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Women's Reproductive Rights and Experience of Reproductive Healthcare in Kashmir: A Sociological Study

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Abstract:
The study attempts to explore the experience of reproductive healthcare among married, reproductive age women in Kashmir within the framework of their reproductive rights. Reproductive issues are faced by women increasingly today and more women seek healthcare regarding their reproductive issues than ever before, in part due to increasing awareness .and due to policies and programmes that target women's reproductive health as an area of development and emancipation. As a part of the study of women's experience of their reproductive rights, the researcher attempts to present their experience of reproductive healthcare to determine their empowerment.

Keywords: *Women, Reproductive rights, Reproductive healthcare, Experience, Empowerment*

1.Introduction

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These 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 the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence. […] As part of their commitment, full attention should be given to the promotion of mutually respectable and equitable gender relations […] (ICPD Programme of Action, Paragraph 7.3).

Thus, reproductive rights are human rights (OHCHR, 2014). Baxi (2001, p. 4) presents reproductive rights in a dialectical fashion: "What are 'reproductive rights?' is a question as important as its close cousin: 'what ought to be the range of reproductive rights?' And yet the element of is and ought to commingle, resisting efforts at analytic segregation." In doing so he points out that the parts make the sum. Rights signify several different types of claims may be at stake (Shanner, 2005). Due to this, these are understood as reproductive self-determination in effect (Cook, 1993; 1995) as the language of rights presents registers of interests and concerns, only some of which assume a binding form of norms and standards (Baxi, 2001). Then viewed as these binding human rights' norms and standards, reproductive rights refer to a group of legal and ethical principles, central to which is the notion of control. More specifically, reproductive rights are about women's ability to control what happens to their bodies and their persons through legal and ethical principles which protect and enhance their ability to make and implement decisions about their reproduction (Moodley, 1995). Berer (1990) links control and choice as central to women's reproductive rights. Moodley (1995) adds autonomy as the third central tenet. This notion has met some criticism though, especially from scholarship in the developing world. Nair (1993) pronounces 'choice can never be free under unfree conditions.' Women's need for children, lack of control in sexual relationships, and the availability of methods and so on are constraining factors on choice for most women. Both choice and the right to control one's own body are meaningless to women who do not have any resources or power, let alone an awareness of their rights.

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Cook (1995) breaks down reproductive rights into components: (i) 'reproductive interests' – involving reproductive security and sexuality, reproductive health, and reproductive equality, and (ii) 'reproductive decision-making' – this she recognizes as the site for women's empowerment and agency. Reproductive health is an important component of reproductive rights. Reproductive health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability 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 the 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 with the best chance of having a healthy infant. (ICPD Programme of Action, Paragraph 7.2).

2. Research Methodology

The researcher has used primary data to collect the information. Exploratory and descriptive research design has been used by the researcher to collect the data. An attempt has been made to explore the social experiences of reproductive-age married women. The universe of the present study comprises of college educated, employed, urban, married reproductive age women in the age group 25-44 years. 300 respondents constitute the sample size taken based on non-probability purposive sampling, also known as judgmental sampling.

3. Objective of the Study

The general objective of the study is to explore women's experience of reproductive rights within the social structure they inhabit. Specifically, the experience of reproductive healthcare is explored in this study.

4. Operationalizing Experience of Reproductive Healthcare

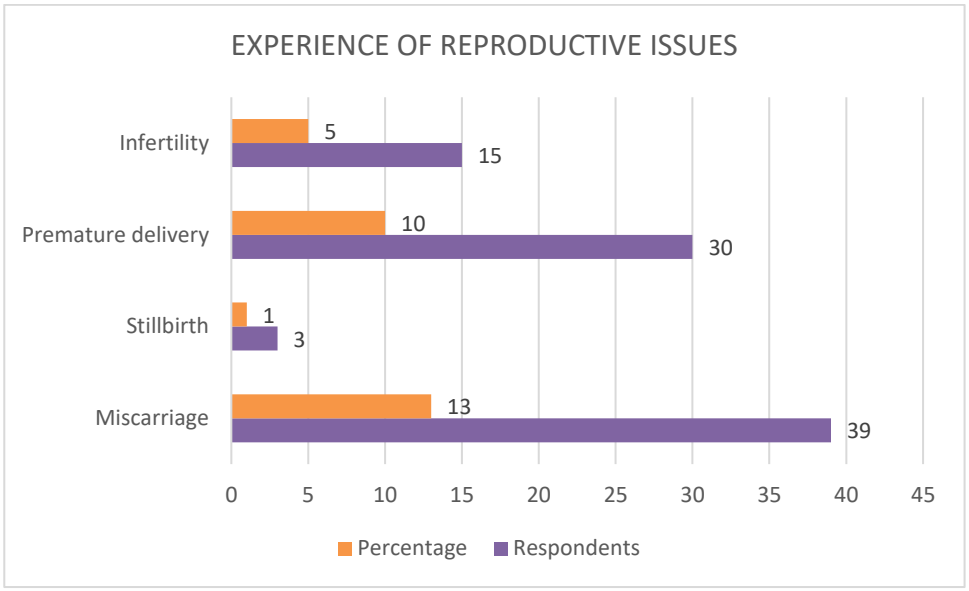
Experience of reproductive healthcare is appraised through experience of reproductive issues, institutionalized birth, type of delivery, treatment sought for reproductive health issues/ issues affecting fertility.

