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**“SEXUAL AND REPRODUCTION
RIGHTS IN RURAL INDIA – AN
EVALUATIVE STUDY OF WOMEN
AS BUILDERS OF SOCIETY
RATHER BEING MERE MOTHERS”**

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ABSTRACT:-

INTRODUCTION:

Adolescent sexual and reproductive health is a global public health concern which has received growing interest and increased research attention over the last two decades. The WHO defines reproductive rights as follows: “Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information to do so, and right to attain the highest standard of sexual and reproductive health. The inclusion of sexual and reproductive health and rights in sustainable development goals by united nations and its enshrinement in international policy instruments obligates countries to ensure its fulfilment and mandate the recognition of sexual and reproductive health within the framework of human rights. India, being signatory to the declaration on the 2030 Agenda for Sustainable Development and home to one-sixth of all humanity is obligated to ensure implementation of policies and laws that look after the sexual and reproductive health rights. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

To address important issues such as early pregnancy, child marriage, adolescent maternal mortality, HIV and sexually transmitted infections (STIs), menstruation, sexuality,

contraception, unplanned pregnancy and safe abortion, domestic abuse; it is vital to study with in-depth interviews that highlights the awareness and implementation of sexual and reproductive health and rights and its situation in poor socio economic effected areas of district Gurugram among young women along with their own attitude and behavior towards it. Sexual and Reproductive rights rest largely on the role of recognition of the basic right of women in reproductive age to decide liberally and responsibly the information, number, spacing and timing of their children and the rights to attain the highest standard of sexual and reproductive health plays the basic role of judgement. The struggle for women's 'reproductive rights' has been severely compromised and the right to contraception being conceded and becoming a taboo in many parts of India thus contributed by various religious and cultural beliefs and women still lack easy access to affordable contraceptives which are free from side-effects even from nearby government peripheral and community health centers resulting in low quality of life and severe "marginalization" depending on various social, political and economic factors as well as the policy, programme and legal environment are structural drivers; and based on which qualitative study has been done on community-based rural women and adolescents of reproductive age based on in-depth interviews.

Over the last decade, Indian courts have issued several notable decisions recognizing women's reproductive rights as part of the "inalienable survival rights" implicitly protected under the fundamental right to life including The Medical Termination of Pregnancy (Amendment) Bill, 2014, Conflation with other regulations - the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 1994, Two-child norms, Protection of Children from Sexual Offences Act, 2012, etc. But in many scenarios right to equality, right to life, right to highest attainable standard of health, right to education, right to information and participation, right to freedom and physical integrity are compromised factors contributing to the fact that various government policies and programmes in state of Haryana to promote health schemes and sexual and reproductive rights will not benefit young women from disadvantaged communities and rights-based, equitable adolescent and youth-friendly services to this vulnerable population needs to be promoted. The 3AQ – Availability, Accessibility, Acceptability and Quality can contribute to mass public awareness. The various schemes for women implemented by government of Haryana are; (1) women helpline number 181 (2) beti bachao beti padhao (3) Pradhan mantri matru vandhana yojna (4) apki beti hamari beti (5) onestop center (6) state resources center for women (7) working women hostel (8) kishori

shakti yojana (9) compensation scheme for women victims / survivors of sexual violence or assault/ other crimes -2018 (10) kanya kosha (11) scheme for relief and rehabilitation of women acid victims (13) improving infant and young child feeding (14) janani suraksha yojana (15) janani shishu suraksha karyakram (16) rashtriya swasthya bima yojana. About 27% of India's population comprises youth aged 15–29 years, which makes India home to the largest adolescent population (243 million) globally by year 2024.

