HUMAN RIGHTS-BASED LIFE SPAN APPROACH TOWARDS SEXUAL AND REPRODUCTIVE HEALTH: MANIFESTATIONS IN INDIA AND NEPAL

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ABSTRACT

This article explores the intersection of socio-legal dynamics and reproductive health rights, emphasizing a disconnect between legal frameworks and human rights principles. It argues that legal interpretations often overlook societal realities, limiting the consideration of broader factors. Beyond examining legal aspects of pregnancy and abortion, the study delves into the biogenic and socio-genic influences shaping women's reproductive experiences across generations. Employing a life-span approach and narrative inquiry method, it assesses the socio-legal dimensions of sexual and reproductive health through the narrative of 'Chunni from Nepal,' analogous to various judicial cases. It traces the evolution of human rights approaches, particularly those outlined in the ICPD, revealing hidden trends within global communities. Focusing on human rights instruments like CEDAW's General Recommendation no. 24, it examines interpretations by scholars and treaty bodies. Comparing India and Nepal, two countries with porous borders and extensive people-to-people interpersonal relationship, the article studies legal scope and challenges in both, especially concerning safe abortion and safe motherhood. The article advocates for aligning legal frameworks with constitutional guarantees to protect reproductive health rights, particularly for marginalized women in both countries.

Keywords: *sexual and reproductive health, life-span concept, human rights approach, access, justiciability*

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I. Introduction

CHUNNI WAS a girl from far western Nepal. Her parents wanted to abort her after learning she was female, but she survived. Her mother was underfed while carrying her, and she did not receive adequate prenatal care, hence Chunni was born malnourished. At 12, she menstruated for the first time and was sheltered in a cowshed, as per the so-called traditional beliefs in the far western part of Nepal. By 14, she was married off by her parents, and by 16, she became a mother to a baby girl. Throughout her married life, she was relentlessly pressured by her in-laws to bear a son. In pursuit of a goal beyond her control, she underwent four unsafe abortions at home. She was then diagnosed with uterine cancer, treatments for which proved ineffective. Despite her deteriorating health, Chunni continued to fulfill her daily household chores, battling cancer and enduring unbearable pain. At 41, Chunni succumbed to the final stage of cancer, leaving her daughter Rani to carry on with her own fate.

The above story of Chunni is a narrative inquiry[1] inspired by an actual phenomena the facts of which are analogous to the Supreme Court case of *Prakashmani Sharma*[2] regarding the issues of gynecological disease and *Laxmi Dhikta*[3] about unsafe abortion. The narrative serves the purpose of humanizing the grave problem to be discussed by the article: inadequate access to sexual and reproductive health.

Sexual and reproductive health (*hereinafter* referred to as 'SRH') is defined as "a state of physical, emotional, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes".[4] The article uses Chunni's story to illustrate that reproductive complications stem not only from biogenic factors but are deeply rooted in sociogenic determinants that force women to endure suffering throughout their lives.

[1]A narrative inquiry is a social science research method through which one or more human experiences as they unfold over time are told in form of stories; D. Jean Clandinin, Jerry Roseik, "Mapping a Landscape of Narrative Inquiry: Borderland Spaces and Tension" in D. Jean Clandinn, *Narrative Inquiry: Mapping a Methodology* 40 (Sage Publication, United Kingdom, 1st edn, 2007).

[2] *Prakash Mani Sharma* v. *Government of Nepal* SCN Writ No. 064, 2008 cited in *Center for Health, Human Rights and Development* v. *Attorney General*, (2020) UGCC 12, *available at:* https://www.escr-net.org/caselaw/2014/prakash-mani-sharma-v-govt-nepal-scn-writ-no-064 (last visited on December 15, 2022).

[3]*Lakshmi Dhikta* v. *Government of Nepal* SCN Writ No. 0757, 2009 *available at:* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf (last visited on December 15, 2022).

[4] World Health Organization, "Report on Sexual Health, Human Rights and the Law" (2015).

The paper explores the interplay between biogenic and sociogenic factors influencing a woman's SRH life experience. Ultimately, it advocates for the recognition of SRH as a right, and adoption of the human rights approach (*hereinafter* referred to as 'HRA') and using the approaches within the broader HRA to better realize rights relating to SRH. As a conceptual framework, the paper introduces and expands on the lifespan approach within HRA that comprehensively recognizes the interplay between biogenic and sociogenic factors of reproductive complications. Far too often the fertility span of a woman is associated with reproductive health, an idea negated by the lifespan concept. In light of that, the paper builds on existing scholarship and offers a more detailed application of the lifespan concept by comparing laws and judicial trends in India and Nepal.

II. The Intricate Interrelationship between the Biogenic and Sociogenic Factors of SRH

Biogenic and sociogenic concepts encompass both inherent characteristics and socially constructed attributes. These terms, commonly utilized in health and social sciences, distinguish between the sociological (sociogenic) and biological (biogenic) factors shaping an individual's life experience.[5] Biogenic factors relate to the physical functions of a woman, such as conception, childbirth, and breastfeeding, whereas sociogenic determinants pertain to the cultural constructions and societal perceptions about a woman's role based on age, consent, spousal relations and family matters, among others.[6] By using these concepts, this article contests the conventional notion that considers reproduction as solely a biological process. Chunni's story exemplifies how women's SRH related complications persist and extend throughout their lifetimes and are transmitted across generations of women.

These challenges manifest in various socially attributed plights, each entailing a blend of social and biological hardships discussed below:

a. *Sex-selective abortions:* Preference for male child may lead to forced pregnancy and/or unsafe abortions.[7] Sex-selective abortion has globally resulted in tens to hundreds of millions of

[5] Dianna T. Kenny, "Constructions of chronic pain in doctor–patient relationships: bridging the communication chasm" 52 *Patient Education and Counseling* 297–305 (2004).
[6] Paul Hunt, "The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health." United Nations Digital Library System 5 (Economic and Social Council, E/CN.4/2004/49) *available at:* https://digitallibrary.un.org/record/516139?ln=en&v=pdf (last visited on August 5, 2023).
[7] Asmita Banerjee, Nandini Chatterjee, "Impact of Son Preference on Women's Extent of Enjoying Reproductive Rights*",* 11 *International Journal of Development Research* 48836 (2021).

missing girls at birth,[8] girl child generally seen as a liability, with very little self-determination over their lives.[9]

b. *Unwanted pregnancy, maternal malnourishment, and SRH*: Pregnant women with unwanted pregnancy often experience malnutrition,[10] leading to increased risks of maternal and neonatal mortality[11] and adverse health risks.[12]

c. *Menstruation as an impurity:* Menstruating girls have been perceived as 'impure' since ancient times.[13] For example, girls are kept in rudimentary shelters in practices of *Chaupadi* in far-west part of Nepal.[14]

d. *Child marriage and its impacts on SRH of child brides:* Child marriage is a global phenomenon despite the conduct being recognized as statutory rape in many countries.[15] In Nepal, 1.3 million girls are married before the age of 15, and 5 million before the age of 18.[16] Child marriages "add a layer of vulnerability to women that lead to poor fertility control and fertility-related outcomes."[17] United Nations Population Fund (*hereinafter* referred to as 'UNFPA') reports that in low and middle-income countries, millions of girls, some as young as 15, experience pregnancies annually.[18] Child brides in South Asia are as evidenced more likely to experience sexual and reproductive health complications.[19]

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[8] Arthur Erken (ed.), *Against My Will Defying the Practices that Harm Women and Girls and Undermine Equality* (UNFPA, June 2020); Géraldine Duthé, France Meslé, *et al., "*High Sex Ratios at Birth in the Caucasus: Modern Technology to Satisfy Old Desires*"* 38 *Population Development Review* 487 (2012).

[9] World Health Organization, "Report on WHO Technical Consultation on Birth Spacing" (2005).

[10] Solomon Zewdie, Sagni Girma Fage, *et al.*, "Undernutrition among Pregnant Women in Rural Communities in Southern Ethiopia" 13 *International Journal of Women's Health* 73 (2021).

[11] Masresha Leta Serbesa, maleda Tefera Iffa, *et. al.*, "Factors Associated with Malnutrition among Pregnant Women and Lactating Mothers in Miesso Health Center, Ethiopia", 3 *European Journal of Midwifery* 2 (2019).

[12] World Health Organization, "Report on Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division" (2019).

