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To Study Reproductive Health Rights Affected by Socio-Cultural Factors in Tarikhet Block Dsitrict Almora, Uttarakhand

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Abstract

Status of women health is affected by multifaceted social, biological and cultural factors. These are interrelated and only be addressed in a comprehensive way. Quality and availability of health is determined not only by reproductive health and care, but also by levels of socio-economic development, women's position in society and the lifestyle. Health of women is compromised not only by the lack of medical knowledge, but also by breach in women's human rights including the reproductive health rights. Poor women, lacking basic health care, adequate food, or advanced contraception, suffer severe magnitudes for reproductive health. Woman who is undernourished and is in poor health runs greater risks in reproductive health issues and usually suffers without proper treatment and dies in most of cases.

Introduction

Women health is compromised not by lack of medical knowledge, but by infringement on women's human rights including reproductive health rights. Poor women, who lack adequate food, basic health care, or modern contraception, suffer grave consequences for reproductive health (Abbasi-Shavazi, 2000). A woman who is malnourished and in poor health runs much greater risks in reproductive health issues and usually suffers without proper treatment and dies in most of cases (Agha, 2002). The right-based advancement to reproductive health is particularly influential and meaningful because all human rights, comprising reproductive rights, are universal, undeniable, indivisible, and inter-reliant (Schensul, 2007). The modern human rights system is based on a series of legitimate international treaties that draw on principles of ethics and social justice, many of which are in directly relevant to reproductive health care. By placing reproductive health in a broader context, a right- based approach can provide tools to analyze the root causes of health problems and inequities service delivery (Freedman, 2001). The notion of reproductive health rights is embedded in the modern human rights system fashioned under the auspices of the United Nations. Since 1945, the United Nations has developed internationally accepted standards for a series of human rights, including the right to health, and has shaped means to promote and protect those rights (Bates, 2004). The women's empowerment movements captured attention to human rights exploitations based on women's poor socio-economic status in society and put pressure governments to change the state of affairs of women's lives (Becker, 2006).

Reproductive fitness and a healthy sexual union and relationship are vital in marriage and in bonding a family collectively. Unluckily, sexually transmitted diseases, comprising HIV/AIDS, are a progressively more common risk to a healthy marital relation. Extramarital relationships of husband multiply the threat of disease that not only may contaminate him but also he may bring disease home that could also take life of his wife (Bessinger, 2004). Probably men are twofold as women to

infect their partners (Joint United Nations Program on HIV/AIDS, 2000; Population Center, 2005). Young females who are forced into sexual union by their husbands may have limited options to save themselves against transmittable diseases, may also find it difficult to leave an obnoxious association and may not have resource to get lawful protection (Chibalonza, 2004). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the ability to reproduce and the freedom to decide if, when and how often do so. Implicit in this last condition are the right of man and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples which the best chance of having a healthy infant (Goodstein, 1995). It promotes the findings of linked studies and reduces the chances of redundant repetition of research work. Some of the related reviews are presented under the subsequent research indicators. Educated women and women with career and employment options may be less abused because they are supposed as extra precious and dear by their husbands, and possibly by the extended family (Abhimanyu, 2011). They also may have more command to leave a bond if their husband became rude and violent (Pettifor *et al*., 2005). The international reproductive health community has acknowledged the importance of addressing gender disparities in reproductive health decision making as fundamental of improving the reproductive health and rights of both women and men. Gender-based power inequalities can contribute to poor reproductive health outcomes especially among women because gender inequality is a key element of the social context in reproductive decision-making (Thinker, 1997). Women's sacrifice of their own wishes for their partner's desires is a result of nonconsensual sexual activity within marriage (a form of gender-based power inequality), is common in all societies (Guntupali, 2003). Women with more schooling may be more comfortable in interacting with medical personnel, may have better access to RH-facilities and above all may have better negotiation power than women who have little education. In addition, better-educated women may be more likely than others to earn incomes, and thus may have greater economic resources that could improve their access to health facilities (Weiss *et al*., 2000). Household economic resources also may affect access to modern RH-Services and methods, and regional areas dramatically unequally distribute them. Similarly, community conditions may influence the availability of modern contraceptives and the perceptions of potential users (Burgard, 2004). Most of the women are contributing in household income but remained unrecognized economically and socially, and have poor knowledge regarding their reproductive health rights especially over the issue of family planning and common sexually transmitted diseases. Sustained improvement in RHR in Uttarakhand can only be achieved by introducing systems which ensure women their right to access care that is convenient, affordable and effective and through social mobilization for creating optimal awareness and behavior change. In past, efforts to promote family planning in Uttarakhand have been disappointing