5. Findings

5.1 Experience of Reproductive Issues

Birth intentions do not necessarily translate into birth realities. Women's health status can be mitigated by looking at what ails them. Women can be healthy and still face hurdles in realizing their reproductive goals. Often more than not, reproductive morbidities and reproductive hurdles are the result of a focus on women's health through the reproductive lens and not a holistic approach to their health which compartmentalizes when to seek healthcare and when not to. Women in the study are no exception to this and have had to experience certain issues in meeting their reproductive goals. Figure 5.1 represents the health issues faced by the respondents.

Figure 5.1
EXPERIENCE OF REPRODUCTIVE ISSUES



***infertile responses include eight of those that experienced it but were able to overcome it.**

Miscarriages have been found to be the most prevalent (13 percent) in the sample, followed by premature delivery at 10 percent and stillbirths at 3 percent. Infertility is suffered by 5 percent of the sample. Together, miscarriage and stillbirth account for 16 percent of pregnancy loss among the sample. Miscarriages can be deadly, so can premature delivery. Sometimes premature delivery results in pregnancy loss too, depending on the timing.

Of these the respondents revealed, they sought treatment for infertility. Eight of the respondents revealed that they had been cured of infertility and could 'feel the joy of motherhood'.

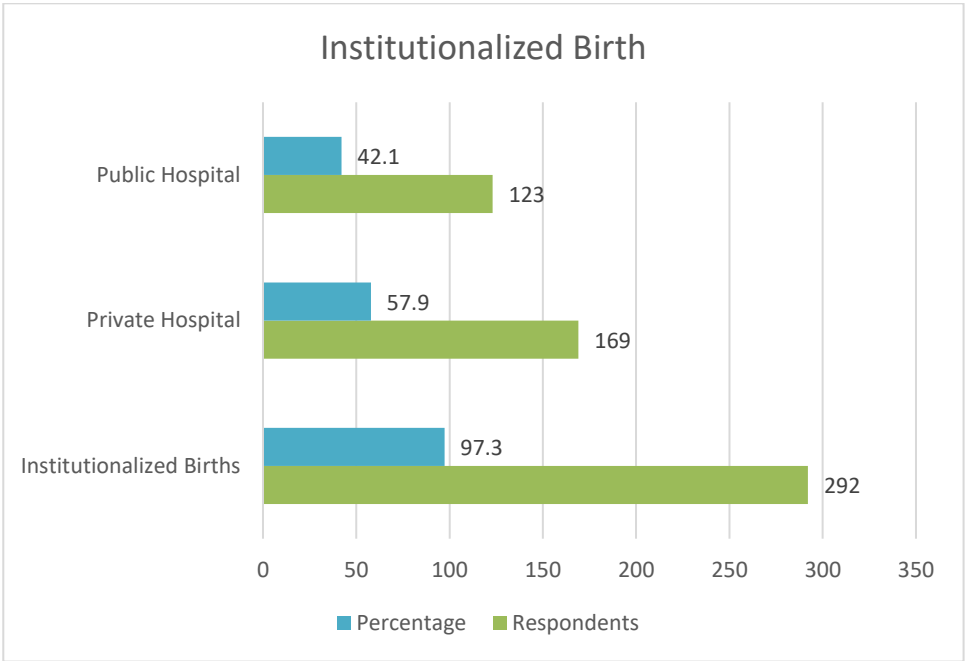
Numerous studies have demonstrated that infertile women are at an increased risk of certain cancers, including cancers of the breast, ovary, and uterus. Study respondents revealed that the risk of various cancers, especially breast and cervix, had been suggested to them by their medical practitioners. None of the respondents though had been diagnosed during the study period. Though the causes of infertility are rooted in biology and explained medically, certain studies have made note of lifestyle and environment factors like earlier age at first intercourse, delayed age at marriage or first birth, contraceptive practices, and exposure to sexually transmitted diseases. However, the social meanings of infertility are of greater significance to sociologists. Studies have highlighted how regardless of the medical cause of infertility, women receive the major blame for the reproductive setback, and they suffer personal grief and frustration, social stigma, ostracism, and serious economic deprivation. The meaning of childlessness is profound in Kashmir where voluntary childlessness is extremely rare. Respondents in the study are no exception and have reported facing stigma from people around them. Even though stigma associated with infertility is categorized as discreditable, respondents' experiences question assumptions granting privacy at a societal level and the conception of bodies experiencing infertility as self-determining, autonomous individuals with choices, in that categorization. Respondents in the study comprised of stigmatized women that, both held the same beliefs and opposed the beliefs of their condition as the rest of the society, respectively. This enabled them to seek recourse to their condition and in many cases (eight in the study) being able to overcome it with the help of modern reproductive technologies and traditional adoption practices. Adoption is problematic in Islamic contexts, but respondents were able to negotiate these concerns in favour of their practical concerns. The respondents in the study were able to mobilize different strategies in the face of childness, specifically through their class location by being able to avail, access and afford reproductive choices. Social class carries with it privilege that affects the

