A STUDY OF THE LEGAL FRAMEWORK FOR THE PROTECTION OF THE REPRODUCTIVE RIGHTS OF WOMEN IN INDIA

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This is to certify that Sushma Sharma has pursued research work under my supervision for more than two years and fulfill the requirement of the Ordinances relating to the Doctor of Philosophy of the University of North Bengal. She has completed her work and the thesis is ready for submission. To the best of my knowledge and belief, the thesis contains the original work done by the candidate and it has not been submitted by her or any other candidate to this or any other University for any degree previously. In habit and character, the candidate is a fit and proper person for the Ph.D. degree.

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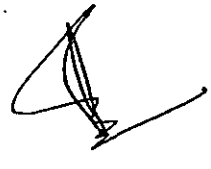

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INTRODUCTION

In most of the societies, sexual behavior is regulated by certain norms and values that vary among different groups and communities. In the past, sexual behaviour was conservative and confined to particular period of one's life, like post puberty and duration of marriage, but such restrictions tended to give rise to sexual liberation. At present, the diversities and complexities of sexuality is greatly influenced by the cultural practices, social development, impact of the mass media and modernization of a given society. Earlier, sexuality was considered personal but today, it has assumed several social forms with the spread of mass media, family planning, diseases like AIDS, STD and mostly with the emergence of the concept of reproductive rights.[1]

Major aspects of sexuality have undergone change and are influenced by both traditional and changing values. The concept of sexuality can be defined only after taking into consideration various factors such as culture, religion, situation, environment and other related factors like education and socialisation. Thus, today, the concept of sexuality is much more vast and involves various rights of human being. It is not just an act of sex but it is the right entitled to human being and thus called as reproductive rights.[2]

When we talk about reproductive rights, we are indirectly talking about women's rights because it is a woman whose life is mostly influenced and affected by the reproduction. So, it is inevitable to mention women when discussing about reproductive rights as they are the focal point of the discussion.

The concept of reproductive rights comes from International endeavour. The first time when reproductive right was clearly mentioned was in Convention on the Elimination of Discrimination against Women. More to the point, reproduction as a

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[1] K. Mahadevan, S.Raju, R.Jayashee and P.M.Sandhya Rani *"Sexuality and Reproductive Health: A Conceptual Model and Policy Implications"* 65 The Indian Journal of Social Work 572 (2004).

[2] *ibid*

social function was discussed in several International Human Rights Instruments and thus, reproductive right is entitled as part of human rights.

Emancipation of women will be incomplete without assuring them reproductive rights. It is only when women have control over their bodies; they can exercise all other rights. Women can be physically and mentally free simply when they have right to take decisions regarding their bodies themselves.

At Alma Ata Conference in USSR, in 1978, primary health care was exclusively discussed and access to family planning, maternal and child health care and prevention of communicable diseases was accepted as basic human rights.[3]

Reproductive right is thus, central to women's rights and their autonomy and respect depends upon their right to take decisions whether about their career, education or reproduction. No doubt, reproductive rights does not barely include events associated with birth but also with women's day to day life, their status, their roles in their home and society.[4]

Also, the length of advancement of women's reproductive right is a good indicator of their position and their autonomy within the family, community and state. Hence, reproductive rights demands respect and pride for women's body contains within it various other human rights that can be called upon to ensure protection and promotion of reproductive rights.

The past few decades have seen significant advancement in women's human rights throughout the world, but the struggle to fully acquire them is not yet over. There has to be a proper legal system for the promotion and protection of these rights. There is a need to create proper legal framework for the protection of these human rights.

[3] WHO 1978 (33).

[4] L.P. Freedman and S.L.Isaacs, 1993.

Moreover, the system for the promotion and protection of human rights of women has tremendous potential to become a key factor to ensure the full recognition of women's rights, especially their sexual and reproductive rights.[5]

Reproductive health as received by women is very blink as women hardly encompass an opportunity to have control over their bodies. Health facilities are considered as privilege for women. They have rarely any control over sexual behaviour. For most of the women, the decision regarding the timing and physical and financial cost of health services sought are closely connected to the demands of the household, its assets and resources, the nature of health care services available and the perspective of the causes of illness and the perceived effectiveness of various cures sought.[6]

Women carry more of the burden of the household and therefore, have less time to seek for health care services making them disadvantaged relative to men in their access and utilization of health care services. Especially, in their role as mother, women carry a greater health risks as well as a greater reproductive health burden than men in households. The gender inequality approach to health considers the gender skewed allocation of resources and power in the household as among the critical factors responsible for women's disadvantageous position in the health care system.[7]

Recent studies have also shown that despite the vast network of health care provision in India, the outreach continues to be poor for women. The focus on women in health delivery programme deals mainly with regard to family planning emphasizing more on population control.

At least until 1994, reproduction has been narrowly defined and was considered important in view of demographic position only. The health care of women generally

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[5] Reproductive Rights in the Inter-American System for the promotion and protection of Human Rights, Briefing paper- www.reproductivereights.org

[6] Maya Unnithan Kumar *"Households, Kinship and Access to Reproductive Health Care among Rural Muslim Women in Jaipur"* March Economic and Political Weekly 621 (1999).

[7] *ibid*

focuses on menstruation and childbirth and local perceptions of the body, reproduction and ill-health.[8]

With the cases of maternal mortality, there has been high incidence of maternal morbidity, disease of women in their reproductive life span with far above the ground relationship between poverty and maternal and infant mortality is widespread. It is well known that infant mortality is crucially connected with maternal health.

Even though, women articulate their health problems in very general terms. It has become important to consider women's reproductive health in the context of their wider complaints regarding reproductive facilities like safe delivery, hygienic condition, family planning measures, safe abortion etc.

The social status of women, the cultural barriers and ineffective policies and programmes of the government is responsible for the lack of reproductive health facilities. Various survey reports clearly show that the maternal morbidity of women is related to a combination of physiological, social, economic and psychological factors. The social consequences of aborted fertility, poverty and lack of nutrition, inability to control infant mortality, the lack of information about diseases and ineffective recourse to cure were some of the realities which took their toll on women's lives.

The fact that the weakness of mother and infant is largely due to their under-nourishment is connected with the quantity and nature of the dietary intake of mothers during pregnancy and after child birth. These small truths are the evidences of poor reproductive health infrastructure.

The task of enhancing reproductive health services outreaches the villages which address not only the question of access to health services but also the provision of facilities which take into account the context specific, gender and age health needs of the local population[9].

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[8] *Supranote* 6.

[9] *Supranote* 6.

Despite the legal emancipation of women in India, their education and employment in modern occupation; the traditional biasness towards female children has not undergone a change. Persistent gender inequality and deprivation of females are among India's most serious social failures. The situation is alarming as there is pre as well as post natal risk to girls.[10]

A venomous fall out of the subjugating position of women is their vulnerability to violence like domestic violence, rape, sexual abuse, dowry harassment, trafficking etc. There is little or no mechanism to combat these violences either by way of effective laws and implementation or civil society action. A pernicious form of violence against women in most parts of India has been still existed such as female foeticide/ inf-anticide.[11]

Reproduction is a biological and social phenomenon which touches interpersonal relationships, the concept of family and structure of society for childcare and child rearing. The subject of women and reproduction is a highly controversial one. The ability of women to bring forth children has been seen both as a capacity, a source of power, providing status-basically as something positive- as well as an incapacity, a source of women's vulnerability and thus as something negative.[12]

In all ages and in all places, there is an attempt to control women's reproductive capacity both by others as well as by women themselves. As pregnancies take place in women's bodies, control over fertility/ reproduction is closely linked to control over women's sexuality. Various societies have devised different kinds of taboos and laws for this purpose.

However, with the introduction of reproductive technology, the phenomenon of reproduction has been changing. There is an increase in scientific understanding of reproductive processes which have become more visible and controllable and

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[10] Ashok K. Jain , *The Saga of female Foeticide in India* 2 (1st Edition 2006).

[11] *ibid*

[12] Jyotshna Agnihotri Gupta, *New Reproductive Technologies; Women's Health and Autonomy* 580 (1st Edition 2000).

intervention has become technological and increasingly diverse and precise. While contraceptive technologies made it possible for women to have heterosexual intercourse without becoming pregnant, with technologies like assisted reproduction, pregnancy become possible without intercourse as well, thus, now sexuality and reproduction is more definitely linked. Therefore, the struggle for control over women's bodies has become even more crucial.[13]

The increasing use of reproductive technologies and the importance given to them in determining reproductive decisions has been responsible for bringing reproduction further into the political domain. It has been pointed out that the technologies are socially controlled, i.e. access to them, their use and application is regulated or controlled. On the one hand, they make wider choices for women in their life, on the other hand, they lead control by others- such as the State, religious leaders, the medical profession and men (through these institutions and individually)- possible. In varying degrees reproductive technologies also have a potential to reduce women's role in procreation and carried to an extreme, they may take the production of human life away from women's bodies' altogether.[14]

Undoubtedly, reproductive technologies redefine reproduction and place before us new dilemmas. They are responsible for a change in our reproductive consciousness. There is a belief that conception can be perfectly controlled. For some women, the desire for a child has given way to the right to biologically own child. New reproductive technologies have brought controversies not among only feminist but among a public as a whole because they crystallized issues at the heart of society-contemporary controversies over sexuality, parenthood, reproduction and the family. It also brought within its womb a philosophical question about the beginning of human life and so on. Specially when used within international and national population policies, these technologies have wide application and acceptance. In promoting population policies through the use of reproductive technologies, national government, population control organization, the multinational drug industry, public and privately

[13] Jyotshna Agnihotri Gupta, *New Reproductive Technologies; Women's Health and Autonomy* 581 (1st Edition 2000).

[14] *ibid*

funded International bodies, medical researchers and health workers have significant impact on the health and autonomy of women[15].

At this point, it is important to place the development and use of new reproductive technologies within the framework of:

a) The cultural context of the ideology of motherhood.

b) The practical realities of health care provision, and

c) Impact of population control policy.

Some of the crucial questions are - Do the new reproductive technologies contribute to women's autonomy? To what extent can women take autonomous decisions in this regard? Autonomy refers to having control or power over one's own life and one's own body in relation to others. In this aspect, autonomy implies two main elements- a) the ability to withdraw from power and control exercised by others; and b) the possibility to exercise control or self- determination. The struggle of the women's movement is not just against individual man but primarily against the structure of a society to achieve full autonomy of their life.[16]

The impact of these new reproductive technologies on women is very important to study. In tracing women's struggle for reproductive autonomy and self determination whether New Reproductive Technologies are useful in this process and for the larger goal of women's emancipation is vital to study and analyse.

The biological fact that woman's body is made such that it can only conceive and carry foetus for nine gestational months and thus, women must have control over their fertility and sexuality. The reproductive role of woman has always been sidelined and the government's attention is on population control rather than on the impact of reproduction on woman's life or their health.

[15] *Supranote* 13.

[16] *Supranote* 13.

Women have hardly any choice in childbearing. The decision depends upon the specific conditions in which they live. They are based on several factors, such as- gender relations, one's own income, adequate housing, facilities and measures such as, information regarding contraceptive methods and accessibility, affordability and availability of services for the same. Their choices are also influenced by the patriarchal structure which determines gender relations, population control, state policies and development policies. As a result of political, cultural, social and economic differences, there is a great variety in the degree of control women have over their own lives.[17]

Viewing reproductive technologies closely shows that it can help women to achieve self determination and control over their bodies; at the same time, they can easily become an instrument of those in power to control women's life including the ideology of motherhood. In theory, birth control can liberate women from being overburdened with unwanted children, provided contraceptive methods are brought within the reach of women. The question of autonomy of women also depends on how much facility women have for availability, affordability and regulation of fertility or infertility management.

Within the context of population issue, reproductive technologies are advocated to achieve the goals of national population control policies. Since 1950s, family planning has been widespread for controlling the demographic problem. Controlling the procreative capacity of women is considered as an instrument in achieving this end. To resolve problems of hunger, poverty, backwardness, degradation of environment and depletion of ozone lawyer- population growth is seen as a primary cause. For these reasons, reproductive technologies such as – contraceptive, abortion and pre-natal test has been encouraged. Further, Population control programme perceive women as an tool for managing population growth and reduce women to fertility factors. This has led to the emphasis on efficacy of contraceptive rather than the health and safety of users.[18]

[17] *Supranote* 13.

[18] *Supranote* 13.

Women's movement has indulged in the need for safe and effective methods of birth control including abortion as a means for self – determination and autonomy. But the government has not focussed on the real issues such as women's health, availability, affordability of family planning measures, access to services, health care programmes etc.

In the process of development and modernization, science and technology have come to play an extremely important role. Not only technologies for production but also technologies for reproduction are proliferating rapidly. We need to ask; what are the ideas that lie behind the development of New Reproductive Technologies? And how do these development influence women's autonomy?[19]

Reproduction is now medicalised at different stages both to avoid pregnancy and to induce pregnancy when it is desired. It may begin with genetic screening of parents to determine whether they may be likely to pass any hereditary diseases/disorders to their offspring. In case of inability to conceive, sperm analysis and screening for tubal pathology etc. may be resorted to. If necessary, artificial insemination and or In-vitro Fertilization may be used for fertilization in a laboratory.

Therefore, there is unnecessary medicalisation of women's lives; for instance, interventions in women's bodies as a solution to male infertility. Similarly, the pre-natal diagnostic technique helps pregnancy to be supervised and conducted under the supervision of a gynecologist. In this way, pregnancy and child birth has now become string of medical events, where pregnancy is viewed as a disease and pregnant woman as needing control and supervision that starts even before conception. First, we had sex without reproduction (through contraception) and later, reproduction without sex (through artificial insemination etc.). Now, the ultimate project of science seems to be to have reproduction outside women's bodies may be in laboratories like cloning.[20]

Further, it is also vital to examine the concept of women's right to choose. In the early years of this century, birth control was seen as an essential part of women's

[19] *Supranote* 13.

[20] *Supranote* 13 at pg. 595 .

emancipation. The demand for birth control was combined with the demand for self determination. It was not limited to controlling the number of children but extended to control over the circumstances under which pregnancy and childcare take place. Earlier, there was the demand from women and the concept of self determination and control over one's body was made not just as an individual right but as a social right. Later on, with the development of technologies in the field of assisted reproductive technologies – the demand now is for the right of equal access to technologies such as technology like artificial insemination is not just for heterosexual but for homosexuals also.[21]

In India, talking about abortion which is a burning issue under reproductive rights; abortion was regulated on ground of the health of the mother. It has since been widely interpreted, in practice, to mean that the health of the mother would suffer from too many pregnancies. Abortion is widely used as a contraceptive measure by women. Further, the practice of sex selective abortion on non medical grounds brought out the new-fangled difficulty. It threw up a new dilemma- can the right of women to decide about abortion be extended to women's use of pre-natal diagnosis and abortion of a female foetus, if found? Most Indian feminists, while supporting women's right to abortion, condemned the practice of sex selective abortion and succeeded in having it banned in 1994.

While some women reject certain technologies, others embrace them in their strategies for autonomy or control over their bodies and lives. With New Reproductive Technologies, there is an increase in individual choices for some women. An increasing number of women are using contraceptive to remain free from unwanted pregnancy. Some lesbian women seek to fulfill self- insemination at home or artificial insemination by donor sperm (AID) performed at a clinic. These technologies provide them with the means to escape from the institution of marriage and the norms of heterosexuality and yet have their own biological children. They have also begun demanding access to In-Vitro Fertilization, surrogacy which gives some infertile women a chance to become

[21] Jyotshna Agnihotri Gupta, *New Reproductive Technologies; Women's Health and Autonomy* 595 (1st Edition 2000).

pregnant or to realize their desire for a biological child. Through, genetic screening of parents and pre-implantation or pre-natal diagnosis, there is an increased chance of detecting congenital abnormalities and of preventing the conception or birth of an "abnormal child'. Infertile couples have new choices to have a child through artificial insemination by donor sperm, through in-vitro fertilization or through a combination of technologies including embryo-transfer (to a surrogate). They can even have a genetic child without the woman desiring the child being actually pregnant for nine months. Older women may also become biological mothers. There are also women who want to profit financially from the new reproductive industry, rather than only be used by it. Surrogacy is a case in point, there are women who are willing to bear a child for another woman/couple for money, although, they believe they are doing it for altruistic reasons.[22]

In India, there are vital issues regarding reproductive rights where some women are seeking recourse to prenatal diagnostic technology followed by sex selective abortion to avoid producing another female child. They see it as a strategy to enhance their individual status or security within the family. What will be the legal consequences of such women?

More choice does not necessarily mean or lead to more autonomy. New Reproductive Technologies also make unnecessary interference in women's reproduction which is now possible. Technologies which give some women certain rights and choices are at the same time bound to give those in position or power, by allowing or denying access to them on a selective basis. The politics around the question of women's access to legal and safe abortion in different parts of the world is an illustration of this.

Unfortunately, the high value attached to fertility in many culture puts an enormous pressure on women to get married and bear their first child as soon as possible. However, these same societies deny information and services for contraception and abortion to adolescents and unmarried women, leaving them vulnerable to coerced

[22] Jyotshna Agnihotri Gupta, *New Reproductive Technologies; Women's Health and Autonomy* 604 (1st Edition 2000).

motherhood. The control over women's mobility may often restrict them from availability of information and services for fertility regulation. Besides this, the control over women's productive labour power and other economic resource and restrictions on their right to inherit movable and immovable property is important factors influencing women's reproductive autonomy.[23]

What's more, patriarchal ideologies including the restrictions on the freedom to dispose of one's sexuality and the ideology of motherhood play an important role in women's freedom to choose.[24]

Do these new reproductive technologies help women? Do they widen their choices? While the difficulties are located in women's social situation, for example, they are not literate, they have no control over their own lives etc.; no one takes initiative to change the situation and so new methods are sought in which women become passive acceptors/ users of methods where women's participation itself is minimized.[25]

Eventually, reproductive freedom is an essential element of women's autonomy but as a pre-requisite for gaining autonomy in other areas of life, it is difficult to achieve. Technological innovation is not a sufficient condition for women's autonomy because technologies do not improve sexual/gender relations in conservative attitude of the society.

Though, new reproductive technologies offer some new freedom to women but with an increase in possibilities to choose, the freedom to choose also increases. What is required, at this junction is more visible and accurate legal framework for the resolution of complex issues of reproductive rights and new reproductive technologies. It is essential to protect and promote women's reproductive autonomy. But without having proper legal system, it is not possible to get out of the age old dogmas and practices.

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[23] *Supranote* 22 at pg. 607.

[24] *Supranote* 22.

[25] *Supranote* 22.

The official draft Programme of Action in Cairo and Beijing has mainly adopted the holistic perspective on reproductive health and rights as part of human rights. It spells out a framework of policies and programme strategies to ensure that these rights are to be exercised in all the signatory states. It calls upon national government and International agencies to reshape their laws and policies to ensure women's health and rights and to make resources available for implementation of those policies. The International women's movement has to ensure implementation of the reproductive health and rights framework. This ranges from transforming gender relations and ideology that govern sexuality and family structures to pressurize governments for creating laws and policies for comprehensive health care and reproductive health services, literacy and education of women and men.

The existing gender inequality in the society also affects sexual and reproductive behaviour of men and women. It is imperative to study economic, social, cultural, religious and political aspects which influence gender inequality in the society. There is no doubt, the scope of women to exercise choice, self determination and control over their sexuality and fertility can be seen in the context of their total lack of control over life circumstances and the lack of basic needs fulfillment.[26] This situation is because of gender discrimination where women are silent victim of age old customs and traditions.

In a culture where patriarchy is accepted as the only proper family system, men and women may be trapped in a pattern of relationship and dependencies. It is taken for granted that change in public sphere- whether economic growth, political transformation, new means of communication and transport will be reflected from changes in individual attitudes and behaviour. But this expectation does not extend to the private sphere where basic issues of identity and family are involved. This anomaly is at the root cause of continuing gender inequality. In patriarchal family system, men are the primary decision makers in family and social relationships. Women always urge for better reproductive health, maternity and child care leading to safe pregnancy and

[26] *Supranote* 22 at pg. 618 .

delivery and breast feeding.[27] But their subordinate position in family or society has been responsible for the lack of reproductive health facilities.

