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REPRODUCTIVE RIGHTS OF WOMEN IN INDIA WITH FOCUS ON TEA PLANTATION WORKERS OF SONITPUR DISTRICT OF ASSAM, INDIA

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ABSTRACT

Health is the pillar of all human activities and a crucial element of human happiness. Generally, reproductive health refers to the healthiness of reproductive systems of both males and females, during all life stages. Good reproductive health ensures that individuals will reproduce and have the liberty to determine whether to reproduce, when and how often to reproduce. In this regard, information and access to a practical, affordable, safe, and acceptable method of contraception and the right to standard healthcare services that enable safe pregnancy and childbirth are essential. Women's reproductive health encompasses numerous human rights viz. the right to health, the right to education, the right to privacy, the right to be free from torture, and the prohibition of discrimination. This paper highlights women's reproductive rights under the ambit of the Indian Constitution, legislative provisions, and various National and State policies. The paper further throws light on the current status of availing safeguards envisaged by these provisions by a particular section of the population, viz. tea garden workers. The study area pertains to some of the Tea Estates in the Sonitpur District of Assam, India. The study depicts the status of reproductive health of women in the study area. It is observed that the health status of these women presents a bleak picture. The paper suggests remedial measures to bring the status of the study area to an acceptable level.

Keywords: Reproductive health; women; tea plantation; Assam

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1. INTRODUCTION

Reproductive health implies all aspects of human reproduction. Men and women should be informed about and must have access to practical, affordable, safe, and acceptable family planning methods of their choice. According to the definition of reproductive rights, as given by World Health Organisation, these rights are reflected in an individual's ability to decide, without any apprehensions, the spacing, number, and timing of their children. It also incorporates all individuals' rights to take decisions concerning reproduction without discrimination, pressure, and violence as expressed in human rights documents (United Nations, 1994). World Health Organization (WHO) states that sexual and reproductive health involves five key components, viz. (i) ensuring family planning choice along with access to safety and infertility services; (ii) improving maternal and

newborn's health; (iii) reducing infections such as sexually transmitted diseases, HIV and other reproductive diseases; (iv) obliterating unsafe abortions and providing post-abortion care; (v) supporting healthy sexual life, including adolescent health, and reducing harmful practices (United Nations Population Fund (UNFPA), 2020).

In simple words, women's reproductive health implies a congenial environment that allows them to have a safe pregnancy and childbirth without any health hazards (Fathalla, 1992). Furthermore, reproductive health comprises sexual health, which aims to enhance personal relations and understanding among couples, provide care and counselling related to sexually transmitted diseases and reproduction (Coll-Black et al., 2007) Women's reproductive rights may incorporate some or all of the followings: the right to education and access to information enabling free and informed reproductive choices; rights to legal and harmless abortion; freedom from forced sterilisation and contraception; the right to birth control; and the right to availing quality reproductive healthcare. Women worldwide struggle for control over their bodies and health, which is considered a fundamental human right. When women's right to reproductive health is well recognised, it is not only the women who win, but their children and the community also win. In 2012, the United Nations (UN) declared access to family planning alternatives as a universal human right, but the unmet need for birth control for women worldwide is astonishingly high (Campbell et al., 2016). Threats to women's reproductive health are still leading to death and illness among the poor section of the population due to restrictions, ignorance or not having proper access to information (Sivagurunathan et al., 2015). Reproductive rights lead to women's empowerment by letting them decide how many children to have, the spacing, and the contraception methods to be used, along with awareness regarding healthy reproductive life. The benefit of awareness of reproductive health among women also leads to a proper family planning decision that further controls the community's population. All these make a woman to have a strong position in the family and increases her decision-making skills. The reproductive health condition of the millions of women worldwide, particularly women in developing and underdeveloped countries, has been reported as pathetic (Filippi et al., 2006; Glasier et al., 2006; Gupta, 2000; Jejeebhoy, 1997). It is also observed that this has resulted from the complications associated with various maternity issues such as complications in pregnancy, pre-natal & neonatal mortality, and unsafe abortion. Reproductive Health rights are a fundamental human right. So the responsibility lies on everyone to ensure the womenfolk healthy empowerment of their reproductive health.