Prevalence subjugated towards evidence that points out to considerable low awareness or research work done on sexual and reproductive health and rights with less frequently implementation among young people aged 15– 24 years, even though quite a considerable proportion is sexually active and many girls out of them are not even prepared from psychological point of view for menarche, leading to fear and panic when they experience their menstrual period followed by early pregnancies. The WHO indicates that it is necessary to recognize victims of intimate partner violence, sexual violence, or their suicidal behavior. The individual cases of violence to women often first come to attention with health care providers. The psycho-social care is generally not available and this leaves a large gap in terms of much required comprehensive care. Recent WHO guidelines emphasize role for physicians and other health professionals, as key gatekeepers in efforts to monitor, identify, treat, and intervene.

REVIEW OF LITERATURE :

Parida et al. mention that social and cultural norms prohibit discussions on sexuality.

R. Khanna et al. Sexual and Reproductive Health Matters 2022 address the girls as “future mothers” rather than as individuals in their own right.

Ninsiima et al. describe interactions between poverty and gender power relations and how they affect the SRHR of adolescent girls in Western Uganda.

George et al. analyze how structural drivers of gender inequality, defined as the “socioeconomic and political processes that structure hierarchical power relations stratifying societies based on class, occupational status, level of education, gender”, also impact the sexual and reproductive rights of adolescents and young adult women.

In *Paschim Banga Khet Samity v State of West Bengal* it was held that the State is obligated to provide adequate medical facilities, and denial of timely medical intervention to a person in need of such treatment by a government hospital is a violation of Article 21.

The Supreme Court in *Suchita Srivastava and Another vs Chandigarh Administration* stated that reproductive autonomy is a dimension of personal liberty as guaranteed under Article 21. It held. It is important to recognize that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on the use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilization procedures.

A study from New Delhi on urban disadvantaged adolescents' perceptions of health needs highlighted girls' fear of gender-based violence by boys in the neighborhood, lack of social networks because of restrictions on mobility, and embarrassment and lack of confidentiality in accessing health services, adversely impacting their sexual and reproductive health and rights.

In 2002, the Commission examined the provisions of the Protection from Domestic Violence Bill and provided suggestions, which it then lobbied to have incorporated. All the suggestions ended up being incorporated in the Protection of Women from Domestic Violence Act, 2005. Additionally, the Commission recommended a number of amendments to the recasting of the Child Marriage Restraint Act, 1929 so as to provide for higher penalty for violations of the provisions of this Act and also to make the offence cognizable and non-bailable. In pursuance of these recommendations, the Government of India introduced The Prevention of Child Marriage Bill which became The Prohibition of Child Marriage Act, 2006. It incorporated all the Commission's recommendations. The Commission has additionally, after a review, recommended amendments in the Immoral Traffic (Prevention) Act, 1956 to the Government of India. India is also a signatory to numerous international conventions, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the Convention on the Rights of the

Child (CRC), all of which recognize reproductive rights. Article 39(a) requires the government to promote equal access to justice and free legal aid as a means to ensure that “opportunities for justice are not denied to any citizen by reason of economic or other disabilities

In The Puttaswamy judgment (2012) the SC specifically recognized the constitutional rights of women to make reproductive choices, as a part of personal liberty under Article of 21 of the Constitution of India.

Similarly, the SC held in Suchita Srivastava v. Chandigarh Administration, that reproductive autonomy is a dimension of personal liberty as guaranteed under Article 216.

In 2011, the Delhi High Court issued a landmark joint decision in the cases of Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors. and Jaitun v. Maternity Home, MCD, Jangpura & Ors , concerning denials of maternal health care to two women living below the poverty line. The Court stated that “these petitions focus on two inalienable survival rights that form part of the right to life: the right to health and in particular the reproductive rights of the mother.”

In 2012, the High Court of Madhya Pradesh echoed the Delhi High Court’s judgment in Sandesh Bansal v. Union of India, a public interest litigation seeking accountability for maternal deaths, recognizing that “the inability of women to survive pregnancy and child birth violates her fundamental right to live as guaranteed under Article 21 of the Constitution of India” and “it is the primary duty of the government to ensure that every woman survives pregnancy and child birth’.

