

WOMEN'S REPRODUCTIVE HEALTH RIGHTS TO POPULATION CONTROL: AN INVESTIGATION CARRIED OUT IN RIVERINE AREAS OF SONITPUR DISTRICT OF ASSAM

Samikshya Madhukullya¹
Anurag Hazarika

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ABSTRACT

Reproductive health rights guarantee that individuals can procreate freely, choosing when and how often to do so, and that they can have fulfilling and safe sexual relationships. This study focuses on the knowledge and practices of women in the riverine area with regard to reproductive health rights. By empowering women to make reproductive health decisions about the number of children they want, how many to have, and how to use contraception, this study contributes to population control. Focus groups and case studies were used to perform a descriptive study with 103 women in the reproductive age range of 18 to 49 years old living in a riverine location in the Sonitpur district of Assam, India. The bulk of the 103 responders or 18–27 years old, were in this age range. The majority of them lacked basic knowledge about reproductive health and rights and were illiterate. Additionally, the women don't use the family planning services that the primary health centers offer. As a result, women in Assamese riverine areas possessed very little knowledge and practiced few reproductive health rights, which led to an imbalance in population control.

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1. INTRODUCTION

When the term "reproductive health" was first used in 1994 at the International Conference on Population and Development (ICPD), it signaled a significant change in the way that population issues were viewed and approached: fertility control was replaced with a much broader field that included safe sex and pregnancy that were free from coercion, discrimination, and violence, as well as pure population control through family planning (Hyoung, 1997). In addition to physical well-being, reproductive health encompasses the right to inclusive, safe, and appropriate health services, relationships that are respectful and healthy, accurate

information access, reasonably priced and efficient contraceptive options, and prompt support and services in the event of an unintended pregnancy (Koenig 2008; Canning & Schultz, 2012). Certain political and cultural settings, as well as certain social relationships, influence reproductive behavior. Realizing the right to health and attaining sustainable development depend on providing comprehensive reproductive health services, which include family planning and HIV/AIDS treatment. An estimated 1.1 million newborn deaths, 54 million unwanted conceptions, and 79,000 maternal fatalities might be avoided annually if unmet family planning needs were satisfied (Pachauri, 2014). Diseases like tuberculosis, malaria, and HIV/AIDS spread due to

¹ Corresponding author: Samikshya Madhukullya
Email: madhusami1000@gmail.com

factors including fertility, migration, urbanization, higher population densities, and unsanitary conditions in urban slums. Social injustices, poverty, and bad health are closely related, and gender inequality and poor mother and child health (Paul et al., 2011) are significantly influenced by limited access to reproductive health services (Hodges, 2006; Darteh et al., 2014; Lekha & Kumar, 2024).

Gender equality depends on reproductive health, particularly the achievement of women's freedom to decide how many, when, and how far between to have children (Wang, 2016). Women and girls who have access to family planning and other sexual and reproductive health services are more empowered and have more opportunity to pursue higher education and careers. Therefore, funding for reproductive health and education benefits women, their families, and sustainable development as a whole in a variety of complimentary ways. By addressing women's family planning requirements, household earnings rise as their health and prospects for economic productivity are enhanced.

The concept of women's reproductive rights itself appears difficult. They were not taken seriously as being a part of the rights to privacy, liberty, security, equality, health, and nondiscrimination for a large portion of human history (Joanna, Ellen & Alison, 2004). Women's socioeconomic and health trajectories throughout their lives are shaped by their reproductive rights, which include the choice of when and whether to have children (Widdows et al., 2005). Numerous human rights, including as the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination, are linked to women's sexual and reproductive health. Because of patriarchal ideas about women's duties in the family, women are frequently valued only for their capacity to procreate. Pregnancy with early marriage, or several pregnancies spaced too closely between (usually as a result of efforts to create male offspring because of the preference for sons), can have a severe and sometimes fatal effect on the health of women. In addition, women are frequently held responsible for infertility, which leads to discrimination against them and other human rights abuses. According to Ciara O'Connell (2018), gender preconceptions about women's reproductive health obstruct their access to necessary treatment and fuel inequity in general.

In its 2008 report, the World Health Organization stated that social justice is a matter of life and death and that women's health, including reproductive health, is influenced by inequality in social, political, and economic contexts. In underdeveloped nations, pregnancy and childbirth are the main causes of death and disability for women between the ages of 15 and 49 (World Health Organization, 2008).

Higer (1999) identified two primary techniques that were employed by the International Women's Health Movement. It is believed that the first tactic is a reformist one. Population stabilization and family

planning were to be approached from a reproductive health perspective under this method. The other approach took a more radical stance. The alternative viewpoint's proponents asserted that women's reproductive health and rights are valuable in and of themselves rather than as a method of accomplishing demographic goals and objectives, and that the present family planning program frequently acts in a coercive manner.

