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UNDERSTANDING REPRODUCTIVE RIGHTS.

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I. INTRODUCTION:

Considering the significance that's been placed on the role of women as a nurturer, it is not surprising that debates have sprung up on all sides regarding the right of reproduction. However, what was first envisaged as a form of protecting women during the process of reproduction, reproductive rights have now come to mean a bundle of rights including the right to health that is available to all individuals to protect their sexual health. The intention of this paper shall be to examine what all encompasses the 'reproductive health rights' as understood today, as well as the duties that have been placed on States to implement and enforce such rights.

II. DEFINITION OF REPRODUCTIVE RIGHTS (WORLD HEALTH ORGANIZATION):

"These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence.[1]*"*

III. WHAT ARE REPRODUCTIVE RIGHTS?

A basic understanding of the Right to Reproduction can be described as thus: 'The right enshrined in every individual as to the decision of whether or not to reproduce'. However, such a definition becomes too simplistic in its understanding when you look at the scope of issues associated with reproduction and sexual health. The issues historically have varied in the following ways: Depending on the cultural influence, the option of abortion is not a fully available choice to most women in many States. On the other hand, forced pregnancies are common in States like India if the child from the pregnancy is found to be female. Many third world States also have higher maternal and infant mortality due to lack of hygienic healthcare

[1] Programme of action of the International Conference on Population and Development, Cairo, 1994. New York: United Nations; 1995: paragraph 7.2-7.3.

amenities; or because the mothers did not receive the right medical care during pregnancies. In other States, the amenities available in regard to family planning (i.e. forms of birth control) are next to nil. While these issues may not plague the rich upper-class societies, they are always a problem in families of a lower economic background, especially in countries of a high population like India.

Hence, it becomes important to have a wider understanding of not just the right to reproduction but the right to *reproductive health*. Reproductive health rights can be defined as, "*human rights that uphold reproductive health and well-being, including rights that protect the ability to decide whether and when to reproduce, guarantee reasonable access to adequate reproductive health services, minimize social conditions that may undermine reproductive health and related decisions, and strengthen health and social systems to support good reproductive health."*[2]

This definition helps to include the ability to obtain healthcare, and access adequate health services ensuring that healthcare and health systems thus become a central tenant in reproductive rights. This idea is further explored by Lance Gable in introducing the convergence between the Reproductive Rights Model and Right to Health Model, to obtain 'Reproductive Health Rights'[3]. i.e., the author combines the decisional aspects of the Reproductive Rights Model (it provides for the rights and liabilities available to individuals), with the foundational aspects of the Right to Health Model (which provides for the conditions and detriments that may affect individuals in regard to healthcare).

While the models itself may be distinct as to their approaches, combining the two would provide an effective framework for reproductive health rights. By combining the two, the author aims to achieve a balance by which women will be invested with the right to privacy, dignity, decisional and bodily autonomy, and their access and availability to reproductive healthcare services will be improved.

IV. REPRODUCTIVE HEALTH RIGHTS AND THE LEGAL OBLIGATIONS ON STATES:

Simply defining and understanding the reproductive rights available to individuals, is not enough. There must also be adequate forms of recognition of these claims in the form of legal

[2] Lance Gable, 'Reproductive Health as A Human Right', (2011) 60:4.
[3] *Id.*

obligations. These may be made by States as part of an international covenant/treaty or through the implementation of their own laws. Either of the two would be a form of ensuring that the State is held to the promise of reproductive health rights for all individuals as in the capacity discussed above.

The benefit of combining the two models as discussed earlier is that the underlying determinants of healthcare will be specifically enforceable against reproductive rights, as well. Since reproductive rights and the right to health is combined to form the right to reproductive health, this means that the States have to comply with the standards for reproductive health as they already provide for under the right to health. One of the main conventions governing the same is the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The covenant was established by the Committee on Economic, Social, and Cultural Rights (CESCR) to create a guideline to which States could adhere to, providing a way to make sure they provided adequate standards of living (economically, socially, and culturally), for all individuals living within them.

General comment No.14 of the ICESCR (Art.12), mainly established the above attainable standards of health that had to be followed. Article 12 mainly consisted of the four As: *Availability*, *Accessibility*, *Acceptability*, and *Quality*. *Availability* meant that there must be sufficient quantities of health care facilities and public health facilities. It was also applicable to the determinants of good health, i.e. States would have to ensure the availability of safe drinking water, trained healthcare personnel, essential drugs, hospitals, clinics, etc. *Accessibility* is considered one of the most important features, as it would force States to ensure that the health care services and determinants were not simply available but also physically and economically accessible.

It also wrote down that States had to ensure non-discriminatory treatments towards all individuals. Accessibility would also mean information accessibility, i.e. States would also have to make sure all individuals are able to seek and receive information necessary reproductive information. Further, Article 12 also required that such facilities be *acceptable* (respectful and sensitive), and also of *good quality*.