[13] Ancient Roman philosopher Pliny the Elder taught that "menstrual blood could make seeds infertile, kill insects, kill flowers, kill grass, cause fruit to fall off trees, dull razors, and drive dogs mad. The glance of a menstruating woman could kill bees, her touch could make a horse miscarry, and contact with her blood could cause another woman to lose her child." Melissa H. Weresh, "Deconstructing the Curse: Menstrual Education and the Stigma of Shame" 43 *Women's Rights Law Reporter* 1 (2022).

[14] Hannah Robinson, "Chaupadi: The Affliction of Menses in Nepal", 1 *International Journal of Women's Dermatology* 193 (2015).

[15] Kaya Van Roost, Miranda Horn, *et.al*, "Child Marriage or Statutory Rape? A Comparison of Law and Practice Across the United States", 70 *Journal of Adolescent Health* S72 (2022).

[16] UNFPA-UNICEF, "Report on Global Programme to End Child Marriage" (2019).

[17] Deepali Godha, David R Hotchkiss, *et. al*, "Association between Child Marriage and Reproductive Health Outcomes and Service Utilization: a Multi-Country Study from South Asia" 52 *Journal of Adolescent Health* 552 (2013).

[18] UNFPA, "Report on Girlhood, not Motherhood: Preventing Adolescent Pregnancy (United Nations Population Fund" (2015).

[19] *Ibid*.

e. *Unevenness in shared domestic responsibility:* Child rearing and household work are generally tasked to women[20] and are entrenched in patriarchy.[21]

f. *Long-term effects of lack of SRH protection and care:* Chunni's story exemplifies the prevalence of fatal gynecological diseases.[22] Many times, the age of first pregnancy, numbers, and circumstances of abortion are linked to the severity of post-menopausal symptoms.[23]

g. *Social Determinants to SRH:* Every two minutes a woman loses her life due to complications during pregnancy or childbirth.[24] Tlaleng Mofokeng, Special Rapporteur on the right to health, has found the enjoyment of SRH is riddled with many obstacles at different levels of clinical and health systems.[25] As a scholar notes: "women are not dying of diseases we cannot treat...they are dying because societies have yet to make the decision that their lives are worth saving."[26] Hence, it is equally important to discuss the "underlying social determinants"[27] affecting the ability of women to make decisions concerning to their sexual and reproductive health.

In sum, the above issues portray the complex relationship between social, cultural, and biological factors that shape women's SRH experiences. From the consequences of sex-selective abortions and child marriage to the stigma surrounding menstruation and the unequal burden of domestic responsibilities underscore the urgent need for comprehensive State and societal interventions. Moreover, addressing the long-term effects of inadequate SRH

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[20] Laura Addati, Naomi Cassirer, "Equal Sharing of Responsibilities Between Women and Men, Including Care-Giving in the Context of HIV/Aids" 4 (2008); Jean Little's Quote, A Man Works from Sun to Sun, but Woman's Work is Never Done in Afaf Ibrahim melesis, Teri G. Lindgren, "Man Works From Sun To Sun, but Woman's Work is Never Done: Insights on Research and Policy" 23 *Healthcare for Women International* 742 (2002).

[21] Convention on the Elimination of All Forms of Discrimination against Women (hereinafter referred as CEDAW) 1979. art. 5 (e) of CEDAW notes the need for appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to eliminating prejudices which are based on the inferiority or superiority of either of the sexes or on stereotyped roles for men and women. United Nations, "Report of the Fourth World Conference on Women" (September, 1995).

[22] Manuela Stoicescu, Simona G. Bungau, *et al*, "Carcinogenic Uterine Risk of Repeated Abortions: Hormone Receptors Tumoral Expression", 58 *Romanian Journal of Morphology and Embryology* 1429 (2017).

[23] Seyedeh H. Sharami, Roya F. Darkhaneh, *et al*., "The Association between Reproductive History Aand Menopausal Symptoms: An Evidence from the Cross-Sectional Survey" 22 *BMC Women's Health* 136 (2022).

[24]Press Release: UNFPA, "A Women Dies Every Minute Due to Pregnancy or Childbirth: UN Agencies", (February 22, 2023) *available at*: https://www.unfpa.org/press/woman-dies-every-two-minutes-due-pregnancy-or-childbirth-un-agencies (last visited on August 11, 2023).

[25] Tlaleng Mofokeng, "Violence and Its Impact on the Right to Health" A/HRC/ 28 (2022), *available at*: https://www.ohchr.org/en/documents/thematic-reports/ahrc5028-violence-and-its-impact-right-health-report-special-rapporteur (last visited on August 23, 2023).

[26] Mahmoud Fathalla, 'Motherhood Shouldn't Be a Death Sentence', *Amnesty International USA*, 1999 cited at Helene Julien, "Is There a Human Right to Safe Motherhood within the United Nations Legal System?" 2 *Queen Mary University Human Rights Review* 1 (2015).

[27] UN. Committee on Economic, Social and Cultural Rights, *General comment no. 22 on the Right to sexual and reproductive health Article 12 of ICESCR*, E/C.12/GC/22, UN ESCOR (May 2, 2016) at 21.

protection and care, along with recognizing and rectifying the underlying social determinants, is essential for empowering women to make informed decisions about their SRH by ensuring their overall well-being following the holistic life span approach.

III. The Concept of the Life-Span approach to SRH under CEDAW

A reproductive life of a woman is not limited to just her fertility span. The life-span (also referred to as a 'life-course' approach) advocates that the reproductive life of a biological woman begins from her birth as a girl child and continues far beyond procreation, pregnancy, and childbirth.[28] It is an evidence-based support of the interrelationship between early life factors and reproductive outcomes,[29] as in the case of Chunni. This social epidemiology approach has also transformed into a HRA which substantiates that safe motherhood is an indivisible part of SRH, hence extends beyond basic maternal health rights, and is closely linked to a bundle of human rights, including the access to underlying preconditions of health[30] and also examines how the indicators of education, empowerment, progress and economic justice impact a woman's reproductive health.[31]

Human rights instruments apart from the Convention on the Elimination of All forms of Discrimination Against Women (*hereinafter* referred to as 'CEDAW') were primarily detached from the life-span concept. No other human rights instruments neither incorporated nor held the essence of this approach before CEDAW. Meanwhile, the women's convention was influenced to adopt the life-span approach as discoursed in world conferences on population and development and women. This approach is directly connected with substantive equality inculcated by CEDAW, which comprises three core principles: non-discrimination, equality, and state responsibility, guiding the implementation of thematic rights. Article 12 of CEDAW interprets women's general and reproductive health based on WHO and ICESCR definitions, guaranteeing both maternal health care and the right to adequate nutrition.[32]

[28] Noriko Cable, "Life Course Approach in Social Epidemiology: An Overview, Application and Future Implications" 24 *Journal of Epidemiology* 347 (2015).
[29] Gita D. Mishra, Rachel Cooper, *et al.*, "A life course approach to reproductive health: Theory and methods" 65 *Indian Journal of Medical Biochemistry* 92 (2010).
[30] Henriette DC Roscam Abbing, "International Organizations in Europe and the Right to Health Care" 8 *Kluwer Academic* 104 (1979).
[31] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General Recommendation No. 21: Equality in Marriage and Family Relations,* A/47/38, (1994).
[32] *Ibid.*

L.C. v. *Peru*[33] was the first individual complaint resolved by the CEDAW Committee, and it concerned the repeated rape and secret pregnancy of a 13-year-old girl leading to her depression and a suicide attempt. However her doctors declined to remove her spinal column due to potential risks to the pregnancy, and the hospital denied therapeutic abortion.[34] The Committee found that denial of therapeutic abortion constituted discrimination under article 12 of CEDAW, and denial of both therapeutic abortion and surgery as a sex-stereotype prohibited under article 5 of CEDAW.[35] In *Alyne da Silva Pimentel* v. *Brazil,*[36] the CEDAW Committee held a Brazil accountable for not ensuring the right to safe motherhood, in particular affordable access to adequate emergency obstetric care, and proper training for health workers[37], in a case concerning a preventable maternal mortality of a 27 weeks pregnant woman who died due to avoidable obstetric complications, including a misdiagnosis and delayed tests at a private clinic.[38]

