CHAPTER 6

CONCLUSION AND SUGGESTIONS

The current focus on reproductive rights/health in India marks deep concern as reproductive health needs have been largely neglected and that the consequences of this neglect has been reflective, particularly for women. There is a need to re-orient India's traditional population programme which focused mainly on demographic targets, contraceptive prevalence and female sterilization. The emergence of the concept of reproductive rights demands more comprehensive focus on reproductive health needs in ways which are sensitive to the socio-cultural constraints women face in acquiring services and expressing health needs.[1]

Initially, reproductive right was understood as the balancing of the population with the economic demands or realities in the society. It is of course naïve to assume that population control is necessary for the development of any society without having facilities for family planning measures. India, for example, started with incentives for population growth, but ironically its need for reduction got to a stage where men has to be sterilized without their consent.[2] Indeed, when the concept of reproductive right appears, the government's effort was restricted to providing family planning measures only.

As a result, today there is general awareness about family planning and small family norm. The advantages or disadvantages of these family planning methods would be a subject of concern to medical experts who give advice at the various medical and family planning clinics.[3] However, reproductive rights deals with various human rights and are not restricted to providing family planning measures only. In India, there is very less effort towards other aspect of reproductive rights.

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[1] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March 1-8 Economic and Political Weekly 475 (1997).

[2] M. Adekunle Owoade *"The Legal Implication of Contraception in Contemporary Nigeria"* 14 Indian Socio- Legal Journal 67 (1988).

[3] *ibid*

Reproductive rights necessitate facilities to men and women to have highest standard of sexual and reproductive health. It involves the right to make decision about reproduction- how and when to have child. It also includes various other rights such as right to safe and affordable facilities for abortion; right to pre-natal and post-natal care, right to choose family size and spacing of children; right to adopt artificial insemination etc.

Presently, the concept of reproductive right is much wider with the interpretation of the term 'reproductive right' within International Instruments. Today, they are called as part of human rights and thus includes within it-right to life, security and liberty; right to privacy; right to health; right to marry and to found a family; right to spacing and numbering of children etc.

Conversely, the new reproductive technologies have changed the face of the traditional reproductive rights issues. Reproduction is more of clinical issue today. Medical science along with bioscience has developed many techniques to satisfy the people who were disheartened for being childless. Now a days infertility clinic are mushrooming almost in all places in India. It is not clear, what is being done in infertility clinics, with what success, at what risk, under what ethical guidelines, under which legal formalities. The issues in connection with these aspects are manifold (as discussed in Chapter IV).

For many decades now maternal health has been recognized as a crucial area of concern. Access, safety and legality issues regarding abortion and abortion services in India have assumed serious dimension in the context of women's reproductive health needs. The Abortion Assesssment Project- India (AAP-I) an all India research study that commenced in August 2000, was initiated with the objectives of assessing ground realities through rigorous research.[4]

[4] Ravi Duggl, Vimala Ramachandran *"Urgent Concerns on Abortion Services"* March 6 Economic and Political Weekly 1025 (2004).

In a two–day National Consultation with experts working on reproductive health issues across the country, held in Delhi in November 2003, the following issues as needed urgent attention[5].

- Changing the mindset of people regarding adoption of abortion as preventive measure.
- Integrating abortion services under primary health centers through a strengthened RCH programme- which would automatically enhance women's access to abortion care services.
- Promoting safer technologies by changing the mindset of providers away from unnecessary use of curettage.
- Strengthening regulation of abortion facilities to evolve minimum standard for quality care and accreditation.
- Promoting safe spacing methods of contraception to reduce the need to resort to abortion as a spacing method.
- Broadening the base of providers by training paramedics for early trimester abortions as is done in many countries like South Africa, Bangladesh etc.
- The need to widely display certification status of abortion facilities so that women can recognize a safe abortion facility.
- The need to educate providers on ethics of sex- determination tests and respecting the provisions of the Pre-Natal Diagnostic Technique Act.
- The need for medical associations to get active in training abortion providers, especially those in the private sector.
- Promoting apprenticeship as a method of training.
- Reskilling of traditional providers to play alternative roles like accompanying supporting abortion sectors to safe abortion facilities.

The various studies undertaken under the Abortion Assessment Project- India clearly indicate that neither the public nor private abortion services have fully measured up of the abortion seekers. While private providers need to be regulated and made accountable to the law as well as educate about safer technologies for

[5] *ibid* at pg. 1026.

improvement of both safety and quality of abortion services, the public sector needs to extend its presence, especially in rural areas, as well as strengthen the provision and quality of existing services to determine up to the satisfaction of abortion seekers. The RCH second phase being planned currently needs to be absorbed in serious note requires the strong strategy if reproductive health and health care is to improve in India.[6]

Whatever the dimension underlying women's poor reproductive health is behavioural concern including lack of autonomy and inegalitarian gender relations. Few studies provide insight into these issues. The constrict women face in attaining good reproductive health- in terms of lack of decision- making authority, freedom of movement and control of economic resources, poor information and education and socio-cultural barriers to recognizing, articulating and seeking care for health problems are critical to understand the correlation of every dimension of reproductive health. These needs to be incorporated into all the health policies especially reproductive health and health policies of the government.[7]

In short, reproductive health data needs in India continue to be considerable. The absence of rigorous data-both quantitative and qualitative- on most aspects of the reproductive health situation remains an important stumbling block in convincing policy- makers of the need for a broader orientation for current family welfare programmes.[8]

There is no proper legal framework to address reproductive health situation and thus, it continues to be incomplete and patchy. Although, the National Family Health Survey (NFHS) has succeeded in updating and enhancing our data base, it has not been able to address some major reproductive health issues that lend themselves to being dealt with in large surveys. Among them, maternal health status

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[6] Ravi Duggl, Vimala Ramachandran "*Urgent Concerns on Abortion Services*" March 6 Economic and Political Weekly 1025 (2004).

[7] Shireen J. Jejeebhoy "*Addressing Women's Reproductive Health Needs*" March Economic and Political Weekly 475 (1997).

[8] *ibid*

and morbidity and their correlation, quality of care concerns and women's ability to exercise reproductive choice are areas where data gaps continue to exist. Therefore proper legal framework has to be made to incorporate all the gaps that remain unfilled till date. Various gaps on the reproductive health in India which are as follows[9]:

i) Safe, effective, affordable and acceptable methods of family planning of choice.
ii) Safe child bearing and access to appropriate health-care services.
iii) Abortion and access to safe and affordable services.
iv) The capability to re-produce- infertility
v) Prevention and care of gynecological morbidity.
vi) Reproductive health of adolescents particularly girls.
vii) Access and of quality of re-productive health care.
viii) Informed reproductive choice.

Now, extending towards other areas of reproductive rights, the most popular measure to avoid unwanted pregnancy is abortion, it is well established fact that neither lack of access to safe procedure nor its illegal status deters women from having abortion. Those who are affluent and can pay for the services of qualified medical practitioners can go for safe procedure and the poor and marginalized section of the community who do not have the financial resources to do so will remain victim of unhygienic and unsafe procedure. It is also very well known that in countries where abortion is illegal, women who have the resources can easily obtain the services of qualified professionals.[10] But those unable to pay high price might suffer risk of life due to unsafe abortion.

