



## Right to reproductive health: Barriers to realization of rights by women

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### Abstract

The aim of this essay is to examine the right to reproductive health and the effect of state policies on this human right. At the outset, the paper will lay out the responsibilities of States as broadly understood through the equality paradigm. The first part of this essay identifies the right to reproductive health as empowering in making individuals across borders both right-holders and addressees. However, it is understood that the application of this right is dependent on state policy. The second part of the essay will examine the effect of socio-economic factors on the realization of the right to reproductive health, including the essential component of menstrual health. The effect of availability and accessibility of contraceptives will also be briefly related. The last part of the essay will explore the highly debated topic of abortion. Through UN General Recommendations and General Comments, it will identify whether the right to abortion exists as a component of reproductive rights. Thereafter, adoption of conservative policies on abortion by states will be explored. The competing right of the mother and the foetus will be also be briefly explored. The themes of indirect discrimination and state obligation will be interspersed throughout the paper. Therefore, the recurring gap between guaranteed rights to reproductive health, presented as state obligations, and the realization of these rights by individual right holders living within these states will be highlighted.

**Keywords:** reproductive rights, international human rights conventions, Indian laws, abortion, reproductive health, equality

### Introduction

Based on the general principle of *pacta sunt servanda*, treaties form one of the most significant sources of international law on account of the binding nature of obligations ratification by state parties <sup>[1]</sup>. While in form, human rights treaties are identical to public international law treaties, there exists a difference in substance. Human Rights treaties are unique in the sense that they are not based on a reciprocity, but rather a commitment by a state to its people through ‘state volunteerism’. This means that such treaties are not a “web of inter-state exchanges of mutual obligations <sup>[2]</sup>; rather they function in a unilateral direction, only seeking to endow individuals, as beneficiaries, with rights <sup>[3]</sup>.

### Understanding State Obligations

In the implementation of these obligations, a tripartite typology has been adopted wherein states must respect, protect and fulfil human rights <sup>[4]</sup>. ‘Respect’ involves a negative obligation upon states to not interfere or violate rights. ‘Protect’ includes an obligation upon the state to prevent harm from non-state actors and take proactive measures to prevent deprivation of rights within the state. This would mean that “*an illegal act which violates human rights and may not directly be attributable to a state can still lead to international responsibility of the state, either because it is a failure of due diligence by the state in ensuring that this violation not take place, or because it allows private individuals to act freely and with impunity against certain aspects of the human rights regime.*” <sup>[5]</sup> The obligation to ‘fulfil’ requires states to take affirmative action to ensure that certain rights are actually promoted <sup>[6]</sup>. Now, to understand

these together: these state obligations reflect the idea of *expected* treatment from the state by individuals. While the obligation to ‘respect’ <sup>[7]</sup> is a negative one, requiring non-interference by the state in the enjoyment of rights, to ‘protect’ <sup>[8]</sup> requires states to ensure that third parties do not cause deprivation of the right within the state, and to ‘fulfil’ requires taking of affirmative actions the realization of the right. This would include ensuring that infrastructure of, *inter alia*, shelter, food, sanitation, health and sex education is available. These obligations are aimed at providing the “highest attainable level of health <sup>[9]</sup>” through the inter-related concepts of availability <sup>[10]</sup>, accessibility <sup>[11]</sup>, acceptability <sup>[12]</sup>, and quality <sup>[12, 14]</sup>. Further, through the negative element of the right, individuals are also endowed with civil and political rights to privacy, bodily integrity, life with dignity, non-discrimination and equality, and to not be subject to cruel and degrading treatment. Together, these elements appear comprehensive in tackling the complexity of the right to reproductive health. The question remains with respect to their effectiveness upon interaction with states and individuals.

