



Review:

Women Reproductive Rights in India: Prospective Future.

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Abstract:

Reproductive rights were established as a subset of the human rights. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children. Issues regarding the reproductive rights are vigorously contested, regardless of the population's socioeconomic level, religion or culture. Following review article discusses reproductive rights with respect to Indian context focusing on socio economic and cultural aspects. Also discusses sensitization of government and judicial agencies in protecting the reproductive rights with special focus on the protecting the reproductive rights of people with disability (mental illness and mental retardation).

Key Words: Reproductive rights; Mental retardation; Abortion

Introduction:

Social change is always difficult, particularly when the basic relations between men and women in families and society are involved. There has been a growing recognition of how the rules governing men and women's opportunities, social endowments and behaviors affect the prospect for accelerated development and justice. In the era of globalization, and urbanization, societies need their own solutions, grounded in a vision of justice and gender equality and consistent with their cultures and conditions, to provide a better life for both women and men.

A series of human rights treaties and international conference agreements forged over several decades by governments — increasingly influenced by a growing global movement for women's rights — provides a legal foundation for ending gender discrimination and gender-based rights violations. These agreements affirm that women and men have equal rights, and oblige states to take action against discriminatory practices. The Vienna Declaration and Programme of Action, the Programme of Action of the International Conference on Population and Development (ICPD) and the Platform for Action adopted at the Fourth World Confer-

ence on Women (FWCW) are international consensus agreements that strongly support gender equality and women's empowerment. In particular, the ICPD and FWCW documents, drawing on human rights agreements, clearly articulate the concepts of sexual and reproductive rights.

Thus the reproductive rights were established as a subset of the human rights at the United Nations 1968 international conference on human rights.(1) Parents have a basic human right to determine freely and responsibly the number and the spacing of their children.(1,2)

The WHO defines reproductive rights as follows:

“Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information to do so, and right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.” (3)

Issues regarding the reproductive rights are vigorously contested, regardless of the population's socioeconomic level, religion or culture (4)

Reproductive rights include some or all of the following rights: (3-7)

1. Right to legal or safe abortion.
2. Right to control ones reproductive functions.
3. Right to access in order to make reproductive choices free of coercion, discrimination and violence.
4. Right to access education about contraception and sexually transmitted diseases and freedom from coerced sterilization and contraception.
5. Right to protect from gender based practices such as female genital cutting and male genital mutilation.

Understanding of Reproductive Rights in Indian Context:

India, as a signatory to the International Conference on Population and Development, 1994, has committed itself to ethical and professional standards in family planning services, including the right to personal reproductive autonomy and collective gender equality.(8) Indian policies and laws so far seem to reflect this understanding, at least on paper. The National Population Policy, 2000, affirms the right to voluntary and informed choice in matters related to contraception.(9)

The issue of right to reproductive health especially abortion, takes on special significance in the Indian context as various national and international stakeholders struggle to bring meaning to the important concepts of women empowerment, rights and choices as articulated in the Cairo Agenda at the 1994 international conference on population and development (ICPD).(10)

The Indian setting combines a number of apparent contradictions in how family planning and abortion policy is set; how services are delivered; how demographic trends and desires about family size and composition shape the demand for contraception and abortion; and the social context defines the pressures, constraints and options for women's reproductive behavior.(10)

Indian experience in implementation of reproductive rights and choices:

The policies and services

Nineteen ninety eight analysis of seven states shows that implementation of the target – free approach varies considerably across states, with some states unwilling or unable to abandon targets. (11) Field level assessment indicate that entrenched attitudes among policy makers and service providers have been difficult to change as illustrated by the following quote from physician at the community health centre: The government says that family planning should be left to free choice, but I don't understand why it is wrong to put pressure on women from poor families".(12)

Although the policy goal is to provide greater choice in family planning methods, the promotion and availability of spacing methods continues to be limited. Data from 1990s document shows that it is only within limited number of highly urbanized centers that Indian women have range of contraceptive options available. In poor, rural areas especially, contraceptive supplies primary health centers and sub centers are frequently inadequate or lacking altogether.(13) The choices for contraception are very limited at rural centers. For e.g. either you have option to undergo tubectomy or laparoscopic sterilization based on the proximity of the rural center to the district head quarter. Specialists who conduct sterilization prefer to move to nearest center for conducting camps than remote areas. This has forced the people to accept only available option and not to choose method of their choice. In true sense it has curtailed the reproductive rights of the individuals.(14) Even when official policy encourages the provision of options to women, service providers often do not practice principles of informed choice. Data from national family health survey (NFHS 2) indicate only 40 % of women remember ever discussing family planning with a health worker, only 10 % had ever discussed the pill, and even fewer have other temporary methods. Only 15% of those who use modern contraceptive were informed about an alternative method.(15)

The Medical termination of pregnancy (MTP) act made abortion legal in India in 1972, but vast majority of women gets abortions outside this legal frame work. In part, this is due to the inherent restrictions regarding registered facilities and doctor consent built into by providers and even poorer understanding among women regarding their legal rights. While official records indicate that somewhere between 550,000-600,000 induced abortions take place in the country per year, recent publications suggest estimates close to 7 million induced abortions per year.(16)