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[9] *Supranote* 7 at pg.480.

[10] Azim A. Khan Sherwani *"Illegal Abortion and Women's Reproductive Health"* 3 Supreme Court Journal 122-123 (1997).

There is a need to hold up the campaign for legal and safe abortion to protect the hundreds of thousands of women who die due to unsafe illegal abortions and the sufferings of so many others who endure the physical and mental anguish of abortion.[11]

The best situation would be for abortion to be regulated by the general health law and for abortion performed without the women's consent to be regarded as illegal. The general health law could regulate counseling for women who have to take such a decision and the quality of care given to women who want to have an abortion.[12]

There is a need to popularize the concept of reproductive rights and women's experiences and also to explain current issues such as- family planning, abortion, AIDS, safe delivery etc., from the stand point of women's health and reproductive rights. There is also a need to evolve a current and composite profile of women's health that goes beyond maternal and fertility description and includes women's life cycle problems, problems derived from socio-economic deprivation and problems derived from skewed gender relations.[13]

Abortion should be safe to protect the life and health of women; well-equipped institutions, the most adequate methods, good follow-up, regular check-ups, counseling to make the decision; all this should be available to women. Social security should cover the costs of the operation.

The urgent requirement is wider and strong demand for action in order to force these issues into public consciousness and onto the political agenda. The first task is to break the mould of silence. The world at the close of 20th century is guilty of immense failure to realize safe motherhood and to remain deaf to the cries of so many women and the sadness and sufferings that travel in the name of maternal morbidity and mortality.[14]

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[11] *ibid*

[12] *ibid*

[13] *ibid*

[14] *Supranote* 10.

Abortion is used as an easily available option for population control in India. The legalised abortion recognizes that women have the right to interrupt their pregnancies if they see no other way to prevent an undesired birth.[15]

Recently, many new reproductive technologies has been made like-amniocentesis test which serve as an excellent purpose in detecting genetic disorder of the foetus and finding out whether a child born would be deformed or abnormal. But, the object of amniocentesis is being misused to find out the sex of foetus and then carrying out the abortions with a view to get ride of female foetuses. On moral ground, the decision to abort a foetus on the basis of a child's sex is an ugly decision and till now there is no strict law to prevent such practices. It is pity that this life saving technique (ultrasound and aminocentisis) is sometimes used for denial of life to an unborn person only on the basis of gender. As many as 50,000 female foetuses are aborted every year after such test.[16] Reproductive rights of women is endanger with such practices as decision to have or not to have child will automatically influence by such test.

Though, it will be wrong to ban amniocenteses per se as it is an important clinical procedure highly beneficial to trace genetic disorders. What is required is to ban sex determination with more stringent law with full determination and political will.[17] The existing legislation is incapable of curbing the issue of sex selective abortion as it is evident from the surveys conducted which shows declining female sex ratio.

The age of globalization where information technology is fast growing and women's liberation is a slogan, there are villages and towns where girls are killed even before their cries leave their throats. Some are even killed in their mother's womb, unseen and unheard.[18] The reproductive rights of women must ensure environment where women are not discriminated simply because of their sex.

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[15] Shakeel Ahmad *"Legalised Abortion : A Gender Selective Foeticide"* 31 Civil and Military Law Journal 234 (1995).

[16] *ibid*

[17] *ibid*

[18] Preeti Mishra *"Female Foeticide :A Violation of Human Rights"* 21&22 Law Review (Lucknow) 71 (1999-2000&2000-2001).

It is the harsh truth that the girl child is perhaps the most socially disadvantaged. At every stage of her life cycle from conception to adulthood, she is vulnerable to Human Rights abuses. It is necessary to protect the rights of the girl child- particularly her right to be born, her right to remain alive and not to be aborted purely because she happens to be a girl. Pre-natal sex determination test is a basic Human Rights violation. Female foeticide is an extreme manifestation of gender violence against women. Female foetuses are selectively aborted after pre-natal sex determination. It has been accepted by demographers that there exist a link between elimination of female fetuses and widening sex ratio.[19]

Besides, there has been no initiative on the part of the government to push for the implementation of the Pre-Natal Diagnostic Technique Act. It suffered the same fate as the other social legislation like- dowry, child marriage, sati and others. The machinery required to enforce the Act at the State and the district levels is not put into place, the required resources were not provided and there was a general unwillingness on the part of various government bodies to take the Act seriously. Further, the family planning programme coupled with the bias for male children in India added pressure on families to depend on sex selection to provide them with the desired family composition. Also, the medical profession and medical associations remained silent over such malpractice by their members.[20]

A ban on government institutions providing such services led to the proliferation of private diagnostic centers offering cheap sex determination test. Centre and state government should take steps for vigorous implementation of the said Act and should not merely treat it with their usual complacency. Registration of ultrasound clinics nursing homes and laboratories should be made mandatory, facilities of amniocentesis and others should be restricted to government hospitals only where it can be easily regulated whereas, ultra-sonography which is used for a host of other purposes can be allowed in private hospitals and nursing homes because by ultrasonography sex of the

[19] *ibid*

[20] *ibid*

foetus can be determined only between 28th and 36th week and abortion is not allowed by law after 20th weeks.[21]

Legal structure should be created for the implementation of the Act at the district level; volunteers have to be actively mobilized to monitor registration and functioning of sex determination clinics in different districts. The Act should also be amended to automatically cover latest technologies that could be misused for sex determination as and when they get into the market, specially those techniques which use pre-conception or during conception sex selection. Besides, all ultrasound clinics should display broads mentioning that they do not conduct sex determination tests on foetus.[22]

One important factor to be realized is that such practice is because of the social environment where there is low status of female in society. This practice can be curbed not by implementing the legislation only but by eliminating the root cause of the issue. Social awareness, equality of women with men, campaigning against female foeticide, full enforcement of dowry prohibition and sexual harassment of women statutes are some of the measures to be adopted for protection of female foetus being killed before they born.

Among other things, the Medical Termination of Pregnancy Act, 1971 and other similar laws that have a direct bearing on the issue of sex ratio should also be reviewed in order to bring coherence among anti-foeticide laws. We need to expose the collusion of unethical medical practitioners with the patriarchal society to fight against the increasing epidemic of female foeticide, non- governmental organization, women's group, health group, the academia, media all important medical professionals, individuals with different priorities and patriarchal forces operating within institutions of the family, government and civil society. A transformation of our gender-bias

[21] *Supranote* 18.

[22] Preeti Mishra "*FemaleFoeticide :A Violation of Human Rights* 21&22 Law Review (Lucknow)73 (1999-2000&2000-2001).

society is necessary for the elimination of female foeticide and perhaps for the protection of reproductive rights of women.[23]

With a significant number of families opting for one or more sons with none or fewer daughters, there will be an alarming drop in sex ratios, which will lead to the long term demographic and social imbalance. Longer life span of women and rising literacy rates have not yet changed the strong cultural preference for sons who will carry the family name, inherit ancestral property, care for parents in old age and light their father's funeral.[24]

A campaign may also be launched to create public awareness about the dangers being posed to the fabric of the society and the physical and mental health of women. Social status of women should also be raised by educating and empowering them through meaningful economic and political participation and by mass mobilization through media. Thus, our challenge today is to initiate a vibrant and effective campaign for women empowerment.