### Relation to Reproductive Health

The right to reproductive health makes individuals across borders right holders of an indivisible human right. In 1979, *Convention on Elimination of All Forms of Discrimination Against Women* <sup>[15]</sup> (‘CEDAW’) as the first feminist treaty in human rights recognising and catering solely to the disadvantage faced by women, in Article 12(1) placed upon states the obligation to take “appropriate measures to eliminate discrimination against women in the field of health care.” With no *de minimis* standard of health mandated, a

wide margin of appreciation was given to state parties in determining 'appropriate measures'. Article 12 (2) lists appropriate services for women in relation to reproductive rights but fails to, expressly, include the right to "termination" or abortion. This noticeable omission has been attributed to states that consider abortion to violate their religious views. Consequently, the right to abortion itself was excluded from the language of CEDAW. In this manner, we observe a persistent effort by states to assert their sovereignty over 'universal' <sup>[16]</sup> international law through dilution of treaty provisions and hence, of treaty obligations. This is in addition to the margin of appreciation to file for limitations (reservations) granted to states.

### **Correlation of the Right to Reproductive Health with other Rights**

Significantly, the right to reproductive health does not exist in isolation. General Recommendations on the right to reproductive health highlights barriers to achievement of this right <sup>[18]</sup>, along with the corresponding rights mandatory for the full realisation of the right to reproductive health. The right to reproductive health gives all right holders the entitlement of unhindered access to health facilities, goods, services and information that ensure full realisation of the right to sexual and reproductive health. According to General Recommendation <sup>[14, 18]</sup>, in order to realize "the highest attainable standard" of this right, rights vis-à-vis "underlying determinants of health" (broadly termed 'socio-economic conditions' in this paper) must also be tackled. Full implementation of this right by state parties would include providing facilities, goods and services in the form of adequate and safe potable water, sanitation, nutrition, health related information and education to all individuals without discrimination <sup>[19]</sup>. Consequently, for a state to fulfil its right to education, it must also impart sex and reproductive education. This education must be imparted to all without discrimination. If fully fulfilled, this should lead to reduction in social problems of child marriage due to knowledge of issues of fistula and other complications inherent in under-age pregnancy. Pursuant to this, states must also impose legislations or policies prohibiting child marriage. Another problem related to the accessibility of this right is the economic disparity within relationships. "A woman is expected to sacrifice her career and [dedicate] herself completely to looking after the well-being of her husband <sup>[20]</sup>." This leads to a woman being financially weaker than her partner. Therefore, financial control and decisions remain with the man. In a poor household, this means that a woman may not be provided money for contraceptives or sanitary pads essential to maintain menstrual hygiene, which are accorded lower priority. This also leaves women more prone to being infected with sexually transmitted infections ('STI') and infections in general. Due to lower negotiating power, a woman may also be denied her right to family planning, leading to violation of her right to dignity, privacy and reproductive health. Therefore, for full realization of the highest standard of reproductive health, state obligations concerning civil and political rights of education, privacy, dignity of life must also be fulfilled.

### **Instances of Right to Reproductive Health in relation to the Right to Non-Discrimination**

As an expansive right, the right to non-discrimination and equality is often violated in the area of reproductive health care. Pursuant to the obligation of substantive equality under the ICCPR and CEDAW, state parties are obligated, *inter alia*, to provide sexual and reproductive services in remote areas <sup>[21]</sup>, and increase economic accessibility of medicines by making the same affordable in relation to economic status of the individual (subsidies or free medical care) <sup>[22]</sup>.