Various programmes have been launched to improve the reproductive health of women. Several projects in India demonstrate valuable measures to improve the reproductive health issues. Efforts have been made to spread awareness about reproductive health, gender relation and the services available.

As gender, sexuality, reproductive rights and health are pertinent issues that affect all women in their lives and experiences. Reproductive role of women is part of the larger social roles defined for women which determine their individual lives and the choices they make. The battle for reproductive right is about freedom to decide about their bodies and right to take decision about their body themselves.[28]

Attaining women's freedom requires that individual is able to exercise control over their sexual and reproductive lives. This includes the right to:

i) Reproductive health as a component of over all health throughout the life cycle, for both men and women.

ii) Reproductive decision-making including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice.

iii) Equality of men and women, to enable individuals to make free and informed choices in all sphere of life, free from discrimination based on gender.

iv) Sexual and reproductive security, including freedom from sexual violence and coercion and the right to privacy.

The importance of reproductive rights in terms of meeting International development goals has increasingly been recognized by the International Community. In the World Summit (September 2005), the goal of universal access to reproductive health was

[27] http:/www.unfpa.org/swp/2000/English/ch04.html -10/9/2009.

[28] http://www.psbt.org/general/sexual_rights-health.

endorsed at the highest level. Reproductive rights are recognized as valuable ends in themselves and essential to the enjoyment of other fundamental rights. Special emphasis has been given to the reproductive rights of adolescent girls and to the importance of sex education and reproductive health programmes.

The various factors that help to protect reproductive rights are in the following areas:[29]

a) Improving health infra-structure
b) Making motherhood safer
c) Family planning measures
d) Prevention of HIV/AIDS
e) Addressing gender-based violence
f) Supporting adolescents and youth

In reality, to incorporate above factors under health infra-structure needs lot of commitment from the government. the causes of poor health is regarded as lying as much in the social domain as physical domain, it makes cultural sense to also seek cures from healers other than from the medical profession where various problems like nutritional deficiency, information about family planning, etc are the root causes.

In India, the provision for health care facilities lies on government's shoulder. It is their main responsibility to provide people with adequate health services everywhere. There are instances where people are dying of hunger; where there is only one or no earning member; in such condition getting adequate food for women or pregnant women or breast feeding mother is almost impossible. There are various cases of the weakness of mother and infant which is caused largely due to their under-nourishment. There is very few steps taken by the government in connection with emphasis on the quality and nature of the dietary intake of mothers during pregnancy and after child birth. Women themselves did not consider it important to take care of their diets and other health issues as there are other more relevant survival issues that they are dealing with, perhaps.

[29] http:/www.unfpa.org/rights.htm.

The task of enhancing reproductive health services outreach in the villages at many levels addresses not only the question of access to existing health services but also the provision of facilities available and fulfillment of the requirement of the health needs of the people.[30]

Moreover, maternal health facilities are unbalanced focusing on immmunisation and the provision of iron and folic acid rather than on sustained care of women or the detection and referral of high risks cases.[31]

Women and health rights activists have been looking forward to the drafting of the bill in the light of the unregulated practices of these technologies and the increasing commercialization and commoditization of women's reproductive capacity. The bill has been drafted and is named as "National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India issued by the Indian Council of Medical Research in 2008.

The draft bill aims to regulate and promote the interest of the providers of these technologies rather than regulate and monitor the current practices. But the bill is inadequate in protecting and safeguarding the rights and health of women who undergo these procedures, surrogate motherhood, egg donors and the children born through these techniques.[32]

Women's life has been revolving around reproductive task, mostly and it is in this area where they are facing critical problems not only relating to physical health but also social problems like gender discrimination, denial of health services etc. Even in the era of equality of sexes; equal status of women is a distant dream. Their capacity to reproduce has become a reason for their dominant position in the society. Therefore, there is a need to protect and promote reproductive rights of women through proper legal framework.

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[30] Jyotshna Agnihotri Gupta,*New Reproductive Technologies:Women's Health and Autonomy* 627 (1st Edition).

[31] *ibid* at pg.628.

[32] http://www.issuesinmedicalethics.org/171co36.

Here, it is pertinent to draw attention on what is the meaning of reproductive right? It means right of all couples and individuals to have highest standard of sexual and reproductive health. It also means to be able to decide numbering and spacing of children. It also includes right to make decision free of discrimination, coercion and violence.

Therefore, in this thesis work, Chapter I is pertaining to "*Delineating the Boundaries of Reproductive Rights of Women*" where the meaning of reproductive rights as given under various International Instruments has been elaborately discussed. Why reproductive right is important for women for their emancipation has been underlined in this chapter. The general observation of how reproductive right plays an important role in the path of women's empowerment has been analysed. Various human rights guaranteed under various international instruments have also mentioned as reproductive rights being part of human rights is also mentioned.

An assortment of human rights which contains the seed of reproductive rights has been discussed here such as right to health, right to privacy, right to life etc. Thus, chapter II delineates the boundaries of reproductive rights of women to the extent of new horizon and encompasses within it the foundation of reproductive rights framework.

Chapter II is "*Women's Health and Medical Technologies-Emerging Challenges*". In this chapter, what are the new reproductive technologies available and its effects on women's health has been discussed. Whether women have been benefiting from these technologies or not has been analysed. New reproductive technologies starting from contraceptive pills to condom; abortion to sex selective abortion; In-vitro fertilization to egg/sperm donation; surrogacy to cloning, all known methods has been categorically discussed highlighting briefly its merits and demerits. An effort has also been made to overview on the subject of how reproductive technologies has brought new phase in the medical world. How far these technologies are using for the benefit of women? Whether these are helping women to achieve their autonomy or not? Whether there are any health risks that women suffers due to these technologies or not? Whether women

are decision maker in choosing these technologies are some of the vital challenges that are brought by these technologies or not? Here, effort has been made to answer all these quarries and the impact of reproductive technologies on women.

The most relevant issues of reproductive rights have been highlighted in chapter III i.e "*Ethical Dilemmas and Legal Issues in case of Reproductive Rights*". The research work is based on examining highly ethical and legal issues of reproductive rights. What are the challenges before the state to regulate the reproductive rights? What are the challenges brought by new reproductive technologies? Whether these technologies are affecting the quality of life women living? Whether these technologies has been misusing or not? If misused what is the redressal agencies? Whether women have control over their fertility or sexuality? What is the status of children born out of such technique? What would be the definition of motherhood/parenthood in the light of these technologies? All these and many more ethical, social and legal issues have been researched into this chapter.

What are the existing laws available for the protection of reproductive rights of women? Whether existing laws are adequate enough to meet the growing challenges of reproductive technologies? What measures could be adopted to achieve quality reproductive health care of women? The policies and programmes that have been implemented so far to enable women to meet their reproductive health goals have been enlighten. What are the defects, if any, that exists in achieving quality reproductive health care of women. What are the areas that are not yet covered by the existing laws? By scrutinizing both international and national instruments, the visible framework for the protection of reproductive rights has been discussed under Chapter IV i.e. "*An Analytical study of laws, policies and programmes for the Protection of Reproductive rights*".

As International community has always shown their commitment towards women's health and rights including reproductive rights. Various rights were recognized at International Conference several times on the human rights of women. The Universal Declaration of Human Rights (1948), The International Convention on Civil and Political Rights (1968), The International Convention on Economic , Social and

Cultural Rights (1966), the Convention on the Elimination of all Forms of Discrimination against Women (1981), The Convention on the Rights of the child (1990), The International Covenant on population and development 1994, Fourth world conference on women (FWCW) etc, all have addressed women's reproductive health as a fundamental human right.

Next to recognition of reproductive rights by International Community, in national level, effort has also been made for the protection of these rights under Indian legal framework. The Constitution of India itself guarantees under Article 14 - 16, gender equality, Article 21 guarantees Right to life and also under Directive Principles of State policy, Part IV provides provision for elimination of inequalities in status, just and human conditions of work and maternity relief and to regard the improving of nutrition, standard of living and public health as among its primary duties. It also provides fundamental duties under Article 51 (A) to renounce practices derogatory to the dignity of women etc.

Besides there are very scarce legislation i.e. The Medical termination of Pregnancy Act 1971, legalize abortion under certain circumstances; The Pre- Conception and Pre-Natal Diagnostic Technique (Prohibition of Sex selection) Act 1994 prohibit sex-selective abortion and The Maternity Benefit Act 1961 protects the right of working women during post- natal care and allows maternity leave for the period of three months (amended to six months but not yet implemented).

So, there are very few existing laws for the protection and promotion of reproductive rights of women. The government's effort is till now limited to the family planning measures with aim to control demographic problem. Though, other health facilities are almost negligible; women have been facing unacceptably high risk of dying during pregnancy and child birth. Sometimes, they even have to take the burden of unwanted pregnancy due to the failure of family planning devices or failure of sterilization operation. The issues arising out of such cases are complex and need to be addressed. There is a need for a sensitive and visible laws and policies to safeguard women from such reproductive health alarm.

Though, five year plan also concentrated on population but reproductive health of women is not much dealt with. The only available facilities are Primary Health Centers with ill equipped techniques and inadequate service providers. However, National Population Policy has been framed but still reproductive rights has not been promoted and protected to the extent it requires.

Over the years, many cases have come before the judiciary on such issues. But the judiciary has never recognized reproductive and sexual rights of women clearly. The court suffers mostly due to the technicalities or practical difficulties. Though, recently court seems to be viewing such issues with wider perspective. It has set a new trend by providing compensation in cases of failure of sterilisation operation.

The new reproductive technologies have also posed many new legal issues. Few years before, a couple reached Mumbai High Court seeking permission to abort foetus at the stage of 24 weeks. The legal abortion cannot be performed after the period of twelve weeks under Medical Termination of Pregnancy Act 1971. But here foetus was found with cardiac anomaly with the help of prenatal detection of foetus. However, court denied to grant permission to abort on the ground of Medical Termination of Pregnancy Act. Such issues require urgent solution. Whether Medical Termination of Pregnancy Act, 1971 is required to have second look? With the latest technology abortion can be done safely even after the period of twelve weeks. These issues are vital for the protection and promotion of reproductive rights.

Chapter V is "*Role of the Judiciary in Protection of Reproductive Rights of Women*" provides case laws on various reproductive rights problems has been discussed. Both International and National cases has been discussed to find out the appropriate solution on emerging issues of reproductive rights. Also to measure how far judiciary is efficient in dealing with the crisis of present scenario that has brought by New Reproductive Technologies. Whether Judiciary has its impact on the protection of reproductive rights? How far judiciary helps in shaping reproductive rights of women in India?

As, in the present situation where there is inadequate laws and existing laws are almost invisible, the only last resort would be the judiciary. Therefore, burden lies on the judiciary to implement and interpret laws according to the present situation.

The reproductive technologies have brought phenomenal changes by separating reproduction from sexual intercourse and marriage. This has let to the change in the concept of parenthood or motherhood. Today, it is possible to have offspring by hiring donor or can hire women who can contribute the egg or carry the gestation over nine month and give birth to a child and paid for the service. This scientific breakthrough has brought new fears.

The Indian legal system is still silent in these emerging issues. There is likelihood that some day people would bang on the doors of the judiciary for an answer to these new problems.

The new techniques of reproduction can be useful to a single women or lesbian etc who has a desire to have a child without involving in long term commitment but there is no law to carefully spell out the legal status of such a single unmarried mother, child status (born out of such techniques) and there acceptance in the society. Reproductive right means women have the right to reproduce and freedom to decide how and when to do so. But once such right will be exercise; what will be the social status of such women is still jeopardize.

The reproductive right framework guarantees a powerful instrument for advancing women's health and empowering them to address the social conditions that influence their health and their lives. As there is still violence against women rampant in the society and there are no adequate laws to safeguard women from such violence. In such a situation recognition of reproductive rights by the state agency is an urgent need.

Though, women movement for their right is going on for so long but still the concept of reproductive right is very recent. The issue on reproductive right of women is not very visible in the Indian legal framework. There is no system of check and balance of new reproductive techniques and thus urgently require clear legal framework.

Moreover, the legal fraternity mostly now reaches into the sphere of family, community and tradition- the areas where the rights of women have to be recognized through legal instruments.

Therefore, it is essential to well equip the legal structure of our country to deal with the challenges of reproductive rights. The present research work is intended to make significant contribution in this area.

The main object of this study is to identify the laws and available legal framework. It aims to invoke the areas where there are no laws or even if there are laws, they are not adequate enough to meet the present challenges. It also attempts to suggest necessary steps to be taken to protect and promote reproductive rights of women in chapter VI as heading "*Conclusion and Suggestions*".

The hypothesis of the present thesis work is that there is no visible and comprehensive legal system for the protection of reproductive rights in India. The existing laws are scattered and underutilized. Even, the Judiciary is reluctant to explore this area fully and basically very few cases have come before the judiciary. Above all, women themselves are hesitant to approach court for their rights.

The methodology of this research work is doctonire in nature where both historical and analytical approach has been adopted. The study has been conducted on the basis of primary and secondary documents. The data necessary for the study of this research work has been collected from established sources and also from local health services available.

Thus, the struggle for the empowerment of women's right will be incomplete without having arena for the protection of reproductive rights. In order to realize this right, visible legal structure is the prime necessity. Thus this thesis is titled as "*A Study of the Legal Framework for the Protection of Reproductive Rights of Women in India*". Here, through this thesis a sincere effort has been made to elucidate the moot causes existed in recognition of reproductive rights. Now moment has come where serious problems

will arise in the absence of clear legislation. Thus, this is high time for the legislators to enact and enforce reproductive rights under Indian legal system.

It is viewed that women constitute the vulnerable section of the society thus every state has to develop an effective legal system for the protection of this group. Though, there are laws for the protection of women but they are not sufficient enough to encourage participation of women in decision making process and enforcing their rights. There is a need to draw attention on the helpless condition of women and their sufferings. Perhaps, what else would be a better tool for women to protect themselves from their age old misery than that from freedom to control their bodies, their sexuality and fertility and freedom to take decision regarding reproduction?

It is high time for the government to plunge into motion with a comprehensive action plan involving various ministries, departments and other non- governmental organization for overhauling the existing social structure. To the end, it is extols that the virtue of motherhood has been seen and still hope to continue to see as god's gift "as *a blessing and not as a curse*".

Indeed, time has come where women would make great reaffirmation in the heart of the humanity where policies and ideals are changing to give them new destiny; the environment where women live with dignity and respect. The moment has come where women has to demand for their self respect and self determination. There has to be an effort for resolution on the part of women to demand that they are women of the highest status of their womanhood and proud to be a woman.

CHAPTER 1

DELINEATING THE BOUNDARIES OF REPRODUCTIVE RIGHTS OF WOMEN

1.1. Introduction

There has been a constant struggle for women's rights in the history of civilization. These struggles include (among various issues) the understanding of women's sexuality and women's reproductive role as a prerequisite factor in achieving women's right as well as freedom. There is a need to open a debate on these highly sensitive and personalized issues and their relation with the socio- economic and political structure of the society.[1]

There is always interconnection between health, reproduction and women's rights. Therefore, the involvement of women in every sphere has been a delineating factor for women's rights and freedom. Though, women have been participating in the making of the government but it has not changed the stereotypes of women. Today, women's position is slightly better but it still has to go a long way. In the movement of women's rights, reproductive health of women plays the crucial role.[2]

It is said that "*there is no freedom, no equality, no full human dignity and personhood possible for women until they affirm and demand control over their own bodies and reproductive process*". The reproductive right is for the conscience of every individual and conscious choice of all women.[3]

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[1] Imrana Qadeer "*Reproductive Health- A Public Health Perspective*" Oct 10 Economic and Political Weekly 2675 (1998).

[2] Instruments on Women's Rights, (FEMNET), by Keroline Kemp www.reproductiverights.org

[3] Monaj Sharma "*Right to life Vis-à-vis Right to abortion, An Analytical study*" 18(3&4) Central India Law Quarterly 410 (2005).

There is no doubt that the reproductive health care is an assessable mechanism to determine the status of women in any society. Women's sexual and reproductive health is to be respected and protected in order to achieve women's rights. In reality, women bear an inconsistent burden because of their capacity to reproduce and fail to participate effectively in the development endeavor.[4]

The reproductive rights and the freedom requires three things –

1. That woman must have right to make decisions that affects her reproduction;
2. There must be least interference of state in relation to reproduction; and
3. Conducive social atmosphere to exercise reproductive freedom.

These three elements have to be guaranteed by the law of the state.[5]

Till this date, women's reproductive rights have been protected by the courts through intervention into the constitutional right to privacy. But there is lack of governmental intervention into this area. At present, a woman's right and/or decision to bear a child or not is significant for women as they equally participate in all the fields including the economic field. A pregnancy affects their capacity of working as an individual.

It is notable that in many feminist theories the reproductive capacity of women is connected with their subordinate position in the society. Biological reproduction is an area of concern for women as it is women who menstruate, become pregnant and give birth to children. This capacity of women has made man and woman biologically different and socially unequal.[6] The struggle of women for autonomy and freedom in the society can be realized only when their reproductive right to decision making will be protected.

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[4] An interim at the African Women's development and Communication Network (FEMNET) www. *reproductiverights .org* by Ritu Anyumba.

[5] Rachael N. Pine "*Principles Governing Reproductive Freedom*" November The Lawyers 13 (1993).

[6] Jyotsna Agnihotri Gupta, *New Reproductive TechnologiesWomen'sHealth and Autonomy* 37 (1st Edition 2000).

The reproductive rights not only deal with the status neither of women nor with their role as mother or their restrictions to a domestic sphere, but also whether or not women control their reproductive capacity.

The traditional values show that the relationship between woman and man is governed by the cultural constraint which has its impact from biological sexual identities. Nevertheless, biological factor seems to be invisible in determining the status of woman and man in the society. But it has explicitly or implicitly played an important role in determining the status of woman and man in the society so far.

The concern of reproduction has always been the prime factor to women's lives. In all ages women have hardly any say in conception, or to get away with unwanted pregnancy, to remain childfree or to deal with childlessness. Thus, interference in reproductive capacity of women is as old as the history of civilization.[7]

Measures of preventing conception like contraception, abortion, menstrual extraction etc. were known for a long period of time. But women hardly have any choice to adopt these practices as they were never considered as decision makers in the household. It was at the option of the male partner the reproductive decisions were taken. The things have not yet changed even though various convenient mode of reproduction has been established now with the invention of various reproductive technologies. Hence, the issue today is do women has control over their reproductive capacity? Whether women are decision maker in the exercise of their reproductive capacity? Whether reproductive technologies have good or bad impact on women's lives?

Research in human reproductive technologies has made great bang on the society. The control of reproductive capacity through these newly arrived technologies have been rampant for the management or control of fertility. This advancement has brought some changes in the concept of health. The attention on hygiene and infectious diseases, immunization on large scale has contributed to a large extent to a reduction of

[7] *Supranote* 6 at pg.13.

infant mortality. With this advancement there arises the use of reproductive technologies immensely for various purposes.[8]

This has brought many social, legal and ethical issues before the society. The reproductive technologies have brought new possibilities for women to shape their lives and make it possible to have choices for them. This has also paved the way for emancipation of women through the instrument of reproductive technologies.

1.2. Meaning of Reproductive Rights:

Reproductive rights of women have its roots in the already existing human rights instruments of women. In the age of the constant movement for women's right, reproductive rights occupy a central position both at the International level and at the national level.

What are reproductive rights? What ought to be the range of reproductive rights? These are the crucial questions to be answered first before embarking into future. The Reproductive rights of women means the right of women to attain the highest standard of sexual and reproductive health and at the same time achieving full participation in the social and economic life.[9] It includes various human rights of women such as- right to abortion, right to make her own decision regarding her body and her reproductive life, right to safe sex, right to procreation and to have family etc.

