social determinants of health*. Final Report on Social Determinants of Health. World Health Organization. Retrieved from http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf
- WHO and UNICEF. (2014). *Progress on sanitation and drinking-water - 2014 update*. Geneva: WHO and UNICEF. Retrieved from http://apps.who.int/iris/bitstream/10665/112727/1/9789241507240_eng.pdf
- WHO, D. O. (2001). *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. World Health Organization. Geneva: World Health Organization. Retrieved from <http://www.who.int/gender/violence/womenfirtseng.pdf>
- Witter S, G. B. (2004). *Something old or something new? Social health insurance in Ghana*. BMC International Health and Human Rights, 9, 9 (20).
- World Bank. (2014). *South Africa. The World Bank*. Retrieved from <http://www.worldbank.org/en/country/southafrica/overview>

- i. See Chapter 2 for Conceptual Framework where these concepts are detailed.
- ii. This included 45 interviews in Accra and 25 interviews in Hyderabad. In South Africa, 30 interviews were conducted in a first round of interviews, but the large majority of these (20 of 30) were of insufficient quality. As a result, a second set of 26 interviews were conducted.
- iii. According to the Population and Housing Census (PHC 2010), the Ga West municipality has a household population of 215,101 with a total number of 55,913 households. The average household size in the municipality is 3.9 persons per household. Children constitute the largest proportion of the household members accounting for 39.0 percent of the total household population. Heads of households and spouses form about one quarter (26.0%) and 12.4 percent respectively of the household population. Nuclear households (head, spouse(s) and children) constitute 31.3 percent of the total number of households in the municipality. Most of the residents in the municipality are Ghanaian by birth (94.4 percent. Another 2.4% have dual nationality and a final 2.4% are from other countries. (GSS, 2010) Rates of both maternal mortality (Adogla D, 2014) and unemployment (GSS, 2009) are quite high among young women in Accra. Despite these statistics, many of the young women respondents had moved to Accra (from their communities of birth), mostly in search of work. The majority of young women between the ages of 15-25 are self-employed, followed by contributing to family work, or looking for employment. (GSS, 2010) Self-employment, primarily petty trading is not prohibited in Ghana for Ghanaians, though it is prohibited for foreign nationals. (Quarty L, 2013)
- iv. Hyderabad is a 400 year old city with a rich, royal culture and is now the capital city of a newly formed Indian state — Telangana. Hyderabad is the sixth largest urban agglomeration of India. It has a population of 4,010,238 with 2,064,359 men and 1,945,879 women as per Census 2011. As per the Census of India estimates, the urban poverty in Hyderabad is measured at 23% of total population. This is the only Indian city which figures in the top ten large cities in the world considered to be the 'Most Sustainable Cities by 2020'. The historic city established by Muhammad Quli Qutb Shah on the southern banks of the Musi River exists as the old city, while the new city encompasses the urbanised area on the northern banks. The old and new cities are connected by many bridges that cross the river, of which "Puranapul" is the oldest. Hyderabad is twinned with neighbouring Secunderabad and the cities are separated through the Hussain Sagar Lake. The southwest and west parts of Hyderabad have grown rapidly since the 1990s, and are home to information technology and bio-pharmaceutical companies.