Research Objectives:

1. To study the demographic characteristics of the respondents having reproductive health right.
2. To study the respondent's access to and use of its reproductive health rights.

Materials and Method

Materials and methods seta path to researcher and guide them how to complete the process of collection, analyzing and interpretation of data. Research design is the "blueprint" which enables researcher to come up with the clarifications to the problems that come across during the research. It provides the study design, selection criteria of sample, sampling procedures, sample size, selection and training of interviewers and different statistical techniques used for data analysis.

Area of the Study:

Tarikhet is small, yet popular hill station located at distance of 8 km from the town of Ranikhet. This village is a famous as a significant site during the India's struggle for independence. Its most popular attraction is the 'Gandhi Kutiya', which is said to be the place where Mahatma Gandhi stayed for a long time during the freedom struggle. Tarikhet block of district Almora in Uttaranchal. GEF Thematic Area: Climate Beneficiaries: 258 households in 5 villages (Khudoli, Thapla, Mori, Doba & Pali).

Table1: Selection of sample from selected localities according to their population

	Population		Village	Selected respondents per village
Total Population	**68563**		**Tarikhet**	**25**
Total Households = 258	**Male**	**Female**	**Thapla**	**10**
	32247	**36316**	**Pali**	**15**

Research Design:

A cross-sectional study was conducted with 50 married women having at least one child to investigate the socio-cultural determinants of reproductive health rights in three village selected Block Tarikhet District Almora respondents were selected. From each village respondents were selected proportionally for the given population size (Population Census 2011); urban and rural areas married women of age 20 – 45 years having at least one child was interviewed. A representative sample of 50 married women was interviewed as discussed. A well designed interviewing schedule was constructed in the light of research objectives and the conceptual framework of the study to collect data and draw inferences.

Data Collection:

A cross sectional survey was conducted for getting data. Using "survey" methods collected the data researcher formed a team of female interviewers for the collection of data from the female respondents headed by the researcher. Before collection of data the team members were trained in gathering information. For the data collection, a well-structured interviewing schedule consisting of open ended and closed ended questions was prepared in the light of research objectives.

Results and Discussion

The data obtained from 50 women in the reproductive health rights age group of 20-45 years was analyzed. Therefore, simple percentage method is used in analyzing the status of respondents .The analysis is based on interviews with 50 eligible women which consists of 37 Hindus, 13 Muslims aged between 20-45 years.

Various Socio Cultural Factors Affecting Reproductive Health:

Information relating to the various socio-cultural factors affecting reproductive health rights of the respondents: - Socio-cultural factors of the respondents having reproductive health right are presented here. The general objective of this study was to analyze the socio-cultural determinants of the respondents and to delineate the women's reproductive health rights in Tarikhet block in Almora district. In this chapter an attempt has been made to discuss, analyze and interpret relevant data for deriving conclusions and formulating appropriate suggestions in the light of the study results

Table2. Area wise distributions of the respondents having reproductive health rights

Area	Frequency	centage
Urban	33	66
Rural	17	34
Total	50	100

The data shown in table reflect that both urban and rural areas, without any discrimination and proportion of population size, were equally represented in this study. Though it was not a comparative study but by doing this it would be possible to make any comparison on any dimension of right reproductive health right, if necessary.

Table3: Religion wise distribution of the respondents having reproductive health rights

Religion	Frequency	Percentage
Hindu	37	66
Muslim	13	34
Total	50	100

The above table shows that only two types of religion structure are found Hindu and Muslim religions. Maximum members 37(66%) are Hindus and smaller number 13(34%) belong to Muslim religion. Thus the majority of respondent are of Hindu religion.

