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Awareness and knowledge assessment of reproductive rights among the tribal women of Lahaul and Spiti, Himachal Pradesh (India)

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Abstract

In the mid-nineteenth century, the women rights movement paved the way for various rights for women's freedom. Numerous movements emerged around the world to stand against the conservative and surveillance society, which controlled basic women's rights over pregnancy, birth control, family planning and abortion etc. Advancements in science, technology, and state legislation gave voice to the campaign for women's rights. In this context, the ICPD conference in 1984 emerged as a watershed moment in women's sexuality rights, known as reproductive rights, which aimed to give women control over their own bodies. As a concept of recent terms, the current study is an attempt to assess the knowledge and awareness of reproductive rights as well as to evaluate the healthcare services of the tribal women in the selected areas of Lahaul and Spiti. In the study, it was found that quite a few number women were aware about the concept of reproductive rights, including family planning and healthcare services, but due to the isolated and difficult terrain, the healthcare services were in terrible conditions, violating their reproductive rights.

Keywords: Reproductive rights; Tribal women; Family Planning; Healthcare services

Introduction

Reproductive Rights: An Overview

"Can a man be free? If woman be a slave?"

-Perscy Bysshe Shelley (1817)

Due to the conservative and restricted society's control over pregnancy, birth control, family planning, and abortion, numerous movements have emerged in the USA. To speak out against the surveillance society, especially regarding pregnancy, many women had to wait centuries for advances in science, technology and state legislation. Less than a decade ago, women's rights, which include self-management of their bodies, began to fill the void. Many feminists and legislators saw it as a potential law. This paved the way for the right on sexuality

The term reproductive rights was first ratified in Amsterdam in July 1984, just before the World Population Conference (ICPD) in Mexico City, at a women's international tribunal and meeting on reproductive rights convened by the International Campaign on Abortion, Sterilisation, and Contraception (ICASC). 'Population Control: No. Women Decide!' was its slogan. The summit in Amsterdam was expected to be the pinnacle of the International Reproductive Health and Rights Movements.

The 4th World Women's Conference held in Beijing in 1995 was path breaking as it was the first time in adoption of Action oriented or the platform of action in the following paragraph

"the human rights of women include their rights to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

This platform's statement was hailed as a watershed moment for not only defining human rights but also reproductive rights for women and men. For the first time, the World Health Organization listed reproductive rights as one of the main rights on its agenda for both men and women. The Beijing Platform of Action forbids the use of the terms "sexual rights" or

"sexual orientation" at this time; instead, "reproductive rights"—defined as "the ability to reproduce and the freedom to decide if, when, and how often to do so"—are now permanently defined and summarised in both the Cairo Program of Action and the Beijing Platform.

In the International Conference on Reproductive health (1998), Dr. Carmel Shalev, explained what is reproductive rights, according to her "reproductive and sexual rights are right to life, liberty and security to the person; right to healthcare and information and the right to non-discrimination in the allocation of resources to health services and their availability and accessibility". Sexual and reproductive rights, according to the United Nations Human Rights Organization, are important in eliminating all types of discrimination against women. In this regard, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was established to investigate issues concerning women's issues.

In the context of human rights, reproductive rights refer to the independence and control of a woman's own body, as well as her right not to be deterred from her sexual and reproductive capability (Dixon-Mueller 1993). Both the right to choose when and how many children one wants to have, as well as the right to use family planning methods and services, are significant components of women's reproductive rights on the global platform. The "right to have control over one body" is the final component that has yet to be announced on the international platform.

The final component, which must be recognised by international instruments, is the freedom from sexual assault, harassment, physical violence, unwanted and exploitative social relationships (child abuse, incestuous relationships, prostitution, rape, and child sexual harassment, among other things), as well as unwanted medical interventions and bodily mutilations (including circumcision).

According to Sundari Ravindran, 2001 reproductive rights include:

- The right to life
- Rights to bodily integrity and security of the person (against sexual violence, assault, compelled sterilization or abortion, denial of family planning services);
- The right to privacy (in relation to sexuality)

- The right to the benefits of scientific progress (e,g, control of reproduction);
- The right to seek, receive and impart information (informed choices);
- The right to education (to allow full development of sexuality and the self);
- The right to health (occupational, environmental);
- The right to equality in marriage and divorce;
- The right to non-discrimination (recognition of gender biases).

