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Women's Reproductive and Health Rights: An Appraisal of Competing Interests

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Abstract

Women play a fundamental role in shaping sustainable societies, so it is imperative to recognise and uphold their reproductive rights, ensuring that they have agency over their bodies and health. This holistic approach is not only essential for achieving gender equality but also for fostering broader social, economic, and environmental progress. By prioritising women's health and well-being, societies lay the foundation for sustainable development that spans generations. The realisation of reproductive rights and ensuring women's health are crucial for individual well-being and integral to the broader agenda of sustainable development. Under the Sustainable Development Goals (SDGs), the global commitment to the unfinished Millennium Development Goals persists. India has pledged to achieve the Sustainable Development Goals (SDGs) by 2030; governments have vowed to lower maternal mortality and ensure universal access to reproductive health and rights as a fundamental human right of women. The quest for achieving reproductive rights and improving women's health as integral components of sustainable development in India is marked by formidable obstacles and persistent challenges. This article delves into the complex landscape of reproductive rights and women's health in India, analysing how ensuring comprehensive access to reproductive health services and upholding reproductive rights are essential to advancing the SDGs. Through an analysis of data, laws, policies, and landmark judgements, the paper sheds light on the persistent gaps and suggests strategies to bridge them.

Keywords: Reproductive Rights, Sustainable Development Goals, Health, Family Planning, Abortion

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1. Introduction

In the year 2000, "The United Nations" introduced MDGs ("Millennium Development Goals"), which were specifically designed to attain specific objectives by the year 2015.[1] The United Nations introduced Sustainable Development Goals (SDGs) to build upon MDGs. In 2015, the UN fortified these MDGs by introducing 17 SDGs, which must be achieved by 2030.[2]

These SDGs span a variety of domains, including *"economics, environment, education, gender, and health*". They were characterised by then UN Secretary-General *"Ban Ki-moon"* as a *"shared vision of the humanity and social contract between the world's leaders and the people".*[3] Each Sustainable Development serves as the

> "fundamental principle for achieving human development goals while concurrently preserving the ability of natural systems to provide essential resources and ecosystem services on which the economy and society rely".

It can be defined as

> "Development that meets the needs of the present without compromising the ability of future generations to meet their own needs".

That concept equips individuals, communities, groups, businesses, and governments to lead sustainable lives, fostering a comprehensive understanding of environmental, social, and economic well-being. Ultimately, it prepares us for the world we will

[1] Sustainable Development Goals to Kick in with the Start of New Year, available at*:* https://news.un.org/en/story/2015/12/519172-sustainable-development-goals-kick-start-new-year (last visited September 2, 2023).

[2] D. Le Blanc, "Towards integration at last? The Sustainable Development Goals as a network of targets" 23 *Sustain Dev*, 176-187 (2015), available at*:* https://www.un.org/esa/desa/papers/2015/wp141_2015.pdf (last visited September 2, 2023)

[3] Supra note 1.

inhabit in the coming century, ensuring we are well-equipped to meet its challenges.

SDG consists of multiple specific *"targets and indicators"* that measure progress. SDGs 3.1., focused on *"reducing maternal mortality rates (MMR)*", SDG 3.7., aims to *"ensure access to sexual and reproductive health care services*". SDG 5.6., provides *"universal access to reproductive rights and health*". Hence, a pivotal question emerges regarding integrating reproductive rights and women's health within India's plans and achievements. This article delves into India's strides in attaining the benchmarks set by SDG 3.1, SDG 3.7, and SDG 5.6.

2. Scheme of study

The research paper is organised into five sections, each serving a specific purpose to enhance the overall clarity and effectiveness of the topic. The initial part focuses on relevant, sustainable development goals (SDGs) for reproductive rights and women's health. The following section explores the reproductive rights and health of women. The third section explores relevant legislation and policies in India. The fourth section deals with data analysis and the finding of various resources. The fifth section addresses reproductive rights and health challenges, followed by the conclusion and suggestions.

3. Objectives

The central objectives of this paper are as follows:

a) To assess the significance of reproductive rights and health of women in sustainable development.
b) Explore the domain of reproductive rights of women concerning health by exploring legal provisions and court decisions.

4. Significance

Reproductive rights and women's health are pressing issues in contemporary society, manifested across various sectors. Women often face discrimination and attempts at domination by their male

counterparts in numerous aspects of life. Additionally, women frequently need more awareness of their rights. Education is pivotal in raising awareness about rights and responsibilities and providing opportunities to combat societal challenges. This paper aims to shed light on reproductive rights and health-related issues of women and explore strategies for achieving sustainable development.

5. Methodology

The methodology employed in this study involves descriptive and analytical to elucidate the advancements, strategies, and deficiencies in the enhancement of reproductive rights and women's health in India. Data collection for this paper is based on secondary sources, including journals, articles, books, online resources, and government documents.

6.1 Relevant Sustainable Development Goals (SDGS) for Women's Reproductive Rights and Health

The significant contribution of women to promoting sustainable development has long been recognised. This recognition can be traced back to significant milestones, including the *"International Conference on Population and Development, 1994"*, the *"Beijing Declaration 1995"* from the *"United Nations' Fourth World Conference on Women,"* and the MDGs. All of these underscored the criticality of empowering women.[4]

The "United Nations" approved a fresh agenda for development *titled "Transforming our world: The 2030 agenda for sustainable development"*. Unlike MDGs, SDGs are comprehensive and all-encompassing, intended for global applicability. The SDGs consist of *"17 goals and 169 targets".* These goals carry a deadline for achievement set for 2030. Like MDGs, SDGs encompass objectives

[4] Cook, Rebecca J., and Mahmoud F. Fathalla, *"Advancing Reproductive Rights Beyond Cairo and Beijing,* 22 (3). *International* Family Planning Perspectives 115,120, (1996) *JSTOR*, https://doi.org/10.2307/2950752. (last visited September 2, 2023).

concerning "gender equality, women's empowerment, and the reduction of inequality".[5] Furthermore, *a "universal goal for promoting good health and well-being across all demographics regardless of age, ethnicity, or sexual orientation*" has been outlined to be achieved by 2030.