Contextually, however, article 12 of CEDAW guarantees adequate nutrition during pregnancy and lactation[39] and as the text suggests, is limited to a short span, rather than encompassing the lifespan or lifecycle approach. The International Conference on Population and Development (*hereinafter* referred to as 'ICPD') in 1994[40] marked a significant shift towards a well-being and empowerment approach in SRH perspectives under human rights instruments, including CEDAW. It defines reproductive rights as the fundamental right for couples and individuals to freely decide the number, spacing, and timing of children, with access to information and means for exercising this right.[41] It also addresses a constellation of methods and services to prevent and address reproductive health complications. [42]

[33] *L.C.* v. *Peru, CEDAW Committee*, CEDAW/C/50/D/22/2009 (4 November 2011); For a first comment see: Ngwena C, "Commentary on LC v. Peru: the CEDAW Committee First Decision on Abortion" 57 *Journal of African Law* 310 (2013).
[34] *Id*, 2.1. The therapeutic termination of pregnancy (TToP) is an induced abortion following a diagnosis of medical necessity to avoid the risk of substantial harm to the mother or in cases of fetal unviability. See for detail, di Giacomo E, Pessina R, et.al, "Therapeutic termination of pregnancy and women's mental health: Determinants and consequences" 11 *World Journal of Psychiatry* 19 (Nov. 2021).
[35] *Id.*, at para 8.15.
[36] *Alyne da Silva Pimentel* v. *Brazil, CEDAW Committee,* CEDAW/C/49/D/17/2008 (10 August 2011).
[37] *Id.*, at para 8.2.
[38] *Id.*, a paras 2.2 – 2.5, 3.5.
[39] *Supra* note 21, art. 12 (2).
[40] UN Population Fund (UNFPA), "Report of the International Conference on Population and Development" 5-13 (September 1994).
[41] *Id.*, at para 7.3
[42] *Id.*, at para 7.2.

General Recommendation 24 (GR 24) of CEDAW[43] links right to SRH, including safe motherhood, with several CEDAW provisions such as access to health-related education including family planning[44] and protection from discrimination related to pregnancy and maternity leave.[45] Notably, it acknowledges intersectional rural women's 'access to adequate health care facilities, including information, counseling and services in family planning'.[46] Hence, GR 24 goes beyond the strict interpretation of article 12 of CEDAW and addresses women's health throughout their life span. It rejects the traditional biological understanding of SRH[47] and recommends states to adopt a comprehensive national strategy promoting women's health at every stage of their life, based on the concept of autonomy[48] that allows women to take decisions concerning her fertility and sexuality free of coercion and gender-based violence.[49]

It also links right to SRH with article 16 of CEDAW, and reaffirming the UDHR and ICCPR, calls for the elimination of discrimination against women in matters relating to marriage and family relations. To this end, article 5[50] urges states to educate men about sharing reproductive responsibilities, which is vital in transforming traditional social patterns related to maternity.

Therein, we can deduce that CEDAW, more particularly GR-24, paved a path for other general human rights instruments to correct their provisions in line with the life-span approach of reproductive health as a HRA briefly outlined below.

IV. HRA to SRH under General Human Rights Standards

The HRA integrates human rights principles and specific norms and standards into all aspects of human development. Ross and Solinger believe that the reproductive justice movement is inherently connected to the struggle for social justice and human rights as it argues how social status and socio-economic environment, cultural practices affect each woman's reproductive

[43] UN Committee on the Elimination of Discrimination Against Women, *General Recommendation 24: Article 12 of the Convention (Women and Health)*, A/54/38/Rev.1 (1999).
[44] *Supra* note 21, art. 10 (h).
[45] *Id.*, art. 11(2).
[46] *Id.*, art. 14(2) (b).
[47] *Supra* note 43, para.28.
[48] Dubravka Šimonović, "Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence", 54 (2019).
[49] Carmel Shalev, "Right to Sexual and Reproductive health: The ICPD and the Convention on the Elimination of All forms of Discrimination against Women" 42 *Health and Human Rights* 4 (2000).
[50] *Supra* note 21, art. 5.

life.[51] For example, research indicates that women living below the poverty line are more susceptible to experiencing unsafe abortions.[52] Hence, reproductive justice requires the recognition of a right to sexual and reproductive health as essence of human rights.

As it is, there is no universal acceptance of the right to reproductive health,[53] and this has led to diverse levels of commitment and implementation across different countries. Nonetheless, the UN and other international organizations have made gradual but considerable efforts in the matter following the Second World War, with a gradual development in the understanding of SRH.

The past and present approach of the ILO

The International Labour Organization (*hereinafter* referred to as 'ILO') was founded in 1919 as a pioneer institution dedicated to upholding and safeguarding the universal right to employment. However, its Convention on Night Work restricted women's night work to protect reproductive and nursing roles[54] reinforcing traditional gender roles under which women were responsible for childbearing and the domestic realm. The International Law Commission abrogated this Convention in 2017.[55] Eventually, ILO fully respected the principles of equality and non-discrimination through introduction of a number of labour standards including Maternity Protection Convention.[56]

The Convention emphasizes shared responsibility between government and society to protect pregnancy. It addresses various aspects related to women's rights in the workplace, including health protection for pregnant or breastfeeding women, 14 weeks of minimum maternity leave, daily breaks or reduced working hours for breastfeeding, leave for pregnancy or childbirth-related illness, access to medical benefits, and cash benefits during maternity leave.[57] Further, the ILO has been actively promoting awareness and knowledge on sexual and reproductive health that "*pregnancy isn't an illness*, and working during it is generally safe unless complications arise. Supporting expectant mothers in the workplace with essentials like water,

[51] Loretta J. Ross and Rickie Solinger, 'Reproductive Justice: An introduction', 102 *Journal of Social Equity and Public Administration* 1 (2023).
[52] Angela Hooton, "A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism" 13(1) *American University Journal of Gender Social Policy & Law* 68 (2005).
[53] *Ibid.*
[54] Convention concerning employment of women during the Night, 1919, arts. 2, 3.
[55] Abrogation of the Night Work (Women) Convention, 1919 (June 23, 2017).
[56] Preamble of Maternity Protection Convention 2000, C-183, (June 15, 2000).
[57] *Id.*, arts. 3, 4, 10.

rest, and prenatal care is crucial for their wellbeing and benefits society as a whole (*emphasis added*).[58]

Acknowledgment of human rights norms and the entitlement to (safe) motherhood

The United Nations Charter was the initial source that introduced human rights norms and their enforcement mechanisms.[59] Articles 1(3), 55, and 56 emphasized universal observance of and respect for human rights and fundamental freedoms.[60] Although an implicit inference for reproductive health within the Charter can be traced within the concept of a 'higher standard of living',[61] it does not explicitly recognize the right to reproductive health.

UDHR balances universalism with women-specific rights[62] as it is the first international instrument to recognize three crucial rights - equality and non-discrimination with broader grounds,[63] marriage and family[64] and 'motherhood'.[65] In pursuit of gender equality, feminists campaigned for the recognition of 'the rights of motherhood' in the UDHR. A compromise was struck with article 25(2), which refrained from asserting mothers' rights as individuals but instead emphasized the importance of providing 'special care and support' for both motherhood and childhood.[66] However, this relational entitlement to special care and assistance has been interpreted as a right to secure motherhood for 'advancing the interest of women'.[67]

There have been two propositions on the definition of safe motherhood, one aims for physical safety and survival of mother and infant, while the other views safe motherhood, as also observable in Chunni's story, as an indivisible part of a woman's reproductive health life experience, and hence turns to the broader definition of reproductive health under the Beijing Platform of Action that aims for complete wellbeing and not merely absence of disease.[68]

[58] ILO, "Working time and family-friendly measures" 7 *Healthwise Action Manual, Module ILO* 143 (2014).
[59] Charter of the United Nations, (24 October 1945), art. 68.
[60] Jerome Shestack, "The Jurisprudence of Human Rights", in Theodor Meron (ed), *Human Rights in International Law: Legal and Policy Issues*,101 (Oxford University Press, New York 1984).
[61] *Ibid.*
[62] Vienna Declaration and Programme of Action, 1993, part 1.
[63] Universal Declaration of Human Rights, 1948, art. 7.
[64] *Id.*, art. 16.
[65] *Id.*, art. 25 (2).
[66] Leah Hoctor, "Reproductive Rights" in Christina Binder, Manfred Nowak et al. (eds.), *Elgar Encyclopedia of Human Rights* 149-155 (Edward Elgar Publishing, 2022).
[67] *Deepika Singh* v. *Central Administrative Tribunal* (2022) SCC 1088.
[68] Beijing Declaration and Platform of Action (October 27, 1995).