*Laxmi Mandal v Deen Dayal Harinagar Hospital & Ors* <sup>[23]</sup>, is clear example of the effect of inadequate health care that is ill-equipped to cater to specific socio-economic situations. In this case, the Applicant, Shanti Devi belonged to a marginalised, scheduled caste, landless family in Bihar. After her marriage, she moved to Faridabad with her husband who is a daily wage labourer in search of a job. The couple live in a compound with 30 other families, all of whom share one washroom cubicle/ toilet. Shanti Devi suffered from anaemia and tuberculosis, and had undergone four pregnancies, of which two were unsuccessful. In the seventh month of her fifth pregnancy, she fell down the stairs. On seeking the advice of a *dai* (as she could not afford a doctor), she was advised to go to a Government hospital. After 2 weeks, once the couple had raised sufficient money to travel, they went to a hospital in Faridabad where they were informed that the baby was no longer alive. The couple was further referred to the Sanjay Gandhi hospital in Delhi as they were eligible to receive free treatment due to their economic status. Notably, no painkillers were offered by the Faridabad hospital for her pain, nor was transportation for the 50km journey offered. She was further referred by the Sanjay Gandhi hospital to the Saroj Hospital due to lack of a bed in the ICU. Despite being eligible to free health care due to her economic status, on approaching the Saroj Hospital, Rs 2.5-3 lakhs was demanded for the removal of the foetus. The Sanjiv Gandhi Hospital Medical Superintendent spoke to the Saroj Hospital representative but to no avail. Finally, a bed was found for her at the Deen Dayal Hospital. This hospital removed the foetus and recognised that she was anaemic. There was no mention of any medical support to redress the same is given. She was discharged while she was still weak and given no information about family planning. Six months after being discharged from Deen Dayal Hospital Shanti became pregnant for the sixth time. In her seventh month of pregnancy she went in to labour at home without any birth attendant. One hour after giving birth she started haemorrhaging and died soon after on 20th January 2010. The audit report after her death stated that non-use of a family planning method was the most critical factor in her death. In retrospect, it may be observed that while a medical facility was provided, it was vastly inadequate. Not only was a bed provided to her reluctantly and for only the most necessary time period (presumably, so that the bed could be freed up for other paying patients), the doctors did not advise her on family planning methods or even treat her for her anaemia.

Lack of geographical and economic accessibility to adequate quality health facilities, and lack of information provided to prevent future complications further aggravated the situation.

This clearly reflects a breach of state obligation wherein the requisite facilities were neither accessible nor adequate. Further, the application faced acute discrimination owing to her socio-economic status. Denial of health care by Deen Dayal Hospital is evidence of the acute discrimination faced by Laxmi Mandal due to her socio-economic status. The state failed in implementing policies accommodating for such circumstanced individuals. Individuals living in poor conditions, with lack of information, education and nutrition are more liable to be discriminated against and hence, unable to realise their right to reproductive health.

### Need for Gender Equality

In addition, state parties must also ensure gender equality and make available all facilities, goods and services that cater to the specific needs of women as per their life cycles<sup>[24]</sup>. States must not interfere in the decisional aspects involving the rights to privacy, bodily and mental autonomy, and the right against discrimination and inequality. The primary challenge is the prohibition of abortion by states. General Recommendation 22 is the first document to include the term 'abortion' and promote the freedom of decision-making including that of abortion or medical termination of pregnancy. It joins General Recommendation<sup>[24, 25]</sup> in strongly urging states to decriminalise abortions. Going a step further, it states that denial of abortion is a violation of the right to life and could even amount to torture, cruelty or inhuman and degrading treatment<sup>[26]</sup>. General Recommendation 24 states that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women"<sup>[27]</sup>. Additionally, states are obligated to ensure that adequate medicines for abortion and post-abortion care are available<sup>[28]</sup>. In all cases, information regarding abortion care must be dispensed.

