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Reclaiming Rights: Analysis of Sexual and Reproductive Health Rights from Global and Indian Perspectives

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ABSTRACT

Sexual and Reproductive Health Rights (SRHR) are the core and fundamental rights essential to uphold and maintain the well-being and dignity of an individual especially women. Despite various initiatives and efforts at the International Conference on Population and Development (ICPD) in 1994, there still exists various grey areas and challenges in the field including but not limited to inadequate infrastructure, lack of awareness, child marriages, unsafe abortions and the overall resistance to change due to lack of education. Although lack of adoption of these fundamental rights, impact the women at large, but primarily it affects the marginalized communities, who are overburdened by the socio-cultural adversities and political inefficiencies. This paper thus attempts to analyze the overall SRHR framework with respect to ICPD, Beijing convention along with India's approach to addressing these rights. It attempts to emphasize on the crucial role of states in promoting the applicability and protection of SRHR whilst also highlighting the various legal gaps that arise in its implementation due to various political, cultural and social differences. Furthermore, the paper underscores the interplay between SRHR and other human rights, advocating for a holistic approach that prioritizes universality and inclusivity. Thereafter the paper also provides key recommendations such as strengthening monitoring mechanisms and fostering inter-sectoral collaboration to resolve the pertinent inadequacies in the regime. By addressing the international and domestic regime, the paper addresses and highlights the need for urgent attention to bridge the gaps in reproductive autonomy, equality, and dignity to ensure development and implementation of the human

rights at a broader level.

KEYWORDS

Sexual and Reproductive Health Rights (SRHR), Gender Equality, International Human Rights Framework, Reproductive Autonomy, Healthcare Accessibility.

INTRODUCTION

There are around 4 million women and young adolescents all over the world who are sexually active and receive substandard level Sexual and Reproductive Health services. Further, there are around 200 million women who are subjected to genital mutilation, child marriages, unsafe abortions and gender-based violence, which is further becoming a leading cause of women's morbidity and mortality[1]. The current devastating status of women and young adolescents in the humanitarian law settings reflect that it is time for authorities and human right institutions to move to a non-conventional definition of emergency which includes degrading human activities and SRHR in its regime as it has become the need of the hour as there has been a hike in resurgent threats regarding theory rights and equal treatment[2]. The need for SRHR has arisen due to social norms and expectations, lack of sex education, sex being a taboo and various gender power dynamics. It has been understood from various reports and instances that SRHR exist in co-dependence with various other human rights. The universality and accessibility of SRHR has become the general pre-condition for the application of other human rights. The development of SRHR was done in the IPCD, 1994 in Cairo, wherein several states recognized that SRHR are fundamental to the well-being of individuals and states. At IPCD there was a massive shift from the narrower scheme of family planning to an integrated approach of protection of rights and the same was reaffirmed in Beijing. Further, as per General Comment 14 of CESCR with regards to the right to life, it has been established that the state shall by several means attempt to provide the highest attainable standard of health to its citizens[3].

MONITORING OF SRHR: BRIDGING COMMITMENTS AND REALITIES

The reproductive and sexual health rights of women and young adults are continuously developing in various international laws, so the

[1] Report of the round-table with human rights defenders on women's rights and gender equality in Europe organised by the Office of the Council of Europe Commissioner for Human Rights (Vilnius, 6 - 7 July 2015).
[2] Lance Gable, REPRODUCTIVE HEALTH AS A HUMAN RIGHT, 60 Case W. Res. L. Rev. 957 2009-2010.
[3] Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, ¶ 12 (2000), U.N. Doc. HRI/ GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, General Comment No. 14].

authorities need to establish a monitoring tool to follow up on whether the compliances and standards of SRHR are complied by states or not. States who have ratified the advancements concerning these rights are obligated to respect, protect and fulfill the standards by imposing positive or negative obligations upon the states. To promote these goals, the state must ensure that information about reproductive as well as sexual health is available, accessible and acceptable to the conscience of the citizens at large.

The state must act as a monitoring tool for fulfillment of obligations of SRHR and other aspects like discrimination and equality amongst others to ensure that no strata of human rights are affecting SRHR. Firstly, the state must ensure that there is no sort of discrimination amongst women and young adolescents based on their marital status, gender, health as well as pregnancy status with regards to services of health facilities, contraceptives, and safe abortion[4]. The state must attempt to achieve formal as well as substantive equality by ensuring consistency and equal allocation of resources amongst all. Further, the state must ensure that there is availability and accessibility of good quality contraceptives so that women have the autonomy to decide whether and when to have children and forcing one to procreate would amount to mental cruelty as has been stated by various courts. To do this, the state must ensure that there is practical, scientific and unbiased information regarding different methods and varieties of contraceptives to help them make an informed and integral decision[5].