While sexual health and reproductive rights had been mentioned in Article 12, the Committee felt that reproductive health rights are so crucial, that they published a General Comment 22 on the Right to sexual and reproductive health. This further increased the obligation on States

from what was already included in Article 12 to more general and specific obligations. The general obligations meant that States had to ensure non-discrimination when it came to reproductive health rights, and the special obligations meant that the States had to *respect, protect, and fulfil* individuals' reproductive health rights. The four As under Article 12 were also expanded to also mean that sexual and reproductive health services had to be *available, accessible, acceptable and of high quality.*

V. IMPLEMENTATION OF REPRODUCTIVE HEALTH RIGHTS:

In order to understand the evolution of reproductive health rights in the States, the best method would be to examine actual cases that have taken place.

In one particular case in Brazil, a low-income Afro-Brazilian woman died after labour (producing a stillborn baby), due to the lack of adequate healthcare facilities and treatment. The lack of timely access to healthcare was seen as a crucial reason in her passing. When referred to the Committee on Elimination on all forms of Discrimination Against Women (CEDAW), they held that States are responsible for providing timely access for maternal healthcare for all women[4]. The case highlighted that healthcare was to be provided regardless of race, caste, creed, etc. and discrimination could have absolutely no place in providing good healthcare and health services. Furthermore, the State of Brazil would be in violation as they had a legal duty to provide good, safe, accessible, and adequate reproductive health services.

In the Laxmi Mandal case[5], the Supreme Court of India decided making the individual travel significant distance in order to obtain health services (which were also eventually not provided), would be a violation of the duties imposed on the State, and a violation of her right to health under Article 21 of the Indian Constitution. The State had a duty to make sure that health services are freely available and accessible. Accessible should not mean only one or two hospitals per state, but rather that hospitals that are willing to admit and treat patients at affordable costs should be made available at closer intervals. The Court also held that information accessibility is as important as physical and economic accessibility; as in this case, if the information had been given, it would have saved the life of the mother. Again, the principle emerges that States (as based on Article 12 of ICESCR) have a legal obligation to ensure that health services are available, accessible, and of good quality. The problems

[4] *Maria De Lourdes da Silvia Pimentel (Alyne) vs. Brazil,* Communication No. 17/2008 decision on 30th November 2007.
[5] *Laxmi Mandal vs. Deen Dayal Harinagar Hospital*.

associated with the implementation of reproductive health rights is not only found in lesser developed countries. The Western States in highly developed areas have also struggled with ensuring that their abortion laws remain non-discriminatory, accessible and available. The State of Ireland was a party in a case in 2016[6], whereby the Human Rights Committee found abortion laws of Ireland to be discriminatory and against the right of equality. The Committee highlighted that reproductive health rights should not be discriminatory in its application and must apply equally to all.

In 2016, the US Supreme Court also held[7], that a Texas Bill was unconstitutional since it placed significant burdens on women's right to abortion. The Court held that any law which prevents the availability of healthcare (clinics were shut down as the cost to run the clinics were increased by 150%) and its accessibility (women had to travel over 150 miles to receive an abortion), would be a violation by the State. Echoes of Article 12 of the ICESCR can also be found where the Court reiterates that abortion is a part of reproductive health and hence States cannot restrict the availability and accessibility of the clinics that provide such services.

VI. CONCLUSION:

On analysis, of all the above cases, it is easy to see that Committees and Courts have consistently upheld the reproductive health rights under General Comment No. 14 and 22 of the ICESCR. While States, in general, have provided healthcare services, in the less developed States there is a problem with providing accessible *and* affordable service. In both the cases in Brazil and India, the mothers passed away due to a lack of adequate services or the fact that she couldn't afford better services.

Lower-income women in such countries shouldn't have to pay with their life for the fact that their countries haven't increased funding for the public healthcare sector. At the same time, lower-income women in developed countries also suffer as their States continue to create more barriers to them receiving adequate reproductive health services. As evidenced by the above cases, the lack of reproductive health services or the restrictions placed on it continues to come from places of discrimination, or even cultural and social differences. It could either be that legislatures are not convinced that reproductive health is an important issue (the lack

6 Amanda Jane Mellet vs. Ireland.
7 *Whole Women's Health vs. Hellerstdt*, 579 US _ (2016).

of female representation could be a strong indicator why), and also that the cultural and social ideas prevent conversation around reproductive sexual health services. In many States, sex and sexual health continue to be very taboo topics that further prevent individuals from receiving full information regarding their health rights. The only way to overcome this is if States put aside cultural and societal differences and make guarantying reproductive health services that are available, accessible in all forms, acceptable, and of high quality- a top priority. The duty is upon the States to make sure that even more individuals do not meet the same consequences as the women in the above cases. States should and must, do better.