At the International Human Rights Conference of the United Nations in1968, reproductive rights were adopted as a subset of human rights (Freedman and Isaacs, 1993). The Act (Final Act of the International Conference on Human Rights) formulated during the conference is regarded as the first document that formally included reproductive health rights within the human rights classification. Section XVIII of the Act established parents' ability to decide the number and spacing of their children conscientiously and freely as a fundamental human right. Additionally, the Act also emphasised the provisioning of rights to education and access to information regarding these aspects (United Nations, 1968). In 1975, the Declaration of Mexico on the Equality of Women and their role in Development and Peace assured the principle of the human body's purity and also highlighted equal rights within the family (Henkin, 1989).

The Vienna Declaration and Programme of Action was approved at the World Conference on Human Rights in 1993. Section 3 of the Declaration explained women's right as their right to access adequate health care, the broadest range of family planning services, and education at all levels, including sexual education, as the pillars of reproductive health (International Review of the Red Cross (ICRC), 1993). However, the International Conference on Population and Development (ICPD) and Programme of Action for the first time recognised that fulfilling the rights of the female population is central to the development of a country. ICPD Program of Action was momentous in noticing that reproductive health rights, gender equality, and women empowerment are the foundations of development programmes. The World Conference on Woman in 1995 (Beijing Declaration and Platform for Action -IV) is a significant turning point in women's health. The United Nations Millennium Development Goals (MDGs) was signed by world leaders in 2000, where maternal health was recognised as one of the development goals. MDGs have aimed to reduce the maternal mortality rate between 1990 and 2015 (Khanal, 2018). India was able to achieve an MMR of 139 per 100000 live births against the target of 130 under the MDGs. Consequently, India is well in track for achieving an MMR of 70 by 2030 under the Sustainable Development Goals that were adopted by world leaders in September 2015 at an historic UN summit and came into effect from January 2016 (Yadav et al., 2020).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979, was also adopted to secure and give one equilibrium Society to women (Byrnes, 2011). Article 12 of CEDAW provides for the human right to health, which compels the States parties to initiate appropriate mechanisms that eliminate discrimination against women concerning health care. State parties are obligated to ensure health care facilities based on ensuring equality of both sexes, including providing access to family planning methods. It further ensures women appropriate and free medical care, where necessary, and adequate nutrition during pregnancy, post-natal period and lactating period (Cook, 1994). Under Article 14, State parties are also

responsible for establishing appropriate methods which abolish discrimination against women in rural areas. It also emphasised the equal involvement of both sexes in rural development and ensured women's right to access good health care services, including information, counselling, and family planning services (Facio and Morgan, 2009). International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); and the Convention on the Rights of the Child (CRC; and several other global organisations have recognised reproductive rights. Being a signatory country to these covenants, India is expected to provide the best health services for women, enabling the safeguard of their reproductive health.

The paper discusses women's reproductive rights under the ambit of the Indian Constitution, legislative provisions, and various national and State policies. The discussion aims to serve as a handy reference for researchers, policymakers, and other people interested in this aspect. Tea garden workers are a vital part of Assam, India's economy; the paper throws light on the current status as to availing of safeguards envisaged by these provisions by tea garden workers as a case study. The case study pertains to some of the Tea Estates in the Sonitpur District of Assam, India. A survey was conducted to assess the scenario relating to maternal health of tea garden workers in three tea gardens of the Sontipur District of Assam, India viz. Hahchura, Sonabeel and Tulip Tea Gardens. The study depicts women's reproductive health status in the study area and suggests remedial measures to bring the study area's status to an acceptable level.

2. METHODOLOGY

Women's reproductive rights under the ambit of the Indian Constitution, legislative provisions, and various national and State policies are presented through a detailed review based on various case laws, landmark judgements, and policies & programmes in India addressing reproductive health. The paper discusses the national and regional perspective of reproductive health using reported literature and statistics, emphasising the reproductive health of tea plantation workers in Assam. A survey-based case study follows the discussion to understand the level of awareness among tea garden women workers in the Sonitpur District of Assam, India, regarding their right to reproductive health. The paper concludes with suggestions on the results of the case study.