Ganatra, Hirve et al. 2000; Mathur, Malhotra et al. 2001; Other research on abortion and adolescent reproductive health in South Asia has also documented that premarital sexual activity for girls is so heavily stigmatized that any efforts at capturing it through surveys yield extremely unreliable results.

In 2016, the Supreme Court issued a judgment in the case of Devika Biswas v. Union of India & Ors. that moved beyond the reproductive health framework to also recognize women’s autonomy and gender equality as core elements of women’s constitutionally-protected reproductive rights. Claims of violations of reproductive rights arising from coercive and substandard sterilization and the lack of access to the full range of contraceptive methods have been brought before the Supreme Court of India and high courts for over a decade. In Devika Biswas, the Supreme Court established that state policies and programs leading to sterilization

abuse violate women's fundamental and human rights. This decision marks a significant step forward from past Supreme Court cases which have justified violations of reproductive autonomy due to concerns about population growth.

In 2011, the High Court of Punjab and Haryana reiterated women's rights to reproductive autonomy by dismissing a suit filed by a husband against a doctor who had performed an abortion without the husband's consent saying that "it is a personal right of a woman to give birth to a child...Nobody can interfere in the personal decision of the wife to carry on or abort her pregnancy...unwanted pregnancy would naturally affect the mental health of the pregnant women.

Further, in the 2013 case of *Hallo Bi v. State of Madhya Pradesh and Others*, the High Court of Madhya Pradesh affirmed the importance of providing victims of rape access to abortion without requiring judicial authorization, stating "we cannot force a victim of violent rape/forced sex to give birth to a child of a rapist. The anguish and the humiliation which the petitioner is suffering daily, will certainly cause a grave injury to her mental health."

In 2017, the Supreme Court clarified that abortion at 24 weeks is legal in the case of anencephaly, which is a fatal fetal impairment that also endangers the pregnant woman's life, stating that her rights to bodily integrity and reproductive autonomy permit her to "preserve her own life against the avoidable danger to it. Although state high courts have had mixed rulings, two recent cases in Gujarat and Chhattisgarh have also progressively interpreted the MTP Act to allow abortions past 20 weeks in cases of sexual violence.

The Madras High Court similarly recognized child marriage as a human rights violation in 2011 and in 2015 issued an important decision establishing child marriage as a violation of girls, fundamental rights under Articles 14 and 15 of the Constitution. This decision, *M. Mohamed Abbas v. The Chief Secretary*, confirmed that the Prohibition of Child Marriage Act (PMCA), establishing 18 as the minimum legal age of marriage for girls, supersedes personal laws without violating Article 25 (freedom of religion) of the Constitution; rather, the ruling emphasizes that under CEDAW, fundamental rights, and directive principles of state policy, girls should be empowered and that child marriage is not in girls' interest.

India is also a signatory to numerous international conventions, such as the Convention on the

Elimination of All Forms of Discrimination against Women (CEDAW); the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the Convention on the Rights of the Child (CRC), all of which recognize reproductive rights. Article 51(c) of the Indian Constitution and the judiciary have established that the government has a constitutional obligation to respect international law and treaty obligations. In India, the central and state governments have both responded with programmes and schemes for adolescents' health and nutrition. The Government of India launched an Adolescent Sexual and Reproductive Health Strategy (ARSH) in 2005 and the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy in 2013, followed in 2014 by the Rashtriya Kishore Swasthya Karyakram (RKSK) which moved beyond adolescent-friendly clinics to providing community-based services to adolescents aged 10–19 years. The RKSK is designed to be a comprehensive programme that goes beyond the ARSH to include non-communicable diseases, mental health, nutrition, substance abuse, and accidents and injuries. As part of RKSK, peer educators are to be trained, and Adolescent-Friendly Health Clinics are expected to be conducted.

Another major programme is SABLE, the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, initiated in 2011-12. This Government of India programme is intended “to enable adolescent girls' self-development and empowerment and improve their nutrition and health status”. The programme is expected to create awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and childcare. It also aims to provide a range of home-based, life and vocational skills, and to bring adolescent girls who are out of school into education, either formal or informal.