More than 1200 specific pledges were made during the Nairobi summit on ICPD25 in November 2019 to support the goal of ensuring everyone has access to sexual and reproductive health and rights by 2030. Reproductive health and rights are typically marginalized in discussions due to the stigma attached to them. Therefore, more has to be done to encourage male involvement and guarantee that women have more power and flexibility to make their own decisions, particularly when it comes to their own reproductive rights and health. The right-based approach represents a radical departure from the restrictive objective of population control and places women's empowerment and gender equality at the forefront of society.

Assam's riverine regions, known locally as Char or Chaparies, have an impact on the state's economic growth. The government is concerned about the rapid increase in population in certain areas. The majority of the population living in these riverine areas on the banks of the powerful Brahmaputra is made up of Bengali Muslims who came to Assam from East Bengal prior to partition and then Bangladesh.

Research Objectives-

1. To determine the societal factors that influence reproductive health.
2. To assess the degree of knowledge that women in riverine areas have regarding reproductive health and rights.
3. To research how rights to reproductive health affect population control.

Research Questions-

The main research questions are as follows-

- Which socioeconomic factors have the greatest influence on women's reproductive health in riverine areas?
- To what extent are women aware of and knowledgeable about their rights around reproductive health?
- What are the advantages of good reproductive health for women?
- What needs and demands do women in riverine areas have that are not being met?

2. METHODOLOGY

The selected research for the study is Sonitpur district of Central Assam of India. The research area chosen for the study comes from the District of Sonitpur, Assam,

which is recognized as an administrative district within the State. The district is situated between the Himalayan foothills and the Brahmaputra valley, with its headquarters located in Tezpur. The district has the third greatest population in the state, with an estimated 1,924,110 people living there overall, according to the 2011 Census data. Due to the blending of multiple language, religious, and ethnic groupings, there is no uniformity within the population. In the district, there were 946 females for every 1000 males, and the projected literacy rate was 69.96%. 2011 Census data The Scheduled tribe comprises over 139,033 people, or roughly 10.60 percent of the district's total population; the Scheduled caste makes up 65,367 people, or roughly 4.98 percent of the total population. The Brahmaputra is the area's main river and includes tributaries like Buroi, Jiabharali, and Borgang. The district of Sonitpur is 5.24 square kilometers in size. The district is situated 172 kilometers west of Dispur, the state capital. The district and Arunachal Pradesh are bordered by shared space.

Using an interview schedule, the respondents provided the primary data regarding socioeconomic characteristics and important demographic parameters, the use of contraceptive methods, knowledge and techniques for family planning, acceptance of family planning, and the size of the family.

Stratified and purposive sampling was used in the study, and further case studies were carried out to bolster the fact findings. The study's sample size was determined by counting 103 female responses. The participants were subdivided into three age groups: 18-28, 29-39, and 40-49 years old. This division was made to streamline the research process and enable more thorough analysis. Additionally, care was made to ensure that there was no bias in the study and that the sample was representative and balanced. Due to the qualitative character of the study, analysis and interpretation were the main focus after data collection. Using qualitative methods has the benefit of allowing for the exploration and evaluation of subjects that are not amenable to numerical summaries. Researchers are not limited to just the characteristics that quantitative research may reduce or simplify to numerical representation. As a result, the analysis used a qualitative methodology.

3. DISCUSSION /ANALYSIS AND OUTCOMES

According to the current study, the majority of women living in rural regions are either less literate or illiterate. The most of the women are housewives and members of the Muslim community. The survey also shows that most women do not know about most reproductive health issues and do not have access to women's reproductive rights. The majority of the women in this survey were married before turning eighteen, the researcher has also discovered. The women in these rural communities are poor decision makers when it

comes to deciding how many children to have and how far apart to space them. Interviews revealed that their husbands or in-laws made the majority of the decisions (Table 1). The decision to reproduce and the number of children to have are influenced by familial pressure and the desire to have a son. Thus, it demonstrates that cultural norms and society have a significant influence on reproductive health. Financial contribution is another important component, explaining why having a larger family means earning more money. The majority of the women used implants as a form of contraception, and their usage was widespread (Figure 1).