Violence against women, maternal mortality, inadequate health care, and a lack of family planning services are all factors that contribute to the infringement of reproductive rights all over the world (United Nations Human Rights Institution Handbook, 2014).

Reproductive Justice:

During the establishment of reproductive rights in the late 1950s, the concept of reproductive justice evolved as a result of a social movement and in a more sophisticated approach (Price, 2010; Ross, 1992). The term reproductive justice arose from the agitation of women of colour, authors, intellectuals, activists, and organisations who were fed up with the pro choice paradigm's individualistic approach to reproductive rights and wanted to integrate reproductive rights into a larger social justice movement (Price, 2010). The reproductive justice root was established within the reproductive rights framework to change the way reproductive freedom is understood by paying attention to intersectionality by identity and connecting reproductive rights with social issues such as economics, immigration, environment, education, globalisation, and degradation (Price, 2010; Smith, 2005). To advocate for abortion is to ignore the inequalities that exist among women and, as a result, the perspectives of women who are disadvantaged because of their age, race, sexual orientation, ability, or socioeconomic status are not taken into consideration (Price, 2010; Smith, 2005; Solinger, 2001; Ross, 1992). Instead of articulating women's intrinsic rights over their bodies, the pro-choice paradigm offers women the freedom to choose, which further reinforces the limits placed on women's choices (Price, 2010; Smith, 2005; Solinger, 2001). The adoption of this paradigm by worldwide organisations and communities is evidence of the rising acceptability of this perspective. World Health Organization, UN, and CEDAW have integrated a reproductive justice approach to their relative positions on sexual consent, access to contraception, access to abortion,

transparency in sexual and reproductive health, confidentiality between doctors and patients, and conscientious objectors (Cook & Dickens, 2009).

According to a UNICEF survey done in 2010 termed the "subsequent coverage survey 2010," there has been little progress in satisfying women's reproductive health needs. The statistics show that in India, women's reproductive options, decision-making, and high standards of sexual and reproductive health are far from reality. Women who are impoverished, uneducated, and socially disadvantaged have greater rates of mortality and illness (Chatterjee & Sheoran, 2007).

The Government of India (GOI) has tried addressed the situation, India is signatory to the Programme of Action of the International Conferences on Population Development (ICPD) in 1994 which stated

“Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights 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 the rights to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents”(UNFPA, Danish Institute of Human Rights & United Nations Human Rights, 2014)

The Indian Supreme Court has held that failing to give timely medical care is a breach of Article 21's right to life (Kumar & Gupta, 2012). Women's health indicators would reflect the country's fundamental rights to life, equality, reproductive health, and autonomy. At a systemic level, India's low performance on health indicators has been mostly attributed to inefficiencies in health service availability, accessibility, acceptability, and quality, notably in the public sector health system (Centre for Reproductive Rights, 2008). As a result, it is critical to integrate reproductive rights in country plans and policies on a regular basis in order to implement and develop them.

Reproductive Rights in District Lahaul and Spiti

The tribals of India constitute about 8.2% of the total population. Majority of Indian population are non-tribals and mainly are followers of Hindu (82.41%) religion (Census of India, 2001).The traditional Tribal Indian social system must be understood in the context of mainstream economic development. Due to the conservative and restricted society's control over pregnancy, birth control, family planning, and abortion, reproductive rights have emerged as a result of numerous movements in the United States of America. For many centuries, social control over women's bodies and pregnancy was like a vacuum, and it was only after advances in science, technology, and the establishment of state legislation that many women began to speak out against the surveillance society, particularly about pregnancy. Women's rights, which include the ability to manage her own body, began to fill in the void that had been pulling women behind for decades. Many women's advocates, feminists, and legislators saw it as a prospective law.

India was one of the first countries in the world to make reproductive rights policies legal. However, it faces numerous obstacles in implementing reproductive rights. The dominance of patriarchal society, lack of decision-making power among women, cultural and religious penalties connected to women's rights, and other major obstacles may be found in various sections of the country.

