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Women's access to reproductive rights & reproductive health services

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Abstract
Despite all the progress, India is still a male dominated country, where women are seen as subordinate and inferior to men. Discrimination is highly visible throughout all strata of society and women face discrimination throughout all stages of their life.
The study has been conducted to find out whether the access of women of low socio-economic group to reproductive rights and choices is free from discrimination and violence or not. Samples have been selected through purposive sampling and 100 women of reproductive age (18 – 40 years) were selected from 5 slums of Kolkata.
The findings demonstrated that respondents are not aware of their reproductive rights. Although they know about family planning but are not in a position to make decisions about their reproductive choices – spacing and timing of child bearing. In most of these families, abortion is not accepted even if the women are willing to abort it. In laws and husband are the decision makers and controllers of women's reproductive activities.
Information on sexual and reproductive health is not reaching out to the respondents through government health care services. Training on Life Skill and Counselling services are not available in most of the slums under Kolkata Municipal Corporation.

Keywords: Status of women in family, socio-economic background, reproductive rights, reproductive health care, discrimination and violence

1. Introduction
Today India offers a lot of opportunities to women in everyday life, in the business world as well as in political life. Nevertheless, India is still a male dominated society, where women are often seen as subordinate and inferior to men. Even though India is moving away from the male dominated culture, discrimination is still highly visible throughout all strata of society.
The Indian constitution grants women equal rights to men, but strong patriarchal traditions persist in many different societal parts where women's lives are shaped by customs that are centuries old. In certain parts of Indian society, women are conditioned from birth to be subservient not only to their future husbands, but also to the females in their husband's family especially, their mother-in-law.
Accordingly, the surrounding society mandates a woman's obedience to her husband and her in-laws. Any disobedience would bring disgrace to both, the wife herself and her originating family, and might lead to the woman being neglected by her own family.
Women are much more vulnerable biologically, culturally and socio-economically. Lack of power and autonomy is the root cause of women's vulnerability. But they are also disadvantaged by other forms of impoverishment in areas such as literacy, skills, employment opportunities, mobility, political representation and pressures on their available time and energy linked to roles and responsibilities. These factors diminish their human development capacity.
Women could not access her right to safe sexuality and autonomy in all decisions relating to sexuality and reproduction. The scope of human rights including reproductive rights are fully extended to economic security as male controls over women's lives in the context of poverty. Women couldn't discuss or make decisions about sexuality due to financial and material dependence on men.

Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce. Major components of Reproductive Health are:

- Well-informed, accessible, affordable, effective and acceptable family planning services
- Right to appropriate health care enabling women to safely go through pregnancy and child birth

Reproductive rights include the right to legal abortion, the right to control reproductive function, the right to access quality reproductive health care, right to access information on reproductive health to make reproductive choices free from coercion, discrimination and violence.

Women belonging to low socio-economic group are not in a position to discuss or make decisions about sexuality. They cannot request for any form of protection or use of any family planning method. If they refuse, they may face any form of abuse. This leads to poor reproductive and sexual health, neglect of health needs and medical care, serious morbidity and mortality.

In this paper, women's access to basic health care services, family planning services, treatment for infertility, safe abortion services, information regarding reproductive health and gender equity has been assessed to understand the extent of reproductive rights of women belonging to low socio-economic group.

2. Review of Literature

Stephenson *et al*. (2002) [2] undertaken a study on the determinants of the use of four types of reproductive health care services (Contraceptive services, antenatal care, delivery in a medical institution and services dealing with reproductive tract and sexually transmitted infections) in Uttar Pradesh, India. The findings revealed that the role of some individual and household factors in determining a person's use of services is mediated by the characteristics of the community in which the individual lives.

The study by Chapagain (2006) [1] revealed that husband's domination directly influences wife's use of contraceptives, choose their types, terminate their application and making decision about seeking antenatal service. Gender difference in reproductive health decision-making strongly attributed to unequal gender power relations, traditional gender roles and the financial cost associated with such a service.

