Chapter 4

4.1 Conclusion

The preceding chapters have etched out the dynamics of reproductive rights *vis a vis* the constraints to achieve these rights. The case studies are a glimpse of the lived experiences of the women about their reproductive health rights. The case studies gave a firsthand experience of the women's marriages, bodies and reproduction. They suffered and endured alone, as reproduction is a women's business as believed by the society and upheld by the state through its policies. The experiences of the woman's reproductive health problems are strategically ignored by the policies which deal with women's reproductive health.

The study began with the following three research questions

1. Are the reproductive health rights upheld among the currently married women?
2. Is the National Health Mission successful in improving the reproductive health of the women?
3. Are the existing health services pro women?

For the first question opinion gathered from the participants, revealed that majority of women got married as a child bride. The sense of right is vague for a child for whom marriage is supposed to bring good things in life. They hardly get time to understand the situation as immediate motherhood follows. All the women participant in the study said that the planning of a child depends on the husband. Though it is a joint decision, final decision is taken by the husband. In the Indian socio-cultural context, women do not make isolated individual decisions about their fertility. The relationship a woman shared with her husband plays an important role in negotiating fertility. If there is any unwanted pregnancy, with due permission the woman has to do away with it. The

women who have gone through the abortions, some of them have tried to abort it by taking medicines available in the local chemist shop, if it did not work out they have gone to private or government hospital for abortions. However majority of them went to the private practitioner for the abortions. Abortion is a politically controversial subject though India is having an Act legitimizing it on certain grounds and women can avail it. The women who have taken help of private practitioners are not aware of their degrees. These practitioners are known as doctor and nurse. Thus one can say that the women participated during the study have not been able to assert their reproductive rights due to various constraints.

The second question regarding the reproductive health and rights were that whether the NHM is successful in improving the health status of the women. Throughout the study it was found that women know about the schemes but not in detail offered by NHM. The services which were offered have certain conditions which are to be fulfilled to receive the services. Therefore, many of the women did not receive the money under the schemes. NHM has been successful in providing antenatal and postnatal care to women; however it is not universal among the participants. Institutionalized child birth was found among the participants which again is a positive indication in attainment of reproductive health. However, none of the participants received any information on the side effects as well as positive aspects of the contraceptives. In fact they were motivated to go for sterilization soon after the second child. The role of the man still distant and aloof in the NHM services concerning reproductive health of the woman. Population control and targeting of the woman's body is still present in the NHM approach.

The third question in the study was to find out whether the health services are pro women. Though the RCH policy talks about community based and need based services, the participants shared that it never happened like a need based programme. The ASHA workers only targeted the expectant mothers in those blocks where they visited regularly. In one of the block the participants never got any visit from the ASHA worker, in fact their health center was not functioning too. None of the women have received any counseling from either the doctor or any other health personnel. The existing health care is pro women when it comes to motherhood and childbirth, where they have provided the prenatal and postnatal care along with institutionalized child birth. This service is extremely important to reduce MMR and IMR in the state.

One of the major findings of the present study is prevalence of child marriage. The presence of child marriage can be seen in both the religious group i.e. Hindu and Islam. Though there is an act to curb the evil practice of child marriage in the country, it is still prevalent in Assam. Assam has a history of various women's organization working for the issues concerning opium use, child marriage, widow remarriage and importance of education since colonial period. The various *Mahila Samities*[5] like *Dibruargh Mahila Samity, Nowgong Mahila Samity and Tezpur Mahila Samity* worked for the development of Assamese women since pre- independence. However, it is ironical that the presence of child marriage is still present in Assam. Reproductive rights will never be achieved if child marriage cannot be addressed as soon as possible in government policies concerning women's health. Besides this, during the study it was observed that the participants shared their multiple identities and vulnerabilities. Being a married woman with children showed a vulnerable position of the woman. Irrespective of

[5] Women's Organizations.