In Himachal Pradesh, a commission named the Social Uplift Through Rural Action (SUTRA) was founded, and it was implemented in five districts of the state between 2012 and 2015. The dropping sex ratio, women's reproductive health, and the adoption of innovative family planning methods were the key issues discussed. This commission was not implemented in the research area of Lahaul and Spiti, and there are no other particular reproductive rights missions or schemes in the area or state beyond 2015. According to an article, Lahaul and Spiti faces a different population problem than the rest of the country, namely population loss due to a -5.0 percent decrease in Total Fertility Rate between 2001 and 2011. The district's rural population is declining, and the fertility rate is decreasing (A. Phull, 2018)

The present study was carried out in one of the most remotest area of India, Lahual and Spiti. The area, is located 200 KMs from the capital of Himachal Pradesh which is Shimla and is famous for its difficult and treacherous roads. It is cut off from the rest of the country for 6-8 months during long harsh winters. The roads are blocked and cannot be

cleared due to constant snowfall and danger avalanche. The study was carried out to find out the level of awareness and knowledge regarding reproductive rights among the women in two areas of the district.

Objective of the study

- To assess the awareness and knowledge regarding reproductive rights among the tribal women of the selected area.
- To evaluate the healthcare services in the selected area in relation to women's reproductive rights.

Research Methodology

The study was carried out in the Himalayan state of Himachal Pradesh, India. The district of Lahaul and Spiti which is the largest district of the state, and was selected on the basis of lack of research related to reproductive rights. The data was collected from the married women of the age group between 18 years to 49 years. This age group was taken so that the scope for the collection of data widens as the researcher wanted to include younger women who are gaining new reproductive health knowledge and experiences as well as older married woman in their reproductive age with their knowledge and experiences. One married woman from each household who are within the reproductive age group was interviewed. Furthermore, the husbands and other family members' opinions and influence was also monitored.

Total number of villages taken for the study was 4, two from each sub district of Lahaul and Spiti. The villages were selected through purposive sampling method, keeping in mind the accessibility of the villages as also, the total sample of 70 **households** was taken for the study through proportionate sampling. One married woman from each household was interviewed for the study which makes it 70 respondents. The households to be selected for the study was taken through random number tables.

The intention is to conduct both qualitative as well as quantitative research. Interview schedule was used for gathering information from the respondents, which were the married women. The interview was largely informally structured with a checklist of (open-ended) questions. Secondary data was also used in the study from books, journals, published and unpublished materials, periodicals, surveys and census conducted by the recognised

groups, newspapers, research reports, etc. After collecting the data SPSS (Statistical Package for Social Sciences) was used to decode and data analysis.

Data analysis and results:

The socio-demographic and economic profile of the respondents in the selected area were of average age between 25 to 35 years, >50% of the respondents were from the Hindu religion followed by Buddhist which was approx. 40%. >50% of the respondents were at least high school graduate along with >40% belonged to the upper caste and 40% to lower caste. 35% of the respondents were self employed, and with average family monthly income of 10,000 to 15,000 rupees ($129.95- $194.92).

Table 1.0 Distribution of the respondents on their awareness of Reproductive Rights

S.No.	Knowledge about Reproductive rights	Number of responses	Percentage %
1	Yes	31	44.8
2	No	39	55.2
	Total	70	100

According to Table 1.0, 55.2% of respondents were unaware of reproductive rights. Sadia Saeed 2021 stated that reproductive rights are human rights. It may impact women's capacity to get health care. Despite the emphasis on reproductive rights nationally and internationally, especially in underdeveloped countries, little effort has been made to educate women about reproductive rights. As a result, the impact of reproductive rights information among women has been minimal, far behind the targets intended. Despite the remoteness and difficulty of access, 44.8 percent of the women knew about reproductive rights. They had heard about reproductive rights in school or from health providers but did not know much about these rights.

In India, the patriarchal social structure hinders women's empowerment, notably in decision-making. Women are heavily dependant on men in rural regions, and men do not expect or ‘allow' women to make their own reproductive health decisions. The study also indicated that only 44.8% of women knew about reproductive rights, with the large proportion of respondents learning about reproductive rights at school (58.4%). In an informal interview with local health workers, it was discovered that approx. 20% had real knowledge about reproductive rights. Therefore, even though the women in the area were

in a very isolated place still they were somehow aware of reproductive rights. Though they exactly did not know about what rights do they hav, but they had read about it or learnt about it through school or health workers.