This can be understood through *Mellet v Ireland*<sup>[29]</sup> where Amanda Mellet, an Irish citizen, was made aware of a fatal abnormality, the foetus she had been carrying suffered from. Upon learning of this, Amanda Mellet found herself unwilling and unable to continue with the pregnancy. Due to Ireland's anti-abortion laws, she was forced to travel to the UK for an abortion. She had to fly back to Ireland soon after the abortion due to the undue expense of staying in the UK. Upon coming back to Ireland, she was further denied post abortion medical and bereavement care. This case highlights three points, i.e., *first* of an instance where denial of abortion can amount to cruel or inhumane and degrading treatment, *second* of the obligation upon the state to at least provide vital information, and *lastly*, through the arguments of the applicant, the discriminatory and unequal nature of abortion laws. In *Mellet v Ireland*<sup>[30]</sup>, the Human Rights Committee observed that cruel, inhuman or degrading treatment, prohibited under Article 7 of the ICCPR, had been meted out to the applicant in being forced to choose between carrying her foetus to term (a situation which could cause further suffering to both her and the foetus), or travelling abroad to abort the dying foetus without any financial coverage. Further, no key medical information concerning abortion abroad was provided. The state's refusal to provide necessary post abortion and bereavement care further exacerbated the situation. Although the case does not invoke the right to reproductive health, we

may infer the effect of denial of abortion and key information on the realisation of the right to reproductive health. Significantly, the Committee also notes the indirect discrimination encountered by women through such policies denying abortion rights. However, it failed to relate the situation of women in relation to men and instead focused only on the comparable differential treatment received by the applicant in relation to other women<sup>[31]</sup>. This observation fails to acknowledge that laws criminalizing abortion "violate the rights to non-discrimination and equal enjoyment of other rights on the grounds of sex and gender<sup>[32]</sup>." Criminalization of abortion disproportionately affects women who need to terminate their pregnancy to preserve dignity, physical and psychological integrity, and autonomy. It penalizes women and not men who owing to their biology are given full agency in relation to their reproductive functions.

The Indian stance on Abortion is evident from The Medical Termination of Pregnancy Act, 1971 ("MTP Act"). Section 3 of the MTP Act, considers that subject to certain laid down conditions, medical termination of pregnancy would be permissible if in the opinion of the medical practitioner, there exists substantial risk that the child would be born with a serious physical or mental handicap. In doing so, India has largely tackled the primary issue faced in the *Mellet v Ireland* Case (i.e., anti-abortion laws). At the same time, the MTP Act clearly places enormous value on the ability of a pregnant woman to consent to such abortion<sup>[33]</sup>. It was this provision that was brought into question in the case of *Suchita Srivastava v Chandigarh Administration*<sup>[34]</sup> ("*Suchita Srivastava Case*"). The case recognised the right of a woman to make reproductive choices as a component of Article 21 of the Indian Constitution. The case further recognised the competing obligation of a state to uphold the right to life of an infant or foetus. For clarity, it is best that the precise extract of the judgment be read:

"(Emphasis added) 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 recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating...* Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. *However, in the case of pregnant women there is also a "compelling State interest" in protecting the life of the prospective child.* Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. 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."

Thus, a cumulative reading of the cases of *Laxmi Mandal* and *Suchita Srivastava* indicates that while India values the right of a woman to make reproductive *choices*, such right is often left unattainable due to, *inter alia*, economic and physical inaccessibility.

### Competing interests: Infant- Motherhood

As stated in the case of *Suchita Srivastava Case*, along with the right to make reproductive choices is the competing right of an infant to life. This has led to the imposition of conditions

upon the right to reproductive choices of a woman; in some cases severely limiting the same. States are often seen to give special status to infants or foetus over 20 weeks due to their status as right holders of the right to life. Therefore, in the event of abortion, the question of the competing rights of the mother and the child remains. In the Arab Charter<sup>[35]</sup> death penalty is not awarded to a nursing nurturing<sup>[36]</sup>. In *LC v Peru*<sup>[37]</sup>, the state argued that procedures for surgery had been delayed to prevent harm to the foetus, mother within two years of giving birth, keeping in view the child's which is placed above the prospect of LC's rehabilitation<sup>[38]</sup>. It was deemed that waiting longer for the surgery would increase the chances of the survival of the foetus. The Committee, in considering this stereotypical notion of protecting the foetus over the health of the mother, found a violation of the mother's right to reproductive health<sup>[39]</sup>. This shows that the right to reproductive health, which includes the aspect of family planning, is fundamental to decisions concerning the foetus, especially when the medical health of the mother is also individually at risk.

