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Reproductive Rights in India: A Comprehensive Analysis of Laws and Policies

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ABSTRACT

International treaties and declarations acknowledge specific rights that belong to every individual. Among these rights is the right to sexual and reproductive health. Since the Cairo Conference on Population and Development in 1994, the human rights movement has embraced the notion of reproductive rights. Women's rights are affirmed in relation to reproductive and sexual health as fundamental to their overall well-being. These rights encompass the right to have adequate reproductive health care, choose the method of birth among others. This paper explores the key legislative and judicial milestones that have shaped reproductive rights in India, including the landmark cases and progressive amendments to laws. Furthermore, the paper analyses the policies and programs implemented by the Indian government to address reproductive health issues, including family planning initiatives, maternal health programs, and efforts to combat gender-based discrimination.

***Keywords**: Reproductive Rights, Maternal Healthcare, Family Planning, Access to Contraception, Reproductive Healthcare.*

I. INTRODUCTION

India, a nation rich in cultural diversity and historical significance, has long grappled with the complex and often contentious issue of reproductive rights. As a country that has witnessed significant social, political, and economic transformations, the discourse surrounding the rights of individuals, particularly women, to make informed choices about their own bodies and reproductive health has been a subject of intense debate and scrutiny.[3] Historically, the legal and policy landscape surrounding reproductive rights in India has been shaped by a complex interplay of religious, cultural, and social norms. While the country has made significant strides in addressing issues of gender equality and women's empowerment, the implementation and

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enforcement of reproductive rights have often been hindered by entrenched patriarchal structures and traditional beliefs. The present research paper aims to provide a comprehensive analysis of the laws and policies governing reproductive rights in India, with a particular focus on the evolution of these frameworks and their impact on the lived experiences of individuals, especially women.

II. REPRODUCTIVE RIGHTS: LEGAL AND JUDICIAL PERSPECTIVES

Reproductive rights encompass a wide range of rights within it. The legislative framework on Reproductive Rights in India can be classified mainly into six categories of rights which represent the key areas of reproductive autonomy:

a) Right to have a Child or not to have a Child.

b) Right to Birth control measures.

c) Right to decide number and spacing between the children.

d) Right to be free from all forms of Coercion (forced Sterilization and Abortion)

e) Right to choose method of child birth.

f) Right to have adequate reproductive health care.

These are discussed below:

a) Right to have a Child or not to have a Child

The right pertains to a 'choice' of a woman to have or not to have a child. As has been already discussed, reproductive autonomy means the power of a woman to make decisions to reproduce or not to reproduce. This right form the base of reproductive autonomy. In India one of the aspects of this right, that is the right to not to have a child, has been recognized to some extent.[4] The legislative framework and the judicial response viz-a-viz abortion have been relaxed time and again.

So far as the criminal law of the country is concerned, the Indian Penal Code, 1860 keeping in view the strict, moral and social foundation of the Indian society, has characterized different offences identifying with unnatural birth cycle, injury to the unborn.[5] These provisions are basically founded on a belief that human existence is consecrated and thus legitimate security likewise reaches out to the unborn in the mother's womb. The code prohibits all kinds of harm to an unborn child, unless the mother's life is in danger. Section 312 of the Indian Penal Code

[4] For example, the Medical Termination of Pregnancy Act, 1971.
[5] Chapter XVI (312-318) of IPC deals with the offences Of the Causing of Miscarriage, of Injuries to Unborn Children, of the Exposure of Infants, And of the Concealment of Births.

provides:

Whoever voluntarily causes, a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description or term which may extend to three years, or with fine, or with bot; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Explanation to this section reads that

A woman who causes herself to miscarry, is within the meaning of this section.

The Section talks about miscarriage only, which has not been defined in the Indian Penal Code. The framers of the Code have not used the word 'abortion', in Section 312, which could have related to an unlawful termination of pregnancy. This was perhaps done to avoid hurting the sentiments of tradition bound and conservative Indian society. However, miscarriage, in its popular sense, is synonymous with abortion, and means expulsion of the immature fetus at any time before it reaches full growth. Miscarriage technically refers to spontaneous abortion, whereas voluntarily causing miscarriage, which is an offence under the Code, stands for criminal abortion.[6] Moreover, this section does not spare a woman as well and she will be an offender if she will cause herself to miscarry the unborn. The explanation attached to this section makes it clear that the offender could be a woman herself or some other individual. The aspiration of a woman to be alleviated of her pregnancy is no defense to end that pregnancy.