Sonitpur, Assam - Key Indicators		NPHS-5 (2019-20)
Population and Household Profile		
1. Female population age 6 years and above who ever attended school (%)		74.3
2. Population below age 15 years (%)		28.0
3. Sex ratio of the total population (females per 1,000 males)		1,027
4. Sex ratio of birth for children born in the last five years (females per 1,000 males)		1,325
5. Children under age 6 years whose birth was registered with the civil authority (%)		68.3
6. Population living in households with electricity (%)		77.9
7. Population living in households with electricity (%)		99.2
8. Population living in households with an improved drinking water source (%)		92.9
9. Population living in households that use an improved sanitation facility (%)		72.2
10. Households completely toilet for cooking (%)		48.9
11. Households using treated salt (%)		99.4
12. Households with at least one member covered under a health insurance/savings scheme (%)		69.9
13. Children age 3 years who attended the primary school during the school year 2019-20 (%)		9.9
Characteristics of Women (age 15-49 years)		
14. Women who are literate (%)		76.9
15. Women with 10 or more years of schooling (%)		24.3
Marriage and Fertility		
16. Women age 20-24 years married before age 18 years (%)		24.3
17. Women in the 5 years preceding the survey that are three or higher order (%)		9.3
18. Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)		6.9
19. Women age 15-24 years who use hygienic methods of protection during their sexual period (%)		63.4
Current Use of Family Planning Methods (currently married women age 15-49 years)		
20. Any method (%)		74.4
21. Any modern method (%)		68.9
22. Female sterilization (%)		6.1
23. Male sterilization (%)		0.1
24. IUD/PPI/Coil (%)		1.7
25. Pill (%)		41.0
26. Condom (%)		8.3
27. Injections (%)		0.9
Unmet Need for Family Planning (currently married women age 15-49 years)		
28. Total unmet need (%)		6.9
29. Unmet need for spacing (%)		2.9
Quality of Family Planning Services		
30. Health worker ever talked to female non-users about family planning (%)		28.4
31. Unmet users ever told about side effects of current method (%)		73.9

Table 1. National Family Health Survey – 5 Report (2019-20)

Source: Secondary survey data

A small percentage of the ladies disclosed that they became pregnant after implantation despite the implants failing. The men oppose the use of any form of birth control, and a small percentage of them even forbid their partners from using any form of birth control. The people living in these rural areas use the PHCs and boat clinics as their primary source of information about family planning and contraceptives, as well as to access their medical services. Accessing health facilities is another problem for these ladies because the area floods for much of the year.

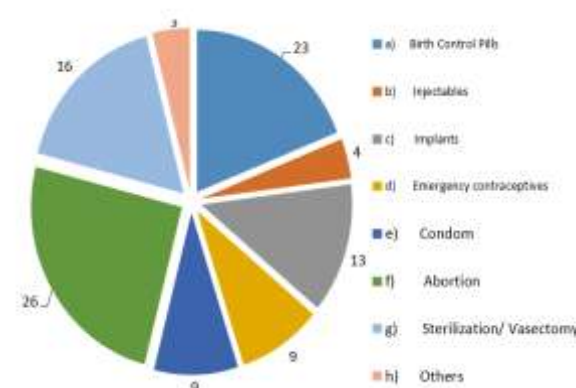


Figure 1. Usage of Contraceptives
Source: Field survey data

The majority of the women in the current survey did not know that they had the right to an abortion. Either their spouse or their in-laws made the decision for them to have an abortion. Thus, it is evident from the current study that women cannot make decisions regarding their reproductive health until they have received knowledge and empowerment (Figure 2). Only then will they be able to understand their rights. Women who have more influence will be able to make decisions about family planning and eventually help to limit the population.

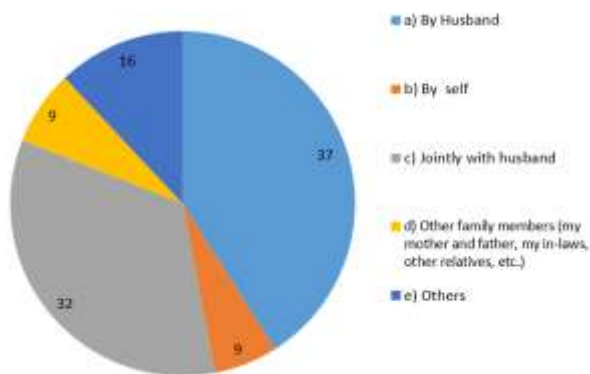


Figure 2. Involvement in decision-making on family size and/or spacing of children