Concern for women's health and well-being has the potential to reflect in the health service provision by way of counseling on contraceptive methods and making them and other concerned persons understand the negative consequences of abortion and the need to avoid repeat abortions. Similarly, providers and/or others from health care facilities can also play the role of educators. The inevitability of women using abortion as spacing method is expected to bring ill-effect to the health of women and it should be communicated to women during abortion care service. However, provider's attitude that women and others concerned were not bothered about using contraceptive may lead to victimizing women seeking abortion care. Besides, their articulation that

[23] Preeti Mishra "*FemaleFoeticide :A Violation of Human Rights* 21&22 Law Review (Lucknow)73 (1999-2000&2000-2001)

[24] Preeti Mishra "*Female Foeticide:A Violation of Human Rights*" 21&22 Law Review (Lucknow) 71-77 (1999-2000-2001).

abortion care service provision fetches their business has a tremendous potential to exploit women's abortion needs. [25]

Sometimes, due to sexual crime such as rape, women may become pregnant where they may not be in the position to keep the child. Women's desperation to get an abortion in such situations naturally tends to be high and thus, leads to having a reduced bargaining power with the medical community. As a result, it is more likely that the quality of abortion care services they receive will be much poorer.[26]

Several social activists, women politicians and feminists from across the country have been advocating for gender equality and demanding equal status and rights for women. Something more needs to be done to educate people. Women organization must ensure that women are given equal position in the society. Women orgnisations have to play a crucial role in educating old orthodox women on this matter for it is these women who more often than not play a decisive role.[27]

The fundamental right to found a family can be for women, a matter of life and death. Laws, social attitudes and traditional values that impair women's reproductive decisions reduce their right to protect their lives and their health as well as those of their children. The United Nations Convention on the Elimination of all Forms of Discrimination against Women (called the Women Convention) guarantees women the human right to plan the size and structure of their families by providing access to abortion and family planning services, as well as equality in decision making process regarding marriage and divorce and other areas of their life.[28]

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[25] Sunita Bandewar "*Abortion Services &Providers Perspectives :Gender Dimensions*" May Economic and Political Weekly 2075 (2003).

[26] *Supranote* 25 at pg. 2077.

[27] H. L. Kapoor "*Foeticide an Inhuman and Brutal Act*" Oct-Dec Journal of Human Rights Oct- Dec 23 (1997).

[28] Malini karkal "*Family Planning and Reproductive Health*" 54 The Indian Journal of Social Work 2 97 (1993).

Establishment of reproductive rights by law is a crucial starting point from which women may begin to exercise all other human rights. The Convention is an important touchstone of progress. It provides hope and a framework for action.[29]

In India, family planning services is not only available without cost, but financial incentives are provided for the acceptors of methods such as sterilizations and IUDs (Intra Uterine Devices). Besides, individual medical practitioners and other non-governmental and private centers, these services are provided through the government funded Primary Health Centers (PHCs) and sub- centers in rural areas and health posts and urban centers in urban areas. As of March 1990, the country had 23,097 PHCs and 138'692 sub-centers, 939health posts and 2648 urban centers. Since, the liberation of the law on abortions, services for induction of abortions are also available free of cost, and as of March 1990, there were 6'681 institutions providing these services (Govt. of India, 1991:227). These figures assure wide availability of services for family planning as well as abortions, for urban as well as rural population.[30]

The question that still remains is, does provision of a large network of centers for all services, ensure women that they can protect their reproductive rights and give them freedom to plan their own fertility? Also, what about the needs for adequate services to protect the health of women?[31]

There is ample evidence that short-term national and international political interests take precedence over the health needs of women. The policies on family planning and abortion, in their formulation, as well as in their implementation, completely ignore the issues of reproductive health of women. Under these conditions, access to the services is determined by social, cultural, economic and political conditions. The status of

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[29] Malini karkal "*Family Planning and Reproductive Health*" 54 The Indian Journal of Social Work 2 97 (1993)..

[30] *Supranote* 28 at pg.298

[31] Shireen J. Jejeebhoy "*Addressing Women's Reproductive Health Needs*" March Economic and Political Weekly 475 (1997).

women and their decision-making power play a crucial role in their ability to receive adequate reproductive health care.[32]

The right to maternity leave and job protection during maternity are important indicators of the extent of which a government is committed to protecting women in their productive and reproductive roles. There is ample evidence that in India, women are forced to avail of maternal leave without pay and maternal protection is denied to women in an unorganized sector. These are clear evidence of the denial of reproductive rights of women.[33]

The patriarchal attitude of the government is indicated by the support that the official agencies provide to the development of new reproductive technology. International Planned Parenthood Federation's Medical Advisory Panel (IPPF 1990) reports the findings of a carefully planned investigation into the incidence of infertility in countries of the world. It says that infertility among Indian couples is around 3 per cent and it varies between 15 to 20% in developed countries. It is very well accepted by the medical profession that high incidence of infectious diseases such as – Malaria and Tuberculosis damage the fallopian tubes and cause infertility. Among other causes of infertility are the effects of infections introduced as well as aggravated by contraceptives such as IUDs which are promoted vigorously through the government family planning programmes. In tackling the issues of infertility in India, therefore, greater attention needs to be paid to the effects of infectious diseases and discouragement to the use of methods such as IUDs. In contrast, it is observed that official programmes are promoting conception through new technologies, which in a real sense are not cures for infertility and promote the mothering roles of women. It should therefore, be obvious that the wide availability of the means to regulate fertility, including free access to abortion, is not an indication of the acceptance of the reproductive rights of women.[34]

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[32] *Supranote* 31 at pg. 477.

[33] *Supranote* 31 at pg. 477

[34] *Supranote* 31.

The major focus of most of the human rights instruments that deal with procreation and reproduction is on the family planning, which is 'birth limitation'. The broader issue of access to health care, economic resources and social security, to say nothing of freedom from sexual abuse and discrimination, remain unaddressed, though these conditions are directly related to women's lack of reproductive self-determination.[35]

The starting point of reproductive rights has to be the health, the well-being and the empowerment of women. The needed approach to reproductive rights has to be 'women centered' and social change oriented. Such an approach not only puts back the Maternal in Maternal and Child Health (MCH), but modifies family planning and related programmes making women's well-being and reproductive choice the central objective. This means giving top priority to reducing women's morbidity and mortality related to reproduction and sex as well as maximizing the conditions that makes authentic choice – whether to have child or not to have one-possible. Women's sexual self-determination is an intrinsic part of her dignity as a human being. [36]

Factors underlying poor sexual and reproductive health situation in India are as follows:

i) lack of awareness

It has been shown in various reports that women in general and adolescent in particular irrespective of marital status –are poorly informed about sexual and reproductive health matters. Similarly, very few married adolescents were aware of sexual intercourse or what was expected of them once married. Isolated from new ideas and supportive networks, married adolescent girls are correspondingly less likely to be aware of central sexual and reproductive health issues. [37]

ii) limited exercise of Informed Choice:

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[35] *Supranote* 31.