Women are vulnerable to health complications due to their reproductive capacity sometimes. Their capacity to give birth, which is said as blessings, may sometimes turnout to be a curse for them. There are instances of death or injury to the women during child birth. Thus, the right to reproductive health care gives rise to a governmental obligation to provide adequate reproductive health facilities that include, measures to promote safe motherhood, care for those with HIV/AIDS or sexually

[8] *Supranote* 6 at pg. 14.

[9] www.*reproductiverights.org*

women's life and let silence speak and the margin becomes centre than and only than

transmitted infections, infertility treatment and a full range of quality contraception including emergency contraception.[10]

It also means a state of complete physical, 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 processes. Reproductive health, therefore, implies that people are able to have satisfying and safe sex and that they have the capacity to reproduce and the freedom to take decisions as to when and how often to do so. It also impliedly provides the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law and the right of access to appropriate health facilities that help woman to have pregnancy and childbirth and also helps a couple to have a healthy child.[11]

Reproductive rights or freedom has brought new revolution in the society assuring equality of relationship between men and women, respect for the integrity of the person, consent and responsibility for sexual behavior and its consequences. Moreover, the places from where the base of reproductive rights arise and can be exercised stand occupied by the pharmaceutical industries, medical education and profession and public health specialists.[12]

Women's self-determination stand together with this and trapped in these variety of places. The reproductive rights self determination must necessarily take into account the conflicts, contradictions and collisions among the production of spaces for activism and the places which furnish sites of its insurrection. To justify the subject of reproductive self determination, it is necessary to make visible those invisible factors of

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[10] Civil and political rights Covenant as referred in using legal Advocacy to advance reproductive rights, Gaining grounds. www.*reproductiveright.org*

[11] International Conference on Population Development Program of Action, paragraph 7.2

[12] Upendra Baxi "*Gender and Reproductive Rights in India:Problems and Prospects for the New Millennium*" October Kali'sYug 24 (2000).

women's life and let silence speak and the margin becomes centre than and only than women's reproductive rights can be realized.[13]

Henceforth, a reproductive right means right to decide whether when and how to have children. The ability of women to control their own fertility forms an essential basis for the enjoyment of other rights and lays down the foundation for equality between women and men. The right to free choice in the matters of sexuality and reproduction is of fundamental value which must be guaranteed by the state.[14] Thus, rights involving to reproduction and sexual health care are originated in a variety of International sources.

1.3. Reproductive Rights – A Part of Human Rights

From the mid-nineteenth century, feminist and socialists advocated for the right to reproductive choice as a basis of women's personal and political liberation. Modern technique of reproduction makes it possible for couples to plan to have child and when to have and also how many children to have. A reproductive right inevitably touches the susceptible issues of the rights of women, their autonomy and the right to decide about their body. In all the liberal societies reproductive rights has been recognized as a part of human rights.[15]

From Tehran to Cairo, Beijing and beyond, there has been a constant effort to establish the reproductive rights of women as a part of human rights. There has been an effort to create an environment favorable for women to take decisions in matter of reproduction. It becomes essential to encourage and create a legal and social structure where women have freedom to take decision whether to bear a child or not. It is the women who have to undergo a physical pain in their pregnancy and they have to bear and carry the pregnancy for nine gestational months. So, women's health and human rights are interconnected and the promotion of one depends upon another.

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[13] *Supranote* 12.

[14] Subhash Chandra Singh *"Reproductive Rights as Human Rights: Issues and Challenges"* 31(1&2) Indian Socio-Legal Journal 59 (2005).

[15] *ibid*

The Final Document of the Tehran Conference on Human Rights, 1968, provides the "basic *human right to decide freely and responsibly the number and spacing of children and the right to adequate education and information in this respect".* The Cairo program further expanded the content of reproductive rights as a *"state of complete physical, mental and social well-being".* The infant concept of reproductive rights matured with the Beijing Platform where it was held that *"the reproductive health to women's rights means to have control over matters relating to their sexuality free of coercion, discrimination and violence".*[16]

In Vienna in 1981, there was a UN Symposium on Population and Human Rights which declares that *the compulsory use of abortion and its unqualified prohibitions would be a serious violation of human rights.*[17]

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) further provides, *"the obligation to ensure the full development and advancement of women for the purpose of guaranteeing them the exercise and enjoyment of human rights of gender equality where man and woman have equal rights"*[18].There is a general obligation to respect, protect and promote human rights of women.

Similarly, the International Planned Parenthood Federation (IPPF) in its meeting in Manila in November, 1995, adopted a new Charter on *Sexual and Reproductive Rights* which is meant to promote and protect sexual and reproductive rights and freedom in political, economic and cultural aspect[19].

Reproductive rights are expressively the human rights and are inalienable and inseparable from basic human rights such as right to food, shelter, health, sexuality,

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[16] www.*reproductiverights.org* International Conference on Human Rights in Teheran in 1968.

[17] *Supranote* 14 at pg 60.

[18] *Supranote* 12.

[19] Subash Chandra Singh *"Reproductive Rights, A part of Human Rights"*3 Supreme Court Cases Journal 13 (2002).

livelihood, education etc. The sexual and reproductive rights included under International Instruments are derived from universally recognized human rights instruments and have high ethical values.[20]

The ability of women to control their own fertility is an essential criterion to enjoy all other rights and lays down the foundation for the equality between men and women.[21] Reproductive Rights include various human rights recognized under International Instruments. These are as follows:-

1) Right to Health, Reproductive Health and Family Planning.
2) Right to decide the number and spacing of children.
3) Right to marry and found a family.
4) Right to be free from gender discrimination.
5) Right to be free from sexual assault and exploitation.
6) Right not to be subjected to torture or other cruel, inhuman or degrading treatment.
7) Right to life, liberty and security.
8) Right to privacy.
9) Right to modify customs that discriminate against women.
10) Right to enjoy scientific progress and to consent to experimentation.

1.3.1. Right to Health, Reproductive Health and Family Planning:

The human rights instrument provides right to health as a basic human right which includes reproductive right as well. The health is the core to the dignity of a person and the state is committed towards the health of the individuals as a fundamental right.[22] It

[20] *Supranote* 14.

[21] *Supranote* 14 at pg. 59-60.

[22] Right to health has been included under Article 21 of the Indian Constitution.

is not possible to realize all other human rights if an individual cannot maintain his or her own health.

The reproductive health is a new concept in the area of International human rights law. The method of expressing it clearly is still going on. Now a days even government is showing its concern towards health, shifting its priority from demographic problem to concern about the needs of the people for their reproductive health such as- providing facilities for safe and affordable measures of family planning like contraceptive, maternal and child health care services etc. The concept of right to health is much wider than this. It means having social and economic condition to exercise choice in reproduction and reproductive health services.[23]

The term 'reproductive health' was first time mentioned in an international document in Chapter VII of the 'International Conference on Population and Development' (ICPD) Programme of Action. After the Cairo Conference, the concept of reproductive health has been increasingly used in the international debate. It has again pointed out in the Beijing Declaration and Platform for Action.[24]

However, reproductive health not only means fertility regulation and family planning, it means much more than that. It implies and incorporates an awareness of social and cultural context in which reproduction and child bearing is carried out, attainment of gender equality and emancipation of women. In other words, to address reproductive health issues, we must address the reproductive rights of women and men and the social and cultural environment that touches reproductive health ends.[25]

The health policies of the government are mostly concerned with the population problem of a country and have always neglected the reproductive health care of women. Here, it is to be noted that women has a right to informed choice and consent in the health care facilities. It is important that women should be well informed of

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[23] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights and Humanitarian Law* 170 (1st Edition 2000).

[24] *ibid* at pg.171.

[25] *ibid* at pg.174.

health services and they should understand the information imparted to them. They must have an informed consent in any medical procedure and they must be informed of its consequences too.[26]

With the concept of reproductive health, the concept of family planning emerges automatically. The concept of family planning as basic human right is relatively recent in International scenario. The term was introduced after World War II, and it was first used in the United Nation Resolution adopted in 1965 by the United Nation Commission on the Status of Women. There it was stated that: "married couples should have access to all relevant educational information concerning family planning". It was for the first time in United Nation Conference on Human Rights held in Teheran, 1968 that matters of procreation and family planning were specifically related to human rights was mentioned. Article 16 of the Proclamation adopted at this Conference provided that "parents have a basic right to determine freely and responsibly the number or spacing of their children. Thereafter, it has been mentioned in various human rights documents.[27]

1.3.2. Right to Decide the Number and Spacing of Children:

The World Population Conference in Bucharest in 1974 stated that: "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so". The couple's right to decide the number or spacing of the children was approved in the International Conference on Population Development final document Beijing Declaration. Further, the Convention on Elimination of All Forms of Discrimination against Women (Article 16(1) (e)) creates an obligation on the state party to take all appropriate steps to guarantee that women have the same right as men to decide freely and responsibly on the number and spacing of their children and to have means to exercise this right.[28]

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[26] The Dictionary of Demography 172(Cristoper Wilson ed, 1985) as referred in Rrethinking Population Policies: A Reproductive Rights framework. www.*reproductiverights.org* by Ronald Prersant.

[27] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights and Humanitarian Law* 183 (1st Edition 2000).

[28] *ibid* at 184

The new age has given woman access to plan her pregnancy through various measures of family planning. But an estimated 350 million couples worldwide do not have access to family planning services they require. In many countries, access to contraception is prohibited by laws and policies and above all there is lack of concentration on the part of the government towards the protection of reproductive rights.[29]

International Community has articulated the right to plan pregnancy as important human rights of women. They have right to determine freely and responsibly the number and spacing of their children. Worldwide there are number of cases of violations of women's rights involving coercion in the use of contraception.

International human rights instrument has always respected and protected independence in decision- making process. It provides for the freedom of the bodily integrity and health. If a pregnancy is unwanted, women must not be legally bound to carry it to term. There has been international acknowledgement of the right to decide freely and responsibly their family size. As decision one makes about one's body especially one's reproductive capacity laid in the domain of private decision- making.

The burden of bearing and rearing of children mostly lies on women's shoulder which affects their personal development and imposes inequitable workloads on them. The decision on number or spacing of children have direct impact on their physical and mental health, thus the right to decide on number or spacing of children must be entrusted within women's reproductive rights.

1.3.3. Right to Marry and Found a Family:

The origin of family formation may be either marriage or parenthood or both. International document guarantees right to marry and found a family to every individual.[30] The Human Rights Convention expresses its concern on early marriage

[29] International Conference on Human Rights in Teheran in 1968.

[30] Article 12, Convention on Elimination for all forms of Discrimination against Women, Article 6 (a)-(c) International Covenant on Civil and Political Rights.

and stated that the high maternal mortality rate may be the consequence of early marriage. The marriageable age of a girl and a boy has been fixed by a law mainly to avoid childbearing at early age as it may result in mental and physical health risk of both mother and child.[31]

Article 12 of the Women's Convention provides that "men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right". It means that men and women have right to marry and found a family and the state is under obligation to provide condition conducive to exercise this right. However, this right is subject to wider interpretation but till now, the Court has not been willing to accept that the right to found a family means right to found a family in the absence of a marriage.[32]

The right to found a family implies the right to procreate. In the past few years, the new technological improvement has totally changed the face of reproductive rights by providing large arena for choice in reproduction. Some scholars have put forward an argument that the right to found a family embraces the right to have access to the medical technology in order to ensure procreation.[33]

The essence of the right to marry is the formation of a legally binding association between a man and a woman. It is for them to decide whether or not they wish to enter an association in circumstances where they cannot cohabit. However, there is no solution provided for those who are single, unmarried and homosexuals; how they will exercise right to found a family.[34]

The biotechnology has totally impinges the concept of marriage and family which is the very basis of the social organization. Science has over-powered the nature which will surely open the way for disturbance in the society in future. The new reproductive technologies such as cloning, amniocentesis, IV F, surrogacy has raised many ethical

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[31] *www.reproductiveright.org.*

[32] Durga Das Basu, *Human Rights in Constitutional Law* 435(1st Edition 1994).

[33] Article 28(2)of CEDAW

[34] *Supranote* 32 at pg.437.

and legal challenges before the society. The mysteries of heredity and procreation has merely made more difficult.

However, right to found a family is provided under Article 12 of the Women's Convention but for some couple the chance will be an empty one because of their incapacity to procreate. In such situation state has to provide either facilities for adoption or artificial technique to produce children. Recently, attention has been switched to artificial reproduction. Though, it cannot be said that Convention positively imposes obligation on a state for accessibility of those measures except why married person may not avail those facilities? Hence, there has been unbeatable debate going on between intellectuals regarding recognition of right to marry and to found a family.

1.3.4. Right to be Free from Gender Discrimination:

The United Nations Charter provides for the co-operation in promoting and encouraging respect for human rights and fundamental freedoms for all human beings without distinction as to race, sex, language and religion. The United Nation is firmly committed to gender equality and its Charter is the first universal law-making treaty explicitly to mention the principle of equality between men and women.[35]

The Women's Convention provides that the discrimination against women includes laws that have either the effect or the purpose of preventing women from exercising any of her human rights or fundamental freedom on a basis of equality with men. Right to reproductive freedom also extends to the legal protection against gender-based violence, such as marital rape, domestic violence, sexual harassment both at home and at work place etc.

The gender based- violence causes an effect on women's physical and mental health. It has been recognized as a major concern and a serious violation of human rights. According to the world report on Violence and Health (2002),out of 69 percent 10 percent of women are molested by their intimate partner in their lifetime. Other

[35] Maja Kisilova Erikson, *Reproductive Freedom in the context of International Human Rights and Humanitarian Law* 21 (1st Edition 2000).

population based studies have experienced some attempted and completed forced sex act by an intimate partner or ex-partner at some time in their lives.[36]

Article 24 of the Convention on the Rights of Child provides rights of the children as well as gender rights of women. It provides that the pregnant women are entitled to appropriate pre-natal and post-natal health care during child birth.[37]

It is evident that men and women are not in the same position with respect to procreation right. Does women's child-bearing function justify special treatment? However, the United Nation Commission on Human Rights in its Resolution 1995/85 reaffirmed that discrimination on the basis of sex is contrary to the Charter of the United Nation.[38]

The Convention for Elimination of all Forms of Discrimination against Women (CEDAW) defines discrimination against women as "any discrimination, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field". The state party with the ratification of the Convention has the responsibility to take a series of measures in order to eliminate discrimination against women. Such measures include[39]:-

a) to incorporate the principle of equality of men and women in the legal system;
b) to abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women;

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[36] World report on Violence and Health 2002 "Intimate partner Violence" www.w*ho.int*

[37] United Nations Population Fund, "The State of world population 2000". Chapter 6: Women's rights are human rights. http:/ www.*unfpa.org.*

[38] *Supranote* 35 at pg. 65.

[39] Yamini Mishra "*Unsafe Abortions and Women's Health*" Oct 6 Economic and Political Weekly 3814-15 (2001).

c) to establish such institutions to ensure the effective protection of women against discrimination; and

e) to ensure elimination of all acts of discrimination against women by persons, organizations or enterprises.

Despite several efforts by international instruments, there is still gender discrimination existed in the society. Thus, there is a need to take more constructive efforts by the government as well as by the individuals to have society free from gender discrimination.

1.3.5. Right to be Free from Sexual Assault and Exploitation:

Reproductive rights also include right to be free from sexual assault and exploitation. Here, a sexual assault and exploitation extends to both the public and private sphere such as – domestic violence, marital rape, sexual harassment at the workplace etc.

Though, there are certain laws under International and national community to curb these evils but still such sexual violence is prevalent almost in every society. A reproductive right means right to respect and protect one's own body. This cannot be achieved without guaranteeing right to be free from sexual assault and exploitation to every woman.

The existing human rights instruments never defined or address the sexual assault or exploitation or in other words violence against women clearly. This gap was especially existed because of the fact that there existed distinction between the abuse in the public sphere or private sphere. The private violence such as- domestic abuse, marital rape, and harmful traditional practices are not mentioned under international, national and regional laws.[40] The measures to protect women from sexual assault and exploitation require visible legal framework and effective enforcement machinery.

The Convention on Rights of Child (CRC), however, requires the state party to "protect the child from all forms of physical or mental violence, injury or abuse, neglect

[40] The Protocol on the Rights of Women in Africa,February 2006. *www.reproductiverights.org*

or negligent treatment, maltreatment or exploitation". Similarly, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) Committee states that "the definition of discrimination includes gender based violence". It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.[41]

1.3.6. Right to Modify Custom that Discriminate Against Women:

Being part of the human rights, reproductive rights guarantees rights to modify custom that discriminate against women. It therefore, ensures women right to be free from harmful practices such as female circumcision and female genital mutilation etc. An effort has been made to eliminate harmful social and cultural practices that affect the dignity, respect and development of women.

In January 1994, International Conference on Population Development (ICPD) Programme of Action issued a Declaration to all the state members that women are entitled to bodily integrity which must ensure that there shall be no violence against women and harmful practices like female genital mutilation or female circumcision. Government should take measures to combat such practices and will be held responsible for such instances.[42]

The Convention on Elimination for all forms of Discrimination against Women (CEDAW) requires the state parties to take all the necessary steps to eliminate social and cultural patterns and practices that are discriminatory to women. The Convention on Rights of Child (CRC) requires the state parties to take all possible measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child. Since women are underrepresented in the judiciary and legal fraternity, there is a need to address such social and cultural practices that discriminate against women, thus, tradition ends where discrimination against women begins.[43]

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[41] *Supranote* 40.

[42] Subhash Chandra Singh *"Reproductive Rights as Human Rights: Issues and Challenges"* 31(1&2) Indian Socio-Legal Journal 59 (2005).

[43] The Protocol on the Rights of Women in Africa, February 2006. *www.reproductiverights.org*

In various International treaties, it has been encompasses that the state parties must take steps to modify the social and cultural practices that discriminate against women through public awareness, information, education and communication strategies, with the purpose to eliminate harmful traditional practices and all other practices based on the discriminatory roles of women.[44]

1.3.7. Right to Life, Liberty and Security:

Right to life is the most important human rights without which no other human rights can be realized. The right to life and security includes right of everyone to bodily integrity which provides the right to make decisions concerning reproduction and to security in and control over their bodies. It provides women the freedom to take the decision whether to have sex or not, whether to carry child to term or not in case of pregnancy.[45]

The right to life, liberty and security does not only mean physical integrity. It also means mental and psychological freedom and security to life. Right to choose hardly means anything when there is no sense of security among women.

It is provided that right to procreation and right to have control over reproductive organs are included in the broader concept of right to life. Every person including a girl has a right to marry and thereby to conceive a child. The right to life also includes that no woman's life should be put at risk by reason of pregnancy. Further, the right to liberty and security of the person recognizes that all persons must be free to enjoy and control their sexual and reproductive life and that no person should be subjected to forced pregnancy, sterilization or abortion.[46]

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) Committee, the treaty monitoring body that monitors government

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[44] *Supranote* 43.

[45] *www.reproductiverights.org*

[46] Manoj Sharma "Right to Life vis-à-vis Right to Abortion:An Analytical Study" 18 (3&4) Central India Law Quarterly 412 (2005).

compliance with Convention on the Elimination for all forms of Discrimination against Women has framed the issue of maternal mortality due to unsafe abortion as a violation of women's right to life.[47]

The right to life is protected in many international instruments. But in the preview of life threatening risks that women take in their reproductive age, especially, cases acknowledging unsafe and unhygienic condition of abortion, right to life hardly appear to be meaningful.[48] The right to life means to establish such condition where women's life is not under threat by reason of pregnancy.

The International Convention on Civil and Political Rights also provides that every human being has inherent right to life. This shall be protected by law. No one shall be arbitrarily deprived of his life.[49]

1.3.8. Right to Privacy:

The right to privacy means the right to be left alone. It provides that certain sphere of an individual's life remains free from state interference. It has been rightly stated in *Eistenstadt* versus *Baird*[50] by the United States Supreme Court that *"if the right to privacy means anything, it is the right of an individual married or single to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether in the judiciary or in the legal fraternity".*

The right to privacy imposed the respect for private and family life which is recognized and protected under International Human Rights Instruments. It is immensely significant to incorporate reproductive rights into the right to privacy.