The Code allowed the abortion only on therapeutic grounds, primarily to save the life of the mother.[7] That is to say, the unborn child must not be destroyed except for the purpose of preserving the precious life of the mother. The provision by implication recognizes the right to life of a fetus.[8]

Hence, it could be said that the criminal law was severe so far as abortion is concerned and the only safeguard available was the “good faith”. The severity concerning the law of early termination of pregnancy brought about the psychological pressure among women and

[6] K.D. Gaur, *Criminal Law & Criminology* 211 (Deep and Deep Pub. Pvt. Ltd., New Delhi, 2002).

[7] Section 312 I.P.C. reads as

> Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine. Explanation. —A woman who causes herself to miscarry, is within the meaning of this section.

[8] Bonda, “The Impact of Constitutional Law on the Protection of Urban Human Life: Some Comparative Remarks” *6 Human Rights* 223- 235 (1977).

consequently, amplified the chances of women resorting to suicides to dispose of the resultant child. It is a matter of common knowledge that most of the maternal deaths at that time were because of illegal abortions. Notwithstanding this, till 1970 the criminal law was not changed and criminal fetus removals remained uncombative.[9] Such early terminations were being carried all through the country by quacks, untrained maternity specialists, incompetent people and people having no clinical involvement with abortions and that too under most unhygienic conditions which prompted high maternal death rates. Then again, the strict abortion laws were by implication adding to high pace of populace growth. Such a rapid increase in the population had repercussions on the economic advancement of the country. In 1957, the Mudaliar Committee provided details regarding the issue of criminal abortions in India; also, the third five-year plan examined this subject in its report on family planning.[10] In 1962, the Family Planning Training and Research Centre in Bombay suggested liberalization of abortion law. The Government of India in 1964 established a Committee to examine the relaxation of the law of miscarriage (abortion) encapsulated in Section 312 of the IPC which makes initiated abortions illicit but to save the existence of a woman.[11] In 1964, the Indian Parliamentary and Scientific Committee under the Chairmanship of Lal Bahadur Shastri proposed to perceive abortion as a solution for failure of contraceptives. In the same year, the Central Family Planning Board (CFPB) suggested the setting up of a Committee to contemplate the issue. A resolution passed by the Health Ministry in September 1964 accommodated the foundation of a committee under the Chairmanship of Shantilal Shah, who was then an individual from CFPB. The exhaustive report of this Committee shaped the proper base of the Medical Termination of Pregnancy Act 1971.[12]

- **The Medical Termination of Pregnancy Act, 1971**

The Medical Termination of Pregnancy Act, 1971 was drafted in tune with the Abortion Act of 1967[13] of United Kingdom. The legislative intent behind passing of this Law was to provide a qualified 'right to abortion' and the termination of pregnancy which has never been recognized as a normal recourse for expecting mothers.[14] The object behind enacting the Act of 1971 was

[9] N.R.M. Menon, "Policy, Law enforcement and the Liberalization of Abortion: A Socio Legal Inquiry into the Implementation for the Abortion Law in India" 16 *Journal of Indian Law Institute* 626 (1974).
[10] https://www.nhp.gov.in/mudaliar-committee-1962_pg (last visited April 22, 2024).
[11] Supra note 96 at 215.
[12] Savithri Chattopadhyay, "Medical Termination of Pregnancy Act, 1971: A Study of Legislative Process" 16: 4 *Journal of Indian Law Institute* 549 (1974).
[13] The Abortion Act 1967 is an Act of the Parliament of the United Kingdom legalizing abortions on certain grounds by registered practitioners, and regulating the tax-paid provision of such medical practices through the National Health Service (NHS).
[14] Kamaljeet Singh and Bhumika Sharma, "Issue of Legalization of Abortion: With Reference to Changed Social Conditions" 116 *Criminal Law Journal* 202 (2010).

set out in its preamble, which provided that:

To provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto.

The Act clearly enumerates the cases where the termination of pregnancy would be permitted. Section 3 of the MTP Act provides the grounds on which a pregnancy would be terminated. These are:

i. a risk to life of the pregnant woman[15]; or a risk of grave injury to her physical or mental health; or

ii. if the pregnancy is caused by rape[16]; or

iii. there exists a substantial risk that, if the child were born, it would suffer from some physical or mental abnormalities so as to be seriously handicapped[17]; or

iv. failure of any device or method used by the married couple for the purpose of limiting the number of children[18]; or

v. Risk to the health of the pregnant woman by reason of her actual or reasonably foreseeable environment.[19]

An important characteristic of this Act is that it does not allow termination of pregnancy after twenty weeks. Sub-Section (2) of Section 3 of the Act which is the pertinent clause on the subject provides certain pre-conditions:

i. Pregnancy may be terminated by a registered medical practitioner.[20]

ii. where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is[21], or

iii. where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are of the opinion formed in good faith that[22]- (a) the continuance of the pregnancy would involve a risk to the life