- v. The Old City of Hyderabad has seen no development in terms of basic facilities such as sanitation, electricity, schools, and healthcare centres. Domestic Violence, religious-based conflict, socio-economic oppression, inadequate education, early marriage and restricted mobility are some of the issues facing the community in the Old City
- vi. The word "Dalit" is based in Sanskrit, meaning "broken, ground-down, downtrodden, or oppressed". Those previously known as Untouchables, Depressed Classes, and Harijans are today increasingly adopting the term "Dalit" as a name for themselves. "Dalit" refers to one's caste rather than class; it applies to members of those menial castes which have born the stigma of "untouchability" because of the extreme impurity and pollution connected with their traditional occupations." National Campaign on Dalit Human Rights at <http://www.ncdhr.org.in/dalits-untouchability/>
- vii. Inter-religious strife has often disrupted life in the decades of the 1970's-2000, triggered by small clashes but simmering as a result of political divides. While the state is ruled by a Regional Party, the Old City is a stronghold of the Majlis-e-Ittehadul Muslimeen (MIM) which has a powerful influence over the lives of the people living here. The old city remains a neglected space, steeped in feudal patriarchal values, cut off from mainstream "developmental" trends that the rest of Hyderabad has encountered. India's creation of "special economic zones" generally and here in the state of Andhra Pradesh led to the large scale displacement of village communities, thus pushing migrant workers towards urban Hyderabad and the old city area. This migration puts more pressure on the already burdened infrastructure as much as it adds to the numbers of unemployed. Many families in the old city inhabit small one room spaces. The women and girls eke out a living embellishing shellac bangles (shellac is a resin obtained from female lac bugs), making stone necklaces, incense sticks and safety pins. Malnourishment and anemia are rampant; there is no awareness of the body or any possibility to discuss sexuality, given the complete control and denial of the female body by patriarchy, religious customs and practices and poverty (leading to a lack of privacy). Official statistics for the Old City are extremely hard, if not impossible, to get. Even the Hyderabad Urban Development Authority /Hyderabad Metropolitan Development area's plans do not include the old city. The new Government has taken an

- initiative to map the socio-economic profile of the people residing in this part of the city however the results are not yet available.
- viii. Most of the young women interviewed had lived in the area from their birth, with their parents being first generation immigrants into Hyderabad. Only one woman had grown up in the village, and one had spent her growing years in a city in Maharashtra. All the parents had moved to the old city in search of work and better prospects of living in a city. They shared a similar and traditional upbringing with certain kinds of cultural and moral values being inculcated in them.
 - ix. Dalits are recognised as a scheduled caste category by the Indian Constitution and are usually marginalised at several levels.
 - x. Mehendi (or henna) application is a traditional art of painting the hands, feet or body with henna.
 - xi. All the women had arranged marriages, and got married between the ages of 14 and 18. Of the five married women, three lived with their husband and other members in extended families. Since most of the respondents were unmarried, they all lived with their parents. Of the married women, three lived with in-laws and extended family, while two of them lived with husband and children alone. In about five cases of the total 25, only the mother took care of the household, while the father deserted the family some time ago. The father was then out of the family, with no compensation or maintenance being provided to this family.
 - xii. A little over twenty years ago, South Africa emerged from an oppressive regime that forcefully segregated people by race, characterised by white rule (often violent) and massive discrimination against Black South Africans. To address inequality and discrimination created during apartheid, South Africa's Constitution (considered to be one of the progressive Constitutions in the world) was developed in an open and transparent manner. However, despite Constitutional promises and the accompanying (progressive) legislative framework, many South Africans are not able to exercise their full scope of rights. In contrast to its noble intentions, the birth of a new South Africa has not resulted in transforming the lives of the poor and among them the Black South Africans. South Africa's re-entry into the global economy after years of isolation led to rapid economic growth and development in the country's first 18 post-apartheid years. Despite its socialist origins, the African National Congress (ANC) largely embraced the neoliberal economic policy framework marked by the "liberation" of the market, privatisation of education, reduction of state social expenditure, tax breaks to corporations and the middle class, removal of market protection measures, privatisation of water and electricity etc. and the shrinking of the nation state. Like in Ghana and India, South Africa has a relatively youthful population, with about 30.0% of the population aged younger than 15 years and approximately 8.% (4.54 million) at 60 years or older. (StatsSSA, 2014) This implies that a significant proportion of its people are of working age and therefore, the dependency ratio is at a level where there are enough people of working age to support the non-working population. This population dividend is however undermined by high levels of unemployment and the effects of HIV (especially on young South African women). South Africa's HIV prevalence rate is among the highest in the world and young women aged 15-24 account for a quarter of all people newly contracting HIV in the country. (UNAIDS, 2014)
 - xiii. The young women who participated in the study came from across the city, and many migrated from rural areas. In fact, some of the young women who are mothers have left their children with family in their rural homes.
 - xiv. The city's unemployment rate was 25%, with youth unemployment at 31.5%. The working age group (15-64) constituted 72.7% of the population while the population growth rate from 2001-2011 was 3.18%. Youth unemployment and teenage pregnancy are two of the most urgent issues faced by young urban women.
