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'Navigating A March from Reproductive Health to Reproductive Justice in India'

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ABSTRACT

The Reproductive Health, Reproductive Rights and Reproductive Justice are interwoven in each other. Sustainable Development Goal Target 3.7 ensures universal access to sexual and reproductive health-care services. India has failed to achieve the target though the performance towards progress is remarkable. The economic disparities, poverty, lack of adequate education, social inequalities and legal hurdles are barriers. The patriarchal approach of the society particularly in relation to marginalised or stigmatised population groups has led to vulnerability of women. Non-discrimination in access to health services and access to education and information is crucial for the realisation of sexual health rights of all persons.[1] However, the legal mechanism and the Judiciary in India has contributed significantly in rendering justice to women. In some aspects Indian laws and judicial trend is far more progressive than their counterparts in rest of the world including the developed countries.

This paper traces the development of the struggle of Indian women through the process of law making and judicial support in their march towards justice.

Key words: Reproductive justice, reproductive health, human rights

Concept and Nature of Sexual Health and Reproductive Rights

The earliest reference to sexual health was in International Conference on Population and Development (ICPD) Programme for Action (Cairo, 1994), which stated that reproductive health, also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.[2] In 1995 at the Fourth World Conference on Women, sexual health found mention as an aspect of sexuality, over which women's autonomy. "The human rights of women include their right 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."[3] The 'availability, accessibility, acceptability and quality' of information, knowledge and services are the vital parameters to enable making informed choices in reproductive health. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice."

[1] . UN Committee on the Elimination of Discrimination against Women (CEDAW), CEDAW General Recommendation No. 19: Violence against women, 1992; UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 35: Gender-based violence against women, CEDAW/C/GC/35

[2] . UN Population Fund (UNFPA), Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1.

[3] . UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

WHO defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity". Sexual health is attained by a positive and respectful approach to sexuality and sexual relationships when it is free of coercion, discrimination and violence. To achieve this, the sexual rights of all persons must be respected, protected and fulfilled.[4]

The decision-making ability about one's own reproductive life is linked with greater relationship stability and satisfaction, education and financial independence.[5] The toxic practices around Reproductive Health include 'denial of access to services, forced sterilization, forced virginity tests, and forced abortion, without women's prior consent; female genital mutilation (FGM), early marriage, Exclusionary Practices During Menstruation, Shaming Of C-Sections etc. These violations are the result of deeply rooted beliefs and societal values pertaining to women's sexuality, patriarchal concepts of women's roles in the society as a means of reproduction, early marriage and pregnancy, unplanned pregnancies and expectations to produce sons. The Reproductive Health is measured mostly in the context of Contraception, Abortion, sexual assault, assisted Reproductive Technology/ Surrogacy, Maternal mortality, Maternity benefit disparity, right to privacy and medical informatics, gender-based violence, sexually transmitted diseases, gender inequality etc.[6]

Reproductive Rights as Human Rights

Women's sexual and reproductive health is founded on multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination. The Convention on Economic, Social and Cultural Rights (CESCR) and the Convention on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health.[7] The Human Rights approach towards Reproductive Rights requires that States have obligations to respect, protect and fulfil these rights. The Millennium Development Goal (MDGs) about the reproductive health and rights could not be achieved in India by 2015.[8] SDGs also call for national strategies and programmes, on access to and use of contraception, availability, accessibility and acceptability of quality sexual and reproductive health (SRH) services, knowledge about sexual and reproductive health rights (SRHR), adolescent fertility, quality of care.[9] All these SDGs are interwoven for the sake of reproductive health and rights.

Right to privacy, and to marriage and family life Article 16 of Universal Declaration of Human Rights (UDHR) and Article 23 of International Covenant on Civil and Political Rights (ICCPR) affirm the right of men and women to marry and to found a family. Similarly, Article 10 of International Covenant on Economic,

[4]. "Defining Sexual Health". 2006. Geneva: World Health Organisation. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf last accessed on 15-10-2021

[5] https://statusofwomendata.org/explore-the-data/reproductive-rights/reproductive-rights-full-section/ last accessed on 20-10-21

[6] . Reproductive%20justice/NHRC%20sexual_health_reproductive_health_rights_.pdf last accessed on 15-10-21

[7] . **Sexual and reproductive health and rights, https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.aspx last accessed on 21-10-2021**

[8] . https://www.un.org/millenniumgoals/ last accessed on 12-10-2021

[9] . UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4

Social and Cultural Rights (ICESCR) considers the family as the natural and fundamental group unit of society which deserves the fullest protection and assistance. Recognizing the particular needs of women arising from maternity, it further stipulates "Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits."[10]

A woman's right to choose her partner is integral to the fulfilment of her right to life, dignity and reproductive rights. Child marriage is prohibited in India but it is still prevalent in many parts of rural India. Child brides have less negotiating power in sexual and reproductive matters and are more vulnerable to violence. More number of children at young age place them at a greater risk of maternal mortality and morbidity.