[15] Section (3) sub-section 2(i) of MTP Act 1971.
[16] Explanation I appended to Section 3 of MTP Act, 1971.
[17] Section (3) sub-section 2(ii) of MTP Act 1971.
[18] Explanation II appended to Section 3 of MTP Act, 1971
[19] Section 3 sub-section 3 of MTP Act, 1971.
[20] Section 2 (d) defines “registered medical practioner” as
"Registered medical practitioner" means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of Section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a State Medical Register and who has such experience of training in gynecology and obstetrics as may be prescribed by rules made under this Act.
[21] Section 3 sub-section 2 (a).
[22] Section 3 sub-section 2 (b).

of the pregnant women or may cause grave injury to her physical or mental health; or (b) there is a substantial risk, if the child were born, that it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The Act has an overriding effect on Section 312 of the Indian penal Code. Hence as long as the conditions of section 3 of the Act are met, no liability shall arise under Section 312 of the Indian Penal Code. Furthermore, if an abortion is done in contravention of the Act then criminal liability arises under the Act as well as the code, both being separate offences.[23]

The validity of this Act was challenged before the High Court of Rajasthan in case of *Nand Kishore Sharma v. Union of India*.[24] The petition alleged that section 3(2)(a) and (b) and Explanation I and II to Section 3 of this Act were unethical and violative of Article 21 of the Constitution of India. But court took the ambivalent view and held that the MTP Act was in consonance with Article 21 of the Indian Constitution as its predominant object was to save the life of pregnant ladies, to forestall any injury to their physical or psychological wellness, and to forestall potential hindrances in the child to be born.

The Supreme Court of India has further deliberated upon this right in the case of *Suchita Srivastava* v. *Chandigarh Administration*[25]a woman's right to make reproductive choice, including the choice to procreate or abstain from procreating has been recognized as part of her personal liberty under Article 21 of the Indian Constitution. The Court stated that:

There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognize that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices.[26]

On the same lines, the Bombay High Court, in *High Court on its Own Motion v. State of Maharashtra*[27] further opined that:

[23] Ishmeet Kaur Taluja and Simran "Reproductive Autonomy and Related Sexual Freedom in India" 4(3) *International Journal of Law and Legal Jurisprudence Studies* 175 (2018).
[24] AIR 2006 Raj. 166.
[25] (2009) 9 SCC 1.
[26] *Ibid*.,para 22.
[27] 2017ALLMR(Cri)3 250 Bombay HC.

According to international human rights law, a person is vested with human rights only at birth; an unborn fetus is not an entity with human rights. The pregnancy takes place within the body of a woman and has profound effects on her health, mental well-being and life. Thus, how she wants to deal with this pregnancy must be a decision she and she alone can make. The right to control their 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.[28]

Notwithstanding, the conditions under which early termination is legitimate are exceptionally limited. Early termination is legitimate up to the second trimester, yet it is the outright discretion of the medical practitioner. A woman can't essentially terminate an undesirable pregnancy; she needs to ensure that she falls in the classes referenced in the section (3) and furthermore, that it tends to be medicinally manifested that the pregnancy would cause grave harm to her. The two explanations appended to section (3) of this Act provide that pregnancy arising out of sexual assault or failure of contraceptive might be taken as injury to the psychological well-being, in any case, the expressions "heath", "substantial risk", even the expressions, "termination of pregnancy" and "abortion" are not clearly defined in the Act. This represents the extent of legal vagueness of this law.

Further the issue in this regard is "how grave such risk should be?" to legitimize the end of pregnancy? The legal language is ambiguous. The MTP Act, 1971 provides that pregnancy can't be ended after the twentieth week except if there is a wellbeing danger to the mother. There might be cases where explanation behind end of pregnancy isn't sex of the embryo yet a few lethal or calamitous abnormalities in the fetus which are detected at later stages of pregnancy.[29] Despite significant developments in medical science, certain fetal impedances can't be distinguished and completely assessed until the twentieth week of pregnancy. This limited access to medical care further prompts delay in proper diagnosis in India. The law does not cater to the necessity of termination of an abnormal fetus at the later stage of pregnancy. Therefore, it could be assessed that the seemingly liberal approach of this Act is basically more restrictive without any such text used in the Act itself.