The sustainable development goals (SDGs) framework addresses the reproductive rights of women. Significantly, this global development framework includes objectives related to health services and objectives that address challenges and human rights facets of reproductive rights and health, as emphasised by SDG 3.1, 3.7, and 5.6.

SDGs 3, titled *"Good Health and Well-Being"* is designed *"to ensure healthy lives and promote well-being for all at all ages"*. SDGs 3.1., aims *"to reduce the global maternal mortality ratio to below 70 per 100,000 live births"* by 2030. *"Maternal mortality"* is described as *"the death of a woman during pregnancy, childbirth, or within 42 days postpartum".*[6] Additionally, SDGs 3.7., endeavors to *"ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs"* by 2030[7] to address SDGs 3.1., strategies encompassed awareness campaigns, enhancements in healthcare system accessibility, and professional training. For SDG 3.7, the approach involved training healthcare practitioners and raising awareness about consanguinity.

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[5] Van Tulder, R., Rodrigues, S. B., Mirza, H., & Sexsmith, K, "The UN's Sustainable Development Goals: Can Multinational Enterprises Lead the Decade of Action", *4*(1) *Journal of International Business Policy* 1, 21. (2021). https://doi.org/10.1057/s42214-020-00095-1.

[6] Hogan, M.C.; Foreman, K.J.; Naghavi, M.; Ahn, S.Y.; Wang, M.; Makela, S.M.; Lopez, A.D.; Lozano, R.;

Murray, C.J. *Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards*

Millennium Development Goal 5, Lancet 1609, 1614 (2010).

[7] WHO SDG 3: Ensure Healthy Lives and Promote Well-being for All at All Ages, available at*:* https://www.who.int/sdg/targets/en/ (last visited September 3, 2023).

SDGs 5, titled *"Gender Equality"* is dedicated to *"achieve gender equality and empower all women and girls".* SDG 5.6., is to *"Ensuring universal access to sexual and reproductive health and reproductive rights as agreed under the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences".*[8] SDG 5.6.1 evaluates women's autonomy in *"making their own decisions regarding sexual and reproductive health and rights*" regardless of their country's legal framework. Conversely, SDG 5.6.2 measures how existing laws either support or hinder equitable access to these rights for both women and men. These SDG Indicators, 5.6.1 and 5.6.2, provide perspectives on the legal and regulatory dimensions of reproductive rights and health while enhancing women's autonomy in making reproductive decisions. This dual assessment helps determine if a country has supportive legal structures and if these provisions genuinely empower all women and girls.

Both S.D.G.s 3 and 5 addressing reproductive rights and health are noteworthy initiatives. Achieving gender equality hinges on fulfilling women's reproductive rights.

6.2 Advancing Women's Reproductive Rights and Health

Reproductive rights and health are not merely fundamental human rights but indispensable for fostering a sustainable world. Their importance lies as fundamental components of the *"intrinsic human rights"* of women. When women can make choices about their reproductive journey and manage their fertility, they can actively engage in their nation's social, political, and economic realms on an equal footing. Neglecting the reproductive rights of women restricts their opportunities, curbing their educational prospects, economic empowerment, and political participation. The explicit acknowledgment and reaffirmation of women's entitlement to

[8] WHO.SDG 5: Gender Equality, available at*:* https://www.who.int/sdg/targets/en/ (last visited September 4, 2023).

control their health, particularly fertility, is foundational to their empowerment.

In many instances, women face significant challenges and societal pressures that lead to unsafe abortion, coercive sterilization, maternal death, and sex- selection. To address this issue, we must offer encouragement and empower young girls. This empowerment will, in turn, contribute to positive transformations and improvements within our country. Women hold a central position in driving sustainable and environmentally friendly changes. Therefore, achieving reproductive rights and health is vital for fostering sustainable and green transformations.

Reproductive rights and health constitute a crucial dimension of environmental sustainability. Reproductive rights pertain to the legal freedoms concerning reproduction and reproductive health. These rights have been implicitly acknowledged as a "human rights" component by the "Tehran Proclamation of 1968". The "Programme of Action", which was ratified during The International Conference on Population and Development 1994 recognized reproductive rights as

> "*basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timings of their children and to have information to do so, and right to attain the highest standard of sexual and reproductive health*".

Furthermore, includes their

> *"right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents".*[9]

Reproductive health, on the other hand, as articulated during the "International Conference on Population and Development Programme 1994" encompasses *" a state of complete physical,*

[9] United Nations, Programme of Action (POA) adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994. Para 7.3.

mental and social well-being in all matters, relating to the reproductive system, and to its functions and processes at all stages of life" which *"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".* That concept inherently involves

> *"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".*

Additionally, it encompasses

> *"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".*[10]

In Paragraph 7.3, the recognition of "reproductive health" as a right of women to manage their fertility and the responsibility of the State to promote women's reproductive health and education is reiterated. This principle was emphasised in the "Beijing Declaration and Platform for Action," adopted during "Fourth World Conference on Women in 1995". The "Beijing Platform for Action" asserts that *women's*

> *"reproductive health is a human right and a pivotal condition for fostering social development and peace*."