Instances, like lack of respect of confidentiality can prevent women from taking advice and treatment relating to their health and well being. It is necessary to protect

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[47] The Protocol on the Rights of Women in Africa, February 2006. *www.reproductiverights.org*

[48] Safe and Legal Abortion is a human Right, 6 August 2004. Center for Reproductive Rights *www.reproductive rights.org*

[49] Prashanth S.J. "*Right to Life of Foetus*" AIR Journal 212 (2005).

[50] *Eistenstadt* v. *Baird.*

the privacy of women. In 1973 the Hon'ble Supreme Court of United State in its decision in *Roe* v. *Wade*[51] recognized that a woman has the right to decide whether to continue with her pregnancy or not and was protected under the Constitutional provisions of individual autonomy and privacy. The choice of maternity is an essential element to recognize the attribute of private and family life.

Medical science has developed many novel techniques to help the couple who were disappointed by nature. With the help of infertility clinics, one can go for measure suitable to their situation for having child. However, it cannot be denied that these reproductive technologies have brought ethical and legal issues with it. One such issue is that of right to privacy of individual to use reproductive technologies for reproduction.

It is not easy to define the term "privacy". It is simply means a right of an individual to be protected against intrusion into his personal life or affairs, or those of his family, by direct physical means or by publication of information. It is a basic human right and the reasonable expectation of every person. The right to privacy has been recognized in many countries. The Universal Declaration of Human Rights under Article 12 provides that.[52]

"*No one should be subjected to arbitrary interference with his honour or reputation. Everyone has the right to the protection of the law against such interferences or attacks*".

Similarly, the European Convention for the Protection of Human Rights and Fundamental freedom protects the right to privacy under Article 8 of the Charter stated as follows:

"*Everyone has the right to respect for his private and family life, his home and his correspondence. Also, there shall be no interference by a public authority with the exercise of this right except as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic*

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[51] *Roe* v. *Wade* (1973 USA)

[52] Dr. George Joseph "*Artificial Reproductive Techniques- The New Horizon of The Right to Privacy and Right to Know*" 4:98 Journal of Indian Law Institute 102 (2006).

well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others".[53]

The right to privacy is essence in the foundation of an environment where women have reproductive autonomy. Reproductive autonomy will be meaningless where enabling conditions are absent. This includes, among other things, genetic information, genetic counseling, abortion, health services free from legal and cultural barriers. The subject of information and confidentiality is very important for recognizing the reproductive rights of women.[54]

1.3.9. Right not to be Subjected to Torture or Other Cruel, Inhuman or Degrading Treatment:

The above right is one of the few absolute rights under International Human Rights Instrument where no restriction is permitted to be imposed on. Traditionally, this right was implemented only to protect the persons in jail who could be treated in cruel way.[55]

However, today in border sense, this right include right to protect both the dignity and the physical and mental integrity of the individual. This amplification is significant to women's reproductive rights protection. It laid emphasis on the respect, protection and the fulfillment of the inherent dignity of women in relation to reproductive rights. The coercive practices in case of reproduction such as forced pregnancy, pregnancy resulting from rape etc., are extreme form of violation of reproductive rights of women. It forces a woman to be subjected to torture or other cruel or inhuman or degrading treatment.

1.3.10. Right to Enjoy Scientific Progress and to Consent to Experimentation:

Human Rights Instruments also provides for the right to enjoy scientific progress and to consent to experimentation which is one of the major concern of reproductive

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[53] *Supranote* 52 at pg 103.

[54] Subhash Chandra Singh "*Reproductive Rights as Human Rights: Issues and Challenges*" 31(1&2) Indian Socio-Legal Journal 68 (2005).

[55] International Covenant on Civil and Political Rights, Article 7.

rights. The scientific progress in reproductive technologies has made reproduction an easy venture. The quality and the status of foetus can be easily detected. Technologies, such as ultrasound, scan; amniocentisis and chronic villi biopsyscan help in detecting the genetic disorders and abnormalities. It can also be used to detect the sex of the foetus.

There are various reproductive technologies which helps couple to have baby in case of infertility of both or anyone of the couple. Techniques like invitro- fertilization, surrogacy, cloning etc have solved the problem of infertility of couple. Scientific techniques also help women to prevent unwanted pregnancies through the methods such as- sterilization, abortion, contraception etc. These scientific experiments and progress have become instruments in the hands of women to control their body or reproductive capacity. These progresses have given women sense of freedom to enjoy their reproductive capacity but there is also a fear of use of such technologies against women's rights and freedom.

The Universal Declaration on the Human Genome and Human Rights (UNESCO, 1997) provides that the practices which are contrary to the dignity of human being such as human cloning should not be permitted. Later on; in 1988, the European Convention on Human Rights and Biomedicine was amended to include ban on cloning.[56]

The above discussed rights have clear implications on all aspects of women's reproductive rights which results into freedom of choice in matters of sexuality and reproduction. There is no doubt that the reproductive rights are human rights which are inalienable and inseparable from basic rights. The reproductive rights are directly derived from human rights instruments and thus are the part of human rights. However, it is also true that without breaking the barriers of cultural values and religious belief the making of reproductive rights as part of human rights is not possible.[57]

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[56] S.K. Verma *"Cloning: Controversies and Law"* 21(1-3) Indian Journal of Criminology and Criminalization 200 (2000)

[57] Dr. Subash Chandra Singh *"Reproductive Rights, A part of Human Rights"* 3 Supreme Court Cases Journal 14-15 (2002).

1.4. Women's Reproductive Health Needs and Health Care

The scripting of reproductive rights into international human rights instrument is a major gain. The effort to expand its range is still continuing. This constant effort towards recognition of reproductive rights has made the progress in feminist's movement. The constructive steps for emancipation of women from the human rights point of view has totally changed the face of woman's rights and made reproductive health of women an integrating part of women's life. The right to life, right to privacy, right to health etc, has been woven in the supple hands of women's rights perspective.[58]

There has been neglect on the reproductive health and the consequences of this neglect have been unredersseible mainly for women. There is a necessity for a change in current health policies, programmes and laws in India. The health policies and programmes has to be shifted from demographic target to much wider aspect of health concerning reproductive health needs of women and the services they require for the purpose. Taking into consideration, the present socio-cultural restraint that women and adolescent girls are facing in acquiring health services, there is an urgent need for the government to take necessary steps.

There is health programme- such as National Family Welfare programme, National Family Health Survey etc. that has been launched for providing health care measures. But these programmes fail to focus on the health of women especially reproductive health. What are the inadequacies in women's reproductive health and what are the priorities for reshaping the health programmes to respond to the present reproductive health needs of women?

As reproductive health means that people have the capacity to reproduce and to regulate their fertility. It, moreover, implies that women have right to undergo pregnancy and child birth safely. It further, provides that in case of any gynecological or other disorder there has to be facility for the medical services. The state must provide

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[58] Upendra Baxi *"Gender and Reproductive Rights in India: Problems and Prospects for the New Millennium"* October Kali's yug 23 (2000).

condition where every individual can enjoy sexual relations free from the fear of disease.[59]

The fact that India's population has increased from 36 crores in 1951 to over 102 crores in 2001 has worried everyone including politicians, administrators, development planners, public health experts, demographers, social scientists, researchers and even common people. An uncontrollable population explosion has become the obstacle for country's progress. The government was so much occupied with solving the issue of population explosion that it has totally forgot the importance of good health of the mother for the good health of the infant.

Reproductive health suffers by a variety of reasons such as- poor health infrastructure, quality of the delivery system and its responsiveness to women's needs.[60] There are various social, economic, cultural and biological factors which are responsible for the slow growth and development of the reproductive rights in India which are underlined as follows:-

1.4.1. Gender Inequality

Gender is socially, economically and culturally imbibed in any society. In studying demographic figures, fertility, mortality, and migration, mostly focused on women being child bearers. No doubt, women have been the passive victim of patriarchal system where women have little choice in procreation. As reproduction exists in close interrelation with social, cultural and political context; without having condition for gender equality, it is not possible to have reproductive rights.[61]

There is no doubt that unequal sex ratio and higher female –infant and child mortality rate in large parts of our country reflect the general devaluation of women. A female literacy and enrolment rates lag far behind than that of males in most sates.

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[59] Shireen J. Jejeeboy "*Addressing women's reproductive Health Needs*" March Economic and Political Weekly 475 (1997).

[60] *ibid*

[61] Tulsi Patel, "Gender Relations, NRTs and Female Foeticide in India" in Tulsi Patel (ed.) *Sex-selective Abortion in India* 27-28 (2007).

Gross enrolment ratio suggest that even in the 1990s, only 88 percent of all girls aged 6 to 10 (compared to over 100 percent of all boys) are enrolled in school. Only about one in three girls aged 6-14 actually attended school, comparing to about three in five boys.[62]

In fact, according to the 2001 Census there were 49 districts in the country, where for every 1000 male children aged 0-6 years, there were less than 850 female children. The neglect and discriminatory behaviour against girls leading to excess female mortality has been widely documented by several studies. The release of 2001 Census results has brought harsh reality and a need for serious concern on this area.[63]

The majority of Indian women are economically active but there is lack of control over economic resources by them. No more than one in five women are reported to be working and no more than one in seven working women is in the organized sector. There are several government sponsored poverty alleviation schemes such as Integrated Rural Development Programme where women are underrepresented among the beneficiaries. For e.g., in 1987-88,against a target of 30 percent female beneficiaries predictable by the Integrated Rural Development Program, Rajasthan achieved as little as 15 percent. They are considered as unskilled, ignorant and pitiable debtors and hence incompetent[64].

The discrimination of women at household level has severally affected their ability to acquire good health and the facilities for healthy living. These disparities have brought lack of autonomy and control over their own bodies. Women lack decision-making power and freedom of choice in relation to their own health. Violence against women are rampant, rape and incest are all part of women's lives and yet invisible. They are the victim of age old usages and traditions which are the product of gender discrimination in patriarchal society.

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[62] *Supranote* 59.

[63] Leela Visaria, "Deficit of Girls in India: Can it be Attributed to Female Selective Abortion" in Tulsi Patel (ed.) *Sex-selective Abortion in India* 61 (2007).

[64] *Supranote* 59.

There is no denying that one of the reasons for poor reproductive health of Indian women is gender discrimination. The reasons of gender discrimination are complex and to point out the most important reasons is the poor status of women in the family, attitude of the society towards them, low level of education, cultural norms, limited assess to resources, poor health and nutritional status etc.

1.4.2. Health Care Programmes:

The health care programme in India functions in the context of the Primary Health Care approach. The broad purposes of the policy of health care delivery system are to provide universal coverage and to enable the whole population to have access to the services. The health care programme made for women are-Maternal and Child Health Services, Reproductive and Child Health Project (RCH) and the Family Welfare Programme. These programmes aim at providing better reproductive services to women encouraging them institutional deliveries and spacing between children.[65]

These programmes also take initiative towards health education. The health education components of these programmes is addressed by the Information, Education &Communication Activities(IEC).Through health education, the government aims to positively intervene in improving the status of women in the sphere of family planning and maternal and reproductive health. There has been an improvement in living conditions and medical facilities throughout the country.[66]

However, despite all the programmes to improve the condition of women, there has been decline in the sex ratio which shows conditions not favourable for women.Health and family planning services have not been sensitise to the situation of women or to the problems they face in seeking or even expressing health care needs.

The main disadvantage of the family planning programme is that it concentrated on population and lacks health service delivery system and communication strategies.

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[65] Reema Bhatia "Health Policy, Plan and Implementation" in Tulsi Patel (ed.) *Sex – selective Abortion in India* 205 (2007).

[66] *Supranote* 65 at pg.205-6.

There is a need for such a programme which focuses on what women want and need and the sensitive ways of addressing them.

India's maternal motality ratio is estimated at 555 per 1, 00,000 live births; about 50 times higher than that of many industrialized nations and six times as high as that of neighbouring SriLanka[67]. It is estimated that India accounted for 19 percent of all live births worldwide and as much as 27 percent of all maternal deaths.

1.4.3. Pre-natal and Post-natal Care:

Lack of care during pregnancy and childbirth including both the obstetric conditions and gynecological conditions, such as reproductive tract infections, cervical cell changes and genital prolapse are very much persistent. About 92 percent women suffer from gynecological disorders such as – genital tract infections, pelvic inflammatory diseases etc, out of these only 8 percent undergo for gynecological examination and treatment[68].

Unsafe motherhood is a reality in much of India, especially in its rural areas. Few women have access to antenatal care, high risk cases go undetected, anemia is acute during pregnancy, deliveries are conducted largely by untrained attendants in unhygienic conditions and knowledge of health and nutrition needs during pregnancy and the post-natal period are poorly understood. Maternal health facilities are unbalanced, focusing on immunization and provision of iron and folic acid, rather than on sustained care of women during pregnancy and after delivery.

In developing countries including India, many births take place outside modern health care facilities especially in rural areas. The modern health facilities are beyond the reach of grass root level that are in large size. As a consequence, most of these deliveries are attended by untrained traditional birth attendants.[69]

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[67] UNICEF 1991.

[68] www.reproductiverights.org

[69] Peter Olasupo Ogunjuyigbe *"The Risks Involved in Pregnancy and Child Delivery: Strtegies for Prevention in Nigeria"* 17.no.3 IASSI Quarterly 125 (1999).

There is a need for adequate care to the women during pregnancy and after delivery as well. But in traditional families there is no excuse for women, they have to take care of domestic work at home and sometimes they may even go to the field to support the family financially.[70]

The International instruments have provided that the state parties shall ensure that the women must be given right to health, including reproductive health. In order to promote and respect this right it must guarantee the following[71]:-

a) the right to control fertility;
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;
d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards and best practices;
f) the right to have family planning education.

The state party must ensure health care programmes for women for the promotion and protection of the above given rights.

1.4.4. Medical Facilities:

In India, medical facilities are poorly equipped to deal with reproductive health problems. There are very few diagnostic centers and moreover, service providers are not well- trained and there is no availability of drugs to treat in case of detection of any abnormalities. There is also no means of sensitive family counseling relating to medical facilities like family planning for limiting the size of the family and for proper spacing of children.

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[70] *Supranote* 69.

[71] www.reproductiverights.org

There is no access to safe abortion which is a part of reproductive health strategy. Despite the fact that abortion has been made legal, there is limited knowledge in regard to access to the facility and above all, high price for good quality has kept safe abortion beyond the reach of poor women.

Another problem is that by sophisticated prenatal diagnostic technique there is increase of abortion of female foetuses. As a result, there have been unsafe abortions and repeat abortions. The complications resulting from such unsafe abortion cost a heavy price on women's life and, thus, constitute a major source of mortality and morbidity and thus cause female foeticide.

The illegal practice of sex determination tests leading to female foeticide is common in almost all the parts of a country. There is mushroomed growth of such clinics. The fact that an ultrasound machine is registered as required by law does not guarantee that it is not misused. There is now a trend of eliminating daughter in mother's womb after determining it through various tests.[72]

However, over 10 percent of all maternal death is due to abortion. The safe abortion services are available only in urban areas, since registered practitioners are rarely available in rural areas. There is a need to pay more attention in providing safe and affordable abortion services as a part of primary health care.[73]

One more underlying factor in regard to the reproductive health facility is treatment for infertility (of both men and women). There are various reasons for infertility in women such as women's poor health and malnutrition, repeated miscarriage and foetal wastage, unhygienic obstetric and abortion procedures. Women's infertility can have serious consequences for her family and herself. Though, there are measures to cure infertility of women through reproductive technologies, but

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[72] Ashish Bose, Female Foeticide in Tulsi Patel (ed.) *Sex Selective Abortion in India* 83 (2007).

[73] Shireen J. Jejeebhoy "*Reproductive Health Information in India- What are the gaps?*" October Economic and Political Weekly 3076 (1999).

these techniques are beyond the reach of common people. Besides, there is no proper channel to provide information and counseling to the infertile couples.[74]

1.4.5. Reproductive Health of Adolescents:

There has been a huge gap of legislative concern on reproductive health of adolescents. It is a known fact that adolescents are highly sexually active which sometimes results into pregnancy at a tender age of her life. They are most vulnerable and are neglected once they become pregnant.

It has been found that marriage and child bearing continue to be early and universal despite the banning of child marriage by the Government. At the family level too, girls are highly vulnerable, son preference is pervasive, resulting in gender disparities in health care, food intake, school attendance and labour contribution of children from an early age.[75]

The complications of pregnancy, pre-natal and neo-natal mortality and low birth weight are much higher among adolescent women than among older women. Early marriage not only causes early child bearing but it is also responsible for the decline in reproductive health. As adolescent can hardly have control over their own lives and ability to say in marriage choices or reproductive choices.

Another important issue is that though unmarried adolescents are also sexually active but it is rarely considered a concern in the Indian context. There has been lack of awareness among young people regarding reproductive health and sexual behaviour.

1.4.6. Population Explosion:

According to some estimates, at the period 1991-2001 the proportion of population growth attributable to population momentum was almost 70 percent, while unwanted fertility contributed about 25 percent; only 5 to 6 percent of the population growth was

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[74] *Supranote* 73 at pg.3077.

[75] *Supranote* 73.

attributed to couples desiring to have more children. This pattern will continue in future also because of the large number of young people.[76]

In India, Apex committee was created known as the Family Planning Research and Programme Committee which sat for its first meeting in July 1953 in Bombay. The Committee took comprehensive view of family planning and suggested that family planning must be defined in a broad sense including not only birth control or the spacing of children, but in a holistic manner. The committee made many recommendations, including that family planning centers be opened around the country for sex education, marriage counseling, marriage hygiene, planned parenthood and infertility issues. Keeping all these issues in view, the Committee gave its recommendations in the year 1953. But unfortunately, such programme has never been materialized and implemented in India.[77]

In brief, the dimension of women's poor reproductive health is behavioral concerns which include lack of autonomy and unequal gender relations. The limitation women face in attaining good reproductive health is because of lack of decision-making power, health care programme, pre-natal and post-natal care, medical facilities and socio – cultural barriers for seeking attention on heath problems which are required to be added into the policy- making.

1.5. Expanding Boundaries of Reproductive Rights:

The reproductive rights of women is increasingly used by women for their struggle for self determination and has become an important concept in the women's movement, particularly, since from the World Conference of the UN Decade for Women held in Nairobi 1985.The reproductive rights of women implies-(a)the right of women to choose whether to have children or not, and the right to decide on the number of

[76] Almas Ali "Population:Myths and Facts" in Shruti Pandey,Abhijit Das, Shravanti Reddy, Binamrata Rani (eds.) *Coercion versus Empowerment* 6 (2006).

[77] *ibid*

children they want, when and with whom;(b)freedom to choose the means and methods to exercise their choice regarding fertility management, and(c)access to good information on means and methods.[78]

This right is directly related to the women's autonomy and freedom. It is the extension of the principle of self determination regarding one's body which provides that women must be able to decide about their own bodies and reproductive capacities. The social structure of the society has placed women in such position where women generally take care of the children thus women must have choice regarding reproduction. They should be the one to decide about the measures to prevent pregnancy and the time when they want to be pregnant. But the fact is that they hardly have their say in relation to reproduction.[79]

In recent years, there has been a rapid growth of medical technologies which have opened the way for intervention into the reproduction. The technologies which facilitate such intervention and manipulate the reproductive functions are artificial insemination, in vitro fertilization pre-natal diagnosis, embryo transfer, cloning etc. These technologies offers benefits to the couples but however, its side effects are also not unknown. These technologies are prone to misuses and its impact on social relation is a disturbing element.[80]

There has been a debate on how far these technologies enhance women's right or whether it has turn out to be against women's autonomy? There is no denying that these reproductive technologies strongly affect women. At this junction, it is important to analyse whether the reproductive technologies are a source of women' empowerment or their weaknesses.