To fill these legal gaps, the Medical Termination of Pregnancy (Amendment) Act, 2020 has been passed by the both houses of Parliament. The amendment allows the termination of Pregnancy beyond twenty weeks[30] but still the preference to the will of woman in this regard

[28] *Ibid* para 15.
[29] Sarbjit Kaur, "Need to Amend Abortion Law in India" 1 *Journal of Law Teachers of India* 35 (2010).
[30] Section 3 of the Medical Termination of Pregnancy (Amendment) Act, 2020.

is lacking and sole authority has been vested in medical practioner whose opinion is determinative under the Act. It has also made abortion legal beyond twenty-four weeks[31] which will be allowed by a Medical Board, constituted by the state government. However, the only reason this could be allowed is the case of fetus abnormality. It could be inferred that termination of pregnancy beyond twenty-four weeks for any other reason, like pregnancy resulting due to rape that have crossed twenty-four-week limit, will not be allowed. Moreover, there is no time frame given within which the medical board can decide. It is submitted that this lacunae in the law needs to be reviewed and an appropriate amendment needs to be incorporated to cater such exceptional circumstances.

- **Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex-Selection) (PC and PNDT) Act, 2003**

Another significant legislation which partially deals with this right is Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex-Selection) (PC and PNDT) Act, 2003. India has a long history of female infanticide.[32] The object of this Act is to prevent the misuse of the technologies used in pre-conception and pre-natal care, which in India are used to determine the sex of a fetus.[33]

The basic spirit of the PC and PNDT Act is to legislate against any discrimination based on sex using any diagnostic technique whether pre, intra or post conception.[34] Thus the sex selective abortions are made illegal through this Act. Pre Birth determination of sex with purpose of female foeticide (abortion of fetus) is an offence and nobody can compel a pregnant woman to undergo such tests.[35] Even no one is allowed to advertise to do pre-birth sex determination or abortion for purpose of female foeticide.[36] Under this Act it is to be presumed that the pregnant woman was compelled to undergo such a test by husband or any other relative and such person shall be liable for the abetment of the offence, unless contrary is proved.[37] Therefore it substantiates the right to have a child even if it would be a female child.

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[31] *Id.*, Section 3 sub-section 2B.

[32] United Nations Population Fund report (2020) showed that 4.6 lakh girls were "missing" at birth each year from 2013 to 2017, as a result of sex selection that prefers a male child to a female child. The report added that 4.6 crore women are "missing" in India over the last 50 years.

[33] Preamble of this Act provides:

> An Act to provide for the prohibition of sex selection, before or after conception, and for regulation of prenatal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide; and, for matters connected therewith or incidental thereto.

[34] Asha Bajpai, *Child Rights in India* 398 (Oxford University Press, New Delhi, 2006).

[35] Section 3A of PC and PNDT Act, 2003.

[36] Section 22 *Ibid.*

[37] Section 24 *Ibid.*

The Supreme Court of India has also played a major role in enhancing this right of a pregnant woman to not to abort a female fetus. In the landmark case, *Center for Enquiry into Health and Allied Themes (CEHAT)* v. *Association of India*[38], the Supreme Court directed the Central Government to make public awareness in sex identification and female foeticide, to actualize arrangements and rules of PNDT Act, 1994 with all power and enthusiasm. The court additionally directed the Central Supervisory Board (CSB) to meet once in a half year. The court also observed in *Chetna, Legal Advisory WCD Society* v. *Association of India*[39] , that if need be, the National Human Rights Commission can likewise be approached in this issue to encourage the proper implementation of the provisions of this Act.

In case of *Centre for Enquiry into Health & Allied Themes (CEHAT)* v. *Union of India*[40] court directed the State Governments to further undertake the survey so that unregistered clinics do not operate in any part of the country.

b) Right to Birth Control Measures

Right to birth control measures is an important aspect of reproductive autonomy. It provides that there ought not to be any interference by the state or by any individual in the issues of reproduction. A woman must be free to decide and choose the method of birth control. This implies that there ought not to be any restriction at all on the contraceptive decisions of a woman. There are two terms used simultaneously for this right. One is the 'Birth Control' another is 'Family Planning. Both are closely connected. It is vital to get that 'Birth Control', is an individual choice of woman to control her fertility and probably, a couple's endeavor to decide family size, while 'family planning' is the public authority/States' endeavor to restrict the number of its residents.[41] Women worldwide have a fundamental right to decide if and when to have children, and access to the information and means to do so and they cannot be robbed of their right to control their fertility, health and lives. Lack of information and access to contraception increases the number of unwanted pregnancies and women's and girls' risks of maternal mortality and morbidity, including from unsafe abortion. More than half of the abortions performed in India are unsafe, leading to an estimated 12,000 women dying each year from clandestine abortion complications.[42]

This right could be catered under the Family Planning Services or Policies available in a

[38] (2001) 5 SCC 577 para 1-2.
[39] (1998) 2 SCC 158.
[40] AIR 2002 SC 3689.
[41]https://sites.google.com/site/saheliorgsite/health/reproductive-rights-in-the-indian-context (last visited February 09, 2024).
[42]See more at https://reproductiverights.org/story/India-state-must-act-on-contraception (last visited February 8, 2024).