SDGs renew these commitments to

> *"alleviate maternal mortality, ensure universal access to reproductive health information, education, and services, and uphold reproductive rights as fundamental human rights for women and girls".*

[10] *Ibid.* Para 7.2.

Enhancing "women's access to safe and lawful abortion" emerges as a critical concern within the reproductive health of women. Reproductive rights can be characterised as a cluster of rights drawn from the *"Right to Health, the Right to Equality, freedom from discrimination, and protection against torture or ill-treatment*". Therefore, these rights impose "an obligation on the State to ensure that women have access to crucial reproductive information, and the state is responsible for facilitating the availability and accessibility of related health services".

Therefore, the Indian judiciary has delivered notable judgments recognizing and upholding reproductive rights as essential to their "inherent right to life". In *Suchita Srivastava v. Chandigarh Administration,*[11] held 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 recognise that reproductive choices can be exercised to procreate as well as abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity, and bodily integrity should be respected".*

The cases[12] involved the denial of maternal healthcare to two economically disadvantaged women. The High Court emphasised that

> *"these petitions focus on two inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother".*

[11] (2009) 9 SCC 1.

[12] Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others; Jaitun v. Maternal Home MCD, Jangpura & Others*, (2010) 172 DLT 9.

Referring to CEDAW and ICESCR, the court concluded that

> *"no woman, more so a pregnant woman should be denied the facility of treatment at any stage, irrespective of her social and economic background… This is where the inalienable right to health, which is inherent in the right to life, gets enforced".*

In *Devika Biswas v. Union of India & Ors*., the Apex Court emphatically asserted that Article 21 encompasses the "reproductive rights of a person". Within this context, the Apex court acknowledged that

> *"reproductive rights constitute an integral aspect of the right to health and personal liberty enshrined under Article 21".*[13]

6.3 Relevant Legislation and Policies in India

The Indian Constitution guarantees various fundamental rights. Article 14[14] mandates *"equality before the law or the equal protection of the laws*". Article 15 "*prohibits discrimination"* on various grounds, and *"sex"*[15] is one of the ground. It further allows the State *"to make special provisions for women and children".*[16] Article 21[17] provides the *"right to life"* or *"personal liberty".* The right to personal liberty encompasses women's reproductive

[13] *Devika Biswas v. Union of India & Others,* AIR 2016 SC 4405.

[14] The Constitution of India, art. **14. Equality before law.—**The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

[15] The Constitution of India, art. **15. Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.—**(1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them.

[16] The Constitution of India, art. **15. (3)** Nothing in this article shall prevent the State from making any special provision for women and children.

[17] The Constitution of India, art **21. Protection of life and personal liberty.—**No person shall be deprived of his life or personal liberty except according to procedure established by law.

choices.[18] Furthermore, the Supreme Court affirmed that women's reproductive choice constitutes a facet of personal liberty under Article 21[19]. The Directive Principles of State Policy serve as guiding principles for the government in shaping policies and legislation, including several provisions relevant to health-related issues related to reproduction. Article 42[20] asserts the State's responsibility "*to make provision … for maternity relief".* Article 47[21] highlights that one of the State's primary responsibilities is *"the improvement of public health".* Although these principles are non-justiciable, meaning the courts cannot legally enforce them. However, they remain integral in informing governmental decision-making processes.

The Maternity Benefit Act, 1961 ensures pregnant women receive total wages during absence from work due to pregnancy *"during and after pregnancy and to provide for maternity benefit and certain other benefits"*[22]*,* signifying a significant measure in protecting women's reproductive functions. The mandatory paid leave period is

> *"from 12 weeks to 26 weeks. Maternity benefits have been extended by the 2017 amendment to 26*

[18] *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

[19] *Meera Santosh Pal v.. Union of India*, (2017) 3 SCC 462.

[20] The Constitution of India, art. **42. Provision for just and humane conditions of work and maternity relief.—**The State shall make provision for securing just and humane conditions of work and for maternity relief.

[21] The Constitution of India, art. **47. Duty of the State to raise the level of nutrition and the standard of living and to improve public health.—**The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

[22] The Maternity Benefit Act, 1961 (Act 53 of 1961), the **Preamble._** "An Act to regulate the employment of women in certain establishments for certain periods before and after child-birth and to provide for maternity benefit and certain other benefits".

> *weeks for women with two surviving children, while those with more than two children will retain a 12-week leave entitlement. Moreover, adoptive and commissioning mothers are granted 12 weeks of leave".*[23]

[23] The Maternity Benefit Act, 1961 (Act 53 of 1961), s. **5. Right to payment of maternity benefit.—** [(1) Subject to the provisions of this Act, every woman shall be entitled to, and her employer shall be liable for, the payment of maternity benefit at the rate of the average daily wage for the period of her actual absence, that is to say, the period immediately preceding the day of her delivery, the actual day of her delivery and any period immediately following that day.
Explanation.—For the purpose of this sub-section, the average daily wage means the average of the woman's wages payable to her for the days on which she has worked during the period of three calendar months immediately preceding the date from which she absents herself on account of maternity, [the minimum rate of wage fixed or revised under the Minimum Wages Act, 1948 (11 of 1948) or ten rupees, whichever is the highest.
(2) No woman shall be entitled to maternity benefit unless she has actually worked in an establishment of the employer from whom she claims maternity benefit, for a period of not less than eighty days in the twelve months immediately preceding the date of her expected delivery:
Provided that the qualifying period of eighty days aforesaid shall not apply to a woman who has immigrated into the State of Assam and was pregnant at the time of the immigration.
Explanation.—For the purpose of calculating under this sub-section the days on which a woman has actually worked in the establishment, the days for which she has been laid off or was on holidays declared under any law for the time being in force to be holidays with wages during the period of twelve months immediately preceding the date of her expected delivery shall be taken into account.
(3) The maximum period for which any woman shall be entitled to maternity benefit shall be twenty-six weeks of which not more than eight weeks shall precede the date of her expected delivery:
Provided that the maximum period entitled to maternity benefit by a woman having two or more than two surviving children shall be twelve weeks of which not more than six weeks shall precede the date of her expected delivery:

The Act now mandates that *"every establishment employing 50 or more women must provide crèche facilities".*[24] It also provides women with the option to work from home for job roles that are compatible with remote work.[25] If a woman experiences a miscarriage or undergoes a medical termination of pregnancy, she is also eligible for leave. [26]

Medical Termination of Pregnancy Act, 1971 serves as the principal framework governing the termination of pregnancies in India. It

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Provided further that where a woman dies during this period, the maternity benefit shall be payable only for the days up to and including the day of her death:

Provided also that where a woman, having been delivered of a child, dies during her delivery or during the period immediately following the date of her delivery for which she is entitled for the maternity benefit, leaving behind in either case the child, the employer shall be liable for the maternity benefit for that entire period but if the child also dies during the said period, then, for the days up to and including the date of the death of the Child.

(4) A woman who legally adopts a child below the age of three months or a commissioning mother shall be entitled to maternity benefit for a period of twelve weeks from the date the child is handed over to the adopting mother or the commissioning mother, as the case may be.

(5) In case where the nature of work assigned to a woman is of such nature that she may work from home, the employer may allow her to do so after availing of the maternity benefit for such period and on such conditions as the employer and the woman may mutually agree.

[24] The Maternity Benefit Act, 1961 (Act 53 of 1961), s. **11A. Crèche facility.—**(1) Every establishment having fifty or more employees shall have the facility of crèche within such distance as may be prescribed, either separately or along with common facilities: Provided that the employer shall allow four visits a day to the crèche by the woman, which shall also include the interval for rest allowed to her.

[25] *Ibid.*

[26] The Maternity Benefit Act, 1961 (Act 53 of 1961), s. **9. Leave for miscarriage, etc.—**In case of miscarriage or medical termination of pregnancy, a woman shall, on production of such proof as may be prescribed, be entitled to leave with wages at the rate of maternity benefit, for a period of six weeks immediately following the day of her miscarriage or, as the case may be, her medical termination of pregnancy.

underwent revisions in 2002 and 2003 aimed at enhancing the safety of its services. This law legalized abortion and granted women the right to make decisions regarding their pregnancies. However, it is essential to note that this right is not absolute. Abortion is permitted under specific conditions, including

> *"when the woman's physical or mental health is at risk, in cases of rape or incest, severe fetal impairment, or contraceptive failure as determined by Registered Medical Practitioners (RMPs)".*[27]

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[27] The Medical Termination of Pregnancy Act, 1971 (Act 34 of 1971), s. **3. When pregnancies may be terminated by registered medical practitioners. —**(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—

(a) where the length of the pregnancy does not exceed twenty weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twenty weeks but does not exceed twenty-four weeks in case of such category of woman as may be prescribed by rules made under this Act, if not less than two registered medical practitioners are, of the opinion, formed in good faith, that—

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from any serious physical or mental abnormality.

Explanation 1.—For the purposes of clause (a), where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of limiting the number of children or preventing pregnancy, the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.—For the purposes of clauses (a) and (b), where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

The Act allows abortions based on

> *"the advice of one doctor between 12 and 20 weeks of pregnancy and two doctors for certain categories of women between 20 and 24 weeks. State-level Medical Boards are established to decide on terminations after 24 weeks in cases of significant fetal abnormalities*".[28]

This Act plays a crucial role in reducing preventable maternal mortality, aligning with the objectives outlined in SDGs 3.1, 3.7, and 5.6.

(2A) The norms for the registered medical practitioner whose opinion is required for termination of pregnancy at different gestational age shall be such as may be prescribed by rules made under this Act.

(2B) The provisions of sub-section (2) relating to the length of the pregnancy shall not apply to the termination of pregnancy by the medical practitioner where such termination is necessitated by the diagnosis of any of the substantial foetal abnormalities diagnosed by a Medical Board.

(2C) Every State Government or Union territory, as the case may be, shall, by notification in the Official Gazette, constitute a Board to be called a Medical Board for the purposes of this Act to exercise such powers and functions as may be prescribed by rules made under this Act.

(2D) The Medical Board shall consist of the following, namely: —

(a) a Gynecologist;

(b) a Pediatrician;

(c) a Radiologist or Sonologist; and

(d) such other number of members as may be notified in the Official Gazette by the State Government or Union territory, as the case may be.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who having attained the age of eighteen years, is a mentally ill person, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.