3. RESULTS AND DISCUSSION

3.1 Reproductive health under the constitution of India and the role of the judiciary

India's Constitution acknowledges many rights as fundamental rights, and the Government is held responsible for upholding them and protecting the "inalienable human rights". Articles 14, 15 and 21 are understood through judicial interpretation to include the rights to dignity, health, privacy, and freedom from torture and ill-treatment (Parmanand Katara v. Union of India, (1989); Chameli Singh v. State of U.P, (1995); Paschim Banga Khet Mazdoor Samity and Ors v. State of West Bengal and Anor, (1996)). Though there is not any specific provision dealing with reproductive rights; under the Constitution of India, reproductive rights are dealt with under Article 14 (Equality before Law), Article 15 (Prohibition of discrimination on the grounds of religion, race, caste, sex, or place of birth), and Article 21 (Protection of life and personal liberty). Through the Directive Principles of State Policy, India's Constitution gives directions to the State to uphold a dignified human life. For example, Article 38 gives the State direction to establish a social order promoting people's welfare. Furthermore, Article 39 establishes certain policy principles to be followed by the State, and Article 42 gives direction to the State to make such provisions for ensuring unbiased and humane settings relating to work and maternity relief. Article 47 also gives direction to the State towards improving public health. Interpretation of Judiciary considering Article 51(c) of India's Constitution has established that respecting international law and treaty is the Governments' constitutional obligation (Apparel Export Promotion Council v. Chopra, 1999). Article 15 (3) upholds that State can make specific stipulations for women and children to better protect and ensure a better human life. Life means not an animal life, but a dignified human life assured by India's Constitution's preamble is universally accepted. So, reproductive rights are also implicitly included under the right to life. The Judiciary of India, considering all aspects of human life, international conventions, and Constitutional values, has pronounced various judgements establishing "Reproductive Rights as an Essential Human Rights" (Sriraam, 2020). Through the various judgments, India's Judiciary has proved that women's reproductive rights are essential for establishing their right to equality (provided under Article 14 of India's Constitution). Women should enjoy their rights of equality through the right of decision making regarding pregnancy. In various maternal health cases, family planning, child marriage, and abortion, Indian courts have

upheld powerful interpretations of 'reproductive rights', which echo human rights standards (Devika Biswas v. Union of India, 2016).

In Suchitra Srivastava v. Chandigarh Administration case (2009), the Supreme Court has held that personal liberty under Article 21 includes the right to make a reproductive choice. In every society, women's right to bodily integrity, dignity, and privacy should always be respected. If the health condition of a woman does not allow her to carry a baby, it should be respected. The Supreme Court holds women's right to have a child or not as her liberty under Article 21 of India's Constitution. In 2011, the Delhi High Court gave a milestone judgement through a joint decision in the instances of Laxmi Mandal v. Deen Dayal Harinagar Hospital and Ors (2010), and Janpura Jaitun v. Maternity Home, MCD (2010) on denials of maternal health services. The Court articulated that the petitions emphasised two fundamental rights implicit in Article 21 of India's Constitution. These are undisputable survival rights that are part of the fundamental right to life, viz. the right to health which includes the right to avail and access minimum standards of medical facilities and access to maternal health facilities. Citing CEDAW and ICESCR, the Court held that a woman during the pregnancy and after the pregnancy also has the right to avail all necessary facilities without any discrimination of her social status and economic status. Availability of equipped maternal health services, blood banks and skilled medical workers are essential in this regard.

The High Court of Madhya Pradesh, in 2012, accepted the principles of the Delhi High Court's judgment in Sandesh Bansal v. Union of India and Others (2012) while looking for accountability for maternal deaths. The Court observed that the women's right to life as guaranteed under Article 21 of India's Constitution is infringed if she is incapacitated of surviving pregnancy and childbirth. The Court also held that it is the Government's crucial duty to ensure that every woman survives pregnancy and childbirth. Significantly, the Court taking the reference of Article 21 and the National Rural Health Mission's aims and objectives, held that minimum infrastructure of health care services should include all basic and emergency health services.