Reproductive health rights under Constitution of India

In India, the reproductive rights can be located in a constellation of laws and policies relating to health, employment, education, provision of food and nutrition, and protection from gender-based violence. The fundamental rights guaranteed under Part III of the Constitution of India viz; The right to life, the right to equality before law, the right against non-discrimination, and the right to freedom and expression are few examples. The Directive Principles of State Policy provide for duties of the State on the issues of health vide Article 32, 37, 39, 42, 45 47. India being a signatory to various international conventions which include the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is bound to protect Reproductive Rights. Article 51(c) of the Constitution of India mandates her to respect the treaty obligations.

Efforts by Government of India

While maternal mortality is accepted as an indicator of a country's maternal health status. Several schemes are currently being implemented by the Union Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MWCD) to address maternal health and the issues related to Newborn, Child and Adolescent Health (RMNCH+A), Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and Pradhan Mantri Matritva Vandana Yojana.

Maternity benefit programmes

The Maternity benefit Act was amended to expand the duration of maternity leave from 17 weeks to 26 weeks. While this was a welcome move, the Act covers only about 18 lakh women in the organised sector, whereas over 2.7 crore deliveries take place in India each year. The Act does not include in its ambit more than 95 per cent of women in the country who are in the informal sector. The meagre wage compensation to women in unorganised sector in the light of the amendment to the MBA is in fact a discrimination and inequality before the law under Article 14 of the Constitution. Maternity entitlements for women in all sectors

[10] Report of the Committee on Maternity Protection, https://www.ilo.org/public/english/standards/relm/ilc/ilc87/com-mat.htm last accessed on 12-10-2021

must be universal and unconditional, and should not be linked to the number of children borne by the woman or to the age of the woman, as these conditions are fundamentally discriminatory against both women and children.

Access to Information and Utilisation of Contraception Services

The right to comprehensive information about contraception and safe, quality contraceptive services is recognised as a human right under various international laws, treaties. There are various disparities in the entitlement of information and use of the same among married/ unmarried women, educated/ illiterate women as the same cannot be availed of under the societal pressure and biases towards them. Legal and practical barriers to contraceptive information and services lead to unwanted pregnancies, harbouring the risk of unsafe abortion, or maternal mortality and morbidity that violate the rights to life and health. Access to voluntary contraceptive services and information is critical to upholding women's and girls' reproductive rights, as it provides women the right to decide whether to have children, and the number and spacing of children thereby preventing unwanted pregnancies, and minimizing their adverse impact on the women's health and well-being. However, it is essential to ensure that the adoption of contraceptive methods is informed and voluntary, and that standards of care are guaranteed.

Failure of implementation of standards and guidelines in sterilisation programmes

The Supreme Court in **Devika Biswas v. Union of India**[11] recognised that the "sterilisation programme is virtually a relentless campaign for female sterilisation", and directed the Union of India to address this issue on grounds of gender equity by criticising the target-based programmes set by the governments. The Court also held that the sterilisation procedures under scrutiny imperilled the right to health and reproductive rights of a person, which were important components of the right to life under Article 21. In 2005, the Supreme Court in **Ramakant Rai and Anr v Union of India**[12] and Ors had passed directions to regulate the sterilisation procedures of men and women. The Supreme Court had directed the introduction of a system of an approved panel of doctors to carry out sterilisation in states/districts/regions, requiring doctors to fill in a checklist of patient information relating to age, health and other relevant information, and setting up of a State Quality Assurance Committee, which would monitor compliance of guidelines for pre-operative measures, operational facilities and post-operative care. The Government of India (GOI) has initiated the Family Planning Indemnity Scheme (FPIS) to provide for compensation in case of death or failure as a result of sterilisation operations.[13]

Abortion care issues and Medical Termination of Pregnancy

The Medical Termination of Pregnancy Act 1971 (MTPA) initiated with a view of population control measure anguished the majority of women by delays or denials in accessing safe, quality and legal abortion care. Poverty, gender inequality, stigma, a weak, unresponsive, biased health care system as well as an unfavourable legal and policy environment are perceived as major barriers in accessing safe abortion. The

[11] AIR 2016 SC 4405

[12] Writ Petition (C) No. 56 of 2004.