[28] *Ibid.*

Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 deals *with "female feticide and the misuse of prenatal diagnostic techniques"*.[29] It forbids *"sex selection"*[30] both prior to and after conception, makes the utilization of *"pre-conception and prohibits pre-natal diagnostic methods for sex determination*".[31]

Surrogacy (Regulation) Act, 2021 addresses surrogacy's regulation and procedural aspects. It outlines several eligibility criteria for couples interested in pursuing surrogacy. These include requirements such as

> "*Intending parents are required to meet specific eligibility criteria, including legal marriage, with*

[29] Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (Act 57 of 1994), the **Preamble.-** *An Act to provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal 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.*

[30] Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (Act 57 of 1994), s. **3A. Prohibition of sex-selection-** No person, including a specialist or a team of specialists in the field of infertility, shall conduct or cause to be conducted or aid in conducting by himself or by any other person, sex selection on a woman or a man or on both or on any tissue, embryo, conceptus, fluid or gametes derived from either or both of them.

[31] Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (Act 57 of 1994), s. **6. Determination of sex prohibited.-** On and from the commencement of this Act,—

(a) no Genetic Counselling Centre or Genetic Laboratory or Genetic Clinic shall conduct or cause to be conducted in its Centre, Laboratory or Clinic, pre-natal diagnostic techniques including ultrasonography, for the purpose of determining the sex of a foetus;

(b) no person shall conduct or cause to be conducted any pre-natal diagnostic techniques including ultrasonography for the purpose of determining the sex of a foetus;

(c) no person shall, by whatever means, cause or allow to be caused selection of sex before or after conception.

> *females aged between 23 and 50 and males aged between 26 and 55, and they should not have any surviving child, whether biological, adopted, or through surrogacy, from previous arrangements".*[32]

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[32] The Surrogacy (Regulation) Act, 2021 (Act of 2021), s. **4. Regulation of surrogacy and surrogacy procedures.—** On and from the date of commencement of this Act, —(i) no place including a surrogacy clinic shall be used or cause to be used by any person for conducting surrogacy or surrogacy procedures, except for the purposes specified in clause (ii) and after satisfying all the conditions specified in clause (iii);

(ii) no surrogacy or surrogacy procedures shall be conducted, undertaken, performed or availed of, except for the following purposes, namely:

(a) when an intending couple has a medical indication necessitating gestational surrogacy:

Provided that a couple of Indian origin or an intending woman who intends to avail surrogacy, shall obtain a certificate of recommendation from the Board on an application made by the said persons in such form and manner as may be prescribed.

Explanation.—For the purposes of this sub-clause and item (I) of sub-clause (a) of clause

(iii) the expression "gestational surrogacy" means a practice whereby a surrogate mother carries a child for the intending couple through implantation of embryo in her womb and the child is not genetically related to the surrogate mother;

(b) when it is only for altruistic surrogacy purposes;

(c) when it is not for commercial purposes or for commercialisation of surrogacy or surrogacy procedures;

(d) when it is not for producing children for sale, prostitution or any other form of exploitation; and

(e) any other condition or disease as may be specified by regulations made by the Board;

(iii) no surrogacy or surrogacy procedures shall be conducted, undertaken, performed or initiated, unless the Director or in-charge of the surrogacy clinic and the person qualified to do so are satisfied, for reasons to be recorded in writing, that the following conditions have been fulfilled, namely:

(a) the intending couple is in possession of a certificate of essentiality issued by the appropriate authority, after satisfying itself, for the reasons to be recorded in writing, about the fulfilment of the following conditions, namely:

(I) a certificate of a medical indication in favour of either or both members of the intending couple or intending woman necessitating gestational surrogacy from a District Medical Board.

Explanation.—For the purposes of this item, the expression "District Medical Board" means a medical board under the Chairpersonship of Chief Medical Officer or Chief Civil Surgeon or Joint Director of Health Services of the district and comprising of at least two other specialists, namely, the chief gynecologist or obstetrician and chief pediatrician of the district;

(II) an order concerning the parentage and custody of the child to be born through surrogacy, has been passed by a court of the Magistrate of the first class or above on an application made by the intending couple or the intending woman and the surrogate mother, which shall be the birth affidavit after the surrogate child is born; and

(III) an insurance coverage of such amount and in such manner as may be prescribed in favour of the surrogate mother for a period of thirty-six months covering postpartum delivery complications from an insurance company or an agent recognised by the Insurance Regulatory and Development Authority established under the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999);

(b) the surrogate mother is in possession of an eligibility certificate issued by the appropriate authority on fulfilment of the following conditions, namely:

(I) no woman, other than an ever married woman having a child of her own and between the age of 25 to 35 years on the day of implantation, shall be a surrogate mother or help in surrogacy by donating her egg or oocyte or otherwise;

(II) a willing woman shall act as a surrogate mother and be permitted to undergo surrogacy procedures as per the provisions of this Act:

Provided that the intending couple or the intending woman shall approach the appropriate authority with a willing woman who agrees to act as a surrogate mother;

(III) no woman shall act as a surrogate mother by providing her own gamete

(IV) no woman shall act as a surrogate mother more than once in her lifetime:

Provided that the number of attempts for surrogacy procedures on the surrogate mother shall be such as may be prescribed; and

(V) a certificate of medical and psychological fitness for surrogacy and surrogacy procedures from a registered medical practitioner;

(c) an eligibility certificate for intending couple is issued separately by the appropriate authority on fulfilment of the following conditions, namely:-

6.4 Government Policies

a) **National Health Mission, 2013:** This initiative seeks to safeguard the "Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A)". It is based on a holistic care continuum to address health needs across various life stages, from childhood to adolescence, reproductive age, and pregnancy. It emphasises coordinated and integrated health services, focusing on factors contributing to maternal mortality, including medical, socio-economic, and health system-related factors.