 - xv. Each of these areas (except Braamfontein) are townships with a mixture of housing stock: four-room houses, built for black people during apartheid when they were moved from the city centres, houses that were built after 1994, and mortgaged houses and shacks often called informal settlements.
 - xvi. 3AQ: 'Availability' as a human rights measure refers to availability of functioning facilities in sufficient quantity. It also refers to the commitment to address underlying determinants to impact health issues. Health, as if often said, is much more than absence of illness: this has been affirmed and reaffirmed, for example in the Programme of Action of the International Conference on Population and Development and its reviews. However, social determinants of health especially with regard to sexual and reproductive health continue to receive inadequate attention. Similarly, access to sexual and reproductive health as an important aspect for the development of any country in terms of increasing equity and reducing poverty has not often been part of the discourse on health. Services which ensure the survival and well-being of young women are not only

important from the perspective of human rights, but are significant in addressing the economic, social and development challenges at large.

- xvii. The term 'accessibility' emphasises that goods and services must be accessible to everyone, with particular attention to marginalized sections of the population, without discrimination, with safe physical accessibility for all, with affordability for all and grounded in the rights to seek, receive and impart information and ideas concern health issues, without compromising on confidentiality and privacy. However, across all three cities, young women had very limited access to accurate information with regard to sexual and reproductive health, as well as health in general. The stigma attached with sexual behavior and sexual violence prevents young women from discussing them openly. As a result, myths and misconceptions abound about contraception, safer sex, sex-selection and HIV and AIDS. In all three cities, television and social media provide some information, but this is patchy and not always accurate.
- xviii. The concept of 'acceptability' suggests that the facilities, good and services must follow medical ethics and respect cultural differences across communities and groups, be attentive to gender and life-cycle differences and be designed to respect confidentiality. The line between personal self and social self is blurred, to varying degrees across all three cities. Life decisions are not necessarily based on individual aspirations or personal abilities alone, but reflect wider gender norms and discriminatory practices.
- xix. Gender-based violence, for example, is a significant barrier to bodily integrity but may or may not be part of the scope of issues addressed in sexual and reproductive health programmes and services.
- xx. Home-based workers carry out work in their own homes, or premises near the home which is not under the control of an employer or contractor and which results in a product sale or service for sale or remuneration. The home-based worker may be self-employed or may be working for an employer or contractor.
- xxi. Decent work is defined by the ILO as "productive work in which rights are protected, which generates an adequate income, with adequate social protection. It also means sufficient work, in the sense that all should have full access to income-earning opportunities. It marks the high road to economic and social development, a road in which employment, income and social protection can be achieved without compromising workers' rights and social standards." (ILO, 1999)
- xxii. This limitation is, of course, precisely what the YUW programme attempts to address. However, for the purpose of this research project, we attempt to match our question to the young women's existing aspirations.
- xxiii. Report of the Special Rapporteur on Extreme Poverty and Human Rights at the 68th session of the United Nations General Assembly.
- xxiv. Recently re-categorised by the World Bank from a low to middle-income country status, Ghana has seen explosive population growth in the past decade, increasing by 30.4% since 2000 (from 18.9 million in 2000 to 24.7 million in 2010). Somewhat notorious for its population density, Ghana has seen an increase from 79 people per square km in 2000 to 103 per square km in 2010, and with 52% of the population living in cities in 2010. The country's age structure reflects a youthful population with about 40 percent of the population under 15 years of age. In 1957 Accra had a population of approximately 190,000 (Grant & Yankson, 2003); today, the city's population is estimated to be over three million (PHC 2010). Accra occupies less than 1.4% of Ghana's land area and is home to 16% of the nation's population.
- xxv. According to the Indian Express "Of the 83 women who underwent laparoscopic tubectomies, over 50 are still in hospital. Twenty-five of them are reported to be critical. According to the central government's guidelines, a medical team cannot conduct more than 30 laparoscopic tubectomies in a day, with three separate laparoscopes — that means not more than 10 tubectomies with a single instrument, as each instrument needs to be properly sterilised after every operation." See (Bhardwaj A, 2014)
- xxvi. The Swarna Jayanti Shahari Rozgar Yojana (SJSRY), in operation across the country since 1997, was revamped in 2009 to provide self-employment and wage employment to the urban poor through skill development training through Urban Local Bodies (ULBs) and community structures.