[13] . Government of India. Ministry of Health and Family Welfare. "Compensation for Tubectomy and Vasectomy Victim." News release, July 18, 2014. Press Information Bureau.

absence of an adequate number of trained, legally registered health care providers throughout the country and the necessary facilities also continue to pose significant challenges to those accessing abortion care. Moreover, evidence points to the abysmal access to information and knowledge about the legal provisions of the MTPA amongst girls and women as well as among health care providers, often compromising access to abortion care. The Act lays down the provisions when and under what conditions an abortion is permissible, where it may be conducted and by whom. The termination of pregnancy violating any of these provisions is considered to be an offence.

A study estimated that among the six million abortions taking place annually in India only one million are legal. This makes access to safe, comprehensive and legal abortion a critical public health issue across India.[14] Abortion related morbidity and mortality is very high and unsafe abortions are believed to contribute to 9 per cent to 13 per cent of the maternal mortality in India and as much as 50 per cent of the maternal mortality in some of the districts in India.[15]

The consent of the pregnant woman has been a base of many legal issues surrounding abortion. The Supreme Court has reaffirmed the centrality of consent to abortion in **Suchita Srivastava and Anr v Chandigarh Administration [16]**. In this case, A woman with an intellectual disability who was living in a Government-run welfare institution in Chandigarh became pregnant following sexual assault. A Court-appointed medical board on examination found that she was physically capable of continuing with the pregnancy, that there were no indications that the foetus had any abnormalities and that the woman had expressed her wish to have the child. The Supreme Court distinguished between a “mentally ill” person and a “mentally retarded” person under the MTPA, and held that the State must respect the personal autonomy of a “mentally retarded” woman concerning decisions about terminating her pregnancy. It further reasoned that the requirement of consent could not be diluted since it would "amount to an arbitrary and unreasonable restriction on the reproductive rights of the victim. The Apex court also cautioned that any dilution of the requirement of consent contemplated by Section 3(4)(b) of the MTP Act is liable to be misused in a society where sex-selective abortion is a pervasive social evil." The Court also referred to the Convention on the Rights of Persons with Disabilities, 2007 the contents of which was binding on India.

In the case of **Nikita Mehta**[17], severe foetal abnormalities posing a risk to the survival of the foetus were detected in her 22nd week of pregnancy, and the abnormalities were confirmed by medical diagnosis in the 24th week of pregnancy. She sought to terminate the pregnancy, The Court denied permission to terminate the pregnancy, citing the limitation under Section 5 and lack of conclusive medical opinion to the effect that the child, if born, it would suffer from severe mental and physical handicaps.

In other cases, the Supreme Court has allowed termination of pregnancies beyond the statutory twenty-week limit. In **Ms. X vs Union of India[18] ,** the Supreme Court allowed the petitioner to terminate her 24 weeks

[14] Duggal, Ravi, and V. Ramachandran. "The Abortion Assessment Project India: Key Findings and Recommmendations." Reproductive Health Matters, November 2004.
[15] . Srivastava, P. C. et al. "Unsafe Abortion: A Study in a Tertiary Care Hospital." Journal of Indian Academy of Forensic Medicine 35, no. 3. 2013.
[16] (2009) 9 SCC 1
[17] Dr. Nikhil D. Dattar and Ors vs Union of India and Ors, Writ Petition (L) 1816/2008
[18] . Writ Petition (C) 593/2016, judgment dated 25th July 2016

foetus, following the recommendations of a Medical Board. In the subsequent case of **Meera Santosh Pal and Ors v Union of India**[19] , the petitioner sought permission from the Supreme Court to terminate her 24-week pregnancy on the ground that the foetus suffered from Anencephaly. The Court deliberated on the dimensions of personal liberty and reproductive autonomy, and considering the medical report and the danger to the petitioner's life, permitted the petitioner to terminate the pregnancy. It held that she had a right to bodily integrity, and to protect and preserve her life, and exercise of the right was "within the limits of reproductive autonomy."

However, the barriers to access services are created many times by the family members and healthcare providers due to lack of awareness about the law. The law does not require spousal or relation's consent for termination of pregnancy except in the case of minors. Nevertheless, medical practitioners frequently insist on such consent, claiming this necessary to pre-empt any socio-legal complications. Further lack of sufficient healthcare infrastructure and man power, its inequitable distribution makes the position of women more vulnerable.