Table4: Caste wise distribution of the respondents having reproductive health rights

Cast	Frequency	Percentage
General	33	66
Other backward	04	8
SC/ST	13	26

Total	50	100

The above table shows that out of 50 respondent 33 belong to general caste, 4 belong to other backward caste and 13 belong to SC/ST caste .Thus looking at the majority general occupies the maximum number i.e.33(66%) whereas SC/ST is in second major position i.e.13(26%).

Table5: Age wise distribution of the respondents having reproductive health rights

Age groups in years	Frequency	Percentage
20-30	15	30
31-35	13	26
36-40	13	26
41-45	09	18
Total	50	100

The information presented in table reveal that 30 % of the respondents fall in the age category of 20 – 30 years where as 26% of the respondent fall in the category of the age group 31 – 35 years and 36 – 40 years. Finally 18% of the respondents fall in the category of the age groups- 41-45 years.

Table6: Marriageable age wise distribution of the respondents having reproductive health rights

Age Group in Years	Frequency	Percentage
15-19	08	16
20-24	18	36
25-29	20	40
30-Above	04	8
Total	50	100

The above table shows that the maximum number of respondents was married in the age group 25-29 years whereas minimum number of respondents was married in the age group 30-above. It can be inferred from the presented information that a clear majority of the respondents were married in their adulthood.

Table7: Husband's education wise distribution of the respondents having reproductive health rights

Educational Level	Frequency	Percentage
Illiterate	15	30
Primary	09	18
Middle/ Metric	12	24
Intermediate	11	22
Graduate	02	4
Post-gradate	01	2
Total	50	100

The information presented in table clearly reflect that 30% of the respondents' husbands were illiterate and never gone to school while 18% were those who received only 1-5 years of schooling. It is also evident from the table that only 18 %& 24 % of the respondents' husbands got up to primary and middle level of education respectively. The table further shows that more than one third (22%) of the respondents' husbands received college level education (intermediate, graduate, & postgraduate level). It can be inferred from the presented information that educational facilities are not only accessible but also affordable to a common man and Govt. of Uttarakhand is making serious effort to increase the literacy rate in Uttarakhand and to achieve the Millennium Development Goals.

Table8: Husband's occupation wise distribution of the respondents having reproductive health rights

Type of Profession	Frequency	Percentage
Govt. Employees	12	24
Private Job	15	30
Un-Employed	08	16
Businessmen	13	26
Other works	02	4

Total	50	100

The table shows that out of 50 respondent 12 i.e. 24% are govt. employs, 15i.e.30% are private jobs, 8 i.e.16% are un-employed while 13i.e. 26 % are businessmen and 2i.e. 4% are others works. The largest numbers of respondent's husband are engaged in private jobs.

Table9: Income wise distributions of the respondents having reproductive health rights

Monthly Income in Rupees	Frequency	Percentage
Don't Know	13	26
1,000 - 5,000	15	30
6,000 – 10,000	05	10
11,000 - 15,000	03	6
15,000-Above	14	28
Total	50	100

That out of 50, 13i.e. (26%) of respondents are not accessible of their monthly income, 15i.e. (30%) of respondents have monthly income between 1000-5000, 05 i.e. (10%) of respondents have monthly income between 6000-10, 000, 03 i.e. (6%) of respondents have monthly income between 11,000-15,000 whereas 14 i.e. (28%) of respondents have monthly income between 15000-above.Therefore highest level of monthly income are of respondents whose number is14.

Table10: Family wise distributions of the respondents having reproductive health rights

Type of Family	Frequency	Percentage
Nuclear	27	54
Joint	21	42
Extended	02	4
Total	50	100

The information presented in table indicates that a majority of the respondents in the study area belonged to 'nuclear family system' (54%) as compared to 'joint family system' (42%) and (4 %) were living in 'extended family system'. The findings of the study show a clear influence of Almora/ Kumauni culture on the living pattern of the people, where most of the families prefer to have nuclear families as their social norms and code of life are pride for them.