Table 1.1 Distribution of the respondents on the basis of their freedom related to making sexual relation with their partner

S.No.	Freedom in sexual relations with partner	Number of responses	Percentage %
1	Yes	62	88.6
2	No	8	11.4
	Total	70	100

Table 1.1 of the study reveals that 88.6% of respondents have the freedom to engage in sexual activity with their spouse, while 11.4% do not. As part of human rights, reproductive rights are viewed as a woman's freedom to engage in sexual activity with her spouse. Therefore, the freedom to engage in sexual relations with a partner is a measure of women's standing in the region. Moreover, it suggests that women play a part in their relationships.

Table 1.1 (a) Distribution of the respondents on the basis of refusing their partner for sexual relations

S.No.	Ever said no for sexual relation to partner	Number of responses	Percentage %
1	Yes	62	88.6
2	No	8	11.4
	Total	70	100

Many women in South Asian countries revealed that the majority of males view sex after marriage to be their right, while women have no say in the matter (UNPF, 2021). In the present study, 88.6% of respondents were determined to have control over their sexual relationship. 11.4% of respondents do not have the right to refuse sexual requests from their husband. The women in the selected location have the right to make decisions, as 88.6% refused sexual demands and the remaining percentage consisted of uneducated and older women. This indicates that elderly women lacked decision-making authority compared to their younger counterparts.

Table 1.2 Distribution of the respondents on the basis of whether they discuss their sexual life with other people

S. No	Discuss sexual life with other people	Number of responses	Percentage %
1	Yes	37	52.9
2	No	33	47.1
	Total	70	100

In many cultures, discussing sexual interactions or sex is considered taboo. In traditional Indian philosophy, sex is feared, and modern dogmas have modified the attitude, making sex and its discussion forbidden. Sexual behaviour has gone from being sacred to being taboo. On average, 52.9% of respondents share their sexual life with anyone besides their spouses, while 47.1% do not..The study indicated that compared to women who did not casually discuss their sexual behaviour, 52.9% of women did so. Thus, the generational component of female sexuality did alter the study's women's responses.

Table 1.2 (a) Distribution of the respondents on the basis of with whom they are discussing their sexual life.

S.No.	If yes, then with whom	No. Of responses	Percentage %
1	Friends	22	59.5
2	Relatives	2	5.4
3	Sisters	13	35.1
	Total	37	100

On average, 59.5% of respondents discussed their sexual life with friends, 35.1% with sisters, and only 5.4% with relatives. Sisters and friends were the most comfortable groups with whom sex was discussed. With the process of enculturation the symbolic exchanges on sex and sexuality are socialised over time and space.

Table 1.3 Distribution of the respondents on the basis of their freedom to have number of children

S. No.	Freedom to have number of children	Number of responses	Percentage%
1	Yes	53	75.8
2	No	17	24.2
	Total	70	100

According to the chapter's table 1.3, 75.8% of respondents are free to have the number of children they want. In order to get the number of children they want, 24.2% of respondents stated their families' opinions and directions are important. Women's reproductive rights include the right to choose how many children to have. This shows the area's female status. Women are treated as property, married young, and given no control in childrearing. Men and women in cultures that do not promote gender equality frequently have pity status, with little control over when and how many children they have. This is one of the reasons why women lack rights in most countries. Hence, the table shows that most of women decide on the number of children they want. Women in the area have decent liberty in determining whether or not to have children. This automatically elevates women's status.

Table 1.4 Distribution of the respondents on the basis of their freedom to choose family planning methods

S.No	Freedom in family planning	Number of responses	Percentage
1	Yes	37	52.9
2	No	33	47.1
	Total	70	100

The current table demonstrates that 52.9% of respondents have freedom to choose family planning methods and just 47.1% do not. Family planning methods are part of reproductive rights, which are part of women's rights. Despite the known benefits of modern contraception and family planning, especially in protecting women's health and asserting their reproductive rights, more than 225 million women worldwide have an unmet need to avoid an unintended pregnancy (Sing, Darroch & Ashford, 2014). The ability to make decisions about one's own reproductive life and the timing of parenthood is linked to higher marital stability and women's status (National Campaign to prevent teen and

unplanned pregnancy, 2008). The capacity to make family planning choices could be the difference between poverty and poor health for women. Compared to other studies, this study's findings are conflicting. It reveals that even though these women are indigenous and live in remote areas, they are aware of and employ family planning methods. This not only helps comprehend the status of women in the area, but also that they have reproductive rights and make their own reproductive rights decisions.