Demography and fertility

In the last decade, India has experienced declining fertility levels. The total fertility rate fell from 3.4 to 2.9 between 1992 and 1998. The mean ideal number of children also fell – from 2.9 to 2.7.(17) This trend is accompanied by a rising demand for contraception, including spacing methods; however, use of spacing methods continues to be limited and permanent methods, more specifically female sterilization, continue to predominate. In 1998, 34 % of currently married women were sterilized (Accounting for 71 % of contraceptive use), but only 7 % were using a spacing method – levels virtually unchanged since 1992.(17)

Unmet needs for family planning is substantially greater than is obvious at first glance. The NFHS-2 calculates unmet need at 15.8% in India using a limited definition of currently married, fecund women who either want no additional children, or want no additional children for at least two years. An ICRW study in Uttar Pradesh calculated unmet need at 31.7% in sitapur using this same definition. But unmet need rose to 54.8% using an expand definition that took into account dissatisfaction with contraceptive methods, more accurate assessment of the protective effect of post partum amenorrhea and incorrect use of traditional methods. (18)

Social Context

India has a vibrant women's movement and strong presence of grass root NGOs committed to bringing rights and choice to women. At the same time, large proportions of women continue to face social and domestic pressures and constraints that limit their ability to formulate and act on reproductive decisions. In particular, the continued strength of son preference is well documented (19); 33% of women would like to have more sons than daughters with 85% of women wanting at least one son.(15) My personal experience of working with people in rural area as medical officer. There was a lady having five children with ongoing sixth pregnancy, my self and my health workers motivated this lady and her husband to undergo laparoscopic sterilization from 6th month of pregnancy onwards. On the day of sterilization when our health workers went to meet her, the voice of old lady from inside spoke there is no need for my daughter in law to undergo sterilization, births are god gifts. Later we learnt that she is the main decision making for five families which stayed together in the same house.(14) What we need to understand from this is, though reproductive right is very much specific to the couples, but in Indian context it is the collective decision of the family. Extrapolation of such rights to Indian social context needs careful examination.

Spousal consent for abortion and sterilization

The right to make free and informed decisions about health care and medical treatment, including decisions about one's own fertility and sexuality, is enshrined in Articles 12 and 16 of the Convention on the Elimination of all Forms of Discrimination Against Women (1978).(20)

Autonomy, the right to informed consent and confidentiality are considered the fundamental ethical principles in providing reproductive health services. Autonomy would also mean that when a mentally competent adult seeks a health service, there is no need for an authorization from a third party.(21) According to recent ethics guidelines in reproductive health research, even use of the term "consent" has been restricted only to the person who is directly concerned; in circumstances where partners are involved it is termed a "partner agreement" Contrary to this Supreme Court judgment when hearing an appeal in the Ghosh vs. Ghosh divorce case, the court ruled on March 26, 2007: "*If a husband submits himself for an operation of sterilization without medical reasons and without the consent or knowledge of his wife and similarly if the wife undergoes vasectomy (read tubectomy) or abortion without medical reason or without the consent or knowledge of her husband, such an act of the spouse may lead to mental cruelty.*"(22) The court also ruled that a refusal to have sex with

one's spouse and a unilateral decision to not have a child would also amount to mental cruelty. Considering the circumstances of the case, the court granted a divorce. The judgement has serious implications for reproductive health services in India, because it mandates spousal consent for induced abortion and sterilization.

The judgement conflicts with the existing guidelines for medical practice, and it is likely to confuse those who are seeking as well as offering these services. It implies that when a woman seeks abortion or sterilization on her own and if her husband is not informed or does not consent, the very act of the woman could be cited by her husband as mental cruelty and grounds to seek a divorce. The judgement thus hits at the very core of reproductive rights: taking a decision and seeking a service without fear of coercion or violence. It is likely to set a wrong precedent and put many providers on guard, because they would not want to be involved in legal tangles. Many clinics may start using this ruling to impose a requirement of spousal consent. Even providers in the public sector may insist on a spouse's signature to avoid legal problems. The highest judiciary in the nation has to demonstrate a better understanding and commitment to human rights, especially women's rights.(23)

Reproductive Rights in Mentally Retarded Women:

In India, a disabled girl-child is usually at the receiving end of a lot of contempt and neglect. Women with disabilities have been consistently denied their rights. Nineteen year-old mentally challenged orphan girl at Nari Niketan, Chandigarh, a government institution for destitute women, was raped some time in March 2009 on the premises by the security guards. In May 2009, the pregnancy was detected (24) Four-doctor Multi Disciplinary Medical Board which included a psychiatrist recommended that woman "has adequate physical capacity to bear and raise the child but that her mental health can be further affected by the stress of bearing and raising her child." Based on these recommendations, the Punjab and Haryana High Court ruling ordered medical termination of pregnancy (MTP). On the NGO appeal against the High courts order, the Supreme Court (SC) of India gave a landmark decision allowing a 19-year-old mentally challenged orphan girl to carry on with a pregnancy resulting from a sexual assault. This case thus raised fundamental issues relating to consent and to the support required while assessing consent. This case was not about abortion per se, it was about whether the law of this country recognizes and protects the agency of a woman to take decisions for her life and body, especially all its nuances when the woman is a person with mental retardation (MR) or any other disability."

