Chapter 12 : Recommendations for Policy Making

The secondary literature and case studies reveal that women’s physical, social, mental and sexual health should be prioritized both at the family level and at the policy level. “The reproductive health and rights should be in the centre of the policy making process, both directly-by adding them to the MDG agenda-and also more discreetly, by means of some of the suggestions. Reproductive health must be brought into the MDG Project agenda through a consortium of agencies headed by the International Planned Parenthood Federation” (Basu, 2005).

In addition to the reproductive child health, policies should be based on adolescent women’s sexual and reproductive health. Women who have not conceived have several gynaecological and sexual health issues which need to be addressed in the policies. Reproductive and sexual health do not always imply motherhood. Women who are not mothers also have sexual and gynaecological issues which are not mentioned in the MDG targets of women’s health. These issues must be reflected in the women’s health policies.

The social vulnerabilities must be addressed for ensuring reproductive health. One strategy for addressing this issue is the legal approach. It means that the state is obligated to play a crucial role in promoting reproductive rights. The state may respond to the political pressure brought upon it by women who fully participate in the decision making process of initiating new reproductive rights provision (Mann, 1997). The human rights framework may be used for analysing and understanding the social-structural roots of reproductive health (Wang & Pillai, 2001).

There should be research that “involves women’s rights in the area of reproductive health” as a “neglected area” and calls for increased attention on the part of social scientists to
reproductive rights and reproductive health policies. (World Bank, 1994). The nulliparous
women also have their reproductive and sexual choices. They have never borne an offspring
but that does not mean that they do not have sexual and reproductive rights. Women’s basic
healthcare facilities should evolve in the healthcare system in order to ensure their reproductive
health status.

There is also great need to incorporate women in the discourse of population as mentioned by
the Cairo Programme of Action. The women’s status should improve including their
reproductive health and freedom, environment and sustainable socio-economic development.
There should have been a consolidated feminist agenda regarding the policies as described in
the Beijing Declaration. There should have been a steadfast commitment to protecting
women’s reproductive freedoms and health, in addition to tackling poverty and improving
education, health, the environment, and the situation of girl children (Norwood, 2009).

Feminists (see for instance Kabeer, 1999) talks about “complex manifestations of
power that contribute to women’s subordination. Policies cannot be implemented without
substantially questioning the dynamics of power and inequality in the society. Women’s
position in society should be a key attribute while developing policies for women”.

At the societal level, Ginsburg and Rapp (1995) posited that “in developing countries a
large proportion of women remain excluded from social and economic participation despite
increases in the level of economic development. The power arrangement involved in societal
relations can leave women’s right to reproductive health care stunted (Yamin, 1996). The need
to empower women through social policies is thus essential for successful public policies
designed to improve women’s reproductive health. Women can get reproductive and sexual
empowerment if they have accessible reproductive health services. The above success depends

Nulliparous is the medical term for a woman who has never given birth to a viable, or live, infant. See
http://womenshealth.about.com/od/womenshealthglossary/g/nulliparous.htm
on the effectiveness to address the social, economic, and political vulnerabilities that jeopardize the health of select subpopulations and groups” (Mosley & Cowley, 1991).

“A gender sensitive human rights approach to women’s reproductive health is needed where the social and personal meaning and the costs of having the children from a woman’s point of view will be encouraged. The process and outcomes of development policies should benefit women. Programmes and policies will be designed keeping in mind this approach” (Wang & Pillai, 2001). For attaining right to reproductive health focus should be there on women’s equity and empowerment. There are no single "magic variable" that would work uniformly well in reducing high fertility rates. What is needed instead is a unified approach that places different variables within a general framework of family decisions on fertility. There is a need to generate awareness at the community level about contraception and safe abortion, in both rural areas and urban slums. The advantage of bringing gender equity and women's empowerment to the center of the stage is that they provide a broad perspective that can accommodate many of the major influences on reproductive decisions. This includes acknowledging the role of educational development (including the schooling of girls), economic arrangements (including female job opportunities), social concerns (including the status of women), and cultural factors (including the value of equity). (Sen, 2001)

Sex-selective abortion, sexual health of women, mental health and primary health rights of women are not included in the MDG targets of women’s health. The same observations can be made while analyzing the case studies. The above health rights are not ensured in majority of the case studies. These observation are very useful while making recommendations after completing my research work.

From the case studies it is very evident that women should have a decision making ability regarding their health rights and they should take part in policy decisions regarding
reproductive health. Women should have the right to make their own decisions regarding reproduction, they should have the freedom of choice regarding reproduction, sexuality and fertility. “The expansion of family planning may appear to be just a demographic intervention, but the real opportunity to practice family planning can also be seen in the broader light of enhancing the decisional freedom of families in general and of vulnerable women in particular. It is important to bring together, under a unified framework of understanding, the diverse influences on fertility reduction that have been identified in the empirical and statistical research. A variety of institutions have constructive roles in this crucial social transformation, including family-planning centers, elementary schools, land-reform facilities, microcredit organizations and free newspapers and other media for unrestrained public discussion. These distinct institutions have their respective roles, but there is a need to integrate the processes of social change that they separately but interactively induce. For example, the debates-often bitter-between advocates of family-planning facilities and female education must give way to a more integrated approach. The crucial issue is the need to recognize that a responsible policy of fertility decline demands gender equity, which is, of course, crucially important for other reasons as well. The way forward is through more freedom and justice, and limiting coercion and intimidation. The population problem is integrally linked with justice for women in particular “(Sen, 2001) Women can get reproductive, sexual, social, economic and political only if they come out in public and raise their voices. In the conclusion we can say by referring to Prof. Amartya Sen that the voice of women is critically important for the world's future-not just for women’s future” (Sen, 2001)
Here spontaneous abortion and forceful abortion have also been included. It means that some of the women who are pregnant for second or third time may have spontaneous abortion or forceful abortion earlier.

The details of the occupation of husbands are not studied or analysed. Their occupations mostly include factory workers, rickshaw puller, auto driver, vendor, tea stall worker, caretaker, embroidery worker.

The health status of all the three category of respondents includes number of diseases. The nature and explanation of the diseases are mentioned in details in the case studies, Chapter 10.

It may be mentioned that the results present from the religion category of all the respondents do not tend to generalize anything within this small data. It does not have any bias over any religion or it is not intended to hurt anybody's religious sentiments. The observations have been made in course of the field survey and the figures have been derived. More light can be drawn from the case studies. But they are unique and independent in nature and do not generalize or make any conclusions based on their religious status.

The perception level regarding mental health is poor in both the groups. It is only after asking several questions we can understand their level of mental distress. An adolescent woman (both married and unmarried) may give rely that he does not have any mental health problem or she does not know about mental health issues. But after asking questions it can be understood that she suffers from depression which she never realized consciously.