Table 1.5 Distribution of the respondents on the basis of family pressure on having children at certain age

S. No.	Family Pressure on having children at certain age	Number of responses	Percentage
1	Yes	26	37.1
2	No	44	62.9
	Total	70	100

India's uncontrolled population problem focuses on family planning. The Indian government has launched numerous plans and programmes to promote the adoption of family planning methods. Problems with female decision making are frequent in India's close-knit rural society. Family has a vital part in maintaining women's place in society. In-laws usually dictated family size. In-law pressure to have children was stronger in homes with less educated or illiterate women (Kartikeyan; Chaturvedi, 1995). An estimated 37.1% of respondents were pressured by their families to have a certain number of children. The fundamental goal of family planning is to have the desired number of children and to space them properly (K. Gogoi, 2017). Many women in communities had blended families, affecting their ability to make family planning decisions. Some of the ladies were more inclined to have children due to family customs. The culture played a role in deciding how many children to have. The majority of women in the study area do not feel family pressure to have a large number of children.

Table 1.6 Distribution of the respondents on the basis of their family acceptance of family planning methods

S.No	Family accepts family planning	Number of responses	Percentage
1	Yes	36	51.4
2	No	34	48.6
	total	70	100

Safe motherhood and reproductive health rights are based on family planning (A. Barrows, 2020). Family Planning can reduce maternal mortality by 40% and infant mortality by 10% by preventing unplanned and unwanted pregnancies (Campbell and Graham, 2006). In the current study, 51.4% of respondents' families accepted family planning methods to some degree, whereas older women and their families had doubts about the methods. It was the rumours of negative effects and higher costs that made women's families reluctant to use other family planning methods than condoms for men. In some areas, like Key and Stingri, where there were no pharmacies, clinics, or chemists, ASHA and AWWs provided contraceptives to the couple. In a culture that values children and considers them a gift from God, limiting medications may not be well received.

Table 1.6 (a) Distribution of the respondents on the basis of reasons of the family to not support family planning methods

S.No	If No, reasons for not supporting	Number of responses	Percentage
1	Not aware	5	14.8
2	Conservative	4	11.7
3	Skeptical	25	73.5
	Total	34	100

Cultural belief, tradition, and individual perception all play a role in tribal communities' acceptance of modern family planning. Many tribal societies still practise unhygienic and risky reproductive practises due to their traditional sexual and child rearing customs (S. K. Palo; M. Samal; J. Behera; S. Pati, 2019). In the current study, 48.6% of respondents' families reject methods of family planning, with 73.5% of respondents' families rejecting due to uncertainty and lack of confidence. The respondents' families refused to use family planning methods due to rumours about infertility, defective foetuses, and infection. 11.7%

of respondents are not in favour of adopting methods that will control on having children due to conservative and religious barriers. About 14.8% of the respondents were either illiterate or from a very poor background which resulted in lack of knowledge and awareness regarding family planning. The study found that educational, cultural and economic factors influenced the use of family planning methods.

Table 1.7 Distribution of the respondents on the basis of distance of health care from their home.

S.No	Distance from health care	Number of responses	Percentage
1	Less than 1 km	3	4.2
2	1-10kms	13	18.6
3	10-20kms	50	71.4
4	More than 20 Kms	4	5.8
	Total	70	100

The table 1.7 of the study shows that 71.4% of the respondents had health care services in between 10-20kms distance and 5.8% of the respondents had distance more than 20 kms radius from their homes. The village chosen was on the basis of availability of health care services. The district headquarters like Keylong and Kaza where the respondents had shorter distance to the healthcare services, whereas the areas such as Stingri and Key which itself was about 20-30 Kms from the main headquarters had longer distances to the healthcare services for the respondents. The geographical area also played a vital role in the distance of the healthcare services. The walkable or mobile transportable roads made the distance longer, due to the hilly and mountainous region. 10-20 kms distance takes almost 1 hour by vehicle and 2 hours on foot. Thus, making it difficult for a large proportion of women to reach or access the healthcare services. Which itself violates the reproductive rights of the women in the study area.