country. India has well-defined Family Planning services which are mainly implemented through administrative policies. The policy was initiated in 1976[43] when there was extensive accentuation on pushing family planning through political and administrative pressure. The strategy basically focused on the population control in India. One of the objectives to be attained through this policy was the implementation of special measures for raising the level of female education; special attention to research in reproductive biology and contraception.[44]

The second population strategy was declared in the year 2000. The prompt goal of the National Population Policy 2005[45] was to address the neglected requirements for contraception, medical services framework and health staff and to offer coordinated assistance conveyance for conceptive and child medical care. The strategy adopted by this policy envisages that by meeting the above expressed unmet requirements, it is conceivable to accomplish population stabilization by 2045.[46]

Family planning has been and stays the premise of population strategy in India regardless of whether the accentuation has been on the decrease in the birth rate or on the other hand on improving the wellbeing, particularly of women and children.[47] In any case, approaches embraced to advance family planning services were changed frequently.

The Policy of the Government of India is to induce more eligible couples to adopt contraceptives for family planning. In pursuance of this policy advice, facilities and services to help eligible couples plan their families are provided free of charge in all Sub-centers, Primary Health Centers (PHCs) Community Health Centre (CHCs) and Rural Family Welfare Centers, District Hospitals, etc. throughout the country. Services are provided through medical and paramedical staff.[48] A cafeteria approach is followed whereby eligible couples may select any contraceptive of their choice offered in the National Family Welfare Programme.[49] However, India has no specific statute governing or controlling the manufacture, advertisement and sale of contraceptives in an exclusive manner. The manufacture, intra and inter-state transmission by mail or public carrier, advertisement, sale, export and import of contraceptives related materials is regulated by Government orders.[50]

[43] Government of India, Ministry of Health and Family Welfare, National Population Policy Statement (1976)
[44] Dr. Usha Tandon, Family Planning in India: A Study of Law and Policy, *available at:* https://paa2010. Princeton .edu/papers/101217 (last visited February 09 2024).
[45] Government of India, Ministry of Health and Family Welfare, National Population Policy Statement (2000)
[46] Supra Note 197 at 2.
[47] B.P.S. Sehgal, *Women, Birth Control and the Law*, 74 (Deep Publications1991).
[48] Government of India, Ministry of Health and Family Welfare, Annual Report, 15 (1996-97).
[49] *Ibid.*
[50]Supra note 197 at 7.

Access to family planning methods is a fundamental human right that should be achieved around the world. Research has shown that globally, 153 million women do not have access to family planning services, and over one-fifth of these women live in India where the needs of women are not effectively addressed in family planning.[51]

Supreme Court of India has also recognized this right in broad perspective of right to reproductive autonomy as it has stated that this includes women's right to refuse participation in sexual activity, to insist on use of contraceptive methods, or to choose appropriate birth-control methods[52] The Supreme Court's holding was reiterated in its later decisions, *Meera Santosh Pal* v. *Union of India*,[53] and *Z v. State of Bihar*[54]

c) Right to decide Number and Spacing between the children

One of the important aspects of the right to reproductive autonomy is the right to decide how many children one can have and when. Free choice of maternity is increasingly recognized as an attribute of private and family life, in order that individuals may propose whether, when, and how often to have children, without governmental control, accountability, or coercion. These are treated as private matters between consenting partners, not governmental decisions or decisions of any third person.[55] Accordingly, women may in principle protect their health in reproduction by determining whether and when to plan pregnancy. Governments may propose to influence reproductive choices through incentives, but cannot apply compulsion or coercive means, such as by punishments or inflictions of harm to individuals' enjoyment of their lives.[56]

d) Right to be Free from All Forms of Coercion (Forced Sterilizations and Abortion)

Regulation of this right by the state is an important step towards achieving the goal of reproductive autonomy of which right to birth control measures is the backbone. However, the state should not resort to coercion in implementing these regulatory measures.

As discussed above, this right provides that a woman cannot be forced to have a child or not to have it. This aspect of reproductive autonomy encompasses the problems of forced impregnation, abortion or sterilization. There should not be any element of force in the free exercise of reproductive autonomy.

[51] JESSIE HUANG "Family planning as a human right: The way forward" *available at*: https://www.orfonline . org/expert-speak/family-planning-human-right-way-forward-53192/ (last visited February 09, 2024).
[52] Suchita Srivastava v. Chandigarh Administration (2009) 9 SCC 1.
[53] (2017) 3 SCC 462.
[54] (2018) 11 SCC 572.
[55] Article 16(1) of CEDAW, Article 23(1) of Disability Rights Convention, Article 14(1) of African Women's Protocol and Paragraph 223 of Beijing Platform for Action have recognized this right.
[56] Subhash Chandra Singh, "Gender, Violence and Human Rights: an International Perspective" XXX (1&2) *Indian Bar Review* 73(2004).