b) **Janani Suraksha Yojana, (JSY), 2005:** JSY aims to "reduce maternal and neonatal mortality by promoting institutional delivery by offering monetary incentives to pregnant women". It also provides cash assistance to pregnant women for post-delivery care. Accredited Social Health Activists (ASHAs) are pivotal in identifying and providing support to expectant mothers. However, this focus on institutional deliveries has led to neglect of antenatal and post-natal care.[33]

c) **Janani Shishu Suraksha Karyakram (JSSK):** Introduced in 2011, JSSK complements JSY by providing pregnant women with

(I) the intending couple are married and between the age of 23 to 50 years in case of female and between 26 to 55 years in case of male on the day of certification;

(II) the intending couple have not had any surviving child biologically or through adoption or through surrogacy earlier:

Provided that nothing contained in this item shall affect the intending couple who have a child and who is mentally or physically challenged or suffers from life threatening disorder or fatal illness with no permanent cure and approved by the appropriate authority with due medical certificate from a District Medical Board; and

(III) such other conditions as may be specified by the regulations.

[33] PLD and Sama Resources Group for Women and Health, Status of human rights in the context of SEXUAL HEALTH AND REPRODUCTIVE HEALTH RIGHTS IN INDIA , 82 (New Delhi, Apr, 2018) available at*:* https://nhrc.nic.in/sites/default/files/sexual_health_reproductive_health_rights_SAMA_PLD_2018_01012019_1.pdf (last visited on November 29, 2023).

entitlements for free and cashless deliveries at government health facilities. It offers several free benefits, including C-sections, drugs, diagnostics, and transportation. JSSK and JSY aim to enhance maternal healthcare by providing these free entitlements, irrespective of age, economic status, or the number of children.[34]

d) **Pradhan Mantri Surakshit Matritva Abhiyan 2016 (PMSMA):** PMSMA provides free antenatal care to pregnant women on the 9th of each month. It aims to strengthen antenatal care services involving the private sector.

e) **Pradhan Mantri Matru Vandana Yojana, 2017:** Introduced in 2017, this scheme provides financial support to pregnant and lactating mothers, providing a direct cash incentive of Rs. 6,000 deposited into their bank accounts for the birth of their first living child.

f) **Ayushman Bharat Yojana, 2018:** This central government funded program, a collaborative effort between the union and state Governments, provides services to roughly 50 crore individuals. It caters to around 50 crore individuals and "comprises two key components: 1) Health & Wellness Centres (HWCs) and 2) Pradhan Mantri Jan Arogya Yojana (PM-JAY)". PM- Jan Arogya Yojana (is the world's most extensive healthcare assurance program, providing extensive secondary and tertiary medical services coverage.[35]

g) **National Health Policy of India, 2017:** This policy aims to attain the utmost standard of health and well-being while guaranteeing universal access to top-tier healthcare services. It advocates for raising healthcare spending to 2.5% of GDP by 2025 and delivering healthcare services that are gender-sensitive and effective, prioritizing safety and convenience.

h) **National Population Policy 2000:** Aim to stabilize the population by promoting informed and voluntary decision-making, reducing maternal mortality rates, encouraging

[34] *Ibid.*
[35] *Ibid.*

marriage postponement, ensuring skilled attendance during childbirth, and providing *"universal access to contraception and reproductive health services".*

7. Data Analysis and Findings

The investigation relies on the analysis of *"Sustainable Development Goals National Indicator Framework Progress Report 2023"* on SDGs from the "Ministry of Statistics and Programme Implementation" (NSO). The "National Indicator Framework (NIF)" delineates the data sources for each indicator, comprising official government statistics derived from various surveys, such as "Ministry of Health and Family Welfare" NFHS-4 (2015-16) and NFHS-5 (2019-21), and "Office of the Registrar General & Census Commissioner, India" the "Ministry of Home Affairs". These targets we referred to were derived from SDGs for 2030.

The study, released on February 20, 2023, in "The Lancet Regional Health–Southeast Asia," reveals that India is not on track to meet nearly three-fifths of the 33 Sustainable Development Goals (SDGs) indicators. These off-target indicators are primarily associated with "*Good Health and Well-Being (SDG 3)* and *Gender Equality (SDG 5)".* From Table 1, it is clear that significant improvements have occurred in various health indicators. However, more than the current rates of progress, as indicated by NFHS-4 and NFHS-5 data, is needed to achieve the goals of SDG 3. To meet these targets, the annual progress rate for antenatal care visits should be 2.5 times higher than observed between NFHS-4 and NFHS-5. Nevertheless, India seems on track to achieve the targets related to births attended by skilled health personnel and maternal mortality if the current rates of progress continue.

Table 1: Progress of India toward Achieving the Health-Related Targets of SDGS-3.1

TARGET 3.1.: By 2030, Reduce The Global Maternal Mortality Ratio To Less Than 70 Per 100,000 Live Births				
National Indicator	**Data Source**	**Value of the Indicator**		**Target of SDG**
3.1.1: Maternal Mortality Ratio (per 1,00,000 live births)	Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs / Periodicity: Annual	Year	value	70
		2017-19	103	
		2018-20	97	
3.1.2: Percentage of births attended by skilled health personnel (Period 5 years)	Ministry of Health and Family Welfare (National Family Health Survey) /Periodicity: 3 Years	Year	Value	100
		NFHS-4 (2015-16)	81.40	
		NFHS-5 (2019-21)	89.40	
3.1.3: Percentage of births attended by skilled health personnel (Period 1 year)	-Ditto-	Year	Value	100
		NFHS-4 (2015-16)	84.40	
		NFHS-5 (2019-21)	90.90	
3.1.4: Percentage of women aged 15-49 years with a live birth, for last birth, who received antenatal care, four times or more (Period 5 years/1 year)	-Ditto-	Year	Value (5 year)	100
		NFHS-4 (2015-16)	51.20	
		NFHS-5 (2019-21)	58.50	

Table 2 reveals a notable increase *in* the *"percentage of currently married women aged 15-49 in India whose family planning needs are met with modern methods".* This percentage rose from 66% in

2015-16 to 76% in 2019-21, surpassing the global SDG target of 75 for 2030. This achievement reflects the government's efforts to improve access to convenient and affordable modern contraceptives. However, India needs to catch up in achieving the target for the adolescent birth rate. Nonetheless, it is progressing toward targets related to institutional births and the use of modern family planning methods by women, provided that current rates of progress persist.