AIM AND OBJECTIVES:

- (1) To study the concept and importance of sexual and reproductive health and rights in India and its co-relation with mental health among women.
- (2) To understand the depriving factors with low awareness & outreach in rural areas and contribution of various health schemes towards knowledge of women legal rights and remedies.
- (3) To evaluate the relation between sexual and reproductive rights with respect to right to education.

MATERIALS AND METHODOLOGY:

The study was carried out in seven low-income rural neighborhood's (Hailymandi, Jatauli, Jataula, Milakpur, Mirzapur, Todapur, Rampur) among 40 sample size in district Gurugram state Haryana on adolescents and young adults between age groups from 15-28 years of age using We documented young women's narratives of their sexual and reproductive lives through in-depth interviews (IDIs) and MSE psychological assessment. The district ayush office and community health centers of Pataudi has been implementing an adolescents and young adults programme in last few years creating awareness regarding various medical conditions including infections like leucorrhea, menstruation and puberty, anemia, calcium deficiencies and other nutritional deficiencies, pre and post-natal care, nutrition and care of under-five children, mental health, immunization of both pregnant women and children, lactation, safe and effective ANC and DNC, wrong effects of undergoing sexual intercourse before marriages, safe sterilization methods, induced abortions before marriages, deworming in children, clean water facilities, use of hygienic sanitary napkins, capacity building of Angadwadi and Asha workers, access to abortion care and services, reproductive morbidities including tuberculosis and cancer along with their screening, gender rights and equality, etc. the rural health network of Gurugram MCG is good with a vast network of various NGO's and private sector with their CSR activities working on both medical and legal aspects. Gurugram still lacks good balance in gender equality, health indicators and age set for marriages with severe number of dropouts among girls. Adolescents who mostly have a shy and uncooperative attitude say that they prefer going to private practitioners, most of whom are Ayush doctors. Essential health and sexuality education is missing in the school curriculum. The population in these respective areas is mainly from socially and economically vulnerable groups.

The inclusion criteria of sample selection included adolescents and young adults – women of married statuses between age groups 15- 28 years of age belonging to 'marginalized' socio – economic category but with difference in educational attainment, marital status and work experience in preferred Hindi language using a recorder. The pilot study was conducted based on designed focus group interview / discussion and one-on-one interview for MSE (mental status examination) for further psychological evaluation. The data was collected starting from experiences from childhood to reproductive stages of life. The interviews were conducted for one year of time from September 2021 – August 2022, in government homeopathic dispensary

away from their respective homes to ensure safety and stability of the individuals. The time period of the interviews ranged from 1-2 hours with 6-7 sittings each with consent and maintaining confidentiality of the individual. The sexually abused victims were later referred to psychiatrist depending upon the severity of symptoms including anxiety, depression, suicidal tendency, etc.

The first staging consisted of life events including background, household composition/ number of siblings, childhood, education and dropout, employment if any, puberty, pre-marital affairs if any. The second staging of life events included marriage, sexual intercourse, pregnancies, unplanned pregnancies, family planning knowledge, husband behavior, medical conditions, health checkups, knowledge of contraceptives and reproductive rights, knowledge of reproductive health and related conditions, impact on mental health both positive and negative, sexual abuse if any. Following the life story, the thematic analysis was compiled according to the conceptual framework. The focus group interview data along with mental status examination data were merged with the thematic content and used to triangulate the data emerging from the in-depth interviews. The analysis sought to explore (1) various aspects of sexual rights, reproductive health and adolescent rights; (2) mental health statuses (3) barriers to the realization of sexual and reproductive health rights. The limitation of the study was the sample size was small with no statistical analysis using t-test. Also I couldn't get another health provider/social worker who would be interested in the task for comparative and longer engagement in the important study. The exclusion criteria largely excluded the unmarried women and the migrants or people who have come from contagious and flood affected areas.