[36] *Supranote* 31.

[37] K. G. Santhya, Shireen J. Jejeebhoy "*Sexual and Reproductive Needs of Married Adolescent Girls*" Oct 11 Economic and Political Weekly 4372 (2003).

The family in India is typically age and gender stratified. Within the family, women have relatively little power and young and newly married women are particularly powerless, secluded and voiceless in matters relating to their own lives. Direct evidence on the extent to which married adolescents are constrained from exerting choices in sexual and reproductive matters is even more limited.[38]

One of the few studies that address sexual complications among young married women in India highlights young women's lack of decision –making ability in matters relating to sex; young women revealed that they were routinely told that it was their duty to provide sexual services to their husband. [39]

Reinforcing lack of decision making is the lack of awareness of sexual behaviour or information regarding services like contraceptive, on the one hand and of communication or intimacy with husbands on the other hand. The role of the husband has been noted in several studies of decision-making regarding the use of contraceptive or health expenditure; for example, in a study in rural Maharashtra, while the majority made the decision jointly, some marginal cases decisions were taken by the husbands alone and in few cases by women alone.[40]

iii) pregnancy related problems

Pregnancy related problems is far from universal in India and adults and adolescents alike are unlikely to receive care during pregnancy related problems. For example, the National Family Health Survey suggests that despite the elevated risks that women may face, adolescent women are as likely as older women to obtain care during pregnancy, delivery and post- partem period.[41]

The widespread use of abortion both by teenagers as well as by matured women is a striking evidence that millions of women do want more control over deciding whether

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[38] K. G. Santhya, Shireen J. Jejeebhoy "*Sexual and Reproductive Needs of Married Adolescent Girls*" Oct 11 Economic and Political Weekly 4372 (2003).

[39] *ibid*

[40] *Supranote* 37.

[41] *Supranote* 37 at pg.4375.

or not and when they shall bear children. Our laws against abortion serve to further women's subservient social status that women's reproductive process is subject to control of masculine prerogatives.[42]

There are figures to show that some 25-50 per cent of maternal deaths in developing countries occur from unsafe abortions. In countries where abortion is legal and freely available to teenagers as well as adult women, abortion pose a minimum threat to women's life but where it is illegal or severely restricted by law, abortions pose a maximum threat, as many cases are handled by non-professionals in a substandard and unsanitary conditions leaving to a high incidence of complications and resulting in chronic morbidity and often death.[43] Globally, in terms of human rights and concern for women's health, reproductive right is the greatest need of the civilized society. Difficult access, religious oppositions and cultural barriers present a serious problem in achieving sexual and reproductive rights for women in India.

It is high time that some constructive step has to be taken on this issue: not just to save women's lives and the lives of their children; not just to save women's lives and the benefits of both; not just because of the liberating value it can bring to family life and the life of women; but because it is a human right.[44]

Women should have an absolute right to decide whether to remain pregnant or not, and if they choose motherhood, how many children to have and when to have. Abortion should always be a matter exclusively of women's choice. It should neither be imposed on an unwilling woman nor should it be denied to anyone on the ground of religion or ethics, if asked within the first trimester of pregnancy.[45]

Similarly, various kinds of violence against women also discourage the protection and promotion of reproductive rights of women. For example, sex related violence such as- rape is not only crime against the person of a woman, it is a crime against the entire

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[42] Subhash Chandra Singh "*Right to Abortion: A new Agenda*" AIR Journal 133 -134 (1997).

[43] *ibid*

[44] *ibid*

[45] *ibid*

society. It destroys the entire psychology of a woman and pushes her into deep emotional crises.[46]

The General Assembly also while adopting the Declaration of the elimination of violence against woman by its resolution dated the 20th December 1993 observed in Article I that violence against women means "*any act of gender-based violence that results in or likely to result in physical sexual or psychological harm or suffering to women including threats of such acts whether in public or private life.*"[47]

Reproductive rights issue has brought latest picture of the new reproductive technologies. Intensive technological interference fosters a value system in society that devalues involuntary childlessness. Such a close focus on women's reproductive capacity magnifies the stereotypical gender notions of women as child bearers. It also overemphasizes the genetic links and overlooks the necessity of treating parenthood more as social relationship.[48]

Each reproductive technology starting from abortion to contraceptive; artificial insemination to surrogacy; egg donation to sperm banking; and sterilization to cloning etc. by itself is capable of raising social ethical and legal questions of its own kind that one perhaps might have to ask "Is it the right thing to do?". The touchstone for evaluation of any reproductive technology should be public policy with reference to the interests of the society in general.[49]

Technology should serve rather than dictate the social needs. It should be realized that there cannot be an absolute individual choice in a social structure. The real choice is where the exercise of choice meets the expectations of the society.[50]

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[46] N.K. Raha "*Right to Privacy under Indian Law*" AIR Journal 51 (2001).

[47] *ibid*

[48] V. Rajyalakshmi "*Reproductive Technology vs. Women*" 1 Supreme Court Journal 52 (1996).

[49] *ibid*

[50] *ibid*

The legal community is yet to resolve the host of problems raised by the use of reproductive technologies for procreation. The existing system as pointed out is not fully equipped to deal with the controversial issues which have arisen from biotechnological developments. Though, issues like artificial Insemination amounting to adultery have been put at rest by the judiciary, answering in the negative. Many issues still need to be resolved. It is clear that, inspite of judicial intervention, issues like legitimacy of the child conceived and born by AID is a sore point in the legal system. Hence, to solve the issues raised, Parliament has to intervene and provide a practical solution.[51]

In the struggle for women's reproductive rights, their right to choose pregnancy, their right to decide whether to bear a pregnancy or not; whether to complete the term of nine months or not; whether to get ride of unwanted pregnancy, the right of unborn foetus is mostly suffered. Talking about the protection available to the foetus, they all are indirect like under Indian Panel Code, Hindu Law or Labour Law or under various other legislations. This is because our law is silent about the status of the foetus. But, now the time has come when our legislative body must start thinking in this direction by balancing the rights of the foetus as well as of the mother.