Table 2: Progress of India towards achieving Reproductive Healthcare Services Related Targets of SDGS-3.7

<table>
<tr><td colspan="6">TARGET 3.7. : By 2030, Ensure Universal Access to Sexual and Reproductive Healthcare Services, including for Family Planning, Information and Education, and the Integration of Reproductive Health into National Strategies and Programmes</td></tr>
<tr><td>National Indicator</td><td>Data source</td><td colspan="3">Value of the Indicator</td><td>Target of SDG</td></tr>
<tr><td rowspan="3">3.7.1: Percentage of currently married women aged 15-49 years who have their need for family planning satisfied with modern methods</td><td rowspan="3">Ministry of Health and Family Welfare (National Family Health Survey) /Periodicity: 3 Years</td><td>Year</td><td colspan="2">Value</td><td rowspan="3">75</td></tr>
<tr><td>NFHS-4 (2015-16)</td><td colspan="2">66</td></tr>
<tr><td>NFHS-5 (2019-2021)</td><td colspan="2">76</td></tr>
<tr><td rowspan="3">3.7.2: Adolescent birth rate (aged 15–19 years) per 1,000 women in that age group</td><td rowspan="3">Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs / Periodicity: Annual</td><td>Year</td><td colspan="2">Value</td><td rowspan="2">37</td></tr>
<tr><td>2019</td><td colspan="2">10.6</td></tr>
<tr><td>2020</td><td colspan="2">11.3</td><td></td></tr>
<tr><td rowspan="4">3.7.3: Percentage of Institutional Births (5 years/1 years)</td><td rowspan="4">Ministry of Health and Family Welfare (NFHS) /Periodicity: 3 Years</td><td rowspan="2">Year</td><td colspan="2">Value</td><td>100</td></tr>
<tr><td>5 year</td><td>1 year</td><td rowspan="3"></td></tr>
<tr><td>NFHS-4 (2015-16)</td><td>78.9</td><td>82.6</td></tr>
<tr><td>NFHS-5 (2019-21)</td><td>88.6</td><td>90.6</td></tr>
<tr><td>3.7.4: Percentage of currently</td><td>Ditto</td><td>Year</td><td colspan="2">Value</td><td>65</td></tr>
</table>

married women (15-49 years) who use any modern family planning methods (similar to 3.8.1)		NFHS-4 (2015-16)	47.70	
		NFHS-5 (2019-21)	56.40	
3.7.5: Percentage of women aged 15-19 years who were already mothers or pregnant	Ditto	Year	Value	
		NFHS-4 (2015-16)	7.90	
		NFHS-5 (2019-21)	6.80	

Table 3 based on NFHS-5 data, indicates that *the "percentage of women and men in India with comprehensive knowledge of HIV/AIDS"* is relatively low, with figures at 21.6% for women and 32.5% for men. It highlights the need for significant improvements in awareness. However, there is a positive trend in the decreasing "unmet need for family planning".

Table 3: Progress of India towards Access Reproductive Rights Related Targets of Sdgs-5.6

Target 5.6. : Ensure Universal Access to Sexual and Reproductive Health and Reproductive Rights as agreed in Accordance with the Programme of action of the International Conference on Population and Development and the Beijing Platform for action and the Outcome Documents of their Review Conferences.				
National Indicator	**Data Source**	**Value Of The Indicator**		**Target of SDG**
5.6.1: Unmet need for family planning for currently married women aged 15-49 years (in percentage)	Ministry of Health and Family Welfare (National Family Health Survey) /Periodicity: 3 Years	Year	Value	Eliminated unmet need family planning
		NFHS-4 (2015-16)	12.9	
		NFHS-5 (2019-21)	9.4	
5.6.2: Whether the country has laws and regulations that	Ministry of Health and Family Welfare/ Periodicity:4 Years	Year	Value	100
		2018	64.8	

guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information, and education		2020	80.7		
5.6.3: Percentage of population aged 15-24 years with comprehensive knowledge of HIV/AIDS	Ministry of Health and Family Welfare (National Family Health Survey) /Periodicity: 3 Years	Year	Value		
			Male	Female	100
		NFHS-5 (2015-16)	31.50	21.70	
		NFHS-5 (2019-21)	28.50	20.10	

8. Women's Reproductive Rights and Health: A Distant Dream in the Indian Context

Women's reproductive rights and health challenges are influenced by behavioral factors, including limited autonomy, unequal gender relations, insufficient medical services, and inadequate health programs and policies. These issues are often rooted in socio-cultural norms, with gender inequality significantly restricting women's access to proper reproductive healthcare.