In the case, Devika Biswas v. Union of India (2016), the Supreme Court held that the reproductive health framework must recognise women's equality and autonomy as prime elements of the reproductive rights protected under the Indian Constitution. The Supreme Court established that women's fundamental and human rights are violated by State policies and programs centred on sterilisation. This is because in sterilisation programmes, women are forcibly enrolled, resulting in gender abuse. The Supreme Court indisputably recognised that Article 21 includes the reproductive rights of a person as part of the right to health and also as an aspect of personal liberty. Here the Supreme Court observed reproductive rights as the ability of an individual to access a range of reproductive health-related information, services, facilities and goods, enabling informed, responsible and free decisions regarding their reproductive behaviour. Further, policies focusing on female sterilisation were attributed to violate women's substantive equality. The Supreme Court emphasised the obligation to ensure the 'reproductive freedoms' of socially and economically marginalised groups expressing concern that informal targets and incentives advocated by these policies have deprived the women of 'meaningful choices'.

In the High Court on its Own Motion v. The State of Maharashtra v. The State of Maharashtra (2016) case, the Bombay High Court directs for improving women prisoners' health status, including providing access to abortion. The Court asserts that women's rights to abortion are an aspect of the fundamental right to live with dignity as envisaged under Article 21 of the Indian Constitution. The judgment identifies that undesirable pregnancies unduly burden women and states that compelling a woman to continue a pregnancy violates her bodily integrity and aggravates her mental trauma, which in turn is detrimental to her mental health. Pregnancy takes place within a woman's body and has reflective impacts on her health, mental wellbeing, and life. Consequently, how a woman wants to deal with her pregnancy must be decided by her, and she alone can make this decision. The right to fertility, motherhood and control of her own body should be left to the women alone. Everyone should respect women's fundamental reproductive rights: the right to autonomy and decide what to do with their bodies, including getting pregnant and staying pregnant.

India has enacted many legislations like the Maternity Benefit Act, 1961; Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994; the Medical Termination of Pregnancy Act, 1971; Infant Milk Substitutes, Feeding Bottles, and Infant Foods (Regulation of Production Supply and Distribution) Act, 1992. However, there still lacks a comprehensive Act that can deal specifically with all aspects of women's reproductive health. Though the International laws provide for broad protections for women during and after pregnancy; the right to be free from humiliating and inhuman treatment and torture; right to security of person; and rights to the highest achievable standard of health, in India, most of these safeguards are found to be violated in practice. The Indian Judiciary has repeatedly uplifted the various provisions of the legislations and policies and it is evident that the Judiciary has a pivotal role in providing safeguard to the reproductive rights of women under the ambit of these legislations and policies.

3.2 Policies and programmes in India addressing reproductive health

The National Population Policy 2000 was launched by India's Government to protect reproductive health, providing essential reproductive health services (Banerjee, 2019). In matters related to family planning,

this policy has encouraged the right to voluntary and informed choices. The policy has also tried to ensure counselling and information services on reproductive health.

National Health Policy (NHP) 2017 was formulated with a vision to attain the best standard of health and wellbeing among all ages and providing each citizen access to quality health care services. The reproductive health-related aspects of the policy, to be reached by 2025, is to have neonatal mortality rate <16, under-five mortality rates <23, infant mortality rate <28, MMR (Maternal Mortality Rate) of 100, a single-digit stillbirth rate, >90% of pregnant women receive antenatal care, >90% deliveries under skilled attendance, >90% full immunisation for infants and >90% requisite for family planning. The key strategies in this regard are to strengthen the entire health system. This has been planned by increasing the share of health expenditure in the Gross Domestic Product to 2.5%, redirecting about two-third of health expenditure to primary health care, upgrading health centres and sub-centres to Health and Wellness Centres to provide all-inclusive primary health care with an emphasis on reproductive health (Gera et al., 2018).

Ayushman Bharat (Healthy India) Initiative launched in 2018 was formulated to translate NHP 2017 into action. The objectives and goals of this initiative concerning reproductive health are articulated in NHP 2017. The initiative aims to upgrade and transform nearly one lakh fifty thousand existing health centres and sub-centres into Health and Wellness Centres; expand access to prescription and essential drugs; expand access to diagnostic services, and strengthen outreach. The initiative also aims to upgrade the expertise of healthcare providers such as Accredited Social Health Activists (ASHA)s and provide monetary security for secondary and tertiary care for forty per cent of the households (Kalla et al., 2018).