Legally, Medical Termination Of Pregnancy (MTP) Act does not deal with access to abortion of women with MR, and that it wrongly distinguishes between women with mental retardation and mental illness, leaving the former out totally. Also that the Act does not understand that both these kinds of women are more likely than not to be destitute, in which case guardianship is not that simple. Since SC has gone ahead to continue pregnancy but has failed to address support mechanism and state's accountability for creating and sustaining comprehensive and reliable support systems for her within a rights framework an obligation under Article 12 of the UN Rights of Persons with Disabilities Convention. This case indicates eloquently that the Indian legal framework has to be strengthened a great deal to bring it in line with international legislation. It also raises the question whether our government institutions are safe enough to protect women and more so people with disabilities.

What needs to be done to empower women's rights to reproductive health?

Inadequate reproductive health care for women results in high rates of unwanted pregnancy, unsafe abortion, and preventable death and injury as a result of pregnancy and childbirth. Violence against women, including harmful traditional practices like female genocide, takes a steep toll on women's health, well-being

and social participation. Violence in various forms also reinforces inequality and prevents women from realizing their reproductive goals. Men also have reproductive health needs, and the involvement of men is an essential part of protecting women's reproductive health.

Providing quality reproductive health services enables women to balance safe childbearing with other aspects of their lives. It also helps protect them from health risks, facilitates their social participation, including employment.(25)

Reproductive health does not affect women alone; it is a family health and social issue as well. Gender-sensitive programmes can address the dynamics of knowledge, power and decision-making in sexual relationships, between service providers and clients, and between community leaders and citizens.(26)

A gender perspective implies also that institutions and communities adopt more equitable and inclusive practices.(27)

As the primary users of reproductive health services, women have to be involved at all levels of policy-making and programme implementation. Policy makers need to consider the impacts of their decisions on men and women and how gender roles aid or inhibit programmes and progress towards gender equality.

Reproductive health care should include following components;

Family planning which involves strong government support, service providers who are well trained, sensitive to cultural conditions, listen to clients' needs, and are friendly and sympathetic. Services are affordable and a choice of contraceptive methods is available, Counseling ensuring informed consent in contraceptive choice, ensuring privacy and confidentiality, comfortable and clean facilities and prompt service.(28)

Safe motherhood programme should provide access to emergency obstetric care, including treatment of hemorrhage, infection, hypertension and obstructed labour. Life-saving interventions, like referring to medical centers. A community-based system for ensuring rapid transport to an equipped medical facility. Training Community health workers to detect and treat post-partum problems, as well as to counsel on breastfeeding, infant care, hygiene, immunizations, family planning, and maintaining good health.(29)

Abortion and Post-abortion Care: Abortion is an important public health issue. Family planning services ensure reduction in unwanted pregnancies and prevent abortions. In circumstances where abortion is not against the law, quality health services should ensure safe abortion practices and effective post-abortion care would significantly reduce maternal mortality rates. (30)

Prevention and treatment of sexually transmitted diseases (STDs and HIV/AIDS): Because of culture as well as biology, women are more vulnerable to STDs than men.(31) The integration of family planning and STD/HIV/AIDS services within reproductive health services can reduce levels of STDs, including HIV/AIDS, by providing information and counseling on critical issues such as sexuality, gender roles, power imbalances between women and men, gender-based violence and its link to HIV transmission, and mother-to-child transmission of HIV; distributing female and male condoms; diagnosing and treating STDs; developing strategies for contact tracing; and referring people infected with HIV for further services.(32-33)

Involvement of men in reproductive health programme: Greater involvement of men in reproductive health decisions will give more power to women, not less. The common aim is the well-being of all family members. Men can advance gender equality and improve their family's welfare by; Protecting their partners' health and supporting their choices (E.g. adopting sexually responsible behavior; communicating about sexual and reproductive health concerns and working together to solve problems; considering adopting male methods of contraception), Confronting their own reproductive health risks (learning how to prevent or treat sexually transmitted infection, impotence

infertility, sexual dysfunction and violent or abusive tendencies) Refraining from gender violence; Practising responsible fatherhood; Promoting gender equality, health and education.(34-35)

Conclusion:

Reproductive health and right to reproductive health is not only women issue it is a family health and social issue. The ultimate aim of the right to reproduction is well being of the family and individuals. At the same time it becomes the responsibility of the governments to give quality reproductive health care and protect the individual reproductive rights while being sensitive to local and cultural issues. There is increased need for sensitization of the judicial and government while protecting the reproductive rights of people with disability especially mental retardation and mental illness. There is also increased need for sensitization of judicial system on process of consent to abortion. To ensure quality reproductive health services, there is need for active community participation and involvement of men (spouse).

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