Table 1.7 (a) Distribution of the respondents on the basis of transport facilities availability

S.No	Transport facility available	Number of responses	Percentage
1	Yes	12	17.2
2	No	58	82.8
	total	70	100

Table 1.7 (a) of the study indicates that the 82.8% of the respondents do not have transportation in the village and only 17.2% have transportation facilities from their home. Transportation is vital in getting to the hospital or health worker quickly. Rural/tribal populations' health and well-being are impacted by transportation. Rural or tribal residents rely on personal vehicles, public transportation, and non-emergency medical transport. Lack of transportation can lead to missed healthcare appointments, delayed healthcare interventions, and missed or delayed medication use, all of which can negatively impact health management. Traveling long distances can be harmful to one's health. These conditions affect women, especially pregnant women. The study shows that quite a large number of women are denied the access to better transportation. Many women face serious problems especially during winter when there is absolutely no transportation due to very heavy and terrible snow and landslides. Thus, again violating the reproductive rights of women.

In an informal interview with these women it was found that during emergency with health issue respondents abide by local health care worker if not available then local shaman (traditional healer) and if that is also not available then these respondents ask their relatives, neighbours or local villagers for help. There have been many incidents where the women (especially pregnant women) are taken on a yak or cows during the winters in the snow to the healthcare centres.

A few suggestions were asked from the respondents on what type of facilities they prefer in their area. A large proportion of women suggested of having proper infrastructure and availability of health workers including doctors and nurses. The medicines availability is also very limited. The area consists of Government Hospitals, Primary and Community health centres run by the government. The problem is that the doctors and nurses appointed do not want to stay in that area due to the harsh weather, isolated area and difficult terrain, thus the healthcare centres are very understaffed. This creates a huge problem for there locals and they have to visit other districts like Shimla and Kullu which are about 200Kms from these selected areas, making it very hard and treacherous journey especially if someone is unwell.

Summary and Conclusion

In the beginning of the study it was pre-assumed that the women would lack awareness regarding reproductive rights due to the location of the area. But, it was found that even

though the area is isolated, cut-off from the rest of the country for 6-8 months during winters and lacks many basic facilities, still the women even though <50% were aware of what reproductive rights were. The media's involvement in promoting reproductive rights was negligible. The hospitals in the selected areas are already understaffed, limiting patient/woman access to doctors and discouraging understanding or awareness of reproductive rights among the population. The data shows that school education imparted maximum awareness regarding reproductive rights, followed by doctors and nurses. One of the important rights in reproductive rights is control over ones body. The right to refuse sexual demands of the partner, this study shows that major portion of the women had a say and denied sexual demands of their partners. The concept of female sexuality is very rarely discussed especially in the countries like India, where it is considered personal or private. Talking about sex and sexuality among women is rarely talked about but it is very much there and women talk about it among themselves but here when describing sexual behaviour, consider gender and generational viewpoints (Ndinda, 2011). Contrary to popular belief, sexuality is a socio-cultural notion (G. Reddy; S. Sumathi & M.P. Damodaran, 2009). It was noticed that in the study women of younger age group did talk about sex and sexuality with their friends and relatives but women who were of older age group did not prefer talking about it. Every human being has the right to good reproductive health education and information. The understanding of various sexual and reproductive health issues can aid women in the long run because they can get treated sooner if they are aware of the issues. Because reproductive health issues are stigmatised, they are rarely discussed in society. The present study revealed that despite the location being in India's tribal areas, a large proportion of women had knowledge about various reproductive health and related problems and diseases such as STDs, RTIs, UTIs, HIV/AIDS and even sexual violence The majority of respondents were aware of various reproductive health issues affecting women's bodies and minds. It was found that the respondents learned about these diseases and issues from school education and doctors. In context to adopting family planning methods and the acceptance of such methods by their families, it was clear that >50% of the respondents had positive and were free to make decisions on adopting family planning methods. The last important point related to reproductive rights was accessibility and reachability to healthcare centres and services which seemed to be very poor in the area. The women living away from the main headquarters had terrible time seeking healthcare facilities and on time. Only women living near the headquarters like Keylong

and Kaza were able to seek healthcare facilities but, with lack of many facilities such as lack doctors and lack of medicine and a very limited infrastructure etc.

Hence, the study very well revealed the overall awareness and knowledge of reproductive rights among women in the area. The lack of any such facilities which hinders women's reproductive health as well as her dignity is a violation of their reproductive rights. If the women are not getting the basic facilities in health or family planning or the family is unsupportive of her decisions is a contravention of her rights. Many women even well educated do not know or are ignorant of their reproductive rights which leads to further abasement of their dignity and their life.

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