Wilkinson, Stephen, E. and Callister, L. C. (2010) [4] found that cultural perceptions, beliefs, expectations, fears and cultural practices influence the childbirth by Ghanaian women. Patterns of thought and behaviours were analysed describing their perception of childbirth as a dangerous passage and fearing the influence of witchcraft on birth outcomes. The study recommended re-designing of reproductive health care interventions to improve the well-being of childbearing women.

Bamiwuye (2015) in his paper presented the interaction effect of poverty – wealth status and autonomy on use of modern contraceptive in Nigeria and Namibia. He found that women with less autonomy are less likely to use modern contraceptives than other women. Modern contraception is nearly 15 times higher among rich women with more autonomy than poor and less autonomous women. This study recommended that more concerted efforts are needed in addressing poverty and improving the autonomous status of women in sub-Sahara Africa.

3. Research Objective

To find out whether women belonging to low socio-economic group are aware of their reproductive rights and whether their access to quality reproductive health care is free from discrimination and violence.

4. Methodology

4.1 Hypothesis

1. Women belonging to low socio – economic group are not aware of their reproductive rights
2. Violence and discrimination hinder women's access to quality reproductive health care services
3. There is an influence of status of women in family and society on their extent of enjoyment of reproductive rights

4.2 Definitions of Variables

4.2.1 Socio-economic status

It refers to an economic and sociological combined total measure of an individual and a family's economic and social position in relation to income, education and occupation. Socio – economic status can be broken into three levels (high, middle and low) to describe the three places a family or an individual may fall into. To place a family or individual into one of these categories, income, education and occupation can be assessed.

4.2.2 Reproductive Rights

Reproductive rights are defined as the rights relating to reproduction and reproductive health. Reproductive rights are often held to include the right to legal abortion, the right to control reproductive function, the right to access quality reproductive health care, and the right to education and access in order to make reproductive choices free from coercion, discrimination and violence.

4.2.3 Reproductive Health Care:

It has been interpreted that married couples should be informed of and have access to safe, effective, affordable and acceptable methods of family planning; also access to appropriate medicines for sexual and reproductive health problems. It also includes Reproductive Health education programs for safety of women during pregnancy and child birth.

4.2.4 Discrimination

It has been defined as the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or gender. This also refers to treating someone as inferior based on their race, sex, national origin, age or other characteristics.

4.2.5 Violence

It has been conceptualised and defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation

4.3 Tools

4.3.1 The Sexual and Reproductive Health Rights Assessment Framework

The Framework was developed by World Population Foundation, Pakistan to assess the status of sexual and

reproductive health and reproductive rights of young people. It comprises of 11 thematic areas. In this study, the Framework was used partially (Out of 11, 7 thematic areas were chosen) to assess the status of reproductive rights of women living is slums of Kolkata.

4.4 Sample
Hundred women were selected through purposive sampling. Age-range of the participants is 18 – 40 years (Reproductive Age). They belong to low socioeconomic status families and they are the residents of 5 slums in Municipal Wards under Kolkata Municipal Corporation.

4.5 Procedure
Data collection was done by personally meeting the respondents in 5 slums of Kolkata and administering the tool. The information obtained through The Sexual and Reproductive Health Rights Assessment Framework were tabulated and analysed.

5. Results and Discussion
5.1 Personal Profile of the Respondents: The personal profile of the 100 women of reproductive age as respondents has been given in Table 1.

Table 1: Personal Profile of the Respondents (N = 100)

Category	Variable	Percentage (%)
Age	18 – 20 years	15
	21 – 25 years	34
	26 – 30 years	31
	31 – 35 years	12
	36 – 40 years	08
Education	Illiterate	24
	Below Class X	52
	Madhyamik	14
	Higher Secondary	09
	Graduation	01
Religion	Hindu	52
	Muslim	49
Marital Status	Married	98
	Separated	01
	Widow	01
Occupation	House Wife	88
	Service	12
Monthly Household Income (In Rupees)	< 10,000	96
	10,001 – 25,000	04

Most of the respondents (34%) are aged between 21 - 25 years, 31% respondents are in the age group of 26 - 30 years, 15% respondents belong to the age group of 18 - 20 years, 12% respondents are in the age group of 31 – 35 years and only 08% respondents belong to the age group of 36 - 40 years.