There has been debate going on that the Right to life under Article 21 of the constitution must also recognize the right of the foetus to take birth but it should be a restrictive right, keeping in view, the health of the mother on grounds of abortion mentioned under Medical Termination of Pregnancy Act, 1971. The necessity of recognition of such a right is necessary in view of the reasons that firstly, the present economic world recognizes economic relations more than the moral and spiritual relations, the recognition of independent right to foetus would give a new direction to use of scientific research for the welfare of human being, and secondly, as is felt above, the healthy foetus depends on health of mother, therefore, the responsibility of mother towards the foetus life cannot be enjoyed unless life is not protected at its inception. Right to abortion of the mother should be made more liberal by including more grounds of abortion such as – right to abortion to widow, unmarried woman and to working

[51] K.R. Mythili "*Artificial Insemination- Legal Issues*" 39 The Journal of the Indian Law Institute 358 (1997).

woman. There is a need for the formulation of national policy for protecting the foetus by providing free ration and medical facilities to the pregnant women. The path of progress of the nation starts from the womb of the mother which requires attention and not avoidance.[52]

Keeping in mind, the various efforts of International level, it is suggested that[53]-

1. The foetus should be recognized as a separate entity enjoying distinct legal rights and is not a part of the mother.
2. The concept of personhood is a myth and a mere creation of law. This legal fiction must not come in the way of conferring rights to the foetus.
3. The inherent right of the foetus to life must be recognized and acknowledged.
4. The right to life of the foetus must be recognized from the point of conception and not from the point of viability. If not it would create a distinction between fetuses and would violate the canons of equality.
5. A balance must be struck between the mother's rights and the right to life of a foetus. The right to life of the foetus cannot be an absolute right; there has to be a balance between the right to health of the mother and the rights of the child. The Medical Termination of Pregnancy Act, 1971 attempts this balancing act; and
6. Failure to recognize the right on the foetus would amount to discrimination thereby violating the right to equality enshrined in Article 14 of the Constitution.

Changes and growth in medical technology have made it imperative for the law to respond to the new distortions and controversies emerging from current reproductive practices particularly in India where there exists virtually no legal reaction so far to this phenomenon. The fore going has highlighted a few of the impediments on the road to a smooth legal regime for the new assisted reproductive technologies. A plethora of other problems yet resolved by law still exist with regard to these new technologies. Say in case of surrogate motherhood, what if any harm occurs to the child conceived. There is no clear cut legal approach to the problems of pre-natal injuries that may be sustained by the child where such child is born alive with some congenital ailments or

[52] H. R Jhingta *"Foetus, Abortion and Right to life:Some Basic Issues"* X M.D.U. Law Journal 10 (2005).

[53] Prashanth S.J. *"Right to Life of Foetus"* AIR Journal 214 (2003).

deformities brought about say by a gestational mother. It is not exactly clear whether a tort action should lie on behalf of the child and whether the primacy of the gestational mother's health may be upheld to determine the health of the foetus. Assuming the injuries were perhaps, as a result of the negligence or illegal conduct of the gestational mother- will she be immune from civil or criminal action either on behalf of the child or the state?[54]

In distant future, the full effects and attendant consequences of the new reproductive technology will be so manifest that immense distortions and damage would have been done in the absence of statutory intervention. To delay legislative regulation in this area is to multiply the legal problems that could result from a socially beneficial practice.[55]

Take instance of Artificial insemination, there is no mensurea or guilty intent of wife resorting to AID. Also, if it is to be treated as adultery, it would give rise to a number of absurdities and complications, example, the donor would be an adult, the carrier of the semen and the doctor who performs the operation would be participant in the act. Also, suppose the seed is used after the donor's death, would the women be guilty of committing adultery with a dead man? A very queer situation would arise in a case where the husband himself transmits by natural act a third person's seed to his wife.[56] There is no legal framework to resolve such issues. Thus, it is the need of the hour to frame legal structure imbibing all such possible issues that might be brought by the new reproductive technologies in the society, if not today but for safe tomorrow.

It cannot be denied that the practice of AID is very likely to affect family peace and harmony. The presence of another man's child is bound to create emotional conflicts and tensions in the family and, therefore, it would be reasonable, nay necessary, to provide matrimonial relief to the husband if the wife resorts to AID without his consent. Only childless couples where the husband's sterility has been medically

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[54] Samson O. Koyonda "*Assisted Reproductive Technologies in Nigeria: Placing the Law above Medical Technology*" 43;1 Journal of Indian Law Institute 91 (2001).

[55] *ibid*

[56] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 294 (1977).

established should resort to AID. The written consent of the husband should be deemed to be his legitimate child. Only licensed doctors of high repute should be authorized to perform the operation. The doctor should carefully select the donor and also maintain a strict secrecy.[57]

As a matter of fact very few cases have come before the judiciary regarding reproductive rights and the use of reproductive technologies till now. But there is no doubt that in future more and more cases will knock the door of judiciary to resolve different issues. Though, many emerging issues have been highlighted in media or newspaper; there are many unreported cases regarding reproductive rights which are yet to see the justice. In the absence of visible legal framework, it would be difficult to address issues of reproductive rights for its redressal.

There is a need to enhance concept of reproductive rights and flesh it out in women's experience and also to explain current issues such as family planning, artificial insemination, use of contraceptive or morning after pill, surrogacy etc. There is also a need to evolve a current and composite profile of women's health that goes beyond maternal and fertility descriptions and includes women's life cycle problems.[58]

Women should have an absolute right to decide whether to remain pregnant or not, and if they choose motherhood; how many children to have and when to have. Abortion should neither be imposed on an unwilling woman nor should it be denied to anyone on the ground of religion or ethics, if asked within the first trimester of pregnancy. Religion should not be allowed to arrest the growth of women's right in anyway. Giving women the power to control their own sexual and reproductive process, is just a way of assuring them- the basic human right of self –determination.[59]

Autonomy and Independence of a woman is directly as well as closely related to her ability to play a role outside home. The inability to decide freely and responsibly on

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[57] *Supranote* 56.

[58] Azim A. Khan *"Illegal Abortions and Women's Reproductive Health"* 3 Supreme Court Journal 122 (1997).

[59] Subhash Chandra Singh *"Right to Abortion:A new Agenda"* AIR Journal 135 (1997).

the spacing of children has, in turn, deprived many women of the advantages of health, education, employment and their roles in family, public and cultural life on equal footing with men as agreed in the United Nations Conference on Population and Development held at Cairo in September 1994. The right and opportunity to women to fully participate in development is an element of human dignity and respect recognized in a number of international human rights agreements and covenants.[60]

Combating the politics of appropriation of reproductive rights with that of reproductive technologies is also an important step forward. Population planning programmes remind us constantly about the ways in which concentration of economic and scientific, hi-tech power appropriate the logic and language of reproductive rights for their own ends. The present formidable evidence demonstrates how state corporate power has all too readily rendered millions of women's bodies as sites for corporate experimentation in reproductive technologies. This has to be checked with appropriate legal framework.

In each generation, social reproduction of human rights activism remains a necessary condition for the realization of reproductive rights. Women's empowerment cannot simply occur in the absence of conditions that secure and entrench the rights of transnational corporation to pursue and own mechanisms.[61]

If women's right to self-determination is to be respected and protected than reproduction must be view in different manner. The position of women in the patriarchal society is the discouraging factor to hinder reproductive self-determination. Another main feature is that the languages of empowerment are not always fully sensitive to the class/gender divide. Feminism of these notions in ways that respect the diversity of women's subject positions, as defined as constructed by them, complicates the reproductive rights discourse. And most importantly, a theoretical adjudication concerning the radical critique of global population policy is beyond the scope of appropriation of the languages of reproductive rights and health.