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[78] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 22-26 (1st Edition 2000).

[79] *ibid*

[80] Asim A. Khan Sherwani "*Illegal abortions and Women's reproductive Health*" 3 Supreme Court Cases Journal 116 (1997).

Even so, these technologies have been commercially published through advertisement in newspapers, in trains, buses, on walls T.V. etc. But these techniques have exposed women to higher risk of reproductive health issues. The pre-natal diagnostic techniques involve the use of technologies, such as- ultra sonography, amniocentesis etc. These techniques help to detect foetal abnormalities and also facilitate the detection of sex of foetus which may cause abortion of foetus especially female foetus.[81]

Another important aspect is that there is great difference between women who are affluent and can go for the services of qualified medical practitioners with handsome perk and the poor women with marginalized income who do not have financial assistance to do so. Consequently, in case of abortion, poor section of the community hardly has any chance of safe and hygienic abortion.

It is no wrong to say that in the name of 'choice' the position of women is likely to be devalued as women hardly have the freedom to take decision in case of abortion or use of any other reproductive technique. In most of the families, decision as to the bearing of a child will be taken by the male member or husband. So, new reproductive technique rather work as an instrument of suppression to the feminism and further strengthened the control of man over reproductive rights of women in future.

Reproductive rights have been a controversial issue on the face of the recent movement of liberalization of women. There has been a need for a sound atmosphere for pregnant woman to take decision to carry her pregnancy or not. The dilemma touches the most sensitive aspects of human life as reproduction involves both husband and wife and the expectation of other family members as well. It stirs strong emotions and brings fundamental changes in the day to day life[82].But at the same time; it is the woman who suffers the most so it is a woman who has to be mentally and physically prepared to have a child.

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[81] Shireen J. Jejeebhoy *"Reproductive Health Information in India- What are the gaps?"* October Economic and Political Weekly 3078-3081 (1999).

[82] Medani Abdul Rabman Tageldin *"Right to Privacy and Abortion- A comparative study of Islamic and Western Jurisprudence"* xii Alligarh law Journal 133 (1997).

The social attitude has always impairs women's reproductive decision and the right to protect their lives and health. The recognition of reproductive rights by law is an essential starting point from which women may begin to exercise all other human rights.

The major question is does state ensure women the freedom to enjoy reproductive rights? Do women enjoy the freedom to plan their own fertility? What are the reproductive health measures? Whether those health measures are available in India or not? However, the first and foremost necessity is to create an environment where women should be treated equally and they will have their choice in all the matters concerning them. There is a need for the change in the attitude and conservative thinking of the society.

The Medical termination of Pregnancy Act (MTP), 1971 has legalized abortion in India. The Act provides for termination of pregnancy (under certain conditions) where the pregnancy would involve risk to the life of the pregnant women or to her mental and physical health or where there are chances that if child were born it would suffer from such physical or mental abnormalities as to be handicapped.[83] But, the saddest truth is that the safe and hygienic abortion is hardly available in most part of India, especially in remotest area.

Various studies show that abortion is the major cause of maternal mortality and the damage done to women's health is unrepairable. It was found that termination of first pregnancy, pregnancy at later ages, at short interval and repeat abortion has caused health hazards to the women. There has been increase in the number of abortions and mostly women themselves are interested to limit the number of pregnancies and they will be ready to undergo abortion even though risking their health and lives.[84]

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[83] Subhash Chandra Singh "*Right to Abortion: A new Agenda*" AIR Journal 129 (1997).

[84] Malini Karkal "*Family Planning and Reproductive Health*" 2 April The Indian Journal of Social Work 299 (1993).

Although, the male dominated society does not allow them to act according to their desire when it comes to the exercising of reproductive rights. Therefore, how much women is involved in the decision- making process is an essential feature of expanding horizon of reproductive rights.[85]

The maternal mortality rate is very high in India comparing with many countries in the world. The official figure shows only data on legal abortions. But there is no denial that there are large numbers of illegal abortions. The death caused by such abortion on the health of women has not been taken seriously by the administration. It is so evident that women are undergoing abortions to terminate unwanted pregnancies and there is no adequate facility for safe abortion because of which the health of women is endangered.

In India, there is Maternal Benefit Act, (1961) which provides for the maternity leave and job protection during maternity which is an important step to protect the reproductive roles of women. But in an unorganized sector, women are forced to avail of maternity leave without pay.

In a patriarchal society, women are not treated as equal partners in marriage and family life. Their status is restricted within the primary roles of mother, wife and daughter and their other role in the society is made secondary. The health services for women are only Maternal and Child Health services (MCH). These conditions largely prejudice the status of women in society thereby causing restrictions on their reproductive freedom.

The family planning services targets women to go through family planning to limit the size of the family.[86] However, the risk of life and health which women undergo through these methods was never attended too. The most of the death of women is

[85] *Supranote* 84 *at* pg 304.

[86] K G Santhya, Shireen J Jejeebhoy "*Sexual and Reproductive Health Needs of Married Adolescent Girls*" Oct.11 Economic and Political Weekly 4370-4377 (2003).

related to the general health of women, the ante-natal and post-natal care that she receives. These are clear indications of the denial of reproductive rights of women.[87]

Abortion has been used as a spacing method by women in cases where contraception fails or conception takes place by accident. Sometimes, there may be situation where even unmarried women undergo abortion as a result of rape or sometimes they involve in sexual activities which resulted into pregnancy and to save themselves from social stigma of being unmarried mother they rather prefer to go for abortion.

Another weak line of reproductive right is the son preference in the society, the social condition of society or family forced women to undergo abortion as their lives are put at stake if they do not produce son. It is also true that unwanted girls run the risk of severe ill- treatment at their natal homes, causing them emotional and mental distress.[88]

The son preference behaviour lead couples approach for sex determination tests and opt for sex selective abortion if it happens to be female foetus. Women also signify that when they already have a daughter, and when they become pregnant again, there was always some pressure from the elders in the family that the next child should be a boy.[89]

Though, Pre-Natal Diagnostic Technique (PNDT) Act is there to prohibit sex determination tests but so far it is not succeeded in dissuading couples from seeking these tests or preventing the medical practitioner from performing them. So, on the one hand there is strong son preference, on the other hand, the well being and the status of girl is so uncertain once they got married, that couples avoid having girl child at any cost.[90]

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[87] Sunita Bandewar *"Abortion Services and Providers 'Perceptions' Gender Discrimination"* May Economic and Political Weekly 2076 (2003).

[88] *Supranote* 87 at pg. 2077

[89] Leela Visaria "Deficit of Girls in India in Tulsi Patel" (ed.) *Sex Selective Abortion in India* 73-74 (2007).

[90] *Suypranote* 89.

Though, the Medical Termination of Pregnancy, (MTP) Act has permitted abortion but it does not recognize abortion as women's rights. Abortion is one of the important means to control one's own body and thus women who shoulder the responsibility of child bearing and rearing should have right to decide whether she is ready to have a child or not. Apart from this, new trend arises as regards women's career aspirations, their entry in the workforce and the responsibilities arising out of that were also seen as a reason for women wanted to have right to abortion as reproductive rights.

The reproductive rights ensure that a pregnant woman should not become the prisoner of a foetus which has no meaning for her since she has not accepted it. The majority of women believe that it is up to her to make the decision about bringing a child into the world or not[91].There is a lacuna in the legal framework to answer the questions raised by the new reproductive technologies with the changing horizon of woman's role in her reproductive capacity.

The reproductive health is enormously connected with the contraceptive behaviour and the quality of contraceptive used by women. More than two in five couples in the reproductive ages currently use methods of contraception. The dependable with programme priorities shows that couple largely ignored non-terminal female method and especially male methods, two out of three contraception couples are protected by female sterilization, and almost nine out of ten by a female method.[92]

The huge emphasis on terminal contraception has resulted into young and low parity women being unprotected from repeated and closely spaced pregnancies, only 16 percent of women below 30 years practice any form of contraception, comparing to 55 percent of all women aged to 30 to 44 years.[93]

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[91] Shakeel Ahmad "*Freedom of Womb, a Human Rights*" 1 Supreme Court Cases Journal 43 (1996).

[92] Shireen J. Jejeebhoy "*Reproductive Health Information in India- What are the gaps?*" October Economic and Political Weekly 3075 (1999).

[93] *ibid*

Here, the main issue to be pointed out is whether the contraceptive behaviour is governing by informed consent or not? Very few women are fully informed of the methods which they choose and their side effects. These issues have never been addressed in any legal documents relating to reproductive health of women. There has been an obstacle women faces while exercising their choice in access to, and ability to take decision regarding reproductive health care, whether relating to pregnancy, childbirth, contraception or abortion.

Over the few years, the concept of women's health has been engrossed with the reproductive health of women. The reason for slow progress in this area is women's own silence and their priorities. Women's health problems and the social constraint on women's lives left very less opportunity for women to express their needs especially health care needs.[94]

The health of women is not of any concern to anyone, including women themselves. There is one aspect of women's health that is important and that is her son bearing. Other aspects of women's health are invisible. If she gives birth to a daughter than she will hardly get any attention or care from the family. Physically and mentally she can rest only after she bears a son.[95]

In such a situation, the reproductive illness is confined to the medical domain of infection, sexual or reproductive processes. At times, causes of reproductive illness are not just cured through medical treatment but require psychological treatment or counseling also as it leaves women with life long scar. There is still no means of awareness programme for the people as there is an inadequacy of knowledge in this area.

The couple sometimes takes protection measures where they adopt female sterilization. The sterilization result in ill health or the acceptance of sterilization may

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[94] Imrana Qadeer "*Reproductive Health- A Public Health Perspective*" October 10 Economic and Political Weekly 2675(1998).

[95] Reema Bhatia "Health Policy, Plan and Implementation" in Tulsi Patel (ed.) *Sex – selective Abortion in India* 218 (2007).

be forced. Sometimes there are chances of failure of sterilization also; in such cases the burden of unwanted baby is questionable. A permanent method of family planning may be desirable from the perspective of family size limitation. It could be the only option available for avoiding unwanted pregnancy. High level of sterilization could be indicative of low quality of services with respect to other methods[96].

However, the advancement in science and technology has sharpened some of the old issues but has forced us to face new ones. A biological advancement has made it possible to take decision about the kinds of people who are to be born. Here, antenatal test has made it possible to detect the foetus in advance.[97]Perhaps, in the absence of decision making power of women these facilities are useless.

The medical science has made it possible to determine the genetic defects in advance. Through, prenatal diagnosis test, it is possible to detect the genetic or developmental abnormalities in the foetus. If the test reveals severe malformation or gross malfunctioning in the foetus, abortion is considered. The methods include- ultrasound scanning, analysis of foetus cells obtained either by amniocentesis or at an earlier stage of pregnancy by chorionic villi sampling, a maternal blood tests to measure the level of alpha fetoprotein (which is abnormally high or low in certain congenital conditions) and foetoscopy in which a sample of foetus blood is examined for abnormal cells.[98]

Today with in vitro fertilization, there is the possibility of transferring to the womb 'healthy' embryo rather than others. The childless couple with the problem of infertility can have baby with the virtue of reproductive technology. This advancement in reproduction has taken reproductive rights to a different horizon. Though, these new techniques have raised many socio- legal and ethical issues still it has also relieved the infertile couples who could have face the curse of incomplete married or family life.

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[96] Mala Ramanathan "*Reproductive Health Index*" December Economic and Political Weekly 3104 (1998).

[97] Dr Subash Chandra Singh "*Genetic Screening and Human Rights, The case of Engenics*" AIR Journal 286 (2003).

[98] *ibid.*

It is not uncommon to have off springs by hiring in-vitro or donor who is unrelated to woman. It is also not unusual to hire woman who contribute the egg or carry the foetus for gestational nine months and give birth to the child, though she may not have legal connection with either the father or mother but who offers to be a paid volunteer for such service. There is likelihood of commercialization of reproductive capacity like donation of egg or renting of womb is not uncommon in the society. This will mostly affect the grass root level woman as they may fall for such business to run their livelihood. They may be influenced by the elite class people who may offer huge amount of money for their services.

A single woman can have her own biological child with the use of method such as artificial insemination. A single woman who has a desire to reproduce but does not wish to have any sexual involvement with, or a long term commitment to a male partner, is provided an alternative solution through various techniques of reproduction. The legal status of such a single unmarried mother and her acceptance in society has been the serious question that has been knocking at the door of the judiciary.

There are chances of encouraging of non traditional form of family such as lesbian or homosexuals' family as new reproductive technology helps such couple to have a child and complete their family. Such situation may give rise to many social and ethical questions.

Nature has embibed women with the blessing to give birth to a new life. But, it is high time to change this belief and considered children as gift of god since children can be the gift of science also. Medical science has developed many ways to satisfy the parents who were disappointed by nature. The last two decade has witnessed a rapid increase in the number of technologies that assist reproduction increasing the chances of conception and carrying the pregnancy to term. Now, maternal health has to be recognized as a crucial area of concern.

The reproductive right is about having full and complete autonomy over one's body and there can be no second thought on that. Many times, the woman might become pregnant as a result of rape. She may not be in such economic condition where she can

take the responsibility to bring up the child and also that she may not be prepared for motherhood. In such situation, if she want to terminate her pregnancy than there has to be access to all such facilities which is required for doing so.[99]

The society has witnessed a rapid progress in reproductive technologies which helps in conception and delivery of a child. The "Assisted reproductive technologies" has become household term, today. The advancement of such technologies has also influenced the way in which society views pregnancy, reproduction and motherhood.[100]

It has been now understood that women's empowerment is critical to human development. It is also necessary to improve people's access to quality health care, in particular, the need for essential and emergency obstetric care for women. Programmes that make contraceptives available to all the people should be enlarged and expanded, and community based health initiatives should be revitalized.[101]

Thus, the reproductive rights have essential value and have elevated not only the level of reproduction but the value of women's life as well. Today, the new reproductive technology has delineated the boundaries of reproductive rights of women. There are legal concerns surrounding the uses of new reproductive technologies and its impact in the society. The upcoming reproductive technology has redefined reproduction and placed before us new challenges. The absence of legal framework to suit the new changes brought by the reproductive technology has been the fundamental issue before the law makers.

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[99] Ashok K. Jain, *The Saga of Female Foeticide in India* 56 (1st Edition 2006).

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

[101] Almas Ali "Population:Myths and Facts" in Shruti Pandey, Abhijit Das, Shravanti Reddy, Binamasta Rani (eds.)Coercion versus Empowerment 76(2006).

1.6. Conclusion

There is however, no denial that the institution of family is as old as humankind. The human civilization developed because of the concept of family. Earlier, there was large family unit as men and women have no idea of family planning. But over the centuries, social, cultural and economic pattern has changed all over the world. People became conscious about the quality of life they are living. This has lead to the international and national concern about the reproductive health especially of women and has lead to reproductive rights as integral part of human rights. Today, government propagated for the family planning programmes so as to raise the quality of life by raising standard of living.

There has been development of various reproductive technologies also. The new outlook towards reproductive process of women and the advancement of reproductive technologies has made it advent to study the real life situation and its impact on women. It is of paramount importance that these technologies should be used for the betterment of women and thus used as an instrument for the emancipation of women. Women life revolves around the reproduction and they can have their autonomy in life only when their reproductive rights are guaranteed through legal framework.

In the society where women live under a constant fear of being sexually molested both within or outside the family, where the evil of dowry still prevalent despite the dowry prohibition Act, where daughters or daughters in law are thrown out of the house for giving birth to a girl child, where there are no social and economic security for women, where there are no emotional, financial and cultural security for them, reproductive rights can be helpful tool for them to gain self respect and status in the society.

Traditionally, women were always considered as a weaker sex everywhere. Today, there has been a steady growth in the status of women and their rights. There is enactment of various laws and policies for the empowerment of women or perhaps to improve the condition of women in fact. There are gamuts of laws for the protection of

their interests, what is required is the honest intention to serve for the purpose and the serious enforcement of the existing laws. Though, international instruments, national instruments including population planning policies, judicial pronouncements, mass media and global human rights activism do enable reproductive rights but not always in the manner or form that empower women. The need of the hour today is to ensure protection and promotion of reproductive rights of women to a new dimension.

CHAPTER 2

WOMEN'S HEALTH AND MEDICAL TECHNOLOGIES – EMERGING CHALLENGES

2.1. Introduction

The rapidly advancing technology in the last 20th century has brought sea-saw changes in the world. Technology has brought humankind into the new era of revolution in each and every field. The standard of life, quality of life and the meaning of life have changed because of the technology. Talking in this context, technology has also advanced in the field of medical facilities. Today, there are latest medical technologies to help human being at the stage of illness. There are artificial reproductive technologies as well to help human being in the process of reproduction.

In the past, having children was seen as a blessing and those unable to have them were considered as unlucky. However, the perspective has changed today and now being parent is a right rather than a blessing and those unable to have own child is called as infertile needing medical help. This right is called as reproductive right and it include the right to life, liberty and the pursuit of happiness.[1]

In this age of medical technology, infertility[2] is considered as disease, a physical illness that requires medical treatment. It is advocated by human rights activist that everyone has right to bear children by any possible means.

Earlier, childless couples were forced to live in the phase of childlessness. They were reluctant to adopt child because of complex procedure and also because there is natural desire to see resemblance in one's own children which is not possible in adoption, but now there is answer to these problems through Assisted Reproductive Technology (ART).

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[1] Adrienue Asch at Wellesley COLLEGE AT Interview on 12th Feb 2005, *www.reproductiverights.org*

[2] Infertility here means failure to conceive after a year of regular intercourse without contraceptive.

Reproductive Technology not only helps infertile couple but it also helps the single adult and homosexual couples to have children. Single adult may not be infertile but they are unable to have children because they have no partners. In this area, medical technology has brought a ground-breaking change by responding in favour of couples who want to have children by separating reproduction from sexual intercourse and marriage.[3]

The phenomenal changes brought by separating reproduction from sexual intercourse and marriage have change the face of modern reproductive process. At one hand, it provides a solution to single adult or homosexual couples who want to have children even without indulging in sexual involvement or a long term commitment. On the other hand, it challenges old concept of family where third parties who are not members of the family are introduced into the procreation process.

The advantage brought to women by reproductive technology is the sexual freedom and control over their bodies through various measures, such as contraceptive, injections, abortion etc. It helps women to avoid conception even after heterosexual intercourse. But at the same time, these measures risk the health of women and may turn out to be disadvantageous to them. These methods may result into some ill-effect such as- menstruation disturbance, headache or weight gain. Although these methods help women to achieve their freedom but sometimes it affects their health which may spoil the quality of life they are living.

The term 'reproduction' has been defined by the *Oxford English Dictionary* as 'the action or process of forming or creating or bringing into existence again'. Generally, the reproduction means the processes relating to conception, pregnancy and child birth.[4]

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[3] www.reproductiverights.org

[4] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 14 (1st Edition 2000).

Likewise, reproductive technologies are made to assist or intervene into the process of reproduction through various ways, like-

a) The prevention of conception and birth, e.g.; contraception, abortion etc.

b) Assisting reproduction or stimulating conception, e.g.; artificial insemination, in-vitro fertilization etc.

c) For pre-natal diagnosis to detect genetic or chromosomal disorders or sex of the foetus also eg; ultrasound scan, amniocentesis, chorionic villi biopsy etc.

Procreation is a natural desire of every human being. The development technology has facilitated people to restrict and control birth and at the same time it also helps fulfill the dream of childless couples to become parents[5].

The new reproductive technologies aim at improving the health and genetic problems of foetus. However, it has its implications on the health of women and their autonomy. The use of these technologies has brought many complex issues before the society as it touches not only women but the whole society.[6]

With the introduction of reproductive technologies it is possible to improve the health of women as well as that of the foetus. But more use of these technologies might bring adverse effect on the health and well-being of women those who have sex without reproduction. The development of these technologies has created many possibilities. Such technologies help women to exercise their freedom of choice.