a) Unsafe abortion: Although abortion is legally permitted in India, obtaining a safe abortion is still a challenge for the majority of women in the country. Out of 6.4 million abortions, a staggering 3.6 million (56 percent) are considered unsafe in India. Alarmingly, unsafe abortions contribute to 8 percent of all maternal deaths, with even higher morbidity rates. To put this in perspective, nearly ten women lose their lives daily due to unsafe abortion practices. The primary focus of the MTP Act is to allow abortion under certain conditions with the approval of authorized medical practitioners. However, it does not ensure universal access to safe and legal abortions. When examining

the reasons behind women seeking abortions, only 31 percent of cases strictly adhere to the grounds permitted under the MTP Act. The majority of cases stem from unwanted pregnancies (71 percent), economic considerations (7 percent), and concerns about the fetus's undesired sex (13 percent).

b) **Lack of Budget:** The National Health Policy 2017 proposed a significant increase in *"public health expenditure to reach 2.5% of GDP by 2025".* Implementing these policy recommendations is paramount for improving healthcare services, particularly maternal and reproductive health services. In alignment with the recommendations of the Guttmacher–Lancet Commission, prioritizing "adolescent sexual and reproductive health in India" is imperative. This approach is essential to mitigate *"unwanted pregnancies, unsafe abortions, unplanned deliveries, and the ratio of maternal mortality while ensuring the well-being of young people".*

c) **Gender Inequality:** In Indian society, deep-rooted gender roles frequently restrict women's autonomy in reproductive decisions, which often confines women to the role of childbearing. Patriarchal norms and discrimination against women lead to lower female literacy rates, restricted access to resources, and unequal opportunities, all hindering the ability of women to exercise their reproductive rights.

d) **Pre-natal and Post-natal Care:** In rural areas, inadequate facilities and limited access to obstetric and gynecological care contribute to unsafe motherhood during pregnancy and childbirth. Access to antenatal care is inadequate, high-risk pregnancies go undetected, anemia is prevalent during pregnancy, and nutritional knowledge is lacking. Modern healthcare facilities are often inaccessible to the general population.

e) **Inadequate Healthcare Services:** Healthcare facilities often prioritize basic tasks, like immunization and nutrient provision, like iron and folic acid, rather than offering comprehensive and continuous care for women during and after pregnancy.

Women are expected to balance household chores and sometimes contribute to family finances, leaving little time for their health. The population control agenda has overshadowed maternal health concerns, impacting overall reproductive health care.

Addressing these challenges requires a holistic approach that promotes gender equality, enhances healthcare services, and ensures proper care during all stages of reproductive health.

8. Conclusion

In conclusion, promoting women's reproductive rights and health plays a pivotal role in achieving sustainable development. Since women comprise half of the population, addressing their needs and interests is imperative to improve society and the nation. India, among 192 other countries, has endorsed the SDGs Agenda 2030. This agenda underscores the significance of addressing women's status inequality, tackling gender biases, enhancing healthcare, promoting education, facilitating meaningful employment, and addressing various developmental challenges. SDGs 3 and 5, focusing on healthy lives and gender equality, are particularly influential in achieving other SDGs. Ensuring continued access to reproductive rights while enhancing women's health are both vital objectives. These objectives can be achieved by shifting the focus towards addressing the underlying conditions perpetuating son preference. The country needs to strengthen and efficiently execute policies that safeguard reproductive rights. It guarantees the well-being of every mother and ensures that every girl child is genuinely desired. Therefore, reproductive rights and health are critical components of sustainable development, with women occupying central roles in pathways to sustainability and environmentally responsible transformation.

9. Suggestions

To enhance women's reproductive rights and health in India and foster sustainable development, the following measures warrant consideration:

a) The "National Health Policy 2017 proposed a target of 2.5% of GDP for public health expenditure by 2025". To enhance the healthcare system in India, with particular attention to maternal and reproductive health services, it is imperative to execute the suggestions.

b) Improving primary health centers and healthcare infrastructure, including reproductive health services, is vital to *"ensure equitable access to antenatal care, nutritious supplements, and other essential services".* Regularizing contractual reproductive healthcare workers is also essential. Ensuring *"universal access to high-quality healthcare, especially for women with disabilities and mental illnesses",* requires a robust legal framework to recognize and safeguard women's reproductive rights. The government must prioritize reproductive rights in healthcare policies.

c) Ensuring women access appropriate, affordable, high-quality healthcare facilities and services is essential. Health programs should prioritize women's health, especially reproductive health, and effective monitoring of these programs is crucial. Implementing laws and programs to promote public health, particularly women's health, is vital. Establishing a monthly door-to-door health check-up service. Empowering women and expanding essential health services, including counseling on safe sex, nutrition, and gender-based violence education, can change officials' perspectives on women's reproductive health standards.

d) Given the increasing prevalence of HIV/AIDS cases, there is a pressing need for government, non-governmental organizations, educational institutions, and other agencies to raise awareness about HIV/AIDS prevention, particularly among women and girls. Early awareness and education on

reproductive health and choice are essential, as many women lack sufficient knowledge. Overall, there is an urgent need to raise awareness about women's health issues and prioritize them at the national and State levels. Health awareness programs should be results-oriented, and comprehensive legislation like the Reproductive Rights (Protection) Act should be enacted to protect and promote the reproductive rights of women. Reproductive rights should be at the forefront of the government's agenda to enhance the status and protect the rights of women.

e) The government should organize awareness campaigns, free workshops, and seminars to address women's prevalent lack of awareness regarding their fundamental rights. The government can also introduce scholarships to motivate rural women and girls to pursue higher education. Reproductive health studies should be incorporated into the curriculum of various disciplines. These studies should emphasise reducing the maternal mortality rate and promoting the reproductive rights of women.