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[60] K.D.Gaur *"Abortion and the Law in Countries of Subcontinent Asian region, United Kingdom andUnited State of America"* 37:2 Journal of the Indian Law Institute 322 (1995).

[61] *ibid*

The medical/pharmaceutical technologies are unimportant for eventual empowerment and even emancipation of women. However, it is maintained that this discourse regards women as objects rather than subjects of governance and development policy.[62]

Here, a solution is that the National Population Policy be reinforced by a legislation that impose non-negotiable duties requiring all pharmaceutical industries, national or multinational, to disclose full toxicological and epidemiological information or contraceptive health hazards.[63]

Certain strategies must also be adopted to overcome the lack of awareness about reproductive rights. Such strategies may include[64]:

i) Mobilization of the policy makers and key governmental officials, opinion leaders and NGOs through the medium of information and communication by print and electronic media and inter-personal correspondence;

ii) Development of virile information, education media and inter personal correspondence;

iii) Improved and expanded services on maternal and child health services etc.

In order to effectively correct the low level of awareness that pervades women's perception of pregnancy risks, reproductive programmes are imperative and they need to address the risks. It is necessary to sort out referral problems where transportation inadequacies, poor communication and distance to health facility were declared as hindrance to formal treatment. Increase the availability of well-equipped hospitals and clinics especially in the rural area. Provide grass root health education about the normal and abnormal conditions of pregnancy. Provide adequate family planning education and contraceptive to women who want to delay or put an end to child bearing. On the whole, there is need for an effective information, education and communication plan

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[62] Upendra Baxi *"Gender snd Reproductive Rights in India: Problems and Prospects for the New Millennium"* October Kali'yug 27 (2000).

[63] *ibid*

[64] Peter Olasupo Oguyigbe *"The Risks in Pregnancy and Child Delivery: Strategies for Prevention in Nigeria"* 17 IASSI Quarterly 135 (1999).

that would create awareness of the dangers to be associated with pregnancy and women should be given the chance to make preferred reproductive health decision on their own.[65]

However, before optional conditions could be achieved, improvement, training and supervision of local attendants to whom the community can relate well and identify with could be pursued. Whether we like it or not the majority of deliveries will still conducted by there people, mainly for economic reasons. WHO has estimated that out of 2.5 billion births worldwide between 1980 and 2000 will up to 2.0.billion will be attended by traditional birth attendants (TBA), relatives or nobody (WHO,1990).[66]

WHO estimated the ratio of physician to population in the developed world to be 1:1000 compared with 1:100,000 in the developing countries. So, there is need for more incentives not only from the government but also from the communities themselves and NGOs to encourage redistribution of manpower[67].

Traditionally, women have been thought to be the weaker sex both physically and socially. Now the world over, there has been a steady rise in the awareness of the women's rights and the need for their empowerment. Enactment of appropriate laws and their enforcement constitute a vital part of any strategy relating to women's empowerment. In India, there is inadequacy of laws which seek to protect the woman's interests and save her from exploitation.[68] Though, few laws are there but they are not been able to address women's miseries and sufferings clearly and visibly.

A demographic variable called the "Missing Girls" has recently engaged the attention of social activities. For Law makers it acts like an indirect yardstick of Female

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[65] Peter Olasupo Oguyigbe "*The Risks in Pregnancy and Child Delivery: Strategies for Prevention in Nigeria*" 17 IASSI Quarterly 135 (1999).

[66] *Supranote* 64 at pg. 137.

[67] *Supranote* 64 at pg. 137.

[68] Banibrata Basu "*Economic Prosperity and Killing of Female Babies – An Interstate Experience*" 50(4) Indian Police Journal 20 (2003).

Infanticide/Foeticide. It is seen that even in an economically highly prosperous state like Haryana, the figure for female survival rate is one of the lowest[69].

If babies die due to poor health care, natural calamities or for general poverty of the families, then boys and girls should die at the same rate or boys at a faster rate than girls should, as girls are expected to be biologically stronger at birth. But society practices gender discrimination and there is widespread female infanticide, female mortality rate (bet. 0-6 years) is much higher than that of boys. This difference called the "gender gap" can be used as an estimate of female infanticide.[70]

Therefore, it can be concluded that mere rise in prosperity and reduction in poverty is no guarantee for reduction in Female Infanticide/Foeticide. Its roots lie deep in the social and cultural traditions of the society and roles given to females by the society. Till, the time society will continue commodifying women and subjugating them, such brutal practice will continue. As, we are also very much part and parcel of the society, we are often imbued by the same traditional values which we may have to overcome in eradication of this menace.[71]

Article 21 of the constitutional of India entails the right to personal liberty. Obviously, it comprises the right to be or not be a parent, the right to use or not to use contraceptives, the right to or not to sterilize oneself. It also includes the right to terminate pregnancy. It is up to the woman to choose to give birth to a child or not.[72]

It is an observable phenomenon that the majority of women having a family of two or more children ask for abortion because they simply find it unbearable to face the psychological, social or economic impact of another child. The U.N. study entitled

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[69] Banibrata Basu "*Economic Prosperity and Killing of Female Babies – An Interstate Experience*" 50(4) Indian Police Journal 20 (2003).

[70] *ibid*

[71] *Supranote* 68.

[72] Suprio Dasgupta "*The Right to Abortion*" February The Lawyers 17 (1994).

"Human fertility and National Development" revealed that induced abortion is probably the single-most widely used method of fertility control in the world today.[73]

The last two decades have been witness to a rapid increase in the number of technologies that assist reproduction, increasing the chances of conception and carrying a pregnancy to term. The term Assisted Reproductive Technologies" (ART) encompasses various procedures, ranging from the relatively simple intrauterine insemination (IUI) to variants of in- vitro fertilization and embryo transfer (IVF-ET), also referred to as IV-F and more commonly known as "test-tube baby technology". Since, the later half of the 20th century, these technologies have developed at a rapid pace. They have also influenced the way in which society views pregnancy, reproduction and motherhood.[74]

The research was conducted to study on the medical, social and ethical implications of ARTs on the lives of women in the Indian context. The research shows that in a patriarchal society, the proliferation of ARTs can impose double burden- the burden of a social system that restricts women's role to that of child bearing and the burden created by what might be described as the medicalisation of everyday life.[75]

Amongst couples women are under immense social pressure to have children. Sometimes, there is a lot of pressure on the woman to get pregnant in the first cycle itself. They go through a lot of psychological strain in such circumstances. Women generally come with a lot of desperation because of the social ridicule to which they are subject.[76]

The existence of this social pressure justified the rapid propagation of Assisted Reproductive Technologies. These technologies provide solutions to those couples who

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[73] Suprio Dasgupta *"The Right to Abortion"* February The Lawyers 17 (1994).

[74] Sama Team *"Assisted Reproductive Technologies in India: Implications for Women"* June Economic and Political Weekly 2184 (2007).