India has a dark history of forced sterilization policies to control the population. The sterilization program was started in the India's family welfare Programme modified in 1956. Beginning with a low rhythm in early years, later on became a well-known technique for family planning.[57] In beginning phases, the Government issued directions requiring the doctors to get the assent of a couple before sterilizing either. Later in April 1968, the Government of India decided to relax the procedure of obtaining sterilization under this Programme and by 1974; the rules for sterilization of either male or female were further relaxed.[58] India's sterilization policy reached its peak in 1975, Sanjay Gandhi (Indian politician and the son of Indira Gandhi, former Prime Minister of India) came up with a five-point programme which included family planning, tree planting, a ban on dowry, each-one-teach-one (an adult education program), and ending social caste. The objective behind these five-points was to reduce the poverty in India and compulsory sterilizations were part of it in lieu of compensation.[59]

A study conducted by the U.S. General Accounting Office found that 4 of the 12 Indian Health Service regions sterilized 3,406 American Indian women without their permission between 1973 and 1976. The GAO finds that 36 women under age 21 were sterilized during this period despite a court-ordered moratorium on sterilizations of women younger than 21.[60] It may have been because women were less likely to protest. These coercive sterilizations embodied gendered violence because they occurred even though vasectomies were much easier and safer than tubectomies. However, women saw lesser compensation for the sterilization themselves, sometimes not receiving any at all. Up to two thousand people died in this drive officially.[61]

Furthermore the civil servants were ordered to have three children only, and in case of violation they would lose their jobs.[62] And when central and state governments were unable to meet impossibly high targets, local administrations set targets for sterilizations for non-health personnel like teachers and forest officers, stopping salaries for non-achievement of these targets, leading to large-scale kidnappings and forcible sterilizations.[63] The introduction of the 'Two Child Norm' involved a plethora of coercive incentives and disincentives in several

[57] S.G.Singh "'India' in the Lee and Larson*", Law and Population*, 108 (1971).
[58] Supra note 194 at 11.
[59]Prajakta R. Gupte, "India: "The Emergency" and the Politics of Mass Sterilization" *available at*: www.Asian studies.org/publications/eaa/archives/india-the-emergency-and-the-politics-of-mass-sterilization/ (last visited February 15, 2024).
[60] https://www.nlm.nih.gov/nativevoices/timeline/543.html (last visited February 15 2024)
[61]https://feminisminindia.com/2020/09/04/history-of-forced-sterilisation-concerns-us-even-today/ (last visited February 20, 2024).
[62] Carolyn Henning Brown, "The Forced Sterilization Program under the Indian Emergency: Results in One Settlement" 43(1) *Human Organization*, 49-54 (1984).
[63] Amrit Wilson, "New World Order and the West's War on Population" 29 *Economic and Political Weekly*, 2201-2204 (1994).

Indian states, including exclusion from eligibility to contest Panchayat (local government) elections of women and men who have more than two children.[64]

The present situation is no less different in this case. India still has an intense policy on population control which is violative of the right to reproductive autonomy. India has done up to 4 million sterilizations during 2013-2014. Somewhere in the range of 2009 and 2012 up to 700 deaths were accounted for because of messed up surgeries.[65] The male to female proportion for sterilizations in 2016-17 remained at 1:52 according to information with the Ministry of Health and Family Welfare.[66]

The Judicial approach viz-a-viz this right has been positive. In case of *Dr. Sukha Raj Singh Rathore* v. *State of UP*[67] wherein Allahabad High Court directed the police to investigate the death of a twenty-eight (28) year old woman who was induced to undergo sterilization process. It came to be noted that this case illustrated the dangers of coerced or induced sterilization on poor persons without their informed consent and without necessary safety precautions.

In case of *Ramakant Rai v. Union of India,*[68] The Supreme Court of India noticed that uniform methodology and standards were not being followed by States for executing the public policy on sterilization. It gave directions to all States to, among other measures, have an affirmed board of medical professionals under a uniform qualification criteria for conducting sterilization processes require them to fill an endorsed checklist, for example, the age of the patient, number of kids and the overall wellbeing of the patient; must take assent of the patient for sterilization in a endorsed format; set up a quality affirmation committee for observing usage of recommended rules; and to hold inquiries and make punitive measures if there would be any violation of public rules. It likewise guided the Union of India to lay down prescribed formats for States to follow the above stated rules and to set down standards of compensation accordingly.