At the same time, these technologies can restrain women's rights and choices in reproduction sometimes. There are apprehensions that these reproductive technologies may be used against the main purpose for which they have been intended. There is apprehension that these technologies may be used for commercial purpose or for some other purposes which is not intended.

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[5] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 283 (1977).

[6] *Supranote* 4 at pg. 23.

How much society is ready to use these technologies is perhaps the biggest question? In the perspective of different socio-cultural climate and different health measures, these technologies are prone to more misuses than usage. For instance, contraceptive is for the management of fertility which is actually used to serve the purpose of population control. Similarly, pre-natal diagnostic technique which is meant to detect genetic or other abnormalities is now highly used to detect the sex of the foetus.[7]

2.2. Reproductive Methods and Technologies

Medical technology has advanced various methods either to prevent birth or to give birth such as barrier methods includes condoms, diaphragm, etc.; hormonal methods such as oral pills, injectables, etc.; immunological methods such as anti-fertility methods ;terminal methods such as sterilization; methods for pregnancy termination like abortion; and also methods to treat infertility –in-vitro fertilization, etc which are discussed below:-

2.2.1. Contraceptives:

Contraception is the means of controlling or preventing conception or birth control. The *Oxford English Dictionary* defines contraception as a 'practice or method of preventing or planning conception. It also defines contraceptive as a device or drug intended to prevent conception.[8] Therefore, contraceptives are the methods of preventing or planning conception. The development of contraceptive has brought reproductive revolution during 1960s and 1970s

The most commonly accepted method of preventing birth or conception is the use of contraceptives. These contraceptives act as a barrier and thus prevent the spermatozoa from meeting the egg. The types of barrier contraceptives include the condom, the diaphragm, the femidom (female condom) and chemical barriers.

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[7] Jyotsna Agnihotri Gupta, *New Reproductive Technologies Women's Health and Autonomy* 52 (1st Edition 2000).

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

These devices works differently in women's body though, serve the same purpose like; ***diaphragm*** is a cup-like device which fits on the cervix (the mouth of the uterus) is often filled with spermicidal jelly. It must be put in place before sexual contact and left there for at least six hours after intercourse. Similarly ***femidom*** is a loose fitting polyurethane sheath with a flexible ring at both ends. It, therefore, covers both the cervix and vaginal walls. These methods are especially important as they serve as barriers to HIV and STDs transmission[9].***Intra Uterine Devices*** (IUDs) are made of copper, plastic or even polyurethane (some even contain hormones). It is inserted into the uterus of a woman; common among them are *copper-T* and *Lipper Loop.*[10]

These devices should be inserted only after proper evaluation of women genital tract. These devices sometimes causes infection leading to pelvic inflammatory diseases with painful menstruation, blockage of fallopian tubes, resulting in sterility or tubal pregnancy and even peritonitis leading to death. In addition to these, other side effects are backache, discomfort, increased bleeding etc.[11]

There is a need for a medical skill and training to insert *Intra Uterine Devices.* There are number of cases where the procedure fails and there is an increased rate of complications as a result of unhygienic and unsafe practices. There are incidence of ectopic pregnancy and catastrophic illness with high mortality (even where all the facilities are available).The condition is even worse in rural areas. The patients wear them even without having knowledge of what it is. Several empirical accounts shows refusal to remove implants when women demands for it.[12]

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[9] Gwendoline M.Alphoso *"Preventing Motherhood: Medico-Legal and Ethical Dilemmas in Contraception"* .5 Law and Medicine 5 (1999).

[10] *ibid* at pg. 6.

[11] *ibid*

[12] *ibid* at pg 10.

This method is popular among women seeking long term protection and who has no time to remember to take pills daily or to use a barrier method every time they have intercourse. It has also another advantage that women can use it without the knowledge of the family members as long as they have no health related problems because of its use.[13]

Injectable contraceptive is injected into a woman's body when she is not pregnant, her body will initiate its defense mechanism against human *Chorionic Gonadoctrophin* (hormone). At the time when fertilization does take place, later, it will serve to prevent implantation of the fertilized egg on the uterine lining. As research shows that this method results in immuno- complex diseases that might even risk the HIV, Anti- Fertility Vaccine- Anti- HCG (Anti Human Chorionic Gonadoctrophin)

Injectable Contraceptives like *Net- en* (2oo mg) is used once every two months and *Depo- Provera* (150 mg) once every three months. It acted at several levels in the body by preventing the maturation, by forming a barrier at the mouth of uterus to prevent entry of the sperm, by slowing down the normal velocity of ovum transport in the fallopian tube etc.

It has been found that injectable contraceptive is more useful for those women who are less educated as they are likely to forget to take the pill regularly. Injectable contraceptives are long acting steroidal preparations which are used by way of injection. This method is also popular among working class women. It is broadly used in about 90 countries around the world approximately by about four million women.[14]

The above said contraceptive has the lowest failure rate. It depends upon the timing of the first and repeat injections. Though, it is also not free from side effects. Some of the ill-effects of such injectables are- bleeding disorders, demineralization of the bones, onset of early menopause, effect on future fertility, effects on the higher brain centers, cancer, severe headaches, nausea, weight gain or loss, possible carcinogenicity etc. If

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[13] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 265 (1st edition 2000).

[14] *Supranote* 13 at pg. 248.

women with breast feeding child is using such contraceptive than they are exposing their infants to small quantities of the drugs through breast milk which has every chance of causing side effect to the child also like, weakness, dizziness, headaches, weight changes etc.[15]

The most common side effect is irregular heavy uterine bleeding and after prolonged use amenorrhoea. A study conducted on 26, 00 women shows that nearly 68 per cent women has discontinued the use because of the above discussed side effects. Mainly, excessive bleeding in women who are undernourished and already anaemic is a serious problem. In the view of medical researchers amenorrhoea is not a major problem. After discontinuing of this the fertility will return slowly and that is why many clinics has limits the use of injectables to women who are already a mother. The use of *Depo Provera* has no risk of cancer of the cervix, ovary or liver, and that they are actually protected against endometrial cancer as held in WHO study. [16]

In India, injectable is now available and commonly used is NET-EN. It is true that women's health organization has shown their reluctance towards unethical use of these contraceptives. There is concern about the side effects of such injectables. There is no provision for the record of its users and the side effects to those users. Primary Health Centers in India has no facilities for such large scale investigation and maintenance of records which is the only source of health service in remote area (particularly).[17]

A study carried out by Indian Council of Medical Research (ICMR) has shown that almost 50 percent of women who had developed amen-orrhea failed to conceive even one year after discontinuing with *Net-en. Depo-provera* is known to increase the risk of facture by 10-15 percent.[18]

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[15] *Supranote* 13 at pg. 249.

[16] Supranote 13 at pg.249.

[17] *Supranote* 13 at 249.

[18] Gwendoline M.Alphoso "*Preventing Motherhood: Medico-Legal and Ethical Dilemmas in Contraception*" .5 Law and Medicine 6 (1999).

Oral Contraceptive pills when taken, there hormones (Estrogen and progesterone) contained in them are absorbed in the blood stream and prevent formation of egg itself, in the ovary. When it is in the blood stream, they are also able to affect every part of the body thereby.[19]

The birth control pill has become familiar in India with the advertisements in huge manner. These pills are provided free of cost in government hospitals. Some pills such as MALA-D are sold in marginal price in market making it affordable for every class of people. However, advertisement shown only reflects the beneficial effects of the pills without showing any concern on its side effects just to draw attention to the product.

There is a need to take greater care while adopting contraceptive pills as these are taken during the active sexual life of the couple. There is a possibility of the pill to affect the progeny. The alteration of the genetic composition of the ovum which could lead to the birth of children with chromosomal anomalies such as Down's syndrome or the drug passing through the placenta and directly effecting the foetus in uterus. Those drugs could also pass through breast milk and affect the breast fed infant if the woman has breast feeding infant.

There is also barrier method i.e. female condom which is not so popular. This method was said as cumbersome and noisy; some feels that it takes away the spontaneity of sexual interaction. But for those who is with STDs and the AIDS it is useful. It is also useful for those women whose partner is not willing to use condom.[20]

Besides, above mentioned contraceptive measures, there are recently developed ***morning - after pills***. These drugs are now easily available and freely advertised in India also. It is to be taken within 72 hours of sexual intercourse which ensures that any fertilized ovum will not implant in the womb.[21]

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[19] *Supranote* 18.

[20] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 239 (1st Edition 2000).

[21] P.M.Bakshi *"Contraception and Abortion: Some Legal Issues" 11* The Lawyers Collective 22 (1996).

These emergency contraceptive has been called "the best kept contraceptive secret". Many women are unaware of the availability of such contraceptive in the past. But, today it is known item to every one. In the developed countries, this contraceptive has often been used for help to rape victims. Nevertheless, in a country with weak health infrastructure these contraceptives can be misused. They are available without necessary information, and thus may be taken in inappropriate portion or too late after unprotected intercourse which may increase the adverse effect.[22]

The advantages and the disadvantages of each of these methods would be an issue of alarm to medical experts who give advice at the various medical and family planning clinics. In the path of contraceptive technology and research on reproductive and child health, some excellent research has taken place and new products have already arrived at the market. Any strategy adopted has to be within the people's health mandate, only then can new reproductive technologies such as contraceptive technology will produce the desired results.

There has been increase in the use of contraceptive by women as now the reproductive processes have been scientifically understood by women and men. There has been growing concern of the medical profession, pharmaceutical industry and organizations on the use of these methods and thus, they are actively involved in its campaign.[23]

2.2.2. Abortion:

Abortion is the termination of pregnancy before the foetus is sufficiently developed to survive independently. In India, under the Medical Termination of Pregnancy Act, 1971(MTPA), the termination is allowed up to 20 weeks of pregnancy. It permits termination in such situation where there is risk to mother's life or grave injury to her physical or mental health or if child born will suffer from such physical or mental abnormalities as to be seriously handicapped.[24]

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[22] *Supranote* 20 at pg 287.

[23] *Supranote20 at* 240.

[24] Ved Kumari "*Fertility Revolution and Changing Concept of Family and Identity*" XXV Delhi Law Review 260 (2003).

Abortion is totally illegal or severely restricted by law in most of the countries. Whether abortion should be permitted or not? As to what extent it should be permitted? These are debatable questions where there is no settled rule.[25] However, in most of the countries including India abortion is permitted under certain circumstances:

a) To preserve the life or physical or mental well-being of the mother.
b) To prevent the completion of a pregnancy that has resulted from rape.
c) To prevent the birth of a child with serious deformity, mental deficiency, or
d) To prevent pregnancy resulted from failure of birth control methods.

In India, abortion has to be carried out as per the terms of Medical Termination of Pregnancy Act, 1971 (MTPA) where legal abortion is permissible under above mentioned conditions till 20th weeks of pregnancy. However, up to 12 weeks of pregnancy only one doctor may form opinion on the termination of pregnancy but after 12 weeks and up to 20th weeks, the decision of abortion should be taken with opinion of two doctors.[26]

Additionally, the Act provides that all operations must be performed in approved premises. But, there is an exception to this general rule that if the termination of pregnancy is necessary to save the mother's life than operation can be performed at any place whether approved or not.[27]

Further, termination of pregnancy is justified only if it is done with the consent of the pregnant woman. If she is a minor or a lunatic than consent of the husband of a married woman is not necessary.[28] However, the consent of father will be taken in case of pregnancy of minor girl where she decides to terminate her pregnancy. But abortion cannot be forced upon a minor who wants to complete her pregnancy and ready to bear

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[25] *Supranote* 24.

[26] Justice Palok Basu, *Law Relating To Protection of Human Rights* 127 (1st Edition 2002).

[27] *ibid* at pg128.

[28] *ibid*

her child. The Medical Termination of Pregnancy, Act provides that father's consent is needed only when minor opt for termination not when she chooses to give birth.

The study shows that some 50 to 60 million abortions occurs per year through out the world, up to half of them illegal and dangerous, killing about half a million women per year. Besides, atleast 500 million women around the world are placed at the risk of repeated pregnancies with serious health problems.[29]

Abortion is said to be legal when done under Medical Termination of Pregnancy, Act in India. However, the truth is that abortion is carried out under unsafe or undesirable condition. Many women fall under recourse to unsafe abortion at the hands of untrained persons which give rise to high morality rate. Women's health greatly affects due to unsafe abortion, such as uterine perforation, chronic pelvic pain or pelvic inflammatory disease.

Abortion is the most commonly used by women all over the world to terminate pregnancy, either as a result of failure of contraceptives or as a way out of an unwanted pregnancy. Even though abortion is legal in India, yet the incidence of illegal abortion is alarming. As many as 10 times illegal abortions are carried out here, and atleast 80 per cent of women are admitted to the hospitals as a reason of some complications caused due to abortion by unqualified doctors. The most important concern relating to abortion on the context of reproductive right is how to ensure access to safe and effective legal abortion facilities to women. There are already data to show that some 25-50 percent of maternal deaths in developing countries occur from unsafe abortios.[30]

2.2.3. Sex Selection Test:

The scientific development in medical field has made the convenient tool for portraying the quality and status of the foetus in the womb. It helps to see the condition of foetus whether there is any abnormality or not especially in such cases where there is hereditary disease in the family. But at the same time, in a country like India, it has

[29] Subhash Chandra Singh *"Right to Abortion: A New Agenda"* AIR Journal 129 (1997).

[30] *ibid* at pg.134.

opened the way for female foeticide eliminating female foetus after identifying the 'foetuses'.[31]

Ultrasound scans, amniocentesis and chrionic villi biopsy are the sex selective techniques which are used to detect genetic disorders and abnormalities during the pregnancy of women. ***Amniocentesis*** (Amnion; membrance, kentesis; pricking) was brought in India in 1975. It is a diagnostic procedure performed by inserting a hallow needle through the abdominal wall into the uterus and withdrawing a small amount of fluid from the sac surrounding the foetus.

The test is to detect various kinds of disorders such as- chromosomal disorder, inherited metabolic disorder and so on. The test may also be performed to identify suspected problems or infections late in the pregnancy. It can also determine lung maturity. Amniocentesis is also used in high risk pregnancies, especially in cases where women conceived late (over 35 years of age).[32]

To perform the test about 10 mls of amniotic fluid is removed from the woman's body. The test is done between 15-18 weeks gestation and there is little chances of harming the foetus or causing the miscarriage. This technique can also be used to identify the sex of the foetus. Now, there is a trend of sex selective abortion after determining whether the foetus is male or female with the help of these tests. After determination of the sex of the foetus if it happen to be female foetus there is every chance of abortion as there is huge son preference prevail in India.

Similarly, ***chorionic villi biopsy***[33] is another such method which involves the removal of the elongated cells (villi) of the chorion (tissue surrounding the foetus), through the cervix. This tissue is than tested for determination of sex. This new technology helps to determine sex between 6 to 13 weeks of pregnancy. Here, abortion can be done in the first trimester itself. This technique is proved to be less painful and

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[31] Foetus refers to the period from the 57th day of pregnancy till the end at birth.

[32] Ashok K. Jain ,*The Saga of Female Foeticide in India* 110-111 (1st Edition 2006).

[33] *ibid* at pg 59.

more accurate than amniocentesis and it risk less bleeding and spontaneous abortion as well.

The cheap technique of detecting foetus is ***ultrasound.*** It can identify up to 50 percent of abnormalities of the foetus. This technique uses inaudible sound waves to get a visual image of the foetus on a screen. It also determines the foetal position or abnormalities and also determines sex of a foetus. This ultrasound prediction is 95-96 percent accurate at the advance stage of pregnancy. This machine allows the doctor to visit from village to village and if the foetus is female a second trimester even a third trimester abortion is also carried out especially in a country like India where there is strong son preference.[34]

These new and sophisticated reproductive technologies have raised the problem of female foeticide in India. There are some technologies such as ***karyo-typing,*** which analyse abnormalities of the chromosomes and reveals the sex of the foetus. This method takes 11 days and costs around Rs. 5000 (approx). *Fluorescent in sites hybridization*, which is 95 percent accurate, takes two days and costs Rs. 10,000(approx); *comparative genomic hybridization* requires two days. These and lot more available at market which can be used to detect the abnormalities in the foetus as well as the sex of the foetus within 5 – 6 weeks of pregnancy, making abortion less serious as compared to methods like amniocentesis that can be done only after 14 weeks of pregnancy. At that time, abortion not only becomes medically dangerous for the mother but also involves the legal and moral questions.[35]

There are some new techniques from which sex selection of the foetus can be done pre-natal even before conception. There are two commonly used pre-conceptional sex selection i.e. ***Ericsson's*** method and **Pre-Implantation Genetic Diagnosis *(P.G.D)*.** Both these techniques are used to identify and discard the female embryo[36].

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[34] *Supranote* 32

[35] *Supranote* 32 at pg 60- 61.

[36] Ashok K. Jain ,*The Saga of Female Foeticide in India* 60 (1st Edition 2006).

In the ***Ericsson's*** method only XY sperm which can produce male child is used for artificial insemination. In this method, first a semen sample is diluted and then centrifuged, X and Y bearing sperms are separated when placed in a chemical solution. The faster moving Y- sperms penetrate the solution's cleanser bottom layers, which are collected and centrifuged. The process is repeated and the Y concentrate is collected for artificial insemination. This method is found 70 percent successful producing a male child and is very expensive.[37]

Another per-conception method is called ***PGD*** which means ***Pre- Implantation Genetic Diagnosis*** which was developed in the West to sort out embryos with inherited diseases like haemophilia. Under it, firstly unfertilized eggs will be collected from the female ovaries. They are fertilized outside the women's body in a petridish with active sperms. The resulting embryos are then nurtured in an incubator. After 72 hours each eight-cell embryo is biopsied by a micromanipulator, which includes glass pipettes and a powerful microscope. While one of the pipettes holds the embryo in place, the second extricates a single cell from the little clump. The extricated cell is taken to a tiny FISH (Fluorescent *in situ* hybridization) laboratory and transferred to a slide under a stereo Zoom Microscope, specially designed for single-cell analysis.[38]

The genetic blueprint of the cell is to be studied to determine the sex of the 'embryo'.[39] Chemical strains are used to single out the X and Y chromosomes from the intricate genetic master plan. It is than 'bathed' to wash away unwanted cellular debris, which could interfere with the analysis. The freshly scrubbed X chromosome (female) shows up as a pink dot while the Y chromosome (male) shows up as a bright green speck. The male embryos which are always fewer in number are than implanted in women's uterus and the female embryos are simply discarded.[40]

These above discussed techniques of detecting genetic abnormalities, metabolic disorders, and chromosomal abnormalities or certain congenital malformations or sex

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[37] Ashok K. Jain ,*The Saga of Female Foeticide in India* 60 (1st Edition 2006).

[38] *ibid* at pg.61.

[39] Embryo refers to the developing human organism formed after fertilization till the end of 56 days.

[40] T.K. Rajalakshmi "*Sex Selection and Questions of Law*" Oct 27 Frontline 103 (2000).

linked disorder is presently highly used for sex selection of the foetus, leading to killing of female foetus commonly known as female foeticide.

It is estimated that the number of female per thousand male is 990. Western Europe has a figure of 1,064 females per thousand and Africa 1,015, Asia as a whole has less number of female than male. In India, there has been a steady decline of the sex ratio over the 20th century. This decline in the child sex ratio has been found in Himachal Pradesh (897), Punjab (793), Chandigarh (845), Haryana (820) and Delhi (865). In all these states, the number of female children per thousand male children in the 0-6 years age group, declined by more than 50 between 1991 and 2001. A 2003 report also shows the decline in the number of girls.[41]

In a state like Punjab or Haryana, ultrasound machines are increasingly used to determine the sex of an unborn child. The doctors and quacks hit upon this money minting racket and had even started carrying these foetus killing machines right into the house of the people. There is also a threat to the decline in sex ratio which is already 888 females against 1000 males[42].