[75] *ibid*

[76] *ibid* at pg.2185.

are desperate to have their own children and are okay with (doing) everything to have a child.[77]

Since, women bear the disproportionate burden and social stigma of infertility and childlessness; they would certainly be willing to subject themselves to all forms of medical interventions in order to bear a child, regardless of the physical, psychological and economic costs that these may entail. By doing so, they reinforce the socially constructed ideal of womanhood which entails a liner progression from marriage to mother. This ideal excludes alternate forms of parenthood or voluntary childlessness.[78]

The pressures from family and neighbours makes women feel guilty for not being able to perform what is believed to be their natural role as mothers after marriage. Women have external social pressures and also personal desires or needs.

In such a situation, it is difficult to distinguish between an individual woman's conscious wish to have a child and the social pressure which makes married woman feel incomplete unless they have given birth to a child, motherhood is viewed as the women's destiny. Women often hold themselves responsible for their childlessness, even when it is the man who has a fertility problem. The social pressure on women to bear children has enabled the rapid growth of the Assisted Reproductice Technology industry in India.[79]

At this point, it is also important to mention that information about possible side effects of such reproductive technologies was either not provided or restricted to the more common relatively milder complications. Besides, often the providers used a lot of medical terminology, which made it difficult for couples to understand them.[80]

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[77] *Supernote* 74 at pg.2185.

[78] Sama Team "*Assisted Reproductive Technologies in India: Implications for Women*" June Economic and Political Weekly 2188 (2007).

[79] *Supranote* 74.

[80] *Supranote* 74.

Whenever people come for any medical treatment, it is good medical practice to give them complete information so that they can make a truly informed choice. In infertility treatment, this must include giving information on the treatment's side effects, complications and its efficacy, preparing couples for the possibility of repeated failure to conceive and offering those alternatives to treatment and costs. Counseling ideally by trained counselors, is especially important in infertility treatment.[81]

India's family welfare programme as is well known has been disproportionately focused on achieving demographic targets by increasing contraception prevalence and notably female sterilization. Woman- based services or those responding to women's health needs in ways which are sensitive to the socio-cultural constraints women and adolescent girls face in acquiring services and expressing health needs have been largely lacking.[82]

The minimum health needs programme was formulated which combined health and nutrition with fertility reduction and the incentive system was stepped up. Subsequent government has cautiously stressed the voluntary nature of the programme, however despite its commitment to a maternal and child health actually in practice was concentrating on sterilization only. More recently, there has been recognition that the singular focus on sterilization neglects the contraceptive needs of women and children. The health system operates through a network of 20,847 primary health centers and over 130,000 sub-centers domiciliary services are expected to be provided by the large number of health workers (ANMs) attached to the various center , despite this outreach continues to be poor.[83]

Much more pervasive is reproductive morbidity and lack of care during pregnancy and childbirth including both the obstetric conditions such as reproductive tract infections, cervical cell changes and genital prolapse. Data on reproductive health and

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[81] Sama Team "*Assisted Reproductive Technologies in India: Implications for Women*" June Economic and Political Weekly 2188 (2007).

[82] Shireen J. Jejeebhoy "*Addressing Women's Reproductive Health Needs*" March Economic and Political Weekly 476 (1997).

[83] *ibid*

constraints to good reproductive health are notoriously limited generally, data on mortality and morbidity come from hospital studies but little is known about their levels and patterns in community settings. Estimates based on hospitals are often seen as a last resort for women with difficult pregnancies or deliveries. On the other hand, estimates based on hospital studies will underestimate morbidity, because they miss the high proportion of women who endure poor health and especially poor reproductive health as their fate in life. It is difficult hence, to assess the magnitude of and the factors underlying women's reproductive morbidity.[84]

Urgently needed is greater light into underlying risk factors into why women's reproductive health needs remain unmet. Health facilities at the community level are poorly equipped to deal with gynecological and obstetric morbidities, since they have neither the diagnostic facilities nor the drugs to treat them. Moreover, service providers are not trained to detect such morbidities; or to provide sensitive counseling. What is required at the primary health center level are facilities for routine diagnosis of gynecological conditions, improved obstetric care, sensitive counseling and sound referred services.[85]

Roughly, five million abortions continue to be performed annually; of there, only about half a million abortions are preferred under the health services network while another estimated 4.5 million occur illegally. As a result, over 10 percent of all maternal services and care at approved centers can be impersonal and intimidating. Frequently, women who seek abortion are denied confidentiality or are coerced to accept an IUDs or sterilization as a pre-condition for the abortion.[86]

In short, much more attention needs to be paid in the context of reproductive health services as a part of primary health care. As far as understanding the context of abortion is concerned, we need to know why women resort to abortion, in large numbers; we need to have a socio-cultural profile of abortion seekers, and the constraints they face in

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[84] *Suprenote* 82.

[85] *Supranote* 82.

[86] Shireen J. Jejeebhoy "*Addressing Women's Reproductive Health Needs*" March Economic and Political Weekly 477 (1997).

obtaining legal abortions in the one hand and contraception on the other and a woman's perspective of the quality of abortion services available. As far as services are concerned, above all, we need a reproductive health approach which incorporates the need for ready access to safe motherhood.[87]

Little evidence is available on the levels and patterns of infertility in India- Evidence from the 1981 census and a village level study in Maharshtra suggest that infertility may be more prevalent in India than in other developing countries, factors underlying infertility include, among other things women's poor health and nutrition status which can lead to repeated miscarriages and foetal wastage, unhygienic obstetric and abortion procedures and even such debilitating diseases as tuberculosis and infertility can have serious consequences for female emotional harassment or marital disharmony.[88]

Information on levels and patterns of sexually transmitted diseases which have severe implications for the reproductive health of both women and men, come predominantly from studies of patients of STDs clinics and rarely from community- based investigations. The limited community- levels evidence available suggests a relatively high prevalence of STDs.[89]

Urgently needed is a primary health care system which caters to the growing problem of STDs, counseling and referral at the peripheral level along with improved diagnostic facilities at the primary health centre level. Also needed are rigorous studies of the socio-cultural aspects of sexual behaviour and the context of high risk behaviour and transmission of infection. At the same time, not enough has been done to educate the larger population and especially secluded, invisible and powerless women- about STDs and HIV/AIDS, their prevention, symptoms, modes of transmission and treatment. On the one hand, strategies need to be devised which can provide information at the doorsteps of secluded women. On the other hand, strategies need to

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[87] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 477 (1997).

[88] *Supranote* 86.

[89] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 475-484 (1997).

be devised to inform, sensitise and communicate with men and particularly young men. Men are an important audience for such communication both in their own interests and because of the role they play in conveying information and disease- to women.[90]

In short, though a large proportion of Indian women are motivated to limit or space childbearing, they are constrained from doing so for reasons which are rooted in the inadequacies of the programme on the one hand and by socio-cultural factors on the other. The focus on sterilisation, target fulfillment and incentives has resulted in obscuring the spacing needs of women and their right to excersise informed choice. Service delivery strategies and quality of care have been largely insensitive to the needs of women, the constraints the average woman faces in seeking services in voicing fears and side-effects and their right to have complete pre-acceptance counseling including information on potential side-effects and complications and post- acceptance follow-up.[91]

Little systematic evidence exists in India about standards of care in the family welfare programme or specific steps which can be taken to improve it. More attention has been paid to physical infrastructure, personnel and equipment than on quality of care especially from the woman's perspective. Quality care comprises several dimensions:[92]

1) Availability of a wide range of contraceptive, MCH and other services;
2) Accessible, complete and accurate information about contraceptive methods including their health risks and benefits;
3) Safe and affordable services along with high quality supplies;
4) Well- trained service providers with skills in interpersonal communication and counseling;
5) Appropriate follow-up care; and

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[90] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 475-484 (1997).