education and employment women participants showed a vulnerable position of not knowing beyond their matrimonial identity. They are afraid of taking any kind of decision concerning their reproductive health without the approval of their spouse and in-laws. The support they received from their natal family was only up to their pregnancy and child birth. The presence of the vulnerability is different among the women in minority community. This vulnerability has hampered the reproductive rights of the participants. The presence of violence both physical as well as emotional violence could be seen among the participants. These vulnerabilities are deepened by the societal norms, their lack of support system, and government's lack of services to the deserted women and the discriminating attitude of the health personnel etc. however, this does not mean that all the participants are having the same experiences though they belong to the same group. The laired identities of women and their vulnerability can be linked to the theory of intersectionality which was discussed in the first chapter. Intersectionality talks about structures of power and exclusion. This can be seen among the participants in terms of their decision making process as well as their access to reproductive health care due to various exclusions present in the family.

Women's every days experiences are the basic premise of standpoint theory and it could be linked to this study as well, where the case studies have given a glimpse of experiences women go through concerning their reproductive rights. Though the study was carried out among the women belonging to lower socio economic group the experiences shared by the women were varied from each other. Therefore, there is a need to look into reproductive rights from these perspectives so that it can be asserted by the women who are burdened with laired identities.

On the basis of the findings and analysis the following recommendations are suggested for attainment of reproductive rights of the women-

4.2 Recommendations

1. As women are getting married as a child or adolescents, it is important that they understand the importance of health and teenage pregnancy which is dangerous to their health. The government needs to create awareness on child marriage through school curriculum, so that children and adolescents become aware of it. There is an urgent need to implementation of The Prohibition of Child Marriage Act, 2006.
2. The school curriculum needs to create awareness on child's rights so that children are aware of their rights. Unless the children are aware of their rights there will be violation of their rights and child marriage will continue to take place.
3. There is a need to give preliminary sex as well as health education at the school level through which children become aware of sexual and reproductive health needs.
4. During the study it was found and observed that women do not have proper access to information. None of the women received any information as how their reproductive organs work, what are the side effects of contraceptives, pros and cons of repeated abortions, their rights over their bodies. Therefore, the RCH programme should have trained personnel to impart all these information to the women so that they can take an informed decision regarding their reproductive health.

5. The study revealed that NHM and RCH care services are not providing any services relating to the counseling of the couple regarding reproductive health, contraceptives, RTIs/STDs/HIV/AIDS. Counseling couples is one of the best ways for the programmes to be successful.
6. There is a need to proper implementation of the programmes at the grass root level. The ASHA workers are only fulfilling the targeted number as their service is incentive based. In that process they are not disseminating the information to the targeted population.
7. The government RCH programme has tried its best to address the reproductive health of the expectant mothers. However, there is a need to create awareness among the men to be understanding towards the reproductive health needs and rights of women. Therefore, the government needs to come up with sensitization programme targeting men both married and single.
8. The RCH programme is a community based programme, however to be successful they have to the take the community into confidence and offer services according to the needs of the community.
9. Another shortcoming in RCH programme is that it is still not taking the woman as a client who can decide for herself. As the study reveals they are offering sterilization to women who have two or more children and those who are with one child are offered with oral contraceptives and IUD. There is no information on the side effects of these contraceptives and follow ups.
10. Gender sensitization programmes are needed for health personnel as well. The health personnel are part of the very patriarchal society. There is a lack of

understanding towards women and their rights. Therefore, right based gender sensitization programme is a must for the health personnel.

11. Reproductive rights are human rights. Therefore, there should be a mechanism to address the issue if there is any violation of these rights.
12. Invisibility principle in terms of Reproductive rights can be seen in the discourse and very few organizations are addressing it. There are no learning materials on the reproductive rights developed by the NGOs working at the grass root level in Assam. Therefore, there is a need to develop materials in lingua franca of each state to impart knowledge on reproductive rights.
13. The Women's Studies Departments and Gender Studies should address the reproductive rights through seminars, research and learning materials. They can collaborate with grass root level organizations so that right based approach to reproductive health goes to the people who are actually lacking it.