There is always neglecting and discriminating attitude towards girls in India and as found in several studies female mortality is always high. In recent past, there has been rapid spread of ultrasound and amniocentesis tests for sex determination in most of the parts of the country, followed by sex selective abortions which have become so easy in India. [43]

The universal desire for son than daughter is apparent from the sex ratio of live births where there is decline in female sex ratio. This could not have been possible to this extent, if there would not be widespread use of pre-birth sex determination tests. There is pressure on wives or daughters-in-law from husband or in-laws to go for sex-

[41]Mohan Rao, *The Unheard Scream-Reproductive Health and Women's Lives in India* 260 (1st Edition 2004)

[42] Law Teller, June 1994 Flash Points 2.32

[43] Leela Visaria "Deficit of Girls in India" in Tulsi Patel (ed) *Sex Selective Abortion in India* 69 (2007).

determination tests during pregnancy and further abortion in case if female foetus found. Many times women themselves wanted to get ride of female foetus.

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 provides for the regulation of the use of pre-natal diagnostic tests for certain purposes. Its main objective is to prevent misuse of such techniques for the purpose of sex determination leading to female foeticide.[44]

.Though, Pre-Natal Diagnostic Technique, Act has been enforced but it is ineffective as there will be hardy any evidence to show that foetus has been removed for being female. The Medical Termination of Pregnancy Act provides various grounds when abortion is allowed to women. The reasons for female foeticide are many, such as-

(i) Women themselves wanted to remove it sometimes; or

(ii) There is pressure from the family for its removal; or

(iii) Medical Termination of Pregnancy, Act can be used as an instrument to prove legal abortion on any of the ground as provided under the Act.; or

(iv) Medical practitioners will not give evidence against themselves; or

(v) There will be no evidence to prove the act of female foeticide through sex selective abortion.

Though, technology alone is not responsible for female foeticide in India. There are various socio-cultural reasons for this practice such as –dowry system, prospect of migration etc. Whatever, the reason for female foeticide but it cannot be denied that increasing number of female foeticide is an alarm for civilization collapse.

The skewed sex ratio in the 0-6 years age group must surely have a negative impact on the overall sex ratio. Perhaps it has already created a tumble effect on the population over a period of time that will now lead to a diminishing sex ratio for the entire country.

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[44] Tulsi Patel "Foeticide,Famiy Planning & State –Society Intersection" in Tulsi Patel (ed) *Sex Seclective Abortion* 322 (2007)

This declining ratio will certainly create an imbalance in the society within this age group and it will be difficult to remove it in the long run.[45]

2.2.4. Artificial Insemination:

Artificial insemination is the form of assisted reproductive technique which is designed to overcome the problem of infertility. In this process, a childless couple will be advised to collect the sperm from a man and injecting it into uterus of a woman for the purpose of conception[46]. Here, sperm is collected either from the husband or a donor. Sometimes, there is use of mixed semen from husband and donor which is referred as combined artificial insemination (CAI).

This assisted reproductive technique has been practiced since 19th century. This practice has become so common that it can be performed without the help of the doctor or fertility specialist also. The unique feature of this technique is that it not only cures female infertility but male infertility as well.

In this process, a woman visits the physician when she is about to ovulate. The physician introduces sperm into her vargina using a syringe that injects the sperm near the cervical cap that the woman will wear for next four to six hours to achieve fertilization of egg[47].

The U.S. Congressional Office of Technology Assessment in 1988 provides that more than 172,000 women resorted to artificial insemination in 1987 and about 65,000 babies that year were born from this method. It is concerned with the transmission of infectious and hereditary diseases.[48]

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[45] J.K.Banthia "Declining sex ratio:a national emergency" in Shruti Pandey, Abhijit Das, Shravanti Reddy, and Binamrata Rani (eds.) *Coercion versus Empowerment* 41 (2006).

[46] Gosden Roger, *Designing Babies; The Brave New World of Reproductive Technology* 23 (1st Edition 1999).

[47] Warren Freedman, *Legal Issues in Biotechnology and Human Reproduction* 27 (1st Edition 1991).

[48] *ibid* at pg 24.

In Artificial Insemination there are three sources from which the seminal fluid can be drawn:

1) Artificial Insemination donor or Artificial Insemination Heterologous (AID) where the sperm is donated by a third person or donor.
2) Artificial Insemination Homologous (AIH) where the sperm is donated by the husband.
3) Combined Artificial Insemination (CAT) where the sperm of the donor and the sperm of the husband are mixed together.

The most famous method is Artificial Insemination Donor (AID) which is legalized in many states such as California, Washington, New York etc(about 29 States) and which makes the child born to the woman, the legitimate child of her and her husband.[49]

AID is most useful where the wife is fertile and the husband is sterile or has cacogenic hereditary characters. Biologically, the child born out of AID is not related to the husband and, therefore, AID can be threatened with the development of the law.

In most countries AID is not easily available to all women. Though, very little expertise is required, the medical professionals maintain strict control over the procedure. Therefore, often lesbian women or single women face difficulty opting for it. It is common that women do not want that their husband should be told about their lack of manhood or rather their infertility. Women come to such clinics with their mother without the knowledge of their husbands and in-laws, because if they fail to produce child they might be deserted by their husband.[50]

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[49] *Supranote* 48 at pg.29.

[50] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 358 (1st Edition 2000).

2.2.5. In-Vivo Fertilization:

The donor woman is artificially inseminated with the sperm from a husband of an infertile woman. After five or six days, the embryo is removed from the donor woman in a nonsurgical procedure and the embryo is transferred into the uterus of the infertile woman.[51]

This method has been used in situation where there is low sperm count of the male or oligospermia, the low motility and penetrability of the sperm and the low compatibility with cervical mucus. This procedure has not achieved popularity due to the reason of it complex procedure.[52]

2.2.6. In-Vitro Fertilization (IVF):

Invitro fertilization means "fertilization in a glass". On July 25^{h} 1978, a girl named *Louise Brown* was born. Astonishment on her birth by the world is because she was the first test tube baby. Her birth was the miracle of science. Louise was conceived by a process called in-vitro fertilization. This involves the fertilization of an egg outside the body, either by subjecting a store of eggs to a population of sperm in a Petri dish or by manually inserting a single sperm into a mature, unfertilized egg, a process called *intracyloplasmic sperm injection* (ICSI).[53]

In this process, procreation is done in three stages. At first, fertility drugs will be given for several days from 3-7 days of a women's menstrual cycle for the purpose of multiple ovulation. Moreover, one or more follicles containing eggs develop after the drug treatment. Through, laparoscopic surgery the oocytes (mature eggs) or ova (mature egg) are removed. After removal of the oocytes, they are first placed in a specially prepared culture and incubated to develop into mature eggs. Secondly, in a Petri dish the ova are incubated with the sperm. To endow the sperm with the ability to pierce the eggs cellular wall a capacitating chemical is used. Thirdly, the resulting zygote when developed into 4-8 cell stage, it is transferred to the women's uterine

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[51] Warren Freedman, *Legal Issues in Biotechnology and Human Reproduction* 3 (1st Edition 1991).

[52] *ibid*

[53] Samson O. Koyonda "*Assisted Reproductive Technol;ogies in Nigeria:Placing the Law above Medical Technology*" 43:1 Journal of Indian Law Institute 73 (2001).

cavity in the hope to implant it. In securing successful implantation, the hormonal preparation of the woman and timing of the transfer are crucial. Pregnancy can be detected 10-14 days later, if it is successfully implanted.[54]

Another process of In-Vitro Fertilization (IVF) is called ***Cryopreservation*** where there is a cooling and dehydrating of an embryo to allow it to be stored for a long period of time. This process allows a woman undergoing IVF procedure to use possibly all her retrieved and fertilized eggs. This process reduces the number of times a woman may have to undergo egg retrieval if the IVF first attempt is not successful in inducing pregnancy.[55]

In-vitro fertilization is a humanitarian milestone for those families who are unable to have children by natural process. This technique bypasses damaged or blocked fallopian tubes and overcome problems of ovulation and certain genetic disorders, as well as low sperm count.[56]

This method is comparatively more successful as seen from the report from Europe, Australia, and United States etc. New ultrasound directed non surgical aspiration methods make IVF an outpatient procedure. Even genetic screening can be performed on in- vitro embryo, one or more cells can be removed and screened for purpose, such as- Down's syndrome and chromosomal testing can make possible treating of an embryo with a defect. [57]

However, there are disadvantages also of In-Vitro Fertilization (IVF), like only one preovulatory follicle is available for aspiration of an egg, protracted monitoring is required to detect the hormonal surge, and the overall pregnancy rate is lower than with stimulated cycles where multiple follicles are available for aspiration

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[54] *Suprsnote* 53.

[55] *Supranote* 53 at pg. 74.

[56] Warren Freedman, *Legal Issues in Biotechnology and Human Reproduction* 4 (1st edition 1991).

[57] *ibid*

IVF is the foundation for a number of other techniques making possible other manipulations, such as pre-implantation diagnosis of embryo for genetic disorders and sex selection. Recent, advances in freezing and storage of sperm and ova have made different variations on the IVF procedure possible. With these procedures the implantation rate is 40- 50 per cent higher than with traditional IVF in a single cycle. The IVF technique does not cure infertility. It simply assists in producing offspring technically, in spite of existing sterility.[58]

Till now, there is neither health risks found in women through the use of this technique nor any to children born out of it. Though, there is large number of children born through this method. In adopting such methods what is remain unaccounted is the mental trauma that women will go through during the visit, basal body temperature sometimes, collecting urine, taking fertility drugs through injections and pills, and several times visits to the IVF centres for the various interventions that are a part of the total IVF procedure.[59]

Some of the health risks associated with IVF are: hyperstimulation syndrome, spontaneous abortion or miscarriage, ectopic pregnancy, multiple births, difficult labour and caesareans, premature births, low weight at birth, pre-natal and neo-natal mortality, and genetic disorders/defects. How much women is informed about the IVF is also an important issue of concern.[60]

2.2.7. Embryo Transfer:

Embryo Transfer is another modern reproductive technique which delineates the transfer of the fertilized ovum from its extracorporeal fertilization into the uterine cavity. An embryo is the product of conception from the moment of fertilization to the end of the eighth week thereafter. An artificial embryonation describes the process whereby the couple utilize a fertile woman who agrees to be inseminated with the man's sperm, four or five days after fertilization, the physician flushes out the embryo

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[58] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 348 (1st Edition 2000).

[59] *ibid* at pg. 350

[60] *ibid*

and implants it into the wife who will than carry the baby to term. Embryo adoption, unlike egg adoption or artificial insemination, refers to a situation where the embryo has genes from neither parent, if a woman has an ovarian or tubal problem and the husband is sterile, another woman is voluntarily inseminated by the sperm of a donor and once fertilized the embryo is flushed out after five days and implanted into the wife for normal maturation and birth.[61]

This method availed a woman with the experience of pregnancy and child birth with the help of embryo transfer. A baby may be genetically of woman's husband although she has no contribution of egg. It is important to be careful while selecting ovum donor, so it is essential to conduct tests for determination of diseases and chromosomal defects of the donor.[62]

The main advantage of this method is that it helps when a woman's ovaries or fallopian tube fails or when a genetic disorder or disease would otherwise be passed to the embryo.[63] The probable disadvantage is that the method is so costly that everybody cannot afford it. It also challenges the idea of biological motherhood. In India, blood bond is really vital for marriage, other rituals and property transfer. This method will raise the complex issue of parentage.

The Embryo transfer rate is higher than that of IVF method with or without donated eggs. The main advantage is that it gives woman the same usual experience of pregnancy and child birth. There are, however, some disadvantages also such as tubal pregnancy in the recipient and a retained uterine pregnancy in the donor.

2.2.8. Egg and Sperm Donation:

Sometimes, infertile couple cannot get benefit from In-vitro fertilization. In some cases, infertility cannot be treated while using the eggs and sperm of the infertile couple. The sperm or the eggs may not be viable or are not being produced. In such cases, egg and sperm donation is the answer. Here, either donor gametes can be used to

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[61] Warren Freedman, *Legal Issues in Biotechnologyn and Human Reproduction* 5 (1st Edition 1991).

[62] *ibid*

[63] *ibid*

produce the embryo or embryo is implanted into the uterus of a woman. At times, woman may be unable to produce healthy eggs on their own, than egg donor can be used. The eggs, thus, fertilized by IVF procedure is than donated to an infertile woman who than can have the eggs inseminated with the sperm of a fertile male.[64]

Sperm donation is common from many years with very little controversy as it has no side effects/ negative effects on the donor. Egg donation is also becoming popular but with strong controversy as egg harvesting can be a dangerous procedure. It involves non-necessary surgery and the drugs used to stimulate the ovaries to overproduce mature eggs have not been tested extensively to determine long term effects on women who have taken them. There are concerns that these drugs can lead to higher risk of ovarian cancer. There is also risk of endangering the fertility of the donor by egg donation.[65]

There are only few sperm banks in India. WHO guidelines do not support the use of fresh semen, as it leads to anxieties relating to sexually transmitted diseases including HIV/AIDS. The main problem is to ensure a regular supply of liquid nitrogen (tank has to be replaced every 3-4 days) without which the extremely low temperature at which the semen has to be stored cannot be maintained. In 1974, when sperm bank was opened there was controversy about it. But due to high demand in recent times, many sperm banks have grown up.[66]

Donors are generally discouraged by the long series of laboratory investigations that need to be performed before a donated sample can be declared safe for use. There are tests conducted of donor before taking semen/egg in donation which include tests regarding sexually transmitted diseases(including HIV/AIDS), hepatitis, blood group, genetic disorders, as well as IQ levels (many times) imposed by American Fertility Association. The height, weight and complexion of donor are also kept in record. There

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[64] . Samson O. Koyonda *"Assisted Reproductive Technol;ogies in Nigeria:Placing the Law above Medical Technology"* 43:1 Journal of Indian Law Institute 74 (2001).

[65] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 359 (1st Edition 2000).

[66] *ibid*

is also International standard imposed on donor that only those having normal two children should be allowed as donor.[67]

However, these norms are not followed by all the medical laboratories with honesty as they are engage in making profit out of it. When a woman comes with a complaint of being unable to conceive, the semen of her husband is also taken into consideration. Another important point is many gynecologists believe that the success rate with fresh sperm is higher than of the frozen one.[68]

2.2.9. Surrogacy:

In surrogacy, there is an arrangement where a woman agrees to bear a child for a couple or for a single person. A woman is either artificially inseminated with the sperm of the commissiong man (or a donor) or she is implanted with the embryo produced in vitro from the gametes of one or both of the commissioning parents (or from donated gametes)[69]. Very rarely surrogacy can be arranged through sexual intercourse.

Basically, the surrogate mother conceives and carries the child for nine months, gives birth and after that releases her parental rights, giving up the child to the couple. Surrogacy can be adopted for various reasons, common being infertility of the woman. There are other reasons also such as, habitually miscarry or for whom the pregnancy would be dangerous or those likely to transfer an undesirable hereditary disorder in an ordinary pregnancy.[70]

Surrogacy is also of various types:

i) Total surrogacy:

Here, woman bears a child that has been formed from the gametes of another woman and man and implanted into her body through In-Vitro Fertilization.

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[67] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 359 (1st Edition 2000).

[68] *ibid*

[69] Commissioning parent refer to describe the person or persons for whom the child is to be borne.

[70] Radika Kollusu and GitanjaliLakhotia "*Surrogacy: Legal and Social Issues*" 5 Law and Medicine 278(1999)

The birth mother is not genetically related to the child. It is also known as gestational surrogacy where the carrier has just carried the child and the child is genetically related to both intended parents.

ii) Partial/ Genetal Surrogacy:

When the birth mother contributes the ovum and the sperm is introduced by artificial insemination, such a method is called as partial or genital surrogacy. Here, atleast child is biologically related to the mother and birth mother is a biological parent.

iii) Commercial Surrogacy:

In such cases, there is financial arrangement for the birth mother and in place of that she will surrender her child. It is a business like transaction where a fee is charged for the incubation service[71].

iv) Altruistic surrogacy:

It is the term used to describe the situation where there is no formal contract or any payment or fee to the 'birth mother'[72]. It is usually an arrangement between very close friends or relatives.

Though, surrogacy is practiced in India but it is still in its formative stage. Some infertility specialists are hesitant to do commercial surrogacy yet, they do buy ova. There is argument that the body of the surrogate mother is simply used as an incubator by the commissioning couple. There is also possibility that the institutional growth of surrogacy may promote an undesirable means of family making, like through single unmarried woman, lesbian or gay.

Surrogacy has posed many legal questions and is full of controversy. But even than in case of surrogacy the child is atleast biologically related to the father. In many countries, surrogacy is not allowed. There in no clear or visible law on the subject matter, including India. No doubt, surrogate arrangement has brought big relief to the childless couples; the arrangement has given them happiness of having their own child. But there are issues like commercialization of birth, renting of womb, women's rights, baby selling etc. Many critics call this process as unnatural and therefore ethically wrong.

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[71] *Supranote* 70.

[72] Birth Mother means a woman who carries the child and gives birth to it, i.e, surrogate mother.

2.2.10. Human Cloning:

The term 'cloning' has been derived from the Greek term Klon, meaning 'twig' which means the taking of a cutting as in plant breeding but it also used to describe a process known as nuclear transfer of genetically identical animals. Nuclear transfer involves removing the chromosomes from an unfertilized egg and replacing them with a nucleus from a donor cell. The transferred nucleus determines all the characteristic of the resulting offspring; a clone will resemble its parents.[73]

Clone is an organism that has the same genetic pattern as another organism. Such unique technique of procuring a genetically identical duplicate of an organism is called as cloning. Cloning has been defined as 'copying and propagation without altering the genome by the Human Genetics Advisory Commission (HGAC) and Human Fertilization and Embryology Authority(HFEA).If the genome-complete genetic identity of any individual is cloned or copied a genetically identical individual is created.[74]

Cloning would be relief to those couples where both are infertile due to genetic insufficiency. In such cases where the male partner lacks gametes, the couple might prefer to opt for cloning rather than sperm donation. If the husband were the source of the DNA and the wife provided the egg that received the nuclear transfer and then gestated the foetus, they would have a child biologically related to each other and would not rely on anyone's gamete or embryo donation.

The human cloning technology could be helpful for cell and tissue therapy and that it helps in organ transplant. A child who needed an organ or tissue transplant might lack a medically suited donor. As *Robertson* points out, in such situation, couples often conceived a child to have the correct tissue type to serve, for e.g., as a bone marrow donor for an older sibling. If the child's disease was not genetic, a couple might prefer to transplant to the affected child to be sure that the tissue would match.

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[73] Naveen Sankaran "*Human Cloning-A Paradox's Box*" 5 Law and Medicine 255 (1999).

[74] S.K.Verma "*Cloning: Controversies and Law*" 21 Indian Journal of Criminology and Criminalistics 197 (2000).

Another important use of human cloning technology is that the couple who are at high risk of having offspring with a genetic disease can opt for such methods. The couples in such situation must choose whether to risk the birth of an affected child, to undergo pre-natal or pre-implantation diagnosis and abortion or the discarding of embryos, to accept gamete donation to seek adoption, or to remain childless. If cloning can be done, than couples will prefer to clone one of themselves or another family member.[75]

Cloning is also useful in such circumstances where child died or there is dying child, so that to have that child live on in some closely related form, which can be done by obtaining sufficient numbers of embryos for transfer to create the resemblance clone.

There has been strong criticism on human cloning. The creation of clones solely for the purpose of providing spare parts (i.e. organ transplantation) would be degrading human values and as a resemblance to dying child as if treating human lives as an object.

2.2.11. Sterilization Operation:

Laparoscopic tubectomy is the commonly employed mode of female sterilization. Here, the fallopian tubes are blocked either by a plastic ring devised by fallopian or by a filshie clip. Two rings are loaded one after the other on the applicator. The ring loaded applicator approaches one side of the tube and grasps the utero-tubal junction. A loop of the tube is lifted up, drawn into the cylinder of the applicator and the ring is slipped into the base of the loop. After this, the procedure is repeated on the other tube.[76]

In rural areas, camps are organized in rural areas to provide sterilization free of costs. In such camps, a mobile team of medical personnel comes to do such operations.