Out of total 100 respondents, 76% is literate and 24% is illiterate. Although the literacy rate is high, majority of the respondents (52%) are not having very good standard of education. They have completed education till primary level. Only 14% have studied till secondary level; 9% studied till higher secondary level.

The respondents belong to low socio-economic group. Their household income is not sufficient to run their family with an average family size of 5. The average monthly income ranges from Rs.5000.00 to Rs.8000.00 and only 4% have monthly income more than Rs. 10,000.00.

The findings reveal that majority of the respondents are married (98%) and economically dependent (88% Housewife) with very low level of education.

Information gathered from the field survey were analysed and presented below:

Table 2: Awareness and Access to Reproductive Health Services (N=100)

Thematic Areas	Level of Awareness (%)	Access to Services (%)
Basic Health Services	88	82
Family Planning Services	66	56
Treatment for Infertility	23	11
Safe Abortion Services	39	20
Access to Information and Counselling	14	14

Responses of the participants indicate that more than 80% respondents are aware about the availability of basic health care services and they can easily access these services. The results also indicate that the community acceptance of quacks is limited.

More than 60% respondents are aware about the availability of family planning services. Although the community acceptance of family planning services is favourable, but only 56% respondents are accessing the services.

Results also show that the community acceptance for safe abortion services is low. But they only accept abortion when it has to be done for saving the life of a married women.

Responses of the participants show a very low score for access to information on issues of reproductive health and the quality of Life Skill Education and Counselling services. In most of the areas, these services are not available.

Table 3: Quality of Reproductive Health Services (N=100)

Scores	Family Planning Services	Abortion Services	Counselling/Information dissemination
Excellent	00	00	00
Good	38	13	02
Neither Good nor Poor	05	01	04
Poor	12	00	07
Very Poor	00	00	00
Don't Know	45	86	02
Service is not available	00	00	86

Findings reveal that 55% respondents are accessing Family Planning Services, out of which 38% are satisfied with the quality of the services. 45% are not aware of these services and hence, they became non-users.

86% of the respondents are not aware of safe abortion services. Only 14% has accessed abortion services which according to them was safe. Most of the families believe in traditional practices and they do not want to change these practices. Women could not get the opportunity to express themselves, especially their opinion regarding reproduction.

Government services are also not reaching out to the community. Health workers didn't make field visit / home visit to provide services, i.e. family planning services, life skill education, counselling services etc.

6. Conclusion

The study was initiated with the aim to analyse whether women belonging to low socio-economic group are aware of their reproductive rights or not and whether their access to reproductive health services are free from discrimination and violence or not. The findings illustrate limited realization of reproductive rights of women.

The closer look at the analysis reveals that

- Respondents are aware of different means of family planning and its availability. But 45% of them are non-users. Rest of the respondents are not satisfied with the quality.
- Acceptance of safe abortion service is very low in the family and community which is directly influencing women's reproductive decisions and affecting their reproductive health
- Awareness among women regarding the treatment for infertility is very low
- Women are having very limited access to information regarding sexual and reproductive health

Women get very limited opportunity to move freely. So, they are not in a position to be aware of reproductive health and the availability of the services. Government or private departments are not providing services for dissemination of information on reproductive and sexual health. Therefore, they are beyond the realization of their reproductive rights, like – to have the information and means to decide freely the number, spacing and timing of their children.

But these women must be empowered so that they are able to control their own lives and in particular their sexual relations. This implies a profound shift in social and economic power relations between men and women. It cannot be achieved tomorrow but action must start today through increased educational and employment opportunities for girls and women and public education campaigns on the effects of unequal gender relations.

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