The National Health Mission 2013 is an amalgamation of the National Rural Health Mission and National Urban Health Mission. This mission's vision was to achieve nationwide access to quality, inexpensive, and unbiased health care services that are accountable and responsive to the people's needs. Regarding reproductive health, this mission aimed to achieve an MMR of 100 per 100,000 live births, an IMR of 25 per 1,000 live births, and prevention/reduction of anaemia in women below 49 years of age by 2017 (Sharma et al., 2016). This mission's key strategies were to reinforce services related to newborn, child, juvenile, maternal and reproductive health. It also aimed to establish a new unit of frontline health workers ASHAs. The Mission introduced various social security schemes to support women and their newborns, like provisional money transfers for institutional delivery.

National Youth Policy 2014 aims to empower youth aged 15-29 to reach their full potential. The expected outcome of the policy is to develop a resilient and fit generation. The policy emphasises an increase in access to health amenities, a targeted health consciousness program and a targeted illness control package for the youth (Ministry of Youth Affairs & Sports, 2014).

Rashtriya Kishor Swasthya Karykram 2014 was launched with a vision to enable all adolescents to make responsible and informed decisions regarding their wellbeing and health. It was launched to provide access to the services and support concerning their reproductive health. The programme aims to promote behaviour, attitudes, and knowledge related to reproductive health, reduce juvenile pregnancy. Also, one of the aims of the programme is to prevent gender-based violence in our country. The programme strategies to establish/strengthen adolescent-friendly health clinics. This programme emphasised a community-based peer education program on health and reproductive health. For the first time through this programme, India has tried to provide facilities of weekly supply of iron and folic acid supplements; supply sanitary napkins; sensitise parents, and build frontline health workers' capability. Another aspect of this programme is to assist the adolescent in addressing their health needs. (Joshi et al., 2017).

National Policy on Women (Draft) 2016 has been drafted with a vision to allow women to participate equally in all spheres of life by attaining their full potential. The policy aims to recognise women's reproductive rights by reducing maternal mortality rates. It has emphasised reducing the dependence on sterilisation as a critical method of contraception. This draft has highlighted upgrading adolescent reproductive and sexual health and provide health coverage to surrogate mothers. This draft has addressed and prohibited any form of violence against women (Ministry of Women & Child Development, 2016). The implementation strategy of the policy is being formulated.

The Assisted Reproductive Technology (ART) Bill 2017, has been explicitly formulated to inhibit ART's exploitation and ensure the ethical and safe practice of ART services. The policy aims to establish National and State boards that will monitor ART services, implement improved standards, and provide plans and principles for the functioning of ART clinics and services (Sharma and Mittal, 2017). Additionally, Surrogacy (Regulation) Bill 2019 aims to eliminate the violation of surrogacy rights and set stringent monitoring criteria for the clients and the surrogates (Asvini and Renuga, 2019).

3.3 Reproductive health – National and regional perspective

India was one of the principal nations to create legal and policy frameworks, as discussed above, ensuring access to abortion and contraception. However, India's female population keeps on facing huge

limitations to enjoy their reproductive rights, which are further hampered by the low quality of health services and females' decision-making power dissolutions. Since ancient times, being a patriarchal country, laws and frameworks related to India's reproductive health have failed to meet their goals. They do not follow a women's privileges-based strategy but emphasises segment targets. Women's reproductive independence has also been undoubtedly weakened through repressive arrangements, for example, the requirement of spousal acceptance for availing reproductive health services. Child marriages are considered illegal in India; however, India reports the maximum number of child marriages and accounts for a significant percentage of maternal deaths globally (World Health Organization, 2013). The National Population Policy of India safeguards women's intended access to the full scope of birth control methods. However, these safeguards are diluted by plans promoting female sterilisation, prompting obligation, unsafe sanitisation techniques, and rejection of access to non-permanent techniques (Banerjee, 2019). Further, despite the provisions of the Medical Termination of Pregnancy Act (MTP Act) 1971, a significant amount of abortions are assessed to happen in India yearly, which is dangerous and brings about 9% of all maternal deaths (Stillman et al., 2014).