experience of stigma, strategies, and resolution. Importantly, respondents did not act alone. Their network of family ties and educational and occupational privilege influenced their strategies of action. Empathy, sympathy, and compassion were experienced in familial and friendship networks in the experience of miscarriage, stillbirth, and premature delivery. Equally the respondents report being subjected to 'pity' from the society at large. Gerdes defines pity as 'a condescending, or contemptuous form of feeling sorry for someone, often directed at people who are perceived as pathetic or having brought about their own misery (2011, p. 233). Implying that women and their bodies are primarily blamed for these events. A possible explanation for the same could be grounding these events in the belief of karmic repercussions where not just the women but their entire families are facing retribution for a moral ill committed by their lineage. Therefore, women outright do not face the brunt of it alone and carry stigma, rather a moral ill is seen as having been accounted for and 'prayers and wishes are offered for a safer pregnancy and a healthy child in the future' and thus are subjected to pity. A common belief in this regard is held in Kashmir that future progeny is held divinely accountable for the misdeeds of their ancestors, which is rooted more in culture than in religious explanations. This has implications for women despite their educational and occupational privilege and social class location. Biological realities are explained by way of socially held explanations, far removed from actual causality, by society at large. Women are then subjected to navigate these myths. Respondents in the study reported feelings of being emotionally hurt by such reactions to their loss of pregnancy. They did not respond by engaging in quarrels rather took time to recover physically and mentally from their loss by depending on the support of their familial and friendship networks. In the absence of dedicated support groups for pregnancy loss, they relied on traditional support networks where their spouses, mothers and female siblings and friends provided emotional support in their recovery. In the eventuality of a loss, the respondents looked to the future where the outcome of a pregnancy would be a live child to subvert their attention from 'thoughtless pitiful remarks'.

5.2 Institutionalized Birth

Institutionalized birth is an indicator of mother and child health. It has also been used as an indicator of women's empowerment as a measure of access to reproductive healthcare. Figure 5.2 presents a positive picture of institutional birth incidence in the study.

Figure 5.2
INSTITUTIONALIZED BIRTH



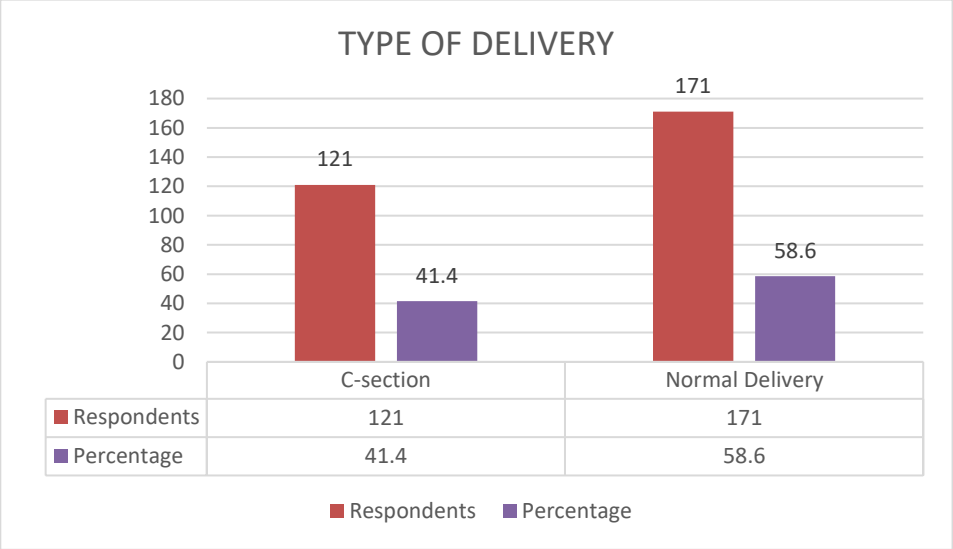
N= 292(excluding infertile respondents)