DISCUSSION:

The generalized analysis obtained depicted various precipitating factors contributing to poor mental, sexual and reproductive health with minimal knowledge of the enabling rights/ acts; including poverty, early dropouts, false customs and traditions of early marriage and early pregnancy still prevailing in rural parts of India, precarious & limited livelihoods of family members, lack of decent work opportunities, lack of awareness among parents, seasonal wages labor, etc played out in their lives. Lack of educational opportunities resulted in low exposure and confidence. Main focus was on the perception of respondents about their rights. While individuals could not articulate their rights or name them, they could undoubtedly identify the

violation of their rights in the local language used during interviews. Respondents described how their rights over their bodies were violated in different ways.

Based on the interviews there was severe marginalization found with awareness of sexual and reproductive health and rights. Various medical conditions including anemia, chronic leucorrhea, malnutrition contribute to it along with socio – economic status, early dropouts, early marriage with repeated pregnancies with no minimal gap of 5 years between children due to family pressure of having male child, unplanned pregnancy, mental stress, hard physical labor and poor nutrition during pregnancy resulted in a neonatal death resulting in low quality of physical and mental health. The individuals experienced severe marginalization in terms of gender discrimination, inability to exercise autonomy, low education, poor nutrition and health status, inadequate care and support, among others.

Adolescent health issues like menstrual hygiene and nutrition under national health mission in all states have gained importance and been made part of community health centers, civil hospitals, peripheral health centers in various districts of Haryana with focus on larger outreach with involvement of Ayush doctors who are primarily working in rural areas in India along with Asha and Angadwadi. Ensure compliance with MoHFW's 'Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence' as well as with other laws such as PWDVA, POCSO, etc. for survivors of domestic violence and child survivors of sexual offences. Ensure that these are implemented in all health facilities across all states and union territories in the country.

ANALYSIS:

In the study followed for a year ; many of the rights as defined by Guttmacher-Lancet Commission were largely violated with severe marginalization. Three out of 40 didn't have the right to bodily integrity and personal autonomy. Four out of 40 had no right to choose their sexual partners or have comfortable sex experiences. Four out of 40 were forced for early dropouts with no right to education. Four out of 40 were forced for repeated pregnancies and abortions with minimal gap maintained between the children in order to have a male child. Three out of 40 had no idea of using contraceptives and had unplanned pregnancies. Seven out of them were suffering from severe infections like leucorrhea and nutritional deficiencies. Four

out of them were forced for early marriages with abusive alcoholic partners. Five of them had no proper availability of health services. Four out of 40 didn't had immunization on time for both herself and her children. Most of them had minimal or nil knowledge of various health services and legal aid and schemes available in their areas. Two of them were psychologically found to have chronic and poorer mental health with hopelessness, suppressed anger, depression, etc.

Various cultural beliefs, poverty, taboo against menstruation, gender inequality restrict women's control over her physical and mental health and also their reproductive decision making. A significant finding of our study was the failure of the various education systems to provide sexual and reproductive health and rights information to adolescents and young girls. Young women's right is seriously compromised because sexuality is a taboo subject. Also parents of rural areas disapprove of their children being given information related to sexuality. The conservative political regime has created further barriers by banning sexuality education in schools in several states of India.

The outreach of various programmes and policies implemented by government at various levels needs sooner and broader outcome with involvement of various NGO's and foundations, educational units, involvement of social workers with higher social marketing and involvement of young creative open minds. Support of men whether be father, brother or husband is crucially important in the life of women. Rights and regulations towards adolescents and young adults need to have a multi-sectoral vision and action plan for addressing marginalization. The urgent step is to enable transformation of unequal gender norms within all institutions including family, education, health to promote young women's empowerment and general mental well-being. Service deliveries through various awareness programmes and public campaigns regarding mental health among women should be implemented at large especially through various social networking platforms.