Various international human rights organisations and experts have upraised apprehensions regarding human rights violations arising from the scope of reproductive rights problems in India. However, India is trying to upgrade its health facilities infrastructure but still lagging behind it. In India, women are still suffering from some reproductive health-related problems which include high maternal mortality and morbidity; unsafe abortions and inferior quality of post-abortion treatment; lack of access to the full spectrum of measures of family planning and dependence on forced and unsatisfactory female sterilisation; and instances of child violence. These organisations have asked India to address these infringements and provide reproductive health care (Cismas, 2014). In this regard, India's Judiciary has a significant role in guaranteeing women's reproductive rights established by their human liberties and constitutional provisions.

As we know, reproductive right is one of the most critical universally recognised human rights. It is the God gifted fundamental right of women. CEDAW lays significant emphasis on safe pregnancy and sound maternal health (Chinkin, 2016). This Convention recognises the reproductive health of women to be safe and dignified. The provisioning of a sound reproductive health care system has been a significant challenge for many of the world's developing countries (Patton et al., 2010). It is worth mentioning that the National Rural Health Mission (NRHM) implementation in India has significantly reduced the Maternal Mortality Ratio (MMR) from 130 in 2014-2016 and 122 in 2015-2017 to 113 in 2016-2018. NRHM has brought India's current MMR below the Millennium Development Goal target, putting India on track to achieve the Sustainable Development Goal (SDG) aim of MMR below 70 by 2030 (Ministry of Health and Family Welfare, 2018). In the meantime, India has also emphasised developing overall health care, emphasising reproductive health. Various schemes for health care facilities have been launched by the Ministry of Health and Family Welfare (MoHFW). The number of community health workers and community level facilities has increased under the ambit of the NRHM, resulting in more institutional deliveries (Sharma, 2009). ASHA, Anganwadi workers, Auxiliary Nurse Midwives (ANM), and staff nurses are engaged in providing routine antenatal care at home or in government-run centres. Anganwadi workers are required to provide essential health services and ASHA's to facilitate care and provide education. Maternity cares refer to health services provided to women, babies and families throughout gestation, labour and delivery, and after birth up to six weeks (Collins English Dictionary, 2018). Maternity care also includes health and wellbeing monitoring of the mother and baby.

Various schemes for the protection of reproductive health have been adopted in India. United Nations Children's Emergency Fund (UNICEF) collaborates with MoHFW, Ministry of Women and Child Development (MoWCD), National Institution for Transforming India (NITI) Aayog and State Governments in planning, budgeting, policy formulation, capacity building and monitoring (UNICEF, 2019). UNICEF assumes a crucial role in supporting health managers' and supervisors' capacities at different levels to design, actualise, screen and manage effective reproductive health care services administrations, emphasising high-risk pregnancies and those in remote, susceptible and socially underprivileged communities. UNICEF also supports the execution of various programmes by the Indian Government, including but not limited to reaching every mother, continuum of care, antenatal care, implementation of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) launched in 2016**,** Janani Shishu Suraksha Karyakaram (JSSK) launched in 2011 and other such policies. UNICEF also supports the policy formulated by MoHFW, which expects every delivery to be carried out in a health care facility and by a skilled health care provider. Also, it advocates a range of approaches focussed on improvement in the health and nutrition of expecting mothers and provisioning quality maternal and newborn health services. This approach aims to improve family planning access, provide antenatal care during pregnancy, improve the handling of normal delivery by trained attendants, provide access to emergency obstetric and neonatal care when required, and provide appropriate post-natal care for both mothers and newborns.

Policies launched by MoHFW such as the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) are monitored by UNICEF. This policy provides pregnant women a fixed day (9th of every month) for guaranteed,

complete and free of cost quality pre-birth care. The main aim is to strengthen antenatal care and detection & follow-up of pregnancies that are evaluated to be high-risk to reduce maternal deaths and, consequently, reduce India's MMR. Another scheme is the Janani Shishu Suraksha Karyakaram (JSSK), which envelopes free of cost services for pregnant women and children, a cross-country scale-up of emergency reference systems, and audit of maternal death aims for improving management and governance of health services at all levels. Another program launched by MoHFW is 'Laqshya' in 2017, aiming to provide quality improvements in the labour room & maternity operation theatre. This scheme also aims to improve the quality of services for mothers and new-borns during the intrapartum and immediate postpartum period.