Lastly, another facet of barrier is legislative obstacles in providing abortion facilities. Another impediment to realising reproductive rights is through legislations that require abortion facilities to meet special standards to carry out legal abortions. In *Whole Woman's Health v Hellerstedt*<sup>[40]</sup>, the Court held Texas law to be unconstitutional as the admitting privileges and surgical centre requirements creates substantial obstacle in the path of women seeking abortion<sup>[41]</sup>. While abortion was not outlawed in Texas, the Government had placed undue administrative restrictions on abortion hospitals in Texas. It required the abortion providing centres to adhere to strict architectural and other guidelines, which were found to have no nexus to the reasonable aim of providing quality medical care.

### Conclusion

Therefore it is clear that realisation of the right to reproductive health requires states to equally respect, protect and fulfil. In fulfilling its obligations concerning the right to health, states must ensure availability, accessibility, acceptability and quality of facilities, services and goods. Further, the right to reproductive health does not exist in isolation. As a right with foundations in both civil and political rights, and in social, economic and cultural rights, its full realization may only be found through realization of other correlated rights. It is unfortunate that states today, in the Hegelian sense, seem to hold the collective will of the states hierarchically above the individual rights of the people, and in that sense, lobby to water down of provisions and limit their obligations through reservations to treaties. However, all individuals universally remain right holders and addresses to the right in question and as such, even when domestic law breaches the same, have recourse (albeit of no binding value) in international law forums.

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- This would involve the State not interfering with the decisional aspect of the right.
- Alyne da Silva Pimentel Teixeira v Brazil* (Communication No 17/2008, 10) marks the first international decision holding a government responsible for the actions of a private institute, 2011.
- UNCESCR. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). 2000, E/C.12/2000/4: 12 ('General Recommendation 14').
- The element of availability mandates that adequate number of functioning health care facilities, goods, services and programs integral to providing the highest attainable standard of health be made available to the population. This also includes geographical availability. See CESCR, General Recommendation No. 22: The Right to Sexual and Reproductive Health (Art. 12 of the Covenant), 2016, E/C.12/GC/22: ¶13 ('General Recommendation 22').
- The element of accessibility requires states to ensure that information, facilities, goods and services related to sexual and reproductive health care are physically accessible, affordable (economically accessible), and its information is accessible. This includes the right to seek, receive and disseminate information and ideas. See General Recommendation 22; 17-21.
- Acceptability requires creation of an environment that is respectful of the culture of all groups' vis-à-vis sexual and reproductive rights. See General Recommendation 22, 22.
- Facilities, goods, information and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date. This requires trained and skilled healthcare personnel and scientifically approved and unexpired drugs and equipment. See General Recommendation. 2011; 22:23.
- General Recommendation, 14, 12.
- UNGA. Convention on Elimination of All Forms of Discrimination against Women. 18, UN, Treaty Series. 1979; 1249:13.

17. The right to reproductive health is increasingly recognised as a fundamental human right. The question then is whether states should be allowed to mould (usually watering down) rights and obligations as per the moral religious trepidation of the state. According to Steiner, the answer lies in the perception of the character of the rights, i.e., whether it is universal (absolute right) or relative (contingent right). Proponents of the cultural relativist position would claim that culture is essential to determine the concept of a right and therefore, states should be permitted to interpret and enforce the right on the basis of their culture.
18. General Recommendation, 22, 2.
19. General Recommendation, 14, 9.
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27. General Recommendation, 22, 10.
28. General Recommendation, 24, 11.
29. General Comment, 22, 15.
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39. *LC v Peru Case*: 7.5.
40. *LC v Peru Case*: 8.15.
41. 579 US, 2016.