Table 1.: Evaluation of sexual & reproductive rights effected with respect to number of individuals

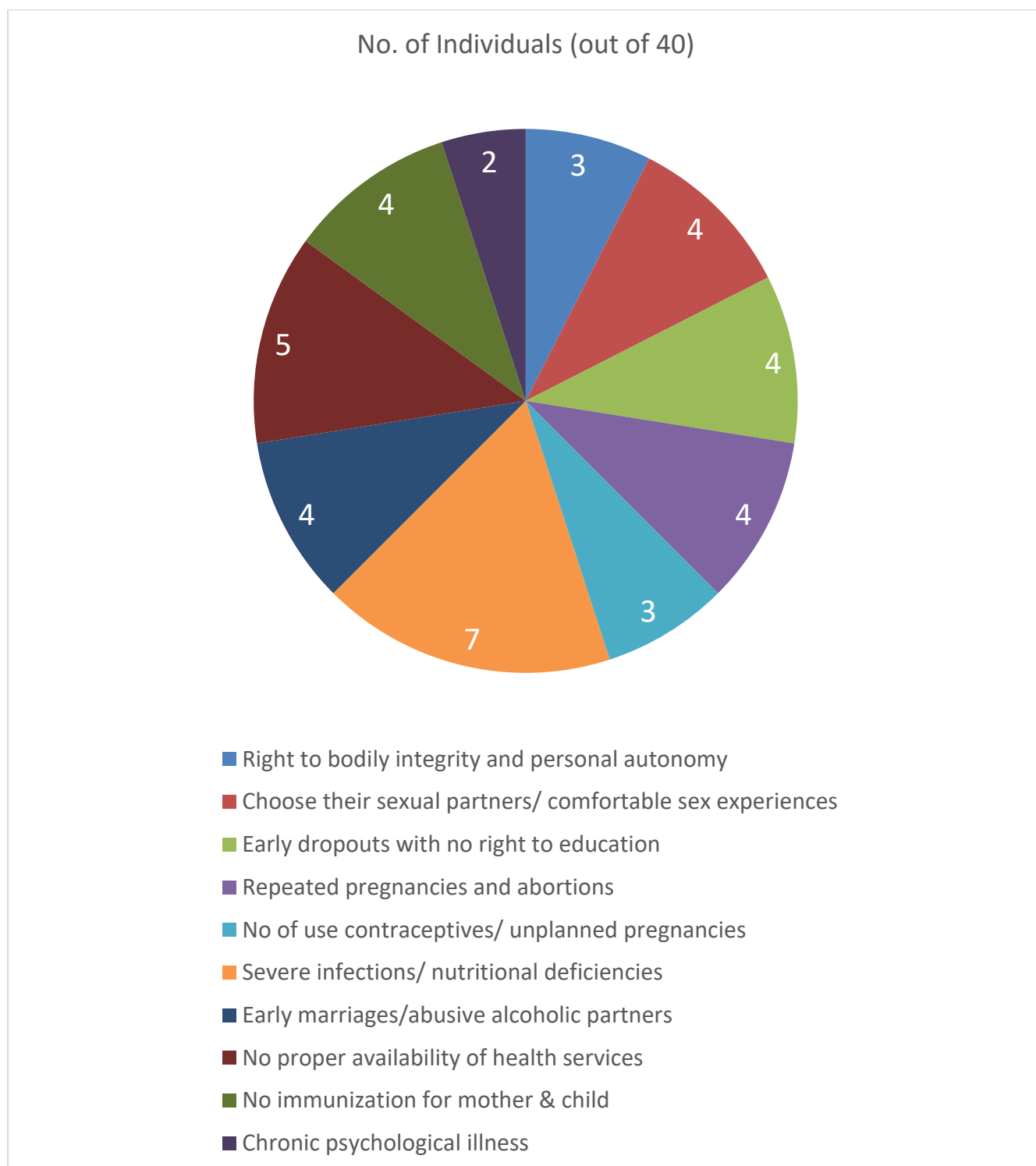


Table 2.: Evaluation of various mental health problems with respect to number of individuals