It may be noted that the most vulnerable section of women belongs to socially and economically underprivileged areas, with a significant share of them being adolescent mothers and women from minority communities and tribal sections. Thus, reaching out to these women is essential in achieving the global aim of strengthening reproductive health and saving women's lives. Talking about Assam, a north-eastern state of India, it reports the highest MMR in the country, standing at 215 during 2016-2018, nearly double the national average of 113 and substantially well below the MDG's (Swagata, 2020) and SDGs.

3.4 Reproductive health of tea plantation workers in Assam

Most tea gardens of India are in Assam, West- Bengal, Kerala, and Tamil Nadu. One of the largest private-sector employers in India is the Tea industry (Table 1). It is estimated that India's tea industry employs over one million workers in the tea industry, which comprises mainly scheduled castes, tribes, and ethnic minorities, of which more than 50% are women (Das, 2016). However, it is observed that the plantation workforce is the most exploited amongst the organised sector workforce of India. Acts and policies like the Plantation Labour Act 1951 provide various economic and social welfare benefits for this workforce. However, several studies have shown that the plantation workforce is subjected to exploitative work patterns and control mechanisms, deplorable housing and living conditions, low wage payments, inadequate supply of drinking water, insufficient welfare benefits, and lack of collective bargaining (Xaxa, 1999).

Table 1: Estimated Number of Workers Engaged in the Tea Plantation Sector (Tea Board India, 2019)

Assam	West Bengal	Tamil Nadu	Kerala	Tripura	Karnataka	Other States	Total
684654	337316	49410	40773	13257	3059	3473	1131942

Tea estates are spread all over the State of Assam. The tea community is observed to be economically backward, with a low level of literacy. The status of this community is a result of continuous subjugation since its start in the 1840s (Besky, 2013). Although the industry's annual turnover is nearly 10000 crores, only a meagre income is shared by the tea community (Tea Board India, 2019). Consequently, the health status of the community is in a deplorable state, which is evidenced by the orders given to the State of Assam by the Gauhati High Court in 2015 against a PIL (Pajhara v. State of Assam, 2012) filed by the director of PAJHRA (NGO), directing improvement of health services in tea estates. When considering the petition, the High Court held that the State should provide immediate reliefs and remedies for the better protection of the health status of tea plantation workers. The Court asked the State authorities to meet the scheme's terms within six months, as prayed in the writ petition. Hon'ble Chief Justice (Acting) Mr K. Sreedhar Rao and Hon'ble Mr Justice P. K. Saikia, in May 2015, took up the matter sincerely and observed all humanitarian laws where India is a party, aim and objectives of International Labour Organisation (ILO), and the Constitution of India. The Court directed State authorities to make significant modifications in the tea estates to improve staffing, provision emergency obstetric care, guarantee safe abortions, and establish blood storage facilities.

Although considerable efforts relating to improved reproductive health of tea garden women workers are visible in black and white, the ground reality is still not very promising. In this regard, a brief survey was conducted to understand the level of awareness among tea garden women workers regarding their reproductive health rights. Target group discussions and one-to-one interviews with community members were conducted for data collection. A door-to-door survey was conducted to interview community members. Sonitpur District of Assam, India, has nearly 59 tea gardens distributed over 14 development blocks. Representative tea gardens (viz. Hahchura, Sonabeel and Tulip Tea Gardens) of some of the development blocks were considered in the analysis. The tea estates were selected for the study based on the geographical locations and size of the tea gardens to get a good representation of the study area i.e. Sonitpur District. A total of 11, 17 and 12 households were surveyed in the three tea gardens, respectively. The respondents were in the age group of 20-35 years on the date of the interview. The average age of the respondents was 25.3 years. Regarding the highest level of school attended, 15.3% were illiterate, 38.5% attended primary school and 46.2% had attended secondary school. The respondents were married at an average age of 18.1 years with 23.1% getting married below the age of 18 years. 38.5% of the respondent belonged to nuclear families while 61.5% belonged to joint families. 30.8% of the respondents had single child, 53.9% had two children and 15.3% had three children.

84.6% did not have a regular employment while 15.4% were occupied in farming. The monthly family income ranged between ₹ 2000 – ₹ 8900 with an average monthly income of ₹ 4990. 84.6% were Hindu and the rest were Christians. All of the respondents were currently married and staying with their husbands. The main attributes used for understanding the awareness level are summarised in Table 2.