Thirdly, the state must fulfill its obligations of promoting and providing safe pregnancy and birth by making sure that there is the availability of professional personnel at birth, safe abortion techniques and services along with emergency obstetric care to maintain mortality rate. The fourth aspect of monitoring is concerning safe abortion facilities in the state. There are various states where abortion is illegal. In the US, it was only after *Roe v. Wade* that abortion became a legal right that was protected by the Constitution[6]. Similarly, various states deny a woman the autonomy to decide whether she wants to have a child or not. This was seen in the case of *P and S v. Poland*, wherein a 14-year-old rape victim was denied the right to abortion and was humiliated and deplorably treated by the authorities that the ECtHR later held that it was a violation right to life and right against torture and inhumane, degrading treatment[7].

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[4] Dias Amaral B, Sakellariou D. MATERNAL HEALTH IN CRISIS: A SCOPING REVIEW OF BARRIERS AND FACILITATORS TO SAFE ABORTION CARE IN HUMANITARIAN CRISES. Front Glob Women's Health, (2021).

[5] Reproductive Rights: A Tool for Monitoring State Obligations, *Centre for Reproductive Rights*, UNFPA, https://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Monitoring_Tool_State_Obligations.pdf

[6] *Roe v. Wade*, 410 U.S. 113 (1973).

[7] Diya Uberoi and Maria de Bruyn, HUMAN RIGHTS VERSUS LEGAL CONTROL OVER WOMEN'S REPRODUCTIVE SELF-DETERMINATION, Health and Human Rights Journal (2013). https://www.hhrjournal.org/2013/10/human-rights-versus-

However various reports under CEDAW depict that the illegality of abortion, lack of clarity about its status, lack of public funding and compulsory waiting periods are some of the reasons wherein abortion happens in an unsafe manner. This is to depict that the lack of legality of abortion in the state does not reduce the chances of induced abortion due to any of the aforementioned reasons, but they only result in contributing to the number of unsafe abortions in the state which further leads to reducing women mortality in the state. Safe abortion services before and after the abortion must be available to the women to protect their right to make free decisions as a part of the minimum healthcare that is provided by the nation[8]. There are several laws and state-made policies that help in fulfillment of one right, but on the other hand, they lead to the violation of other important women-oriented human rights.

Several health institutions deny women the autonomy to decide matters concerning their delivery during pregnancy. For example, a New Jersey woman refused to pre-consent to a caesarean section if it became necessary and wanted to reserve that consent when the situation arose, but after a normal delivery, the child was taken away from her because the state believed that the child's welfare was harmed because of lack of consent[9]. But the same was later reversed by the high court as it is the responsibility of the state to fulfill, protect and respect these fundamental rights, especially the right to dignity and autonomy.

SRHR: INDIAN PERSPECTIVE

In India, when it comes to SRHR, religion plays a potent role in determining the status of women in society. In India, several religious texts promote male dominance and patriarchy thus leaving women in a demeaning position. These religious texts and codes especially *Manusmriti* have a problematic ideology regarding women's rights and duties. Manusmriti was the core source of Brahmanical patriarchy, oppression and gender-based violence in the state. Several feminist scholars like Uma Chakravarti have researched and stated that Manusmriti which acts as the Hindu code of conduct tries to maintain regulations on the sexuality of women which further leads to SRHR violations. It states that the only purpose of a woman's life is to get married and procreate.

Further, the text treats and places women at a derogatory level and compares them to sexual tools for pleasure of men and if she chooses to deny the man pleasure, then he has to power to deny her basic rights like food, water and bedding[10]. Along with this, several other SRHR

legal-control-over-womens-reproductive-self-determination/

[8] Paul Hunt and Judith Bueno De Mesquita, THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH, Human Rights Cnetre, University of Essex, https://core.ac.uk/download/pdf/20607636.pdf

[9] Chynoweth SK. ADVANCING REPRODUCTIVE HEALTH ON THE HUMANITARIAN AGENDA: THE 2012–2014 GLOBAL REVIEW, (2015).

[10] Naseera and Moly Kuruvilla, THE SEXUAL POLITICS OF THE MANUSMRITI: A CRITICAL ANALYSIS WITH SEXUAL AND REPRODUCTIVE HEALTH RIGHTS PERSPECTIVES,

violations are embedded in the text as well as the culture. These religious codes and texts must be read thoroughly with a gender-neutral lens to pick out evils like casteism, sexism and racism. But, in the present times, the Indian judiciary has made several attempts to recognize SRHR[11]. In the case of *Devika Biswas v. Union of India*[12], they tried to provide a robust definition of "reproductive rights" including all fundamental levels of human rights and gave importance to reproductive autonomy.