The denial of services is a violation of the right to privacy and the right to health. To procreate or to abstain from procreating forms a part of women's reproductive choices. It is important to respect a women's right to privacy, dignity and bodily integrity. Further, the disclosure of personal health information has the potential to be embarrassing, stigmatizing and discriminatory. Insisting on the Aadhar card for provision of health services by hospitals is a gross violation, and highly arbitrary.

In the 2016 case of **High Court on its Own Motion v. State of Maharashtra**[20], the Bombay High Court directed 'to improve women prisoners' access to abortion and strongly affirmed women's rights to abortion as an aspect of the fundamental right to live with dignity under Article 21'. The Court held that "unwanted pregnancies disproportionately burden women and states. Further forcing a woman to continue a pregnancy "represents a violation of the woman's bodily integrity and aggravates her mental trauma which would be deleterious to her mental health." The decision boldly identifies an unborn foetus as a non-exiting entity not entitled to human rights. As the pregnancy has deep effects on her health, mental well-being and life; how she wants to deal with this pregnancy must be her decision only. The right to control her own body and fertility and motherhood choices should be left to the women alone. Let us not lose sight of the basic right of women: the right to autonomy and to decide what to do with their own bodies, including whether or not to get pregnant and stay pregnant.[21]

The recently introduced MTP (amendment)Act 2021 is introduced to render reproductive justice in view of plethora of judgements delivered over the last decade by the Hon'ble Supreme Court and various High Courts. This is a very positive step when the developed countries like USA are turning the clock in a reverse direction to deny reproductive justice by the judgement in **Dobbs v. Jackson Women's Health**

[19] Writ Petition (C) 17/2017, judgment dated 16th January 2017

[20] . PIL No. 1 of 2016 (BOM H C)

[21] Human Rights Law Network (HRLN), The High Court of Madhya Pradesh allowed a pregnant female prisoner to exercise her reproductive rights under the Medical Termination of Pregnancy Act (2013).

Organsiation.[22]

Menstruation as an aspect of Reproductive Right

Accessibility and affordability of safe menstrual hygiene products and facilities are crucial for women and girls to manage periods with dignity. But the law and policy need to be at place to ensure that dignity. In **Neera Mathur v. LIC**[23] the Supreme Court ordered LIC to re-instate Mrs. Mathur and set aside the order of discharge on the grounds of her failure to disclose personal facts of last menstruation in her declaration that are not required to be disclosed to an employer.. It further observed that if one indirectly seeks to evade providing maternity leave and benefits to a female candidate by not hiring her if she is pregnant at the time of entering the service, the same may be open to a constitutional challenge. Recently the states of Kerala, Bihar, Odisha have adopted menstrual policies and the private sector players like Zomato and Swiggy have developed their menstrual policies for women.

Gender Based Violence (GBV):

The Gender-based violence encroaches upon a range of human rights of including their rights to life, health, equality and non-discrimination, liberty and mobility, free speech and expression, education, work and livelihood, shelter and adequate standard of living, and participation in social and political activities. Sexual abuse, female genital mutilation, sexual harassment, domestic violence, and marital rape are all forms of gender-based violence.[24] The World Health Organisation (WHO) in its 2009 report, 'Women and Health: Today's Evidence Tomorrow's Agenda' states that "violence is an additional significant risk to women's sexual and reproductive health and can also result in mental ill-health and other chronic health problems". In 1995, the Platform for Action of the UN Fourth World Conference on Women, Beijing, was the first to declare the need to strengthen health systems and to involve health care providers in provisioning services to address violence.[25]

GBV impedes the exercise of reproductive freedom by women and curtails their right to attain the highest standard of reproductive health. Sexual violence can lead to unwanted pregnancies and sexually transmitted diseases, and physical and emotional violence may limit a woman's choices regarding the use of contraceptives and family planning. Economic abuse affects a woman's ability to pay for and access health services.

The two significant laws pertaining to GBV, that is, the Protection of Women from Domestic Violence Act (PWDVA), 2005 and the Criminal Law (Amendment) Act,2013(Section 166B, 357C CrPC) have expanded the definitions and remedies for sexual assault. Similarly, the Protection of Children from Sexual Offences (POCSO) Act, 2012 provides for strong legal regime for child survivors of sexual violence. Marital rape, however, continues to remain outside the purview of criminal law and is yet to be recognised as a criminal offence in India. PWDVA, however, recognises rape within marriage as a form of sexual violence.