Source: Field survey data

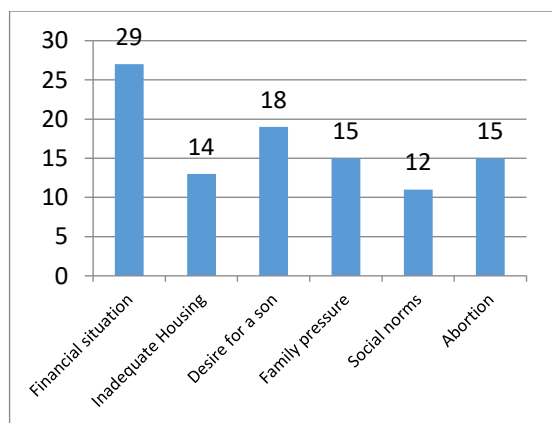


Figure 3. Factors affecting decision on family planning

Source: Field survey data

Numerous socioeconomic variables effect reproductive health, including the quality, acceptability, accessibility, and availability of reproductive health treatments and information. Socioeconomic position, gender disparity, culture and religion (Sarap et al., 2013). geography, stigma and prejudice, and a variety of environmental factors are some of the major social determinants of reproductive health (Figure 3). Reproductive health outcomes are impacted by poverty, poor income, and restricted access to chances for education and work. Due to their low poverty and lack of access to high-quality reproductive health care and knowledge, residents of impoverished regions may be more likely to become unintentionally pregnant or contract STDs (O'Connell & Zampas, 2019). Because we live in a

patriarchal society, women face numerous obstacles to accessing reproductive health services, including restricted access to safe abortion and contraception, as well as limited autonomy in making decisions about their own reproductive health. Due to the fact that these women are Muslims, their culture and religious beliefs also affect their reproductive health practices. The chance of maternal and newborn mortality is thereby raised. Due to their geographic isolation—char regions are frequently encircled by water—access to reproductive treatments and information is particularly impacted by these constraints.

4. CONCLUSION

The Assamese government has also acknowledged that the key to population control, especially among minority communities, is financial inclusion, health, education, and ending child marriage. A serious worry has been the exponential population growth of Muslims in Assam who are of East Bengali descent. There is no denying that early marriage and having more children when a mother is poor are detrimental to her health and increase the state's infant and maternal death rates. In terms of the SDGs, Assam has done badly, especially in the areas of health and well-being. To ensure the health and welfare of the low-income moms, we must work together. The current government's attempt to portray the community as a threat to indigenous communities' civilization will not aid in accomplishing the goal of empowered, literate, and healthy motherhood, which will aid in meeting population targets.

A multi-sectoral strategy is needed to address the social determinants of reproductive health, which include eliminating stigma and prejudice, increasing gender equity, enhancing access to education and work opportunities, and tackling poverty. Thus, it is necessary to choose a peaceful and healthy strategy built on mutual trust. Although China withdrew the national two-child policy early this year, India does not have one; instead, states have created and enforced their own variations of the norm. Assam and Uttar Pradesh now intend to join this list of states. The Assamese government even intends to raise the minimum age at which a woman must marry. A population army made up of a thousand young people from the riverine districts will also be identified, and they will be tasked with distributing contraceptives and organizing awareness campaigns in the area. These policy ramifications will undoubtedly raise women's knowledge of their rights to reproductive health and will also aid in population control.

Educating medical professionals and offering easily accessible, reasonably priced reproductive health treatments. Male engagement should also rise since it is just as important for them to be involved as it is for the women in char regions. The underlying social and economic causes of reproductive health problems, such

as gender inequality and poverty, must also be addressed.

Because they empower people to make educated decisions about their reproductive lives, reproductive health rights are essential to population control. These women from the char regions will be able to choose family planning wisely and have the number and spacing of children they want when they get access to complete reproductive health services. The prevention of unwanted pregnancies, which significantly contributes to population increase, is another benefit of having access to reproductive health services. High fertility rates brought on by unintended pregnancies cause population growth to exceed social and economic advancement.

Reproductive health rights also contribute to a lower risk of illness and mortality among mothers. Women are

less likely to face difficulties during pregnancy and childbirth when they have access to safe and efficient family planning techniques. Reproductive health rights can influence population control on a larger social scale in addition to individual levels. Unchecked population expansion can cause resource depletion, environmental damage, and other social and economic problems.

It's also critical to remember that population control strategies must to be carried out in a way that upholds individual liberty and human rights. Restrictions on reproductive freedom and coercive measures should not be the main priorities of any campaign to promote population control; instead, education and access to reproductive healthcare should be given priority.

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Samikshya Madhukulya

Guest Faculty, Department of Cultural Studies, Tezpur University, India
madhusami1000@gmail.com
ORCID: 0009-0002-1206-1284

Anurag Hazarika

Guest Faculty, School of Engineering Tezpur University, India
anuraghazarika2@gmail.com
ORCID: 0000-0002-0005-4813

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