Thereafter, in *Devika Biswas* v. *Union of India,*[69]the Apex Court that moved beyond the reproductive health framework and recognized women's autonomy and gender equality as core elements of women's constitutionally-protected reproductive rights. Court categorically rejected the state policies of forced sterilization. The Court further observed:

[64] Mohan Rao, "Two-Child Norm and Panchayats: Many Steps Back" 38 *Economic and Political Weekly,* 3452-3454 (2003).
[65] See more at https://www.mohfw.gov.in/ (last visited February 20, 2024).
[66] *Ibid.*
[67] 2004 Cri LJ 4553 (All).
[68] (2009) 16 SCC 565 para 1-3.
[69] (2016) 10 SCC 726 / 733.

The manner in which sterilization procedures have reportedly been carried out endanger two important components of the right to life under Article 21 of the Constitution – the right to health and the reproductive rights of a person. It is well established that the right to life under Article 21 of the Constitution includes the right to lead a dignified and meaningful life and the right to reproductive health is an integral facet of this right. Over time, there has been recognition of the need to respect and protect the reproductive rights and reproductive health of a person. Reproductive health has been defined as "the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour." "The freedom to exercise these reproductive rights would include the right to make a choice regarding sterilization on the basis of informed consent and free from any form of coercion.[70]

Various petitions were also filed that challenged the 'two child policy' prescribed as a qualification by state governments. These are the indirect modes to control the population. Rajasthan High Court faced this question in case of *Mukesh Kumar Ajmera* v. *State of Rajasthan*[71]wherein the provisions of the Rajasthan Panchayati Raj Act, 1994 disqualified the persons having more than two living children after a prescribed date from holding certain public offices in the Rajasthan Panchayat. However, the Court rejected this contention and held that the rights to life and individual freedom are not absolute and can be diminished considering convincing State interest which for this situation was controlling the "threat" of population menace. The Court held that population control was fundamental to accomplish objectives set down under Directive Principles of the State Policy enshrined under Articles 39(e) and (f), 41, 43, 45 and 47 of the Indian Constitution and that while the quantity of kids made little difference to the performance of officials of the Panchayat, the officials of the Panchayat should set an example for the electorate.[72]

Subsequently this issue cropped up before the Supreme Court of India in case of *Javed* v. *State of Haryana*[73] where the same provision under Haryana Panchayati Raj Act, 1994 was challenged. The Court held that the exclusion of people having multiple children after a recommended date fulfilled the criteria of reasonable classification and had an objective nexus with the target of advancing general wellbeing, family welfare and population control. Perusing fundamental rights read with Directive Principles of State Policy, the Court held that these

[70] *Ibid*. para 81.
[71] AIR 1997 Raj 250.
[72] *Id.*, para 37.
[73] (2003) 8 SCC 369.

provisions didn't abuse the right to life and personal liberty under Article 21.[74]

However, this judgment can be criticized because it is a sheer violation of not only the right to reproductive autonomy but the whole narrative of Human Rights approach that if the state coerces its people to undergo the process of sterilization to achieve the goals of welfare state by controlling the population boom. It is more relevant than any time to change the narrative around family planning overall, alongside the stereotypes that turn into defining narratives.

e) Right to choose the method of Child Birth

The right to Reproductive autonomy is wide enough to incorporate pregnant women's option to decline clinical treatment and to choose whether to go for a cesarean section or to have a natural delivery. No medical professional can force a woman to go through a specific method of labor unless there is a likelihood of health complications. While pregnancy extends the individual obligations of a woman it doesn't decrease her will to choose the method of childbirth.

Recently it was observed that cesarean sections or commonly known as C-Section births were given more impetus due to the financial gains of the medical professionals. According to the guidelines laid down by the World Health Organization (WHO), the procedure should only be used in complicated pregnancies. C-sections have, however, become increasingly common in both developed and developing countries, including India, where experts call the trend “an epidemic”, blaming it on an “unregulated market”, financial incentives and an increasing trend of women opting for it.[75] Even Doctor’s Association of Kashmir has said that Doctors perform unnecessary cesarean deliveries for 'financial gains'.[76] Women may support choice in principle, but in practice women’s autonomy is limited by both available care provision and individual circumstance.[77]

In India there is no specific legislation or policy which reflects this aspect of reproductive autonomy.

f) Right to have Adequate Reproductive Health Care

At a basic level, reproductive wellbeing has been seen as an establishment to successful childbearing, the passage of mother and baby through critical stages. The idea of 'reproductive

[74] *Id.*, para 25.
[75] See more at https://theprint.in/health/caesarean-deliveries-have-become-an-epidemic-in-india-record-300-jump-in-last-decade/334291/ (last visited February 22, 2024).
[76] https://www.greaterkashmir.com/news/health/doctors-perform-unnecessary-cesarean-deliveries-for-financial-gains-dak/ (last visited February 22, 2024).
[77] Department of Health. Maternity matters: choice, access and continuity of care in a safe service. HMSO, 2007. [http://www.dh.gov.uk/en/Publicationsandstatistic (last visited February 22, 2024).