Ministry of Health and Family Welfare in 2014 released the 'Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence' that identified the responsibility of healthcare providers in responding to the survivors of sexual violence. It further laid down a proforma ensuring the discontinuation of two-finger test and the inclusion of comments on the laxity of the vagina in the medico-legal documentation of the survivor or victim of sexual assault, etc. However, since then a very few states have started implementing the same. To develop an empathetic, efficient and accountable healthcare system is far from

[22] . 597 U.S. 215 (2022)

[23] . AIR 1992 SC392

[24] **. Declaration on the Elimination of Violence against Women, Proclaimed by General Assembly resolution 48/104 of 20 December 1993**
https://www.ohchr.org/en/professionalinterest/pages/violenceagainstwomen.aspx last accessed on 20-10-21

[25] . https://www.unwomen.org/en/news/in-focus/csw59/feature-stories last accessed on 20-10-21

reality to impart reproductive justice.

Mental health and reproductive health rights

Mental health issues with regard to menstruation and menopause, pregnancy and maternal outcomes, sexuality, gender violence, sexually transmitted infections including HIV and AIDS, family planning, uterine prolapse, obstetric fistula and infertility are widely known. There is substantial evidence that stressful life events and reproductive health problems are closely associated with depression and anxiety disorders. However mental health issues have never been the focus of reproductive health policies and programmes.

People with disability "have equal rights to sexual and reproductive desires and hopes as non-disabled people, however the society has disregarded their sexuality and reproductive concerns."[26] The people particularly women with disabilities are perceived as either asexual or even hypersexual beings. Their reproductive and sexual health and rights are not affirmed and often overlooked.

Issues in Assisted Reproductive Technologies (ARTs)

The absence of effective regulatory mechanism, inexpensive reproductive services and easy availability of women willing to offer their reproductive biological capacities to childless couples and individuals as a means to earn livelihood have significantly boosted to the recent growth of ART industry and commercial surrogacy. The surrogate mothers entering into this industry as service providers are vulnerable to economic exploitation resulting to human rights violation.

In 2011, the Delhi High Court issued a landmark joint decision in the cases of **Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.**[27] and **Jaitun v. Maternity Home, MCD, Jangpura & Ors**[28]. concerning denials of maternal health care to two women living below the poverty line. Citing CEDAW and ICESCR, the decision held that "no woman, more so a pregnant woman should be denied the facility of treatment at any stage irrespective of her social and economic background…This is where the inalienable right to health which is so inherent in the right to life gets enforced."[10] However, the ART Act 2023 and Surrogacy Act 2023 are hopes to regulate ART industry and ensure reproductive justice to surrogate mothers.

In 2012, the High Court of Madhya Pradesh resonated the Delhi High Court's judgment in **Sandesh Bansal v. Union of India**[29], a PIL seeking accountability for maternal deaths by recognizing that "the inability of women to survive pregnancy and child birth violates her fundamental right to live as guaranteed under Article 21 of the Constitution of India" and "it is the primary duty of the government to ensure that every woman survives pregnancy and child birth."[11] Importantly, the Bansal decision specifically rejected financial constraints as a justification for reproductive rights violations, and established that government obligations under Article 21 require immediate implementation of maternal health guarantees in the National Rural Health Mission.

Conclusion

The legislature and judiciary have played a significant role in addressing the legal and practical issues that created barriers to deny women their reproductive rights. The robust recognition of reproductive rights as fundamental rights emerging from Indian courts has developed a mandate for the government to shift away from population control approaches, confront discriminatory stereotypes towards women centric approach in case of rights to dignity, autonomy, and bodily integrity in reproductive health. International law also has a great impact on this journey from recognising reproductive rights by Legislature or Judiciary towards actually imparting justice to women. Now it is for women to wake up and realise their rights for themselves and all the women

[26] . Addlakha, Renu, Janet Price, and Shirin Heidari. "Disability and Sexuality: Claiming Sexual and Reproductive Rights." Reproductive Health Matters 25, no. 50, 4-9. July 5, 2017. doi:https://doi.org/10.1080/09688080.2017.1336375

[27] W.P.(C) 8853/2008 Delhi High Court)

[28] *W.P. No. 10700/2009(Delhi High Court)*

[29] W.P. No. 9061/08. 06,(MP High Court)