Significant results were obtained from the survey. It was observed that 69.2% of the respondents were aware that reproductive health is a human right, while the rest considered it still not recognised as a human right. 92.3% of the respondents felt that the reproductive health of women is not respected. Only 38.5% of respondents were aware that reproductive health was a fundamental right in India, 46.2% did not think reproductive right to be a fundamental right and 15.3% did not have any idea on this. 61.5% did not know that they could avail themselves of reproductive health care facilities for free, 30.8% were aware of this, and 7.7% did not know anything about this. 30.8% of the respondents opined that reproductive health should include the choice not to reproduce another human being; 46.2% were against this, while 23.1% were not aware of this aspect. Significantly, 69.2% believed that their husbands controlled their reproductive rights, while 23.1% did not believe so. Also, 92.3% believed that Indian women were not aware of their reproductive rights and considered the reproductive health care system deficient in rural areas. Most significantly, 98.4% of the respondents considered that women of tea plantation areas are ignorant of their reproductive rights.

There prevails unhygienic environment in some of the respondent's families; no toilet, no urinal and no concern with a healthy environment. Level of illiteracy and lack of exposure to media also poses hindrance towards increasing the level of awareness among the target group. Lack of proper nutrition and proper diet is another concern. Also, the society is patriarchal in structure and an environment of male domination was observed in the surveyed households. In fact, the women in the society are expected to serve their husbands as 'God'. Polygamy was observed to be an acceptable norm in the society for the men but it is considered a taboo for the women to remarry. Alcohol and tobacco consumption was found to be prevalent in the society especially among the male population. Another observation was the prevalence of superstitious beliefs in the society.

Table 2: Attributes for Evaluating the Awareness Level of the Respondents

Sl. NO.	Assertion	Responses (Tick the appropriate response)
1	Reproductive health is a Human right.	Yes/Still not recognised as Human Right
2	In India, women's reproductive health is not respected.	Yes/No/Do not know about this
3	Reproductive health is a fundamental right in India.	Yes/No/Do not know about this
4	Reproductive health care facilities are available free for all in India	Yes/No/Do not know about this
5	Reproductive rights should include the choice of not to reproduce another human being	Yes/No/Do not know about this
6	In India, women's reproductive rights are controlled by their husbands	Yes/No/Do not know about this
7	In India, women are not adequately aware of their reproductive rights	Yes/No/Do not know about this
8	How is the reproductive health care system in the rural area of India	Good/Poor/Do not know about this
9	Women in the tea plantation area are very ignorant about their reproductive rights.	Yes/No, they are aware/Do not know about this.

4. CONCLUSION

The women workforce is a vital component of the tea industry. However, the state of their health, especially reproductive health, is in a very pathetic state. Critical analysis of the factors influencing the health status of these women is necessary. Although the tea garden women considered reproductive health as a human right, majority of them are ignorant about their reproductive rights. Moreover, these women do not understand the importance of their reproductive health, which becomes evident from the high maternal morbidity rate prevalent in the areas habituated by the tea garden workforce. It is also worth mentioning that many constitutional provisions and policies provide safeguards to the tea garden women's health. However, the ground reality provides a bleak picture attributed to the low level of legal literacy prevalent in these areas, which bars them from reaping these provisions' benefit. Also, there are very few studies highlighting these issues. Their traditional food habits, unhygienic environment, low income, and illiteracy level are some of the most critical barriers to their development. The prevalence of various superstitious beliefs amongst them makes them apprehensive towards modern scientific treatment and facilities. Their society is generally male-dominated. A husband can have more than one wife in their society, while it is considered taboo for the wife to remarry. A surprising fact is that women of tea plantation areas serve their husbands as 'God'. Although there are various national and international NGOs which are working in this field, they have not been able to touch

on various crucial issues concerning family and health aspects.

Policies and programmes are to be aligned/formulated to increase literacy in these areas, increasing awareness and utilising critical health-related aspects, especially reproductive health. Another urgent requirement is the prohibition of tobacco and liquor consumption among the tea communities. Tea estate management has a significant role in increasing their concern towards their employees' health rights. The Judiciary also has a vital role in playing suo moto and reporting through PIL to monitor the successful implementation of the policies/programmes centred on safeguarding the tea garden women employees' health rights.

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