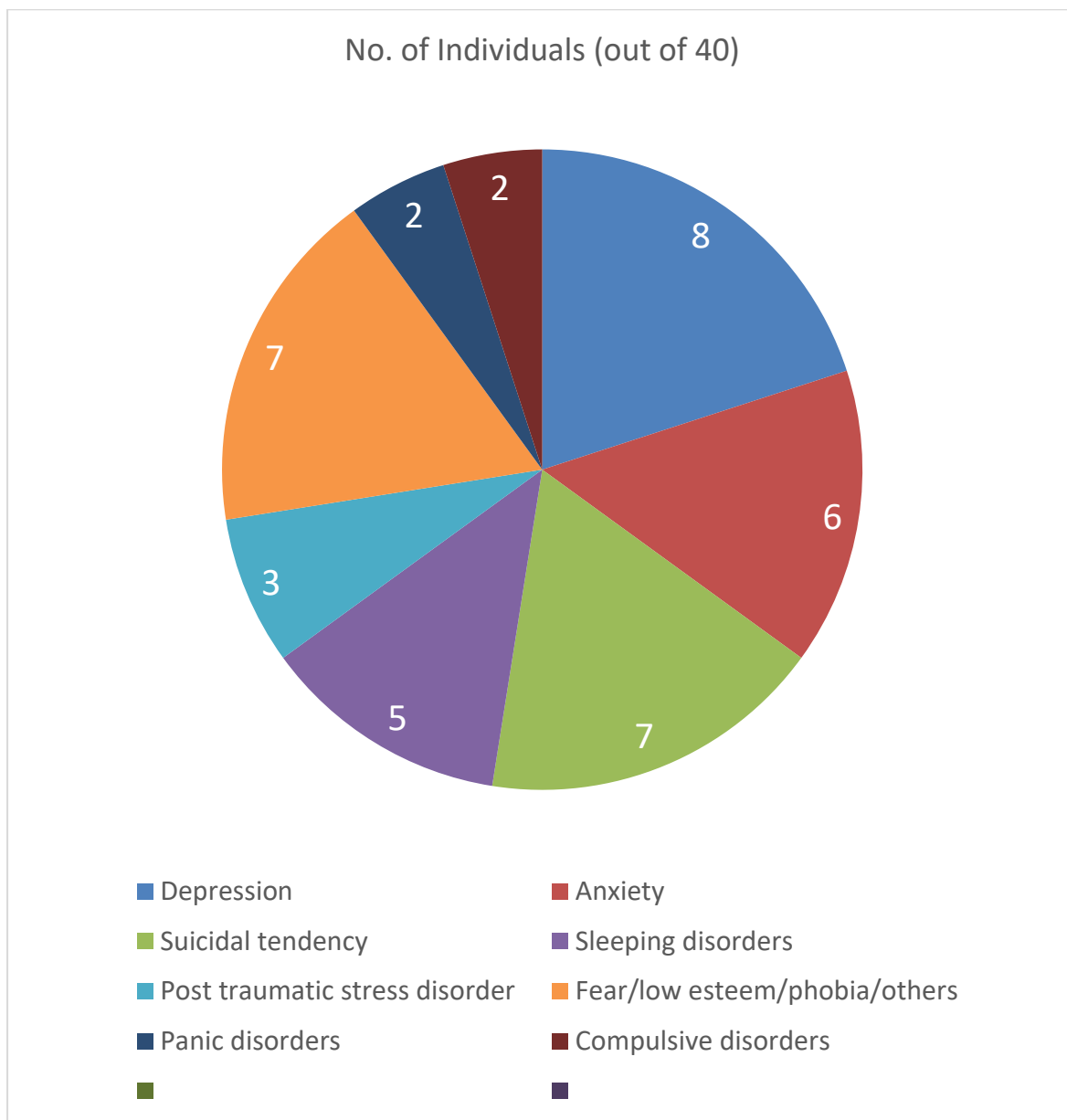
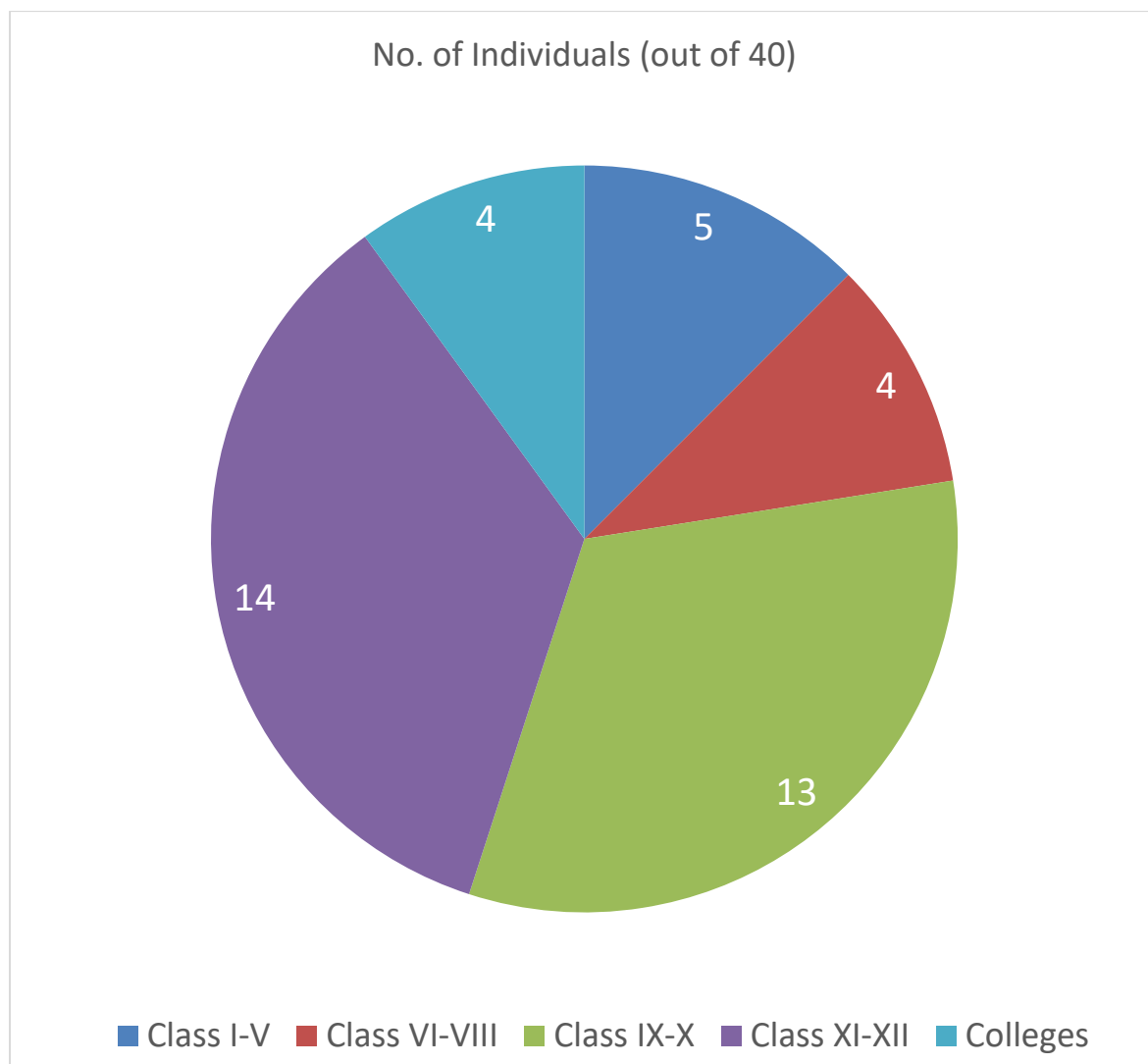


Table 3.: Evaluation of number of drop-outs with respect to number of individuals



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