Table11: Education wise distributions of the respondents having reproductive health rights

Education level	Frequency	Percentage
Illiterate	30	60
Primary	12	24
Middle/ Metric	04	8
Intermediate	02	4
Graduate	01	2
Post-graduate	01	2
Total	50	100

The information presented in table clearly reflect that 60% of the respondents were illiterate and never gone to school while 24% were those who received only 1-5 years of schooling. It is also evident from the table that only 8 % of the respondents got middle/ metric level of education respectively. The table further shows that aggregate 8% respondents' received college level education (intermediate, graduate, & postgraduate level). It can be inferred from the presented information that educational facilities are not only accessible but also affordable to a common man and Govt. of Uttarakhand is making serious effort to increase the literacy rate in Uttarakhand and to achieve the Millennium Development Goals

Table12: Distribution of the respondents as per their awareness about available facility/ies at clinic/Health center of their area.

S.N.	Response	Frequency	Percentage
1	Aware	17	34
2	Not aware	33	66
3	Total	50	100

The data presented in table shows that an enormous

majority (66%) of respondents had do not knowledge/information about the available health facilities in their areas. While according to a bit more than one tenth (34 %) of the respondents though they heard about the available health facilities in their area but they had no information about the nature of the available health/medical facilities available in their area.

Table13: Distributions of the respondents as their knowledge about available facility/ies at clinic/Health center of their area

S.N.	Available Health Facilities	Frequency	Percentage
1	Provide general primary health services e.g. fever, skin problem	35	70
2	Immunization & Primary health services	04	8
3	Immunization, Primary & reproductive health -services	09	18
4	Immunization, Primary & Secondary health services	00	00
5	Counseling on reproductive health rights Immunization & Primary health services	02	4
7	**Total**	50	100

The data presented in table indicate (70%) of the respondents had knowledge about the facilities available in their areas i.e. general primary health services e.g. fever, skin problem,(8%) had information that only immunization and primary health services were available within their area, (18 %) of the respondents had knowledge that health facilities like 'immunization, primary & reproductive health -services' were available in their areas and (4%) of respondents have knowledge i.e. Counseling on reproductive health knowledge of Immunization & Primary health services It can be inferred from the given data in the table that almost half of the respondents had knowledge that reproductive health facilities were available in their areas.

Table14: Distribution of the respondents according to their responses as lady doctor ever visited to their location.

S.N.	Response	Frequency	Percentage
1	Visited	04	8
2	Not visit	46	92
3	Total	50	100

The data presented in table shows that an enormous majority (92%) of respondents says that lady doctor do not visit in their areas. While according to a bit more than one tenth (8 %) of the respondents says that lady doctors visit in their areas.

Table15: Distribution of the respondents according to response regarding their knowledge about reproductive health rights

Response	Frequency	Percentage
Yes	08	16
No	42	84
Total	50	100

The above table shows that 16% of the respondents have knowledge about their reproductive health rights whereas 84% of the respondents have no knowledge about their reproductive health rights.

Table16: Distribution of the respondents as per their responses about where did they go for Reproductive health Services

Reproductive health Services Availed By Respondents	Frequency	Percentage
At home	18	36
Lady doctor other area	20	40
Female Gynecologist some	12	24

other area		
Total	50	100

The data given in table reflect the information related 'where did they go for Reproductive health Services' if they never visited to local available RH services. In this regard the data show that more than one third (40%) of the respondents went to female gynecologist of some other area. Similarly 24% of them got guidance about RH related issues from some senior relatives 'at home'. Further the information presented in table show that a little less than one fifth (36%) of respondents visited 'female doctors of some other area'

Conclusion

Looking at some sociological writing on reproductive health rights two specific objectives have been proposed to be studied in the beginning of this study. The aim has been to understand the socio-cultural determinants affecting reproductive health rights in Tarikhet block of Almora. Women's health status is affected by complex biological, social and cultural factors, which are interrelated and only can be addressed in a comprehensive manner. Reproductive health is determined not only by the quality and availability of health care, but also by socio-economic development levels, lifestyles and women's position in society. Women health is compromised not by lack of medical knowledge, but by infringement on women's human rights including reproductive health rights. Poor women, who lack adequate food, basic health care, or modern contraception, suffer grave consequences for reproductive health.

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