- xxvii. A central government scheme launched in 1972-3 under the Ministry of Women and Child Development, the purpose is to promote availability of safe and conveniently located accommodation for working women, with day care facility for their children.
- xxviii. STEP is a central government scheme launched in 1986-87 that aims to provide an integrated package of services to women enabling them to become economically independent and to improve their socio-economic status by upgrading skills for self and wage employment. It seeks to support women's work by providing a range of inputs and services like facilitating organization of women, upgrading of skills through training,

- marketing and credit linkages to ensure sustainable employment, Legal literacy and Health check-ups, referral services, mobile crèches, elementary education, and gender sensitization
- xxix. Source:<http://www.telangana.gov.in/government-initiatives/shaadi-mubarak>)
- xxx. Started in October 2, 2014 these programmes are designed for unmarried girls, who have completed 18 years of age at the time of marriage and whose parental income does not exceed Rs. 2 lakh per annum. Under this scheme, the Government will offer a one-time financial assistance of Rs. 51,000 at the time of marriage for brides who are residents of Telangana State. The scheme is just gaining popularity.
- xxxi. Launched in January 2015, Arogya Lakshmi is a programme to provide one nutritious meal every day to pregnant lactating women and children below the age of six through Aanganwadi centres.
- xxxii. A whopping 87.57 lakh eligible families, approximately 2,86,00,000 (two crore eighty six lakh) beneficiaries, are being supplied rice from 1st January, 2015
- xxxiii. The programme is designed to help take care of girls, by providing financial benefits to girls for their health and education. (<http://www.bangarutalli.ap.gov.in/home.jsp>).
- xxxiv. Each team has a small camera to record the movements of suspects. The police team in civilian clothes mingle with the general public, to keep an eye on the suspects. This measure was aimed at dealing with all cases of harassment of women including physical and mental abuse.
- xxxv. Initiated in 1975 to provide supplementary feeding to bridge the nutritional gaps that exist with respect to children below 6 years and expectant and nursing mothers. Another important element in achieving the objectives of ICDS is introduction of Anganwadi centre. An Anganwadi is a centre for convergence of services for children and women.
- xxxvi. Implemented since 2000 to empower adolescent girls and enable their growth and development in a manner that can help them take charge of their lives. KSY is a redesign of the already existing Adolescent Girls Scheme being implemented since 1992 using ICDS infrastructure.
- xxxvii. Initiated by the Government of India under the under Ministry of Women and Child Development as a centrally sponsored program in 2011. The major objectives of the program are as follows: enable the adolescent girls for self-development and empowerment, improve their nutrition and health status, promote awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and child care, upgrade home-based skills, life skills and integrate with the National Skill Development Program (NSDP) for vocational skills, mainstream out of school adolescent girls into formal/non formal education and provide information and guidance about existing public services such as PHC, CHC, Post Office, Bank and Police Station (<http://wdcw.ap.nic.in>, 2014).
- xxxviii. The scheme seeks to provide day care facilities to children in the age group 0-6 years from families with a monthly income of less than Rs. 12,000/-. In addition to being a safe space for the children, the crèche provides services like supplementary nutrition, immunisation, pre-school education, emergency health care etc. for running a crèche for 25 infants for eight hour.
- xxxix. Pradhan Mantri Jan-DhanYojana (PMJDY) is National Mission for Financial Inclusion to ensure access to financial services, namely, Banking/ Savings & Deposit Accounts, Remittance, Credit, Insurance, Pension in an affordable manner. Account can be opened in any bank branch or Business Correspondent (Bank Mitr) outlet. PMJDY accounts are being opened with Zero balance. However, if the account-holder wishes to get a cheque book, he/she will have to fulfil minimum balance criteria.
- xl. A special small deposit savings scheme for a girl child. The main objective behind the launch of this scheme was to secure financial future of the girl.
- xli. The Constitution of South Africa
- xlii. Global Employment Trends 2014: Risk of a jobless recovery? The International Labour Organization, Geneva, 2014.
- xliii. Among the prerequisites to termination of pregnancy is the requirement that information must be provided with regard to alternatives that are available to the woman with regard to the unwanted pregnancy. The alternatives include foster parenting, adoption and maintenance.