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[75] Naveen Sankaran *"Human Cloning-A Paradox's Box"* 5 Law and Medicine 257 (1999).

[76] Surya Malik *"Failure of Sterilization Operation-Whether Medical Negligence"* 292 AIR Journal (2004).

These people themselves works under pressure as they have to achieve certain targets. In these camps a single surgeon performs 300-500 laparoscopies in 10 hours per day. In such a situation the attitude of medical personnel would be callous. There will be no follow up care in such mass programme which only provides the facility for sterilization and move on. In such areas there are no hospitals and clinics where women can go in case of any problem later on. The situation of government hospitals and family welfare clinics is no better.[77]

There are number of instances of failure of sterilization operation where woman again become pregnant and gave birth to the child. In such cases, aggrieved party suffers physically as well as mentally. The Court has started granting compensation to the parents/patient for bringing up those unwanted child which is the result of failure of sterilization operation. However, it is evident that no method of female sterilization is absolutely reliable.[78]

There are common causes of such failure which are as follows:-

i) Slipping or tearing of the ring.
ii) Recanalisation of the cut ends of the fallopian tubes by the natural process of union.
iii) Tube- peritoneal fistula formation.
iv) Inappropriate application of the ring due to deep adhesion among the nearby structures, when identification of the tube becomes difficult.
v) Diseased condition of the lower abdomen such as PID endometriosis.

Justice P.K. Sarkar has rightly remarks *"the failure of sterilization is the nature's overpower on human effort to maintain the nature's rule of progeny.*[79] In a majority of cases, it was found that there are sometimes natural and unavoidable

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[77] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 277 (1st Edition 2000).

[78] *ibid*

[79] *Archana Paul* v. *State of Tripura* (AIR 2004 Gau 7).

circumstances that can lead to a failure of the operation, though done with due care and caution.

In such cases, it is very difficult to prove medical negligence of the concerned doctor. In all other cases, proved failure rate is a ready defense for the medical practitioner. The doctor/ hospital have been able to avoid its liability of payment of compensation/ damages for birth of an unwanted child. Taking into consideration such cases, *the doctor should be held liable if*[80]*:*

i) Sterilization operation is incomplete;

ii) The doctor fails to inform the patient that:

- Even though the operation was successful there might be a conception (since person has right to decide if they wish to undergo this treatment where pain, inconvenience and at times money are vital factors).
- In case where after sterilization operation if woman misses her menstruation, she has to go for medical check up at earliest possible time.

iii) Even after medical check-up the doctor fails to detect the conception at a time when pregnancy could be medically terminated.

This shows that the liability of the doctors does not end with the operation. The liability begins from the time when a couple comes to the hospital and is informed about the procedure and continues till a woman concerned reaches her menopause.[81]

It is important on the part of the practitioner/ hospital to impart all the necessary information regarding sterilization as well as its failure. In USA and the UK, it is mandatory for the doctor to inform the patient about the procedure, alternative and the

[80] *State of Haryana* v.*Smt.Santra* (AIR 2000 SC 1888).

[81] Surya Malik "*Failure of Sterilization Operation-Whether Medical Negligence*" AIR Journal 295 (2004).

success rate. However, in India, there is no trend of informed consent of the patient[82]. It is because of the lack of awareness among people regarding their rights and mostly because of the illiteracy in a country.

Women go for sterilization operation for different purposes, some go on their own, and others may be prevented from going there by their husband or in-laws. For some, and sterilization is for prevention of unwanted pregnancy where termination is conducted on the condition of consent for sterilization by women. For some sterilization is just to have incentive offered by the government in different states and only for very few it is for the fertility control.[83]

2.3. Overview:

A civilized society always looks after the health of its citizens. It is the responsibility of the government to provide health services to the public. It includes providing health services to the pregnant women also. However, there are inadequate health services at government hospitals and apart from this, many times, many women die due to the wrong treatment and negligence on the part of the medical professionals.

The present human civilization is flourishing largely because of the dominant role played by technology. In the last 20th century, scientists, doctors, and technologists have come together to understand life processes. The large scale research is going on both in private or public sectors world wide. The researches in biotechnology have contributed to the development of reproductive technologies also benefiting the people but at the same time bringing new challenges before the society.

The evidence from demographic research on the world population estimates that between 60 million and 100 million girls and women are missing. They are missing as a combined result of female infanticide and mistreatment that leads to death. The Census

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[82] *Supranote* 81.

[83] *Supranote* 78 at pg. 278.

data shows that female population deficit has risen from 3 million in 1901 to 36 million in 2001 (table below).[84]

Table1

Population of India(in millions)			
Census Year	**Population**	**Male**	**Female**
1901	238	121	117
1951	361	186	176
1961	439	226	213
1971	548	284	264
1981	683	253	330
1991	846	439	407
2001	1,028	532	496

The Census 2001 reveals that India's sex ratio was 933 females per 1000 males, an increase from 927 recorded in the year 1901. The child sex ratio is the sex ratio for the 0-6 years age group, it is the medium through which attitudes and social responses towards the girl child is scrutinized.[85]

Ironically, a sharp decline in the sex ratio demands the political, legal and administrative sectors to address the issue of missing girls into action. The concern has started just from the publication of 2001 census and seriously country cannot wait for

[84] J.K.Banthia "Declining sex ratio:a national emergency" in Shruti Pandey, Abhijit Das, Shravanti Reddy, and Binamrata Rani (eds.) *Coercion versus Empowerment* 40 (2006).

[85] *ibid* at pg. 41

another 2011 census to find out whether the sex ratio has improved or not. There is a need for the active campaign of "save the girl child" slogan from governmental and non-governmental agencies to balance sex ratio.[86]

From the Census it was also found that economic development does not necessarily indicate an increase in women's status. Moreover, violence has occurred as a major cause of death for women in the reproductive age group and severe neglect, maternal mortality and undernourishment are the main hurdles for their well-being.

Even Family Planning Programmes has been implemented in such a manner that has led to numerous human rights violations for women. Like, in many parts of India, the average age of sterilisation for women is 20-21 years. This is one of the gross violations of women's bodies as it makes them vulnerable to violence and desertion within their households if a child dies at some later days, especially if it is a male child. [87]

Sometimes women are verbally abused and even slapped, at Public Health Centres (PHCs) if they scream or shout while in labour.There are instances where women are forced to sign consent forms for tubectomies while they are in labour pain.[88]

The Medical Termination of Pregnancy Act, 1971 has made the abortion legal and free but in reality in many government hospitals abortion is often offered on her acceptance to contraceptive methods chosen by her providers after abortion. For this reason women are compelled to go to the private sector at their own expense or resort to illegal and potentially unsafe abortions.[89]

Apart from this, women's reproductive health has been deteriorated because of the government's two-child norm which is enforced through a mechanism of incentives

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[86] *Supranote* 84 at pg.41.

[87] Manisha Gupte "Delining sex ratio, the Two –Child Norm, and Women's status" in Shruti Pandey, Abhijit Das, Shravanti Reddy, and Binamrata Rani (eds.) *Coercion versus Empowerment* 52 (2006).

[88] *ibid*

[89] *ibid* at pg.53.

and disincentives that are anti-women. Actually, women are the main targets of this campaign. The public health service perception of women is as either mothers or potential mothers. They easily lose interest in a woman's health and well being once she opted for tubectomy. This careless and instrumentalist approach adversely affects women's health and neglects their needs.[90]

Reproductive health problems such as cervical prolapses, cancer of the reproductive system, Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) are not treated at PHCs centre or rural hospitals; even though it is well known that if RTIs and STIs are not treated at time it will cause HIV/AIDS. Rather than making efforts to fully equip a health services, the government is moving towards opposite direction. The proof is withdrawal of government services in rural areas, promotion of private sector of health services and reduction in health budgets are rather few evidences of government's action.[91] Health service is the fundamental right of citizen and it has to be provided by the government as their primary duty.

There has been invasion of more and more new types of contraceptives but all targeted towards women, and even the target population control measures are still focused on women. At one hand, government is imposing two-child norm on the other hand families still want them to produce at least two sons. For this sex determination test has become the logical answer to this situation where couples are pressurize to have only one or two children.[92] It is no wrong to say that ideology of population control has now become a killing machine for women.

The *World Health Organization* and *UNICEF* estimate that more than half a million women die per year due to pregnancy related problems, most in developing countries. Worldwide woman face a 1 in 75 times risk of dying due to maternity- related causes.

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[90] Manisha Gupte "Delining sex ratio, the Two –Child Norm, and Women's status" in Shruti Pandey, Abhijit Das, Shravanti Reddy, and Binamrata Rani (eds) *Coercion versus Empowerment* 53 (2006).

[91] *ibid* at pg. 54.

[92] *ibid*

This risk varies from 1 in 4.085 in industrialized countries to 1 in 6 in the developed countries of the world.[93]

In India also, the ratio of maternal mortality rate is very high. The available facilities regarding reproductive health care is not so sound. Some of the major problems that need attention are as follows. There is a need for:

a) Accessibility to health care.
b) Pre-natal care and post natal care.
c) Nutritional care during feeding period.
d) To prohibit experiments without consent.
e) To prohibit violence against women including unwanted or forced sex.
f) To prohibit violence affecting reproduction and child bearing, and
g) To reform laws and practices that discriminate against women.

The ability of women to control the number, spacing and timing of their children is a fundamental right. Universal access to modern methods of reproductive technologies such as contraceptive, artificial insemination, abortion etc provides women control over their fertility. The right to health which is an essential right to realize all other rights of an individual also includes reproductive rights. It is the pre-condition to realize and enjoy human rights and dignity.

The right to health has undergone tremendous hypothetical study and within the framework of human rights instruments it has been defined right to health as "enjoyment of the highest attainable standard of health is one of the fundamental right of every human being".[94]

Today, everyone has started family planning progrmmes. Presently, more than half of the world's married couples are family planning users. The contraceptive technology in its simplest form has reached even in the remote area. Most of the people

[93] www.*reproductiverights.org*

[94] Rabindranath Jhunjhunwala "*AIDS and Human Rights: Time for an Empowered Response*" 5 Law and Medicine 39-101 (1999).

know about family planning and many people know some family planning methods. Couples now can choose from a variety of range of modern methods.[95]Here, the main line to be drawn is that the woman must have freedom to make choice in taking decision to adopt any family planning measures. It should not be enforced by any one either husband or family members.

There is no second thought that family members routinely make important decisions relating to women's reproductive health and rights such as regarding fertility, family planning, childbirth and abortion. A women's ability to make independent decisions in these area is further constrained by restrictive population policies such as two child norm of the government which aim to dictate the number of children women can and cannot have.[96]

There is a necessity to protect women from coercion and discrimination when seeking such reproductive health services. Their right to take decision on reproductive choice, child bearing and access to infertility treatment should be secured. Their right to take decision regarding their own body is yet to be achieved.

In many traditional societies infertility is often taken to be caused by a curse or evil spirits. Male fertility is less known due to the prevalence of the customs in many social orders. Apart from that spouses feel disappointed at being unable to conceive, they feel guilty towards their partners, once he/she is found to be infertile. Today, with assisted reproductive technologies infertility can be cured.

At this point, it is necessary to study the impact of current reproductive technologies. It is true that the reproductive technologies have many advantages but it cannot be denied that it has its disadvantages also. How much these technologies affect the life of women is crucial to understand.

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[95] Nandita Das, *Law and Medicine* 128 (1st Edition 2007).

[96] Pallavi Gupta "Rajasthan" in Shruti Pandey, Abhijit Das, Shravanti Reddy, Binamrata Rani (eds) *Coercion versus Empowerment* 103 (2006).

Till mid- 1980s infertility treatment consisted of diagnosing the reason for infertility rather than finding way out. Than the corrective way become popular where those unable to conceive by reason of infertility of any of the partner was given the option of adopting children or accepting childlessness as their fate. Nowadays, a whole range of options exist, from artificial insemination by husband or donor to in vitro fertilization with variety of forms. With the developments of reproductive technologies, infertile couples are offered with many sophisticated techniques. Although, the main focus the government policies are on the use of reproductive technologies has been on the objective of population control. But at the same time various private clinics has been opened with the facility to provide treatment for infertility. From some time now, it is no wrong to say that assisted reproduction is expanding in India.[97]

There are many reasons for infertility and one such reason is late motherhood. There is a need to pay attention on the increasing phenomenon on late motherhood. Women delayed their pregnancies at the most fertile stage of their life because of which there has been increasing trend in the use of In-Vitro Fertilization or other reproductive technologies. The study shows that in 1970, 63 percent women became mothers for the first time in the age of 25 years. In 1990, this has gone down to 31 per cent; 21 per cent be above 30-35 years of age at the birth of their first child. There are incidents where women with higher education postponed pregnancy till they establish a career and later, realize they want to have children before it is too late.[98]

No doubt, technology such as- In-Vitro Fertilization (IVF) is proliferating very fast which actually was developed to cure women with blocked fallopian tubes who were unable to conceive naturally. Thereafter the use of IVF has been extended to cover husband/partner's infertility and sub-fertility. A considerable number of women on IVF programme are fertile but they are there due to husband's infertility or sub-fertility. The cost involved in the IVF is very high. The high costs have raised questions regarding

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[97] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 339 (1st Edition 2000).

[98] *ibid.*

the benefit of IVF and the definition of IVF children as luxury items available only to the rich people.[99]

Another core of concern is that the subordinate position of woman in society is the root cause for a rapidly increasing rate of infection (relating to reproduction) among them. Women and girls are often unable to discuss safer sex or to avoid the HIV-related consequences of the sexual practices of their husbands due to social and cultural attitude and economic condition. There is no protection of sexual and reproductive rights of women which includes the rights of women to decide freely and responsibly on matters relating to their sexual health and reproduction.

Women are not empowered to quit relationship that threatens them with HIV infection if their spouses are infected with HIV/AIDS.[100] There is lack of accessibility to accurate information regarding risk factor of pre-natal transmission of disease, voluntary and informed choices about reproduction etc. Equal rights for women is lacking within the family to confer safe sex with their husbands or to leave the relationship if they cannot assert their rights. The socio- economic fabric has placed women as the suppressed class and incidentally, the HIV epidemic has made them the unfortunate victims of the sexual behaviors of the spouse which is one of the instances of curtailment of reproductive rights.

The shift of emphasis to sterilize women rather than men is likely to have serious effects on the health of women. Very few women go for the sterilization on their own choice; others may be forced by their husband. They are often pressured or coerced by the family to undergo sterilization because of the monetary or other incentives that government offered. Though, it may be difficult to ascertain whether sterilization is voluntary or coercive. It seems that the sterilization is more concerned with population

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[99] *Supranote* 97 at pg.344.

[100] Rabindranath Jhunjhunwala *"AIDS and Human Rights: Time for an Empowered Response* 5 Law and Medicine 65 (1999).

control than with reproductive rights which guarantee individuals with control over their fertility.[101]

When women go to the Mother and Child Health (MCH) (the Family planning programme) they are pressurized to adopt an IUD or sterilization. This has sometimes discouraged women from using MCH facilities. Another point is MCH programme is shown as meant for married women only and thus not assessable to unmarried women. This is contrary to reality where 46.7 per cent of unmarried girls in the study were found to have had sexual intercourse. Though, in India, pre marital and extramarital sex is prohibited by cultural and religious beliefs.[102]

Oral pills are not regularly available in rural areas. Women have little knowledge about these pills. Sometimes, they regarded it as abortifacient and take them when they missed a period, or only just before sexual intercourse. In some case, husband used to keep the pill and give them only when they think that their wives need them. Various family planning programme shows that there is an unmet need for contraceptives.[103]

The birth preventive measures allow the people to exert greater control over their fertility. The reproductive rights enable people to have control over their fertility without compromising their integrity, health and well-being. A development of new contraceptives is in the interest of women only when women themselves will exercise control over its use. Thus, the use of reproductive techniques has direct effect on their daily lives and their social relationships.

So, when popularizing methods like contraceptive; concern has to be on the control over fertility and sexuality by women; safe and effective method of contraception and information and counseling that helps to enhance their well-being. There is an increase in the health problems of women due to the use of certain contraceptive methods.

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[101] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 280 (1st Edition 2000).

[102] *ibid.*

[103] *ibid.*

Reproductive health and rights require that there has to be informed choice when taking decision regarding use or continue or discontinue of any methods of contraceptive. Choice should be based on sufficient information. The doctors should provide all the methods available, how to use them, their adverse effects, beneficial effects etc, and than allow the individual to make decision.[104]

Henceforth, after adopting any methods there have to be facility for follow up care so that in case of any complication women can go for medical check-up. Similarly, more attention has to be given to men to use barrier methods as a partner themselves rather than forcing women to use contraceptive. To decline individual access to new reproductive technologies is to frustrate the reproductive freedom. But it is also necessary to deal with the issues of reproductive technologies.

Women's choice of reproductive technologies depends upon the economic, social, cultural and political situation in which they are living. Even if freedom of choice is given to them, can they be able to make conscious choice. Choice implies awareness of possible consequences, and a decision based on that. What measures state will take to make women aware of the methods of contraceptive? On that basis only one can say that reproductive rights have been fully enjoyed by women or not.[105]

WHO survey report shows the incidence of infertility in different countries of the world. It shows that in India, about 10 per cent of couples suffer from problem of infertility. Nearly 16 million couples or 32 million individuals in the age group of 18-35 years age groups are afflicted by the problem, making infertility one of the most widespread problems in the country.[106]

There are traditional practices and methods to prevent pregnancy such as certain traditional norms and cultural practices, like prohibition of pre-marital sex, late marriage, post-partum taboos- for example, avoidance of sexual relations for a certain

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[104] *Supranote* 101at pg.326 .

[105] Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy* 326 (1st Edition 2000).

[106] *ibid* at pg. 339.

period after the birth of a child, or on certain days (either religious days, or auspicious days), and a long period of breast feeding are the most commonly practiced preventive measures.[107]

It is also necessary that women should learn how to tell when the fertile time of her menstrual cycle starts and when it ends. With the help of this method, the couple can avoid pregnancy. They can abstain sex or they can use as a barrier method or withdrawal during the fertile time. If used properly this method can be more effective and without adverse effects on the health of women. But there has to be cooperation between sex partners and full commitment from the man. This is commonly practiced during fever, vaginal infection, after childbirth or while breastfeeding.[108]

"Fertility awareness" means that a woman is aware of the fertile time of her menstrual cycle i.e. the time when she can become pregnant. The methods of fertility awareness includes- calendar calculation, cervical secretions, basal body temperature and the feel of the cervix. The couple can avoids pregnancy by changing their sexual behaviour during fertile days. Abstain from sex completely during the fertile time is also called as Natural Family Planning. Normally, unprotected sex should be avoided from 8th to 21st days of the woman's menstrual cycles i.e. 14 days. This method recorded a higher failure rate.[109]

Another most important feature of reproductive health is that the number of adolescent pregnancies is rising constantly. At times these pregnancies are at risk. Many of these are undesired and occur in unmarried adolescents. Generally, they adopt an illegal and unsafe abortion which means that abortion is conducted under poor medical conditions and by untrained persons. These illegal abortions mostly cause health hazards and sometimes endanger life.[110]

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[107] *Supranote* 105 at pg.343.

[108] Nandita Das, *Law and Medicine* 138 (1st Edition 2007).

[109] *ibid*

[110] *ibid*

However, such incidents can be prevented among the young people through educational programmes. There is large number of illiterate and school drop-outs in India. In conservative families sex is not discussed nor is any sex education given to the young people. Adolescents are not aware of family planning methods. Due to unprotected sex amongst adolescents, there are many times undesired pregnancies leading to abortion.[111]

In the growing field of modern reproductive techniques and genetic engineering, it is of interest to note that eggs, sperm, embryo, womb etc acquires patentable subject matter. Obviously these and other patentable subject matter must aid scientific progress with respect to the biological present and future. The