wellbeing' offers a complete way to deal with well-being related to reproduction. It puts women at the focal point of the interaction and recognizes, regards and reacts to the necessities of women. The definition of Reproductive Health was adopted and expanded, in the Programme of Action developed at the ICPD held in Cairo in 1994[78], and at the International Conference on Women, also sponsored by the United Nations, which was held in Beijing in 1995. The full definition reads:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[79]

So far, the position in India is concerned various initiatives have been taken by the Government of India to meet the international standards in reproductive health care. Notable schemes and initiatives of the government in this regard are:

1. Janani Suraksha Yojana was launched in 2005. It comes under the National Health Mission. The Main objective behind this scheme is to reduce the Maternal Mortality Rates (MMR) which mainly occurs because of poor reproductive health care.[80]
2. The Indira Gandhi *Matritva Sahyog Yojana*, also known as *Pradhan Mantri Matritva Vandana Yojana (PMMVY).* It was introduced in 2010 and comes under the Ministry of Women and Child Development. Its objectives are to provide monetary benefit to pregnant women so that she can have a safe delivery and better health services. It also provides that new mothers have to follow Infant and Young Child Feeding (IYCF) practices for the first six months.[81]

[78] UN, Population and Development, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations, New York: Department for Economic and Social Information and Policy Analysis, ST/ESA/SERA/149, 1994) para 72.
[79] UN, Department of Public Information, Platform for action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, 4-15 September 1995 (UN, New York, 1995), para 94.
[80] See more at https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309 (last visited February 25, 2024).
[81] Dr.Babita Singh, "Women Health In India: Issues And Schemes", 5(4) *International Journal of Research and*

3. *Janani Shishu Suraksha Karyakaram* was launched by GoI in 2011. The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. It promotes the idea of institutional deliveries as well. The services include free and cashless delivery, free drugs and diagnostics, free transport from home to health institution etc.[82]

4. Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) 2013 was launched by the Ministry of Health & Family Welfare Government of India. The main focus of this scheme is promoting maternal and child health, reproductive health and other components like family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques.[83]

5. *Pradhan Mantri Surakshit Matritva Abhiyan* was launched by the Ministry of Health & Family Welfare (MoHFW), Government of India in 2016. The main focus of this programme is to ensure at least one antenatal checkup for all pregnant women in their second or third trimester by a physician/specialist. It provides a fixed day for assured, comprehensive and quality antenatal care free of cost to pregnant women on 9th of every month. This Programme strengthens antenatal care detection and follows up of high-risk pregnancies, contributes towards reduction of maternal deaths and reduces the MMR of India.[84]

III. CONCLUSION AND SUGGESTIONS

Despite such programmes and schemes, reproductive health care is still low in India.[85] Courts in India have adjudicated upon this right as a subset of Right to Health. In *Laxmi Mandal* v. *Deen Dayal Harinagar Hospital & Ors,*[86] The Delhi High Court held that the right to health (including the right to access and receive a minimum standard of treatment and care in public health facilities), the reproductive rights of women, and the right to food are inalienable survival rights forming part of the right to life. In *Kali Bai* v. *Union of India*[87] the Court held that the right to health incorporates the right to have access to public health facilities. Noticing that such rights to health and the right to have adequate reproductive healthcare facilities are

Analytical Reviews (2018).

[82] See more at https://www.nhp.gov.in/janani-shishu-suraksha-karyakaram-jssk_pg (last visited February 25, 2024).

[83]See more https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168 (last visited February 25, 2024).

[84] https://www.unicef.org/india/what-we-do/maternal-health (last visited February 25, 2024).

[85] India is among the top twenty countries in the world with the highest maternity mortality rates (MMR) see more at https://www.macrotrends.net/countries/IND/india/maternal-mortality-rate (last visited February 25, 2024).

[86] (2010) 172 DLT 9.

[87] 2017 SCC OnLine Chh 1081.

basic parts of Article 21, the Court issued directions for the improvement of public health services including reproductive health care.

This analysis of the legal and policy framework in India reveals that while the country has made significant strides in addressing reproductive rights, there is still much work to be done to ensure that these rights are fully realized and protected. There lies the plethora of hurdles in form of unawareness, educational backwardness, social taboos and the deep rooted patriarchal socio-cultural set up; which have to be overcome in unison if at all some success has to be achieved. Continued advocacy, policy reform, and a concerted effort to address socio-cultural barriers will be crucial in ensuring that all individuals in India, regardless of gender, have access to comprehensive reproductive health services and the autonomy to make informed decisions about their own bodies and reproductive choices.

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