- xliv. A recent report on health and informality in South Africa found “a multiplicity of ‘atypical’ employment arrangements. For example, informal wage workers may be found working for informal enterprises in unconventional and unprotected places of work such as roadsides, informal marketplaces, and landfills, or they

may be working under formal labour regulations (such as domestic workers), but in 'atypical' places of work such as private residences which are difficult to regulate and monitor, or they may work in formal workplaces, but under an informal arrangement that does not provide labour protections. It is this last category of informal workers that forms a "large and growing percentage" of informal wage employment in South Africa." (Alfers L R. M., 2014)

- xlv. Thirteen percent of the interviewees in Ghana relied on traditional herbs for their abortions.
- xlvi. The women shared that they did however need permission from the head of the household to leave the house.
- xlvii. Eve teasing is a euphemism for public sexual harassment or molestation (often known as street harassment) of women by men. The fact of its relatively innocuous 're-naming' in India raises questions about how such a grave violation is toned down in this euphemistic way, leading to the normalisation of violence.
- xlviii. While these women did not claim direct impact, they all knew of incidents that had happened to friends.
- xlix. The main sources of fuel for cooking in most households in the municipality are gas (46.7%) and charcoal (44.0%). The main source of drinking water is "sachet" water and this is used by 63.2% of the households. A much smaller number has access to "pipe-borne" water outside their dwelling (10.5%) or inside (8.6%).
- I. <http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividend-or-a-demographic-bomb-in-developing-countries>
- ii. One major difference among the young women across the three cities is their families' access to resources—particularly in terms of their education, the availability of public (or essential) services (free or low-cost education, piped water, electricity, etc.) as well as social protection benefits (childcare support, creches, health insurance, etc.). Johannesburg's public services and social protection are far more generous than Accra's or Hyderabad's provisions; however, the marginalisation of communities in each of the locations may also impact their burdens of work. In terms of the employment structure—in Accra, the large number of women are self-employed as traders; in Hyderabad they earn from small craft businesses and home based work; and in Johannesburg, a large number of 15-19 year olds are finishing secondary school—and this implies different working conditions and levels of income as well as capacities to negotiate economic security. One major difference among the young women across the three cities is their families' access to resources—particularly in terms of their education, the availability of public (or essential) services (free or low-cost education, piped water, electricity, etc.) as well as social protection benefits (childcare support, creches, health insurance, etc.). Johannesburg's public services and social protection are far more generous than Accra's or Hyderabad's provisions; however, the marginalisation of communities in each of the locations may also impact their burdens of work.
- iii. All of the young women work hard and live in extremely cramped conditions, and face significant general health problems—which are related to overwork; cramped living conditions and lack of privacy; and lack of sleep, due to the double burden of paid and unpaid work.
- iiii. The education of women and girls is widely recognised as a powerful tool to enhance bodily integrity and economic security while empowering them within the family and society. It is a key pathway to employment and earnings on the one hand, and health on the other. Within this strategy, comprehensive sexuality education is essential by which to shift norms and attitudes, and empower young women to negotiate safe, consensual and enjoyable sex. Educated women are more likely to marry later, use modern contraception and access health care. They are also more apt to demand their rights. In addition to formal education, young women also would benefit from more skill building opportunities and exposure to the lives of women like them who have broken these barriers. Each of the countries that participated in the study (Ghana, India, South Africa) have a number of skills and employment programmes for young people, but the young women who participated in the study have little to no information about them. They would benefit from attention by local and national organizations, especially youth organizations, to advocate and liaise with municipal officials responsible for such programmes (such as LEAP in Ghana; the new youth employment policies in South Africa; and employment programming for girls in India) to enroll the young women, such as those who participate in the Young Urban Women project into existing programmes that could support their economic security. Exchange visits and use of information and communication materials that showcases stories of women change makers would go a long way in enhancing a sense of empowerment.
- iv. See "Sustainable Development Goals," more recently coined the "Global Goals" and sometimes referred to as the "Post-2015 goals" were agreed by the Un General Assembly in September 2015. The document that contains the goals and the vision that animates them is "Transforming our world: the 2030 Agenda for Sustainable Development" accessible at <https://sustainabledevelopment.un.org/post2015/transformingourworld>



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