All study respondents reported institutionalized births, of which the majority (57.9 percent) happened in private hospitals, followed by 42.1 percent at public hospitals. Public hospitals are run by the government. Even though they are superior in terms of infrastructure and skilled personnel, the quality-of-care leaves much to be desired, because of which respondents preferred costlier private hospitals to them. Decisions regarding where to birth are arrived at by respondents keeping in mind issues of affordability, easier access, distance, and infrastructure, together with where a practitioner of choice practices. These decisions are arrived at collectively. Word of mouth by friends and relatives who have better experiences at certain hospitals also influence the respondents' decisions of where to deliver a child.

5.3 Type of Delivery

Type of delivery in the study is assessed as either c-section or normal delivery. C-section involves surgical intervention whereas a normal delivery, as the name suggests, relies on the bodily contractions, labour, to deliver. C-sections are quick in comparison to a normal delivery which may take a day even. C-sections have been shown to negatively affect both mother and child, yet the world faces what is termed a 'c-section epidemic'. Figure 5.3 gives a breakdown of the type of delivery prevalence in the study.

Figure 5.3
TYPE OF DELIVERY



N=292(excluding infertile respondents)

The study reveals that even though normal deliveries are more prevalent (58.6 percent), yet c-sections are alarmingly high (41.4 percent). The respondents did not desire birth by c-section, yet they could not escape it. Increased economic stressors for hospitals along with a move to commodify time have resulted in an upsurge of c-section births. C-section more than 15 percent of the population poses serious risks to the lives of mothers. It is also identified as a factor in limiting fertility and compromising the immunity of the child. Respondents have undergone both primary and repeat c-sections. Even though they are aware of the risks and that informed consent is to be obtained, respondents observed that in most cases it was not obtained rather they were instilled with fear for their and the child's life to give a go ahead for it.

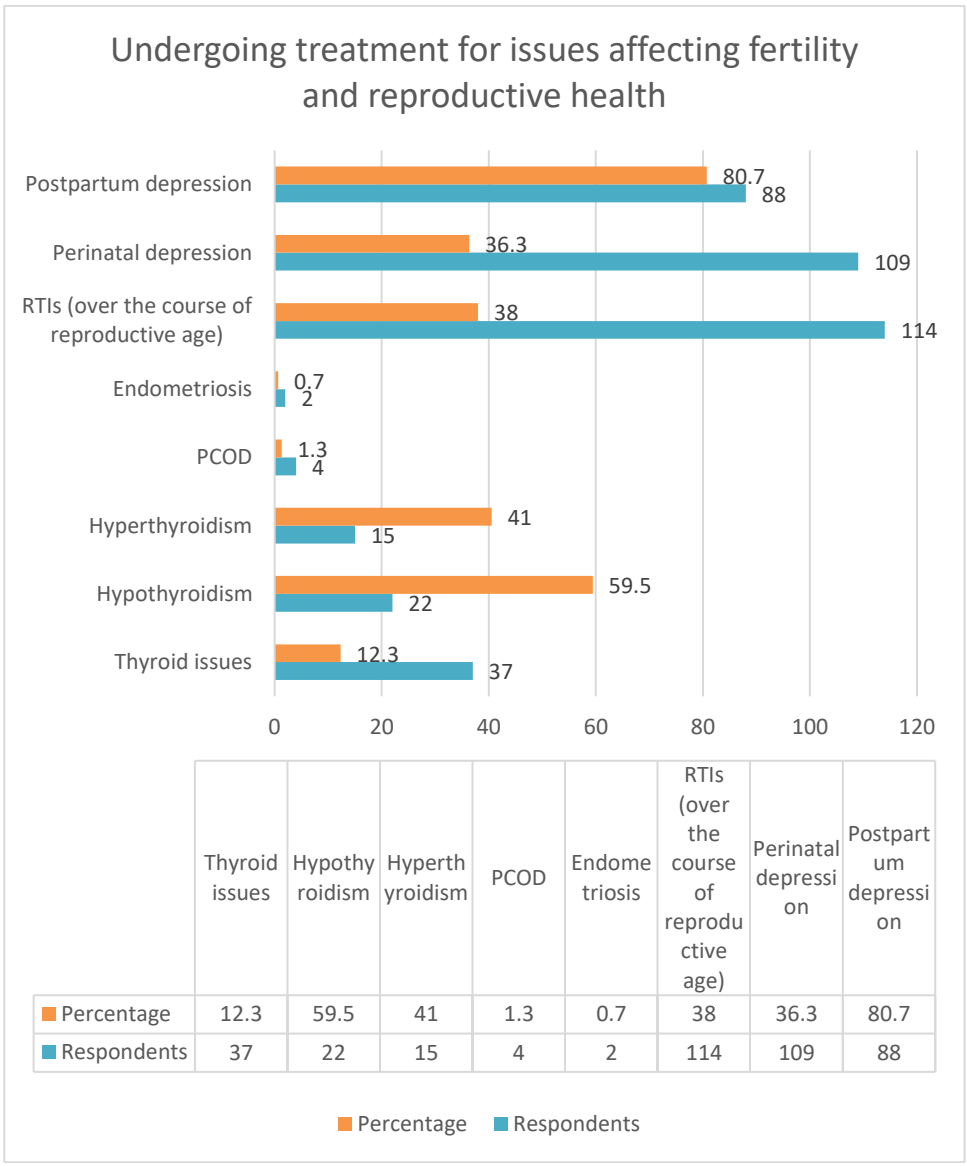
5.4 Undergoing Treatment for Reproductive Health Issues/ Affecting Fertility