The courts have provided a judgement on how SRHR forms the basis of various other social, economic, cultural and political rights. Further, in 2011, in *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors*[13], an EWS girl was denied maternal care, the court in this case, thus mentioned the provisions of CEDAW (Article 10 and 16) and ICESCR (General comment 14 and 22) and stated that no woman can be denied the right to maternal care based on their socio-economic background. Further, in other decisions, the court showed development, growth and shift from Manusmriti to safe abortion, abolition of child marriage and accessibility of contraceptives among others[14]. These well-articulated judgments and newly developed legislative framework thus show that the Indian judiciary is making a stride to promote and defend SRHR of women across all sections regardless of their colour, race, caste or economic background[15].

PERSISTENT GAPS IN SRHR ACCESSIBILITY AND UNIVERSALITY

As has been observed that the progress of SRHR from the 1990's till today is remarkable in the International as well as Indian arena, but its accessibility and adaptability remain substandard and paltry across the globe despite it being a fundamental human right from which other human rights grow and develop. This generally happens because of the persistent gap in the cultural, political and environmental factors across different jurisdictions. First comes the *political factors,* wherein due to certain humanitarian, socialist and liberalist structures and institutions there is some friction at the horizontal level which further leads to an inadequate and inefficient distribution of resources related to sexual and reproductive health. This also happens because of the increased number of displaced people and the elimination and

23 *Journal of International Women's Studies*, 22-27, (2022).

11 Reproductive Rights in Indian Court, *Centre for Reproductive Right* (2022). https://reproductiverights.org/sites/default/files/documents/Reproductive-Rights-In-Indian-Courts.pdf

12 Devika Biswas v. Union of India, W.P. (C) 81/2012.

13 Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others, W.P. (C) No. 8853/2008.

14 Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 4 March 2016.

15 Committee on the Rights of the Child, Concluding Observations: India, U.N. Doc. CRC/C/ IND/CO/3-4 (2014); CEDAW Committee, Concluding Observations: India, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).

ignorance of certain parts of society under the SRH scheme. For example, young adolescents are neglected by both adult and child protection schemes. Furthermore, the lack of safe abortion services in the minimum health care scheme is inefficient along with that there is a lack of funding, training and evaluative programs.

Next comes the *socio-cultural* aspect wherein several women are discriminated based on sexual identities, pre-marital pregnancies and vulnerabilities. Further, the difference in various cultural beliefs and languages also causes hindrances in the availability and universality of SRH across different sects of women. Various religious and cultural beliefs amongst various groups cause discrimination, ill-treatment and miscommunication amongst service seekers and providers thus resulting in the encumbrance of SRHR. This is where the debate of cultural relativism vs. universality plays a pertinent role. The next aspect is the *environmental factors*. This states that whenever there is a natural calamity, the number of displaced people increases thus further placing the burden of the same on humanitarian law.

Furthermore, in situations of a pandemic like COVID-19, the maternal mortality rate increased by 70% because all the resources of SRHR were neglected further there was an immense increase in gender-based violence and unintended pregnancies and there was a sudden reduction in SRH services like safe abortion and accessibility of contraceptives all over the world. This shows that conditions and situations related to SRHR are still one of the leading causes of death and distress among women[16]. These gaps discussed above are exposing women to riskier situations where there is an urgent requirement of SRH goods and services along with holistic care, to reduce the gap and maintain universality, heavy investment and comprehensive guidelines must be imposed in secluded and poorer establishments.

CONCLUSION: TOWARDS A FUTURE OF EQUALITY, AUTONOMY, AND DIGNITY

Violations of SRHR continue to be a significant contributing factor to the highest rates of mortality and injuries among women globally. There has been a massive increase in people in need of SRHR, but the resources for the same are inadequate which is why there has been a huge step-back in the comprehensive care that is needed but cannot be provided. To achieve universal SRH, the state must fulfill its obligation as a monitoring tool to cover up the persistent gaps. Moreover, other policy changes along with inter-sectoral collaboration are required to overcome this inefficiency and inadequacy in services. The states must fulfill their responsibility to respect and protect the dignity and reproductive autonomy of women and young adolescents by reviewing the legislative framework that creates a barrier while accessing SRHR

[16] United Nations Development Programme (UNDP), Effects of laws criminalizing women's sexuality (New York, UNDP, 2010). Available at http://content.undp.org/go/newsroom/2010/march/outlawing-women–effects-of-laws-criminalizing-womens-sexuality.en.

services. Lastly, the state must make sure that the provisions of international treaties like CEDAW and ICESCR are respected, and safeguards and oversight mechanisms are established to ensure that appropriate maternal and prenatal care is provided by protecting the fundamental aspects of equality, autonomy, free consent and dignity[17].

[17] Tazinya, El-Mowafi. *et al.* SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN HUMANITARIAN SETTINGS: A MATTER OF LIFE AND DEATH. *Reprod Health* 20, (2023). https://doi.org/10.1186/s12978-023-01594-z