[91] *Supranote* 89.

[92] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 481 (1997).

6) Regular monitoring and evaluation of performance, incorporating the perspectives of clients and beneficiaries. Thus, for these elements of quality of care have been largely missing.

The health delivery system has been largely insensitive to the reproductive health care needs of women and the restrictions they face in expressing and obtaining such services. Doorsteps services are essential for secluded women and these are rarely undertaken and where undertaken, focus largely on contraception rather than on reproductive health in general. Health workers themselves are poorly informed about reproductive morbidity (especially gynecological conditions) and thus, can be insensitive in probing and recognizing symptoms and are preoccupied with meeting contraceptive targets rather than offering a range of reproductive health services. Also, women's lack of autonomy and decision- making authority, it is unlikely that sick women will take the initiative in obtaining health care for themselves. In particular there is a tendency to endure obstetric and particularly, gynecological morbidity as a fact of life and a shyness to reveal there conditions to or discuss them with health care providers.[93]

Despite the fact that the large majority of births continues to take place and is attended by untrained personnel, the incorporation of trained traditional dais (TTAs) in the provision of ante natal and natal services has not been a priority in the health system. Since, younger generations are unwilling to become dais there is the likelihood of a serious shortage of delivery attendants. While, there have been programmes to train traditional dais and provide them with materials and safe delivery kits, there has been little rigorous assessment of the impact of this training and from all accounts, success has been limited.[94]

The persistence of an unmet need for contraception is further evidence of the poor quality of services and care, since women are inclined to prefer an unwanted birth rather than accept available contraception services. Moreover, morbidity arising from

[93] Shireen J. Jejeebhoy "*Addressing Women's Reproductive Health Needs*" March Economic and Political Weekly 481 (1997)

[94] *ibid*

contraception is cause for concern. More serious conditions ranging from excessive bleeding to pelvic inflammatory disease have also been reported and point to a need for more hygienic service delivery conditions in general and a programme which is sensitive to the needs of and constraints women facing, in particular.[95]

At the service delivery level, there are few examples, client oriented family planning and reproductive health services. The government programme remains focused on fertility reduction and reproductive health as secondary concern.[96]

As far as service delivery is concerned, we need to learn from successful small reproductive health programmes on the one hand and expand the programmes of other NGOs to include comprehensive reproductive health programme based on the needs of women on the other. These include:[97]

1) quality outreach services delivered in ways which are sensitive to a cultural milieu which inhibits women from expressing their reproductive health needs or seeking health services;
2) services which go beyond the current exclusive programme which includes safe motherhood, treatment of gynecological and obstetric infections, abortion and fertility services as well as greater attention to continuity of care, sensitive counseling, screening, follow-up and treatment;
3) more attention to women's information needs through culturally acceptable media and messages; and
4) more attention to the quality of service provider-client interaction.

As far as research work is concerned limited resource is available from the perspective of individual clients and women in particular on the kind of services and care they receive; on the linkages between how women perceive health care services and their utilization of these services, on how women's perceptions of quality of care affect their lives. Social scientists tend to have a narrow interpretation of reproductive

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[95] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 481 (1997)

[96] *ibid*

[97] *Supranote* 93.

health, rarely addressing, for example, the user's perspective of health care services. Moreover, it is increasingly clear that in order to document women's perceptions, experiences and needs, what is required is a blend of both in- depth qualitative research as well as more familiar quantitative survey methodology.[98]

While women, are by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly, a gynecological problem, unless it is very advanced. Lack of decision making, freedom of movement and time can restrict visits to health centers, even where a health problem has been recognized. There is, unfortunately, little rigorous research on women's constraints to health seeking in the area of reproductive health. Moreover, service delivery strategies remain oblivious to the real constraints women face in acquiring good health care.[99]

Communicating new ideas to poor, illiterate and secluded women is no easy task. As we all know that literacy and school enrolment levels are generally low and school dropout rates are relatively high in India, especially among women.There is a glaring lack of attention to sex education in the official programme. Sex education and even knowledge of menstruation or of AIDS for example, is extremely limited and vague, especially among young females.[100]

Although, the NGOs sector has tried to fill the gap of sex education for sometime now, their effort is not sufficient. There is a need to re-orient communication and education activities to incorporate a wider interpretation of reproductive health; to focus attention on the varying information needs of women and especially spread of sex education.[101]

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[98] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 475-484 (1997).

[99] *ibid*

[100] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 475-484 (1997).

[101] *ibid*

A focus on the health needs of women- their reproductive health needs, their nutritional status, the risks of early marriage and child bearing- is urgently required. At the same time, the knowledge about health information needs of adolescent girls remain particularly ignored including their bodies, sexual behaviour and pregnancy .[102] To bridge the gap between these factors has become a critical need.

People still ignore their right to make reproductive choices and to demand family planning services from Primary Health Centers (PHCs). The adoption of two-child norm aims at stabilizing population but indirectly it is affecting the reproductive choices of women and men. Moreover, 42 percent of people living below poverty line do not think about limiting the size of the family over attaining their basic needs. If government could ensure fulfilling basic needs of the people than people would no doubt adopt small family norm.[103]

Any kind of coercion on the part of the government would be violation of human rights of people to limit their family size. There has to be an effort on the part of the government to adopt sound policy for small family norm rather than imposing two-child norm which contain the seed of violation of reproductive right.

Moreover, we must address within our legal framework violence against women within the domestic and public sphere. We cannot afford to leave communal or domestic violence unanswered. The laws must aim to enhance women's status by preventing child marriages, bigamy and pre-natal sex-determination. It must not only be enacted, but also effectively implemented.

There is little understanding of the socio- cultural context of reproductive health of women's actual access to health care and the constraints women face in acquiring good health. The day has come when more realistic efforts have to be made in order to

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[102] Shireen J. Jejeebhoy *"Addressing Women's Reproductive Health Needs"* March Economic and Political Weekly 475-484 (1997).

[103] Devika Biswas "Bihar" in Shruti Pandey, Abhijit Das, Shravanti Reddy and Binamrata Rani (eds.) *Coercion versus Empowerment* 70 (2006).

realize the protection of reproductive rights of women. A growing recognition that population dynamics, quality of life and women's status are closely interrelated argues strongly for a fresh look at Indias' laws and health policies.

Last but not the least, acknowledging that women occupy subordinate position in the society because of which she has been the victim of age old discrimination is the first stepping stone for the foundation of empowerment of women. Another step is to provide education to all women of all levels. This will help raising awareness among women about their human rights and also help enhancing self-esteem and self-confidence among them. Finally, there is a need for regulation of reproductive process through proper legal framework for the protection and promotion of women's rights.