To assess women's access to reproductive healthcare, information was sought regarding their treatment seeking for reproductive health issues. Figure 5.4 provides a description of the issues for which the respondents were undergoing treatment or seeking treatment. Self-reported morbidities were avoided as these are unlikely to be valid measures of prevalence without clinical examination. Also, conceptual frameworks for understanding these and their implications are lacking.

12.3 percent of the respondents were seeking care for thyroid issues, of which 59.5 percent suffered from hypothyroidism and 41 percent suffered from hyperthyroidism. Majority of the respondents (38 percent) suffered from reproductive tract infections at one point in time or the other. 36.3 percent respondents revealed that they were suffering from perinatal depression, out of which 80.7 percent were seeking care for postpartum depression. 1.3 percent respondents had a polycystic ovarian disorder and 0.7 percent respondents had endometriosis. All respondents revealed that uterine tract infections (UTI) were commonplace and experienced at various instances.

Women are aware of their health concerns and are able to seek healthcare for their addressal. The fact that women recognized their mental health had been compromised and were not hesitant to seek out care for it can be inferred as exhibiting agency. Kashmir as a society devalues mental health even though a significant portion of its population is diagnosed with post-traumatic stress disorder. In such a scenario, recognition and addressal of this grave concern points to not just access to reproductive healthcare but also an awareness of unmet health needs.

Figure 5.4
UNDERGOING TREATMENT FOR REPRODUCTIVE HEALTH ISSUES/ AFFECTING FERTILITY



	Thyroid issues	Hypothyroidism	Hyperthyroidism	PCOD	Endometriosis	RTIs (over the course of reproductive age)	Perinatal depression	Postpartum depression
Percentage	12.3	59.5	41	1.3	0.7	38	36.3	80.7
Respondents	37	22	15	4	2	114	109	88

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6. Conclusion

Women's reproductive rights and reproductive health are connected. Their experience, interaction, and utilization of reproductive healthcare is an indicator of their empowerment. As in other spheres of life, women face challenges in the reproductive sphere and overcome those by applying different strategies in the reproductive field- be it resistance, alignment or negotiation. In doing so they achieve self-defined empowerment by exercising agency. Women's access to, utilization of and expenditure on reproductive healthcare is no mean feat in a society that constantly neglects women's various needs and is only concerned with their reproductive role in so far as to produce desired progeny. Women in the study navigated social stigma, pity and apathy by garnering support from their family and friendship networks, relying on traditional support networks, in the absence of substantial professional networks of support. They not only made use of traditional methods to achieve their reproductive goals but also made use of modern methods by using Artificial/Assisted Reproductive Technologies like IVF. They negotiated traditional norms to their benefit by securing adoption. Their social location and social privilege played a part in this, which in many cases was an achieved status. In the choice of hospital and choice of delivery, respondents had a major stake in decision-making though they felt informed consent was not obtained for c-sections. This has serious implications for their overall health and bodily autonomy and bodily image They articulated a concern not just for their physical well-being but also mental well-being. Thus, the experience of reproductive healthcare is varied and enabling. It offers an avenue for women to assert their choices and in the process empower themselves.

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