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Reproductive Health Rights as Influenced by Socio-Cultural Factors in Tarikhet Block District Almora, Uttarakhand, India

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Abstract-
The present study highlights the demographic characteristics of the respondents having reproductive health right. 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. 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. 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's health is harmed by violations of their human rights, particularly their right to reproductive health, not by a lack of medical understanding. There are serious ramifications for reproductive health for impoverished women who do not have access to modern contraception, basic healthcare, or enough food. 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. 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.

Keywords- Married Women, Socio-Economic Factors, Life Styles, Medical Knowledge.

1. Introduction

The idea for this special issue emerged through our conversations and conference attendance during which we observed that the topic of women's health, which was more visibly present at our forums previously, has had a muted presence in health psychology and behavioral medicine in recent years. This observation is echoed also in other fields, which find a reduction of articles discussing women's health from a critical or social justice perspective (Benyamini and Todorova, 2017). Women heal this compromised not by lack of medical knowledge, but by in fringement 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 [1]. 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 [2]. 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 [3]. A number of lawful international treaties that are grounded in social fairness and ethical principles-many of which have a direct bearing on reproductive health care-form the foundation of the contemporary human rights framework. A right-based

approach can offer tools to investigate the underlying causes of health issues and inequities in service delivery by contextualizing reproductive health.

Freedman, [4]. 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 international accepted standards for a series of human rights, including the right to health, and has shaped means to promote and protect those rights [5]. The women's empowerment movements captured attention to human rights exploitations based on women's poor socio-economic status in society and put pressure on governments to change the state of affairs of women's lives [6].

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 [7]. 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 [8].Reproductive health therefore implies that people 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 to do so. Implicit in this last condition are the right of men 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 child birth and provide couples which the best with chance of having a healthy infant [9]. It promotes the findings of linked studies and reduces the chances of redundant repetition of research work. Some of their lasted reviews are presented under the subsequent research indicators. Educated women and women with career and employment options may be less abused because they are considered to be extra precious and dear by their husbands, and possibly by the extended family [10]. They also may have more command to leave a bond if their husbands became rude and violent [11]. The international reproductive health community has acknowledged the importance of addressing gender disparities in reproductive health decision-making as fundamental to improving the reproductive health and rights of both women and men. Gender-based power inequalities can contribute to health outcomes especially among women because gender inequality is a element of the social context in reproductive decision-making [12]. Women's sacrifice of the wishes for their partner's desires is a result of non-consensual sexual activity within marriage (a form of gender-based power in equality), is common in all societies [13]. Women with more schooling maybe 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 [14]. 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 contribute 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 are 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.

1.1 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 their reproductive health rights

2. Research Methodology

The methodological aspects of this study consist of collection and analysis of information. The materials and methods provide a path to the researcher on how to complete the process of collection; analyzing and interpretation of data. The research design is the "blueprint" that enables the researcher to come up with the solutions to the problems encountered during the research .It gives the study design, selection criteria for respondents, sampling procedures, sample size, selection and training of interviewers and different statistical techniques used for data analysis.

2.1 The Area of 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 longtime 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).

Table-1 Selection of sample forms elected localities acc or doing to their population

Block Tarikhet	Population		Village	Selected respondent pervillage
Total Population		68563	Tarikhet	25
Total households =258	Male 32247	Female 36316	Thapla Pali	10 15

2.2 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 villages 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 were 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 frame work of the study to collect data and draw inferences.

2.3 Data Collection

A cross sectional survey was conducted for getting the data. Using "survey" methods the 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.

2.4 Data Analysis

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 who

consist of 37 Hindus, 13 Muslims aged between 20-45 years.

3. Results and Discussion

3.1 Socio Cultural Factors Influencing Reproductive Health Rights

Information relating to the various socio-cultural factors affected 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 section an attempt has been made to discuss, analyzed and interpret relevant data for deriving conclusions and formulating appropriate suggestions in the light of the study results.

Table-2
Distribution of the respondents having reproductive health rights according to area

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

The data shown in Table 2 reflect that both urban and rural areas, without any discrimination and proportion of population size, were 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 rights, if necessary.

Table-3 Distribution of the respondents having reproductive health rights according to religion

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

The above Table 3 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.

Table-4 Distribution of the respondents having reproductive health rights according to Caste

Caste	Frequency	Percentage
General	33	66
Other backward	04	08
SC/ST	13	26
Total	50	100

The table shows that out of 50 respondents 33 belong to general caste, 4 belong to other backward caste and 13 belong to SC/ST caste. Thus majority of the respondents belong to the *general* who has the maximum number i.e.33 (66%) where as SC/ST is in second major positioni.e.13 (26%).

Table-5. Distribution of the respondents having reproductive health rights according to age

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-5 reveals that 30% of the respondents fall within 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.

Table-6 Distribution of the respondents having reproductive health rights according to age at time of marriage

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

The above Table-6 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.

The information presented in Table 7 clearly reflect that 30% of the respondents husbands were illiterate and never gone to school while 18% were those who have received only 1-5 years of schooling. It is also evident from the table that only 18% and 24% of the respondents husbands got up to primary and middle level of education respectively. The table further shows that more than one third (23%) 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 the common man and Government of Uttarakhand is making serious effort to increase the literacy rate in Uttarakhand and to achieve the Millennium Development Goals.

Table-7
Distribution of the respondents having reproductive health rights according to husband's level of education

Educational Level	Frequency	Percentage
Illiterate	15	30
Primary	09	18
Middle/Metric	12	24
Intermediate	11	22
Graduate	02	04
Post-gradate	01	02
Total	50	100

Table-8. Distribution of the respondents having reproductive health rights according to husband's occupation

Type of Profession	**Frequency**	**Percentage**
Govt. Employees	12	24
Private Job	15	30
Un-Employed	08	16
Businessmen	13	26
Other works	02	04
Total	50	100

The Table 8 shows that out of 50 respondents 12 i.e. 24% are government employees, 15 i.e.30% are private jobs, 8 i.e.16% are un-employed while 13i.e. 26% are businessmenand2i.e. 4% are others work. The largest numbers of respondent's husband are engaged in private jobs.

Table-9 Distribution of the respondents having reproductive health rights according to monthly income

Monthly Income (in Rupees)	**Frequency**	**Percentage**
Don't Know	13	26
1000-5000	15	30
6000–10000	05	10
11000-15000	03	06
15000-Above	14	28
Total	50	100

That out of 50, 13 (i.e. 26%) of respondents had not access to of their monthly income, 15 (i.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 is 14 (Table-9).

Table-10 Distribution of the respondents having reproductive health rights according to type of family

Family	**Frequency**	**Percentage**
Nuclear	27	54
Joint	21	42
Extended	02	04
Total	50	100

The information presented in Table-10 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 is pride for them.

Table-11
Distribution of the respondents having reproductive health rights according to their level of education

Education level	Frequency	Percentage
Illiterate	30	60
Primary	12	24
Middle/Metric	04	08
Intermediate	02	04
Graduate	01	02
Post-graduate	01	02
Total	50	100

The information presented in Table 11 clearly reflects that 60% of the respondents were illiterate and never gone to school while 24% were those who received only 1-5years 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 an aggregate 8% of 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 the common man and Government of Uttarakhand is making serious effort to increase the literacy rate in Uttarakhand and to achieve the Millennium Development Goals.

Table-12
Distribution of respondents having reproductive health rights according to their awareness of available facilities at clinic/health centre in 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 12 shows that an enormous majority (66%) of respondents had no knowledge/information about the available health facilities in their areas, while slightly more than one tenth (34 %) of the respondents noted that though they heard about the available health facilities in there are abut they had no information about the nature of the available health/medical facilities available in their area.

Table-13
Distributions of the respondents according to their Knowledge about available facilities at clinic Health center of their area

S.N.	Health Facilities	Frequency	Percentage
1	Provide general primary health services' fever, skin problem	35	70
2	Immunization & Primary health services	04	08
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	02	04
7	Total	50	100

The data presented in Table 12 indicate (70%) of the respondents knew the facilities available in their areas i.e. general primary health services e.g. fever, skin problems, (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 about 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.

The data presented in Table 13 shows that an enormous majority (92%) of respondents says that lady doctor do not visit in their areas. While according to a bit less than one heath (8%) of the respondents says that lady doctors visit in their areas.

Table-14

Distribution of the respondents according to their responses regarding lady doctor's visits to their area

S. N.	Response	Frequency	Percentage
1	Visited	04	08
2	Not visit	46	92
3	Total	50	100

Table-15 Distribution of their respondents according to responses 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.

Table-16

Distribution of their respondents having reproductive health rights according to their responses regarding where they access reproductive health services

Reproductive health Service availed by Respondents	Frequency	Percent age
At home	18	36
Lady doctor other area	20	40
Female Gynecologist some other area	12	24
Total	50	100

The data given in table reflect the information related to where they went 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 Looking at some sociological writing on reproductive health rights two specific objectives have been proposed to be studied in the beginning of this study.

4. Conclusion

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, life styles 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.

Competing Interests

Author has declared that no competing interests exist.

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