Philip Alston proposes that safe motherhood should be considered a 'new right' encompassing the fundamentally important social value of women's lives and control over their bodies[69] and his seven-criteria for right to safe motherhood elucidate the 'umbrella concept' of the highest attainable health standard, encompassing survival and empowering human rights like nutrition, clean water, and education.[70] Similarly, the scholarly opinions of Jack Donnelly,[71] Andrew Byrnes[72] and Hillary Charlesworth[73] support recognizing women's control over their bodies as a critical concern of safe motherhood.[74] Rebecca J. Cook asserts "for a woman to die from pregnancy and childbirth is a social injustice. Such deaths are rooted in women's powerlessness and unequal access to employment, finances, education, basic health care and other resources. These factors set the stage for poor maternal health even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun".[75] All these views suffice the socio-genic concept of reproductive rights and health.

SRH rights as freedoms and entitlements under the ICESCR

Under ICESCR, the prohibition on discrimination based on sex and other grounds[76] is a negative obligation, while ensuring equality between men and women[77] requires positive measures to achieve substantive equality for women, going beyond merely prohibiting discrimination.[78] These are closely intertwined with several other provisions including the right to the highest attainable standard of health that also includes SRH.[79] Further, pursuant to the principle of indivisible human rights, SRH is connected with several thematic rights such as the right to education.[80]

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[69] He has developed seven criteria for the recognition of safe motherhood as a new right. *See* Philip Alston, "Conjuring up New Human Rights: A Proposal for Quality Control" 78 *American Journal of International Law* 607 (1984).

[70] This concept was used by Van Bueren to analyse child's right to development See, Geraldine Van Bueren, *International Law on the Rights of the Child* 293 (Martinus Nijhoff Publishers, Leiden, 2nd edn., 1998).

[71] Jack Donnelly, *Universal Human Rights in Theory and Practice*, 43 (Cornell University Press, Cornell, 3rd edn. 2013).

[72] Andrew Byrnes, "Women, Feminism and International Human Rights Law-Methodological Myopia, Fundamental Flaws or Meaningful Marginalisation? Some current issues", 205 *American Yearbook of International Law* 12 (1989).

[73] Hilary Charlesworth and Christine Chinkin, *The Boundaries of International Law: A Feminist Analysis* 22 (Manchester University Press, Manchester, 2000).

[74] Tatyana A Margolin, "Abortion as a Human Right", 81 *Women's Rights Law Reporter*, 77 (2008).

[75] Rebecca J Cook, "International Protection of Women's Reproductive Rights", 24 *NYU Journal of International Law and Politics* 645 (1992).

[76] International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, art. 2 (2).

[77] *Id.*, art. 3.

[78] Ben Saul, David Kinley et al, '*The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases, and Materials'*, 285 (Oxford University Press, March 2014).

[79] *Supra* note 76, art. 16.

[80] *Id.*, arts. 13 and 14.

The General Comment 14 of the CESCR[81] emphasizes a freedom and entitlement approach to the right to SRH, focusing on availability, accessibility (geographical, information), affordability, acceptability, and quality.[82] The General Comment 22[83] also defines the right to SRH as a set of freedom and entitlements, in the following manner:[84]

> The freedom includes the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the Covenant.

In line of the above, it recommends that states respect, protect and fulfill SRH rights by: 1) eliminating discrimination and social barriers; 2) addressing and eliminating stereotypes related to sexuality and reproduction; 3) progressively realizing SRH through targeted legal and resource mobilization; 4) ensuring equal access to information, goods, and services; and 5) not limiting or denying access to SRH, including through criminalizing laws, while maintaining health data confidentiality.[85] Some of the remarkable concrete recommendations under GC 22 include:

1) ensuring unbiased access of adolescents to comprehensive sexual and reproductive health information, including family planning, contraceptives, and prevention of sexually transmitted diseases;[86]
2) using evidence-based standards for delivering maternal health services including safe abortion and infertility treatments;[87]
3) ensuring adequate budget allocation to national strategies for equitable access to SRH services, especially for the marginalized communities;[88] and,

[81] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14 on the Right to the Highest Attainable Standard of Health, Art. 12 of the ICESCR*, E/C.12/2000/4 (August 11, 2000).
[82] *Supra* note, para. 15, 20 and 21.
[83] *Id*., para. 11 and 21.
[84] *Id*., para. 5.
[85] *Id*., at Chapter IV.
[86] *Id.*, at art. 18.
[87] *Id*., at art. 45.
[88] *Id*., at art. 49 (b).

4) contributing at a minimum 0.7 percent of their gross national income for international cooperation and assistance.[89]

The CESCR acknowledges that right to SRH means providing appropriate services to women in accordance with *their life cycles*.[90] (*emphasis added*)

SRH as Civil and Political Rights

Unlike the ICESCR, the ICCPR imposes explicit and immediate negative and positive duties, such as adopting legal or other necessary measures to "respect" and "ensure respect for" rights.[91] Right to information provides a framework to access family planning information, therefore empowering women with greater control over their lives.[92]

The Human Rights Committee (*hereinafter* referred to as 'HRC') is the most influential among all the human rights treaty bodies. The GC 28 of the HRC recognizes women's subordination in reproductive decisions to high rates of prenatal sex selection and abortion of female fetuses.[93] In General Comment no. 36, the HRC has linked for the first time[94] the right to life, survival, and security with access to safe and legal abortion, specifically for pregnant women and girls.[95]

The HRC calls upon states to address practices like female infanticide, protect women from unwanted pregnancies, and prevent life-threatening clandestine abortions.[96] It urges states to report pregnancy and childbirth-related deaths of women, including statistics.[97] It also calls for gender-disaggregated data on infant mortality to identify cases of sex-selective clandestine abortions leading to life-threatening unsafe abortions.[98]

[89] *Id*., at art. 50.
[90] *Id*., at art 25.
[91] Sandra Coliver, "Civil and Political Rights and the Tight to Non-discrimination: The Right to Information necessary for Reproductive Health and Choice under International Law", 12 *American University Law Review* 44 (1995).
[92] WHO "Framework for ensuring human rights in the provision of contraceptive information and services" (2014).
[93] Human Rights Committee, *General Comment 28 on the equality of rights between men and women, Article 3 of ICCPR*, CCPR/C/21/Rev.1/Add.10, (March 29, 2000); Juan Mendez, "Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" (2013).
[94] Human Rights Committee, *General Comment 36 on the Right to Life, Article 6 of ICCPR,* CCPR/C/GC/35, (September 3, 2019), paras, 6, 8 , 11, 20.
[95] *Id*., at art. 2.
[96] *Id.*, at. art. 28.
[97] *Id*., at. art. 36.
[98] *Id*., at. art. 11.

HRC views that lack of access to abortion or unsafe abortion as cruel, inhuman, or degrading treatment, and that such cruelty in cases of rape or incest constitutes torture.[99] Similarly, the UN Committee Against Torture (*hereinafter* referred to as 'UNCAT') has observed that restrictions on reproductive health services including emergency contraception and access to post-abortion amount to torture.[100] It recommends allowing abortion in cases of pregnancy related physical or mental distress,[101] for victims of sexual violence or those carrying nonviable fetuses.[102]

V. Scope of HRA and Right to SRH in India

While the Constitution of India does not explicitly guarantee SRH as a fundamental right, Chapter IV of the Constitution has incorporated socio-economic and cultural aspects in the Directive Principles of State Policy (*hereinafter* referred to as 'DPSP').[103] While not legally binding *per se*, the DPSP have been used by the Supreme Court of India to derive an expansive understanding of right to life (article 21) and equality (articles 14 and 15) in the sense that these encompass socio-economic right to health, among others. Further, India is a state party to the ICESCR and CEDAW that encompasses the right to SRH as elaborated in the earlier sections. The courts of India have cited these instruments to respect, protect and fulfill reproductive rights.

In the *Laxmi Mandal* case,[104] the Delhi High Court deeply analyzed factors of poor reproductive health and issued a significant decision to protect SRH rights. This case represented *Shanti Devi* who faced complications during her pregnancies due to financial constraints, leading to her tragic death during her sixth pregnancy without skilled assistance.[105] Factors like her poor health and limited resources due to socio-economic status contributed to her death. The court

[99] K.*L.* v. *Peru, Human Rights Committee,* CCPR/C/85/D/1153/2003, (November 22, 2005). The decision was endorsed by the CAT Committee's concluding observation on Peru; See, Committee Against Torture, CAT/C/PER/CO/4 (May 16, 2006).
[100] CAT Committee, *Consideration of Reports Submitted by State Parties Under article 19 of the Convention Concluding Observations on Chile,* CAT/C/CR/32/5 *(*2004) at 7.
[101] CAT Committee, *Consideration of Reports Submitted by State Parties Under article 19 of the Convention Concluding Observations on* P*araguay*, CAT/C/PRY/CO/4-6, (2011) at 3.
[102] For example, in its 2011 review of Paraguay, the CAT Committee expressed concern about a law that outlaws abortion in cases of rape, incest, or when the fetus is not viable. See, Center for Reproductive Right "Reproductive Rights violation as torture or ill-treatment", *available at*: https://shorturl.at/nwGV7 (last visited on August 11, 2023).
[103] *Unni Krishnan J.P* v. *State of Andhra Pradesh,* AIR 1993 SC 2178.
[104] *Laxmi Mandal* v. *Deen Dayal Harinagar Hospital*, High Court of Delhi, 2010, W.P.(C) 8853/2008, 19-27; *Jaitun* v. *Maternity Home, MCD, Jangpura* High Court of Delhi, 2010, W.P.(C) 8853/2008, 19-27.
[105] *Ibid.*

considered this a severe example of maternal health care denial for impoverished women, emphasizing the inalienable right to health and reproductive rights as part of the right to life.

The decision referenced CEDAW and ICESCR, stressing 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 so inherent in the right to life gets enforced."[106] Likewise, in the *Devika Biswas* v. *Union of India,*[107] the Supreme court of India, expanded on right to life under the Constitution of India to include right to access and receive a minimum standard of treatment and care in public health facilities including "access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behavior."[108]

In the landmark case of *Justice Puttaswamy* v. *Union of India,*[109] the Supreme Court of India recognized sexual and reproductive autonomy as essential choices safeguarded by the right to privacy. It held that "Privacy encompasses the safeguarding of personal intimacies, the sanctity of family life, marriage, and procreation, the home, and sexual orientation... It upholds individual autonomy, acknowledging one's capacity to govern crucial facets of their life." [110]

This verdict marks a significant advancement in aligning SRH-related laws and policies of India with a rights-based approach for women, and has prompted scrutiny of laws, such as the Medical Termination of Pregnancy (*hereinafter* referred to as 'MTP') Act enacted in 1971[111] that originally aimed at population control approach to maternal protection, and did not sufficiently emphasize the SRH and well-being of women. However, this Act represents a notable enhancement compared to section 312 of the IPC in terms of specifying pregnancy termination only through a certified medical practitioner with a recognized medical degree.[112]

[106] *Ibid.*
[107] AIR 2016 SC 4405.
[108] *Ibid.*
[109] *Justice Puttaswamy* v. *Union of India,* AIR 2017 SC 4161.
[110] *Ibid.*
[111] The Medical Termination of Pregnancy Act (MTP Act), 1971.
[112] *Ibid.,* s.3.

Progressive shifts in the MTP Act

Supreme Court of India's historic decision in the *Puttaswamy*[113] and subsequent rulings like *Navtej Singh Johar* v. *Union of India*[114] and *Joseph Shine* v. *Union on India,*[115] paved way for the amendment in the MTP Act, 1971 and its Rules. Eventually, the MTP (Amendment) Act, 2021 was approved on March 25, 2021. Many scholars applauded these decisions and called "for a reevaluation of the "conditional right" approach to abortion under the MTP Act as well as the continued criminalization of abortion in India."[116]

The MTP (Medical Termination of Pregnancy) Amendment Act, 2021 has introduced significant provisions as follows:

i. It allows termination of pregnancies up to 20 weeks in cases of contraceptive failure, extending this right to unmarried women as well.

ii. For termination, the Act mandates the opinion of one Registered Medical Practitioner (*hereinafter* referred to as 'RMP') for pregnancies up to 20 weeks, while two RMPs are required for pregnancies between 20-24 weeks. After 24 weeks, termination is allowed only with the opinion of a State-level medical board, specifically for cases involving substantial fetal abnormalities.

iii. The upper gestation limit has been extended from 20 to 24 weeks for special categories of women such as rape survivors and victims of incest.

iv. The Act emphasizes confidentiality, ensuring that the identity of women whose pregnancies have been terminated remains protected except where authorized by law.

v. The provision of RMP reflects a direct commitment to women's reproductive health[117].

vi. The amended Act expands the eligibility for MTP due to contraceptive failure from being available accessible to all women. It extends the gestational age limit for MTP to 24 weeks for rape survivors and permits termination at any time in case of fetal abnormalities, in contrast to the previous limit of 20 weeks for all indications. The amended Act also increases the requirement for third-party authorization, mandating permission from one RMP up to 20 weeks and two RMPs from 20-24 weeks, with the additional requirement of approval from a medical

[113] *Supra* note 109.
[114] *Navtej Singh Johar* v. *Union of India,* AIR 2018 SC 4321.
[115] *Joseph Shine* v. *Union on India*, AIR 2019 SC 4898, at 33.
[116] Dipika Jain & Payal K. Shah, "Reimagining Reproductive Rights Jurisprudence in India: Reflections on the Recent Decisions on Privacy and Gender Equality from the Supreme Court of India", 39 *Columbia Journal of Gender & L*aw 1 (2020).
[117] *Ibid*.

board beyond 24 weeks. Furthermore, it introduces stricter penalties for the disclosure of a woman's identity.

Although the amended Act aims to reduce preventable maternal mortality in alignment with Sustainable Development Goals (*hereinafter* referred to 'SDGs') by improving access to safe abortion services, there are differing opinions on termination, reflecting the challenge of balancing reproductive rights with the state's responsibility to protect life. The issue has also been raised that the requirement for abortions to be performed by specialized doctors in gynecology or obstetrics could pose challenges in rural areas due to a shortage of such medical professionals in community health centers.

The MTP (Amendment) Rules, 2021

The Ministry of Health and Family Welfare (*hereinafter* referred to 'MoHFW') of India on October 12, 2021 issued the Medical Termination of Pregnancy (Amendment) Rules, 2021 amending the MTP Rules, 2003 (*hereinafter* referred to as 'MTP Rules 2021'). Pursuant to clause (b) of sub-section (2) section 3 of the MTP Act 2021, Rule 3B has been included in the MTP Rules, 2021.[118] This Rule lays down the following eligibility criteria for termination of pregnancy up to 24 weeks:[119]

(a) survivors of sexual assault or rape or incest;

(b) minors;

(c) change of marital status during the ongoing pregnancy (widowhood and divorce);

(d) women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)];[120]

(e) mentally ill women including mental retardation;

(f) the foetal malformation that has a substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped; and

(g) women with pregnancy in humanitarian settings or disaster or emergency situations as may be declared by the Government.

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[118] Medical Termination of Pregnancy (Amendment) Rules, 2021, *available at*: https://sansad.in/getFile/loksabhaquestions/annex/177/AS186.pdf?source=pqals#:~:text=(b)%20%26%20(c),made%20more%20accessible%20to%20them. (last visited on March 31, 2023).

[119] *Ibid.*

[120] The Rights of Persons with Disability Act, 2016, s. 25 (2) (k), *available at*: https://www.indiacode.nic.in/bitstream/123456789/15939/1/the_rights_of_persons_with_disabilities_act%2C_2016.pdf (last visited on March 31, 2023).

WHO and other organizations have welcomed the amended MTP Act for expanding permissible pregnancy termination grounds including some protective procedural and substantive measures.[121] In sum, MTP Amended Act and corresponding Rules behold the substantial scopes in governing matters related to abortion which directly-indirectly impacts overall reproductive health right.

Judicial Trends upon amendments on MTP Act and Rules

The judiciary of India has further contributed by applying and interpreting the provisions, discussed below:

Pregnancy termination in extreme health conditions

The case of *Pratibha Gaur* v. *Government of NCT of Delhi*[122] brought a landmark legal precedent. Despite crossing the 24-week limit under the MTP Act, Gaur sought termination due to severe fetal cardiac anomalies. She argued that continuing the pregnancy would severely harm her mental health, asserting her reproductive rights under article 21 of the Indian Constitution. The court ruled in her favor, emphasizing that reproductive choice is integral to personal liberty. Despite the statutory limit, the court permitted termination under section 3(2)(b)(i) of the MTP Act, highlighting the importance of considering substantial fetal abnormalities that impact mental health as valid grounds for late-term termination. This judgment underscores the importance of prioritizing women's reproductive health and well-being, especially in cases involving severe fetal abnormalities, and aligns with previous legal precedents that emphasize women's rights and health.

Hence, the courts have alluded to the nexus between non-cognizable provisions under DPSP to the fundamental rights and the human rights treaty obligations of India, and later the progressive amendments under the MTP Act, to provide approaches, ways and strategic tools for the effective implementation of SRH rights. These rulings reflect the freedom, entitlement, empowerment and well-being approach inherent to the lifespan and HRA approach to sexual

[121] World Health Organization, "India's amended law makes abortion safer and more accessible", (April 13, 2021). See also, Pai SN, Chandra KS., "Medical Termination of Pregnancy Act of India: Treading the path between practical and ethical reproductive justice" *Indian Journal of Community Medicine* 510 (2023).
[122] *Pratibha Gaur* v. *Government of NCT of Delhi*, DHC, 2021, LNIND 2496, W.P.(C) 14862/2021.

and reproductive health. However, reproductive justice as a social justice approach "will only be achieved through broader social struggle" [123]

Termination of pregnancy as fundamental right of women

Recently in 2023, the Bombay High Court ruled in favor of a woman's right to choose a medical abortion even beyond gestational limit imposed by the MTP Act.[124] The petitioner, ABC, sought permission for a late-term abortion due to severe fetal abnormalities discovered after the gestational limit. The court held that the decision to terminate a pregnancy should not be solely at the discretion of a medical board but should respect a woman's fundamental right to make decisions about her body and reproductive health.[125] The court found that the gestational limit infringed upon women's autonomy and dignity and should not restrict their reproductive choices. The decision emphasizes the need for updated legislation that considers evolving medical knowledge and the changing needs of women. It also recognizes the importance of preserving women's decisional and reproductive autonomy.[126]

This judgment has significant implications for women's reproductive rights in India, marking a crucial step towards gender equality and reproductive justice. The decision sets a precedent for the protection of female reproductive rights and ensures that abortion remains a safe and legal option for women in India.

Urgent termination of pregnancy of minor girl

In the recent case of a minor,[127] who had been involved in an accident, petitioned the court for the urgent termination of her pregnancy. The circumstances leading to this request were highly critical. The petitioner's pregnancy was only discovered after the accident, and it was later revealed that she had become pregnant as a result of sexual assault, leading to her dire situation. The petitioner's medical condition had significantly deteriorated since the accident, with her suffering a cardiac arrest and requiring advanced cardiac life support. Given the precarious nature of her health, the hospital treating her recommended the immediate termination of her pregnancy to prevent further risks to her life.[128]

[123] Jameen Kaur, 'The role of litigation in ensuring women's reproductive rights: An Analysis of the Shanti Devi judgment in India', 20 *Reproductive Health Matters* 21 (July 9, 2012).
[124] *ABC* v. *State of Maharashtra*, Bombay High Court, 2023, WP ST No. 1357 (2023).
[125] *Ibid.*
[126] *Ibid.*
[127] *X* v. *State of West Bengal and others*, Calcutta High Court, 2023, LNIND 2023 CAL 337.
[128] *Ibid.*

The court considered the provisions of the MTP Act, 1971, which allows for pregnancy termination under specific circumstances. Section 3(2) (b) of the Act permits the termination of pregnancy when it exceeds 20 weeks but does not exceed 24 weeks, subject to the opinion of two registered medical practitioners that the continuation of the pregnancy poses a risk to the life of the pregnant woman, or would result in grave injury to her physical or mental health, or would substantially risk physical or mental abnormality in the child is born.[129] Rule 3B of the MTP Rules 2021, further specifies categories of women eligible for termination between 20 to 24 weeks, including minors and survivors of sexual assault. In this instance, as the petitioner was a minor, her mother's written consent was required for the termination, and her mother had already provided such consent in writing.

Given the urgency and critical medical situation, the court ordered the hospital to proceed with the immediate termination of the petitioner's pregnancy, as both statutory provisions and the medical circumstances justified this decision. The court stressed the importance of following all mandatory procedures and certifications during the medical termination of pregnancy, with reports to be submitted to the police authorities both before and after the procedure.[130] This ruling aimed to safeguard the life and well-being of the petitioner in an exceptionally sensitive and critical situation.

Mental health and reproductive health

In one of the cases,[131] the petitioner sought permission for the medical termination of her pregnancy, which had advanced to approximately 25-26 weeks. The petitioner claimed to be a victim of repeated instances of rape between August 13, 2021, and January 24, 2022, leading to her pregnancy. She argued that the continuation of this pregnancy caused significant mental anguish and would further harm her mental health if allowed to proceed. The petitioner relied on section 3(2)(b) and section 3(4)(a) of the MTP Act, 1971, as amended by the Medical Termination of Pregnancy (Amendment) Act, 2021, which permits termination if the pregnancy poses a risk to the pregnant woman's life or grave injury to her physical or mental health. Additionally, section 3(2)(b) provides that if pregnancy results from rape, it is presumed to cause grave injury to the pregnant woman's mental health.[132]

[129] *Id.*, at para. 6.
[130] *Id.*, at para. 6.
[131] *X.* v. *State of Maharashtra*, Bombay High Court, 2022, LNIND 2022 NGP 18.
[132] *Id.*, at para. 5.

The court considered the Medical Board's opinion and found that the conditions of section 3(2)(b) were satisfied in this case. The Medical Board had opined that continuing the pregnancy would harm the girl both physically and mentally, and if the baby were delivered, it would not receive proper care.[133] Moreover, since the pregnancy was caused by rape, there was a presumption of anguish and grave injury to the pregnant woman's mental health. The court cited several precedents that supported its decision to allow the termination of the pregnancy under these circumstances.[134] It emphasized the importance of adhering to the procedure prescribed in the MTP Act, including obtaining the written consent of the pregnant woman and permitting the Investigating Officer to collect appropriate samples for DNA testing and profiling.[135]

From a reproductive health perspective, this case underscores the significance of timely access to safe and legal abortion services, particularly in situations involving sexual assault and pregnancies that pose risks to the physical and mental health of pregnant individuals. It highlights the role of legislation and legal procedures in protecting the reproductive rights and mental well-being of women and girls in cases of unwanted pregnancies resulting from sexual violence.

Unmarried women's right to reproductive health

In another case,[136] a woman requested authorization to end her pregnancy under the regulations of the MTP Act, 1971, as amended in 2021. The petitioner was an unmarried woman, conceived due to a contraceptive failure within a consensual relationship. She filed a writ petition in the High Court of Delhi, urging the inclusion of unmarried women within the scope of rule 3B of the MTP Rules 2021, allowing termination of pregnancy up to twenty-four weeks in specific cases.

The High Court acknowledged the writ petition regarding the inclusion of unmarried women under rule 3B but did not address other aspects of the petition. Unfortunately, the petitioner reached 24 weeks of pregnancy shortly after. The main issue centered on interpreting the MTP Act and rule 3B concerning unmarried women's rights to terminate pregnancies.

[133] *Id.*, at para. 7.
[134] *Id.*, at para. 8.
[135] *Id.*, at para. 9.
[136] *X* v. *Principal Secretary, Health and Family Welfare Department*, 2022 SCC OnLine SC 1321,

In its interim order, the Supreme Court recognized that denying an unmarried woman the right to a safe abortion infringed upon her personal autonomy and freedom. It stressed that personal autonomy and reproductive choices are safeguarded under article 21 of the Indian Constitution. The court determined that subjecting the petitioner to an unwanted pregnancy would contradict the legislative intent and directed the formation of a Medical Board to evaluate the abortion's safety. If deemed safe, the petitioner would be permitted to proceed with the abortion. The court also emphasized that delays in the judicial process should not prejudice the petitioner's rights.

This case underscores the importance of protecting a woman's right to make reproductive choices, irrespective of her marital status, and emphasizes the necessity of interpreting laws broadly to safeguard personal autonomy and freedom in such matters.

The MTP (Amendment) Act has triggered a surge in legal cases, particularly concerning gestation periods and termination of pregnancies where the Court is carefully observing the scope of the amended MTP Act and the Rules. However, there appears to be a significant gap in addressing socio-economic factors and safeguarding reproductive health rights comprehensively. Moreover, the state's responsibility towards ensuring equitable access to reproductive health services remains underemphasized. A more holistic approach, considering the life course of reproductive health and socio-economic determinants, is imperative to uphold reproductive rights effectively. This entails not only addressing termination rights but also ensuring comprehensive reproductive health services, including prenatal and postpartum care and support.

VI. Scope of HRA and Right to SRH in Nepal

The Interim Constitution of Nepal 2007 marked a shift by explicitly guaranteeing reproductive health as a fundamental right.[137] The judiciary of Nepal has significantly contributed over the decades to the latter development culminating in the acknowledgment of reproductive rights as fundamental rights and human rights, as detailed below:

The case concerning uterine prolapse[138]

[137] Interim Constitution of Nepal 2007, art. 20 (2).

[138] Uterine prolapse occurs when pelvic floor muscles and ligaments stretch and weaken until they no longer provide enough support for the uterus. *Uterine Prolapse: Overview*, *available at*: https://www.mayoclinic.org/diseases-conditions/uterine-prolapse/symptoms-causes/syc-20353458 (last visited on August 10, 2023).

Advocate *Prakashmani* and others filed public interest litigation in 2007 seeking to enforce women's reproductive health rights, based on article 20(2) of the Interim Constitution and human rights treaty obligations of Nepal.[139] They argued that despite government's budgetary allotment, no effective programs addressed uterine prolapse, affecting countless women. The petitioner emphasized the link between physical health and women's social well-being, urging the court to draft a reproductive health bill, establish a special committee, and implement informative programs through media to address uterine prolapse.[140]

The Supreme Court quotes article 12 of ICESCR on the highest standard of physical and mental health and its interpretation to include proper health services during pregnancy and post-natal periods, including free services and adequate nutrition, and article 10 of CEDAW requiring access to health information.[141] The decision emphasizes human rights treaty compliance not only because it is obligatory to comply with them as pursued by the treaties.[142] The Court declared that constitutional recognition of right to reproductive health alone is insufficient, and that the government must take meaningful action by creating laws and necessary accessible physical facilities for its realization.[143]

It recognized that women's health cannot be comprehended using the same framework as men's due to the profound biological changes women experience throughout their lives.[144] It observed that these health variations extend beyond biology and have significant broader social dimensions.[145] It concluded that uterine prolapse occurs due to a combination of inadequacies including those related to food, access to family planning and awareness, health centers supporting women's physical and mental well-being, and the existence of violence against women.[146] The jurisprudence analyzes the sociogenic factors of uterine prolapse, and seems to align with and implicitly refer to the lifespan approach towards SRH rights.

[139] *Supra* note 2.
[140] *Ibid.*
[141] *Ibid.*
[142] *Ibid.*
[143] *Ibid.*
[144] *Ibid.*
[145] WHO, "Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring", 29 (2006).
[146] *Supra* note 2.

The case concerning safe abortion

The landmark case of *Lakshmi Dhikta*[147] involves a financially struggling woman in Nepal's far-western region, a mother of 5, who faced an unwanted pregnancy. Due to financial constraints, she could not afford even NRs. 1,130 as an abortion cost and was compelled to continue the pregnancy and give birth. In her writ petition, she claimed the violation of her fundamental rights to reproductive health and equality including protection through special measures[148] as well as right to self-determination under article 1 of ICCPR and ICESCR, and demanded that a writ of mandamus be issued for making abortion services accessible, affordable and reliable.[149] Here, the Supreme Court linked the right to SRH to fundamental rights to life and social justice, and emphatically observed that pregnancy and abortion concerns "cannot be regarded as personal problem and isolated from the public duties of the State."[150]

The Supreme Court issued a writ of mandamus, including directives to:[151]

a. enact a comprehensive abortion law;
b. establish a government fund to cover abortion procedure costs; ensure more robust safeguards for women's privacy;
c. promote access to safe services for all women; and,
d. disseminate information about safe abortion services to health service providers and the public.

Shifts in Laws on Right to Reproductive Health

Constitutional guarantees

The above cases have led to significant legal and policy changes, notably the continuation of reproductive health rights in the fundamental guarantees under the existing Constitution.[152] Articles 18 and 38 of Nepal's Constitution guarantee essential protections regarding reproductive rights, encompassing both negative rights against discrimination based on 'marital status' and pregnancy,[153] as well as positive rights ensuring "safe motherhood and reproductive health" for all women.[154] Furthermore, article 47 of the Constitution mandates the enactment of enabling legislation within three years of the Constitution's commencement. By this

[147] *Supra* note 3.
[148] Interim Constitution of Nepal, 2007, art. 13 (1).
[149] *Supra* note 3.
[150] *Ibid.*
[151] *Ibid.*
[152] The Constitution of Nepal, 2015.
[153] *Id.*, art.18 (2).
[154] *Id.*, art. 38 (2).

constitutional obligation, the 'Right to Safe Motherhood and Reproductive Health Act' was passed in 2018.[155]

Moreover, this Act incorporates directives from the Supreme Court, as well as human rights standards, particularly those guaranteed in the CEDAW and its General Recommendations, along with guidelines adopted by the ICPD described earlier.

Highlights on Key provisions of Safe Motherhood Act

Provisions for Safe Abortion

The legislation provides specific timeframes for safe abortion procedures, delineating between 12-weeks[156] and 28-weeks[157] of gestation. Generally, 12-week timeframe underscore the fundamental principle that a pregnant woman retains the right to opt for a safe abortion within this timeframe. It recognizes the importance of providing timely access to abortion services, allowing women to make informed choices about their reproductive health without undue delay. In contrast, the provisions extend the timeframe for abortion up to 28 weeks under specific circumstances, thereby highlighting critical exceptions to the general rule. Beyond the 12-week mark, the decision to undergo abortion becomes complex medical assessments and evaluations.

This extension recognizes the evolving nature of pregnancy and the potential emergence of complications or risks that may necessitate a later abortion procedure. This exceptional provision is permissible, including cases where there is a danger to the life or health of the pregnant woman, instances of fetal abnormalities or disabilities, and pregnancies resulting from rape or incest. By accommodating these exceptions, the provisions seek to safeguard the well-being and autonomy of pregnant women, ensuring that they have access to necessary healthcare services even in more complex or sensitive circumstances.

The involvement of licensed doctors and health workers in evaluating the risks and implications of abortion underscores the importance of informed decision-making and patient-centered care. Through this collaborative approach, the provisions aim to uphold ethical standards and ensure

[155] The Right to Safe Motherhood and Reproductive Health Act (hereinafter referred as Safe Motherhood Act), 2018.
[156] *Id.*, s. 15 (a).
[157] *Id.*, s. 15 (b).

that abortion procedures are conducted with due consideration for both the woman's rights and the potential welfare of the fetus.

These provisions, mainly allowing exceptional conditions anticipate to balance the principles of autonomy and medical necessity, recognizing the diverse circumstances in which women may seek abortion while prioritizing their safety, well-being, and right to make informed choices about their bodies. By delineating clear guidelines and exceptions, these provisions aim to ensure equitable access to safe abortion services and uphold the fundamental rights and dignity of pregnant women. The Act prohibits forced family planning, contraceptive coercion, and sex-selective abortion.[158]

Access to Reproductive Health Services

The Act ensures various assurances, including;

i. access to reproductive health services such as education and counseling;[159]
ii. access to antenatal and postnatal care, and autonomy over family planning,[160] right of individuals irrespective of their gender to access contraceptive information and usage for family planning purposes;[161]
iii. woman's right to safe abortion services under specific circumstances;[162] comprehensive healthcare during pregnancy and postpartum, encompassing nutrition, rest, counseling, and obstetric care;[163]
iv. emergency obstetric and newborn care as an inherent right;[164]
v. safe and confidential abortion services by designated providers in specified health institutions;[165]
vi. confidentiality and privacy of information related to reproductive health services,[166] including records of births, issue birth certificates, and track infant mortality, miscarriages, and abortions;[167]

[158] *Id.*, s. 17.
[159] *Id.*, s. 3 (1).
[160] *Id.*, s. 10.
[161] *Id.*, s. 3 (4).
[162] *Id.*, s. 15.
[163] *Id.*, s. 3 (6).
[164] *Id.*, s. 3 (8).
[165] *Id.*, s. 19 (1).
[166] *Id.*, s. 4.
[167] *Id.*, s. 9.

vii. paid maternity and paternity leave;[168]

viii. reproductive health morbidity care, including examination, counseling, and treatment.[169]

Most importantly, the Act prioritizes the provision of affordable and secure reproductive health services for individuals across their lifespan,[170] ensuring accessibility and sustainability.

VII. Comparing the Right to SRH in India and Nepal

In this section, the article examines the legal framework of SRH in India and Nepal by way of comparison. The comparison between India and Nepal's laws concerning sexual and reproductive health of women is both pertinent and insightful due to the shared socio-cultural and geographical contexts between the two nations. India and Nepal, despite differences in population size and economic development, face similar challenges in ensuring comprehensive healthcare services, particularly regarding sexual and reproductive health. While comparing the status and situation of reproductive health laws and jurisprudence in these countries, certain similarities and differences emerge:

1. Both Nepal and India have acknowledged their responsibility to uphold the right to reproductive health by ratifying key human rights treaties, including the ICCPR, ICESCR and CEDAW, whose SRH approaches have been discussed in this paper, reaffirmed by judicial interpretations in both nations.
2. Sexual and reproductive health has a constitutional basis in both nations. In India, judicial interpretations of the Constitution, particularly the expansive interpretation of fundamental rights in relation to SRH through the DPSP, have led to a broader understanding of the right to life and equality. Landmark cases like *Laxmi Mandal*[171] among others have highlighted the intrinsic connection between reproductive rights and the broader framework of right to life and human dignity. The transformative *Puttaswamy*[172] judgment further bolstered SRH rights by recognizing an individual's sexual and reproductive autonomy as a core aspect of the right to privacy. The evolution of the MTP Act in India, influenced by judicial activism, reflects a commitment to expanding reproductive choices and safeguarding women's health. Subsequent amendments, driven by progressive jurisprudence, have broadened the grounds for permissible pregnancy termination and stressed the importance of medical consultation, indicating a comprehensive approach to SRH.

[168] *Id.*, s. 13.
[169] *Id.*, s. 20.
[170] *Id.*, s. 3(9).
[171] *Supra* note 104.
[172] *Supra* note 109.

3. In contrast, Nepal is distinguished by its explicit constitutional recognition of reproductive health as a fundamental right. The shift in the Interim Constitution towards safeguarding SRH rights laid the groundwork for the existing Constitution of Nepal and enabling legislations, including the enactment of the Safe Motherhood and Reproductive Health Rights Act of 2018. Judicial interventions, as seen in cases concerning uterine prolapse and safe abortion, demonstrate the judiciary's dedication to ensuring the meaningful realization of SRH rights. Recognition of the socio-economic and cultural dimensions of women's health aligns with the lifespan approach to SRH, acknowledging the multifaceted nature of reproductive well-being.

Comparison between the MTP (Amendment) Act 2021 of India and Safe Motherhood and Reproductive Health Rights Act (SMRHR) 2018 of Nepal

Similarities

1. Both the MTP Act, 2021 in India and the SMRHR in Nepal represent significant legislative efforts to address reproductive health issues and safeguard women's rights.
2. Both Acts allow for safe abortion under certain conditions and specify gestational limits within which abortion can be sought, albeit with different thresholds.
3. Both Acts require consent from the pregnant woman to seek abortion.
4. Additionally, both Acts emphasize the importance of confidentiality, protecting the identity of women undergoing pregnancy termination.
5. Both Acts permit abortion beyond the initial gestational limit in cases where there is a threat to the life or health of the pregnant woman, fetal abnormalities, or if the conception resulted from rape or incest.

Differences

Objectives**:** While both acts aim to improve maternal health outcomes and ensure access to safe abortion services, they exhibit differences in title, scope, provisions, and approaches.

Grounds for Abortion**:** While both Acts allow abortion beyond the initial gestational limit in cases of threat to the life or health of the pregnant woman, fetal abnormalities, or conception resulting from rape or incest, the specific conditions outlined for each category may differ between the two Acts.

Authorization**:** The MTP (Amendment) Act 2021 in India mandates approval from one or two RMPs depending on the gestational age, along with authorization from a state-level medical

board for terminations beyond 24 weeks. In contrast, the provision in Nepal does not explicitly specify the requirement for multiple medical practitioners' approval.

Additional Provisions**:** The provision in SMRHR Act includes additional grounds for abortion, such as for women infected with a virus deteriorating the immune system (e.g., HIV) or suffering from similar incurable diseases, and if the fetus is likely to become non-viable or unlikely to survive after birth due to fetal impairment.[173] In contrast to Nepal, India does not have specific provisions outlined. Nonetheless, the judiciary may interpret the MTP Act and Rules to broaden their scope. For instance, the MTP Act does not provide a clear definition of "substantial fetal abnormalities." Consequently, the Court sought guidance from the practices followed in other countries to interpret this expression.[174]

Harmonizing legal framework: The "Safe Motherhood and Reproductive Health Right Act" serves as a comprehensive legal framework aimed in advancing safe motherhood and reproductive health rights, aligning with article 38 (2) of Nepal's Constitution. Consequently, this Act encompasses a wider spectrum of reproductive health rights beyond solely focusing on motherhood. Conversely, India's MTP Act was enacted with a specific thematic focus and isn't designed to comprehensively address all facets of reproductive health rights, as there are numerous other laws. For example, in 2017, an amendment to section 5 of the Maternity Benefit Act, 1961,[175] extended paid maternity leave from 12 weeks to 26 weeks, with up to eight weeks allowable before the expected delivery date. Additionally, section 5(5) of the Act also allows for the possibility of remote work, subject to agreement between the employer and the woman, based on the nature of her assigned tasks. This practice could be considered as one of the effective methods that Nepal could adopt to ensure the alignment of women's reproductive health rights in the workplace.

VIII. Conclusion

Not merely limited to reproduction, the human rights-based life span approach to sexual and reproductive health advocates the integration of biological (biogenic) and socio-cultural (sociogenic) elements. Far too often the sociogenic aspects of sexual and reproductive health are ignored in comparison to its biogenic aspects. For instance, the GR 24 laid down by the CEDAW Committee, which outlines the life-span concept, has received less attention from the legal community. This lack of focus has led to less strategic litigation on the topic, and where

[173] *Supra* note 170., s. 15 (d).
[174] *MRS. X* v. *GNCTD*, 2022 SCC OnLine Del 4274.
[175] The Maternity Benefit (Amendment) Act, 2017.

such litigations have occurred, they have been inadequate in fully integrating the life-span approach as advised by GR 24.

In India and Nepal, the human rights-based approach to sexual and reproductive health has progressed through constitutional, judicial, and legislative efforts, driven by international commitments and societal expectations, offering potential for mutual learning. Despite significant progress in adopting a HRA to SRH in both India and Nepal, challenges persist. Socio-economic disparities, cultural norms, and access barriers hinder the full realization of SRH rights for all women. Moreover, legal frameworks in both countries, while evolving, still have limitations in addressing the entirety of sexual and reproductive health needs, particularly for socio-economically marginalized intersectional women.

Having studied the normative legal domain of India and Nepal on the issue, the article recommends: *first*, India may adopt a comprehensive overarching legislation concerning Sexual and Reproductive Health Rights. Since the MTP Act is limited in its scope, an umbrella Act so as to harmonize with human rights standards, constitutional spirit and court directives. The said umbrella law may stress on state's positive obligation relating to guaranteeing the access to reproductive health services; *second*, Nepal may adopt good practices of India such as the 'court on motion' procedure observed by Indian courts in collaboration with relevant NGOs. *Finally*, to achieve the end result, law and human rights professionals, including researchers and public interest litigators of both countries should conduct targeted research to analyze how laws impact women's' reproductive health across different life stages. They should then use their research as empirical testament for strategic litigation, policy advocacy on gender equality, and contribute to scholarly discussions for the effective implementation of laws and enforcement of Courts' rulings and directives on sexual and reproductive health rights and wellbeing of women especially focusing vulnerable factors and needs.

In a nutshell, *Chunni*'s narrative symbolically underscores the critical importance of prioritizing women's sexual and reproductive rights. By studying her plight, we discern the imperative need to review the policies and foster societal changes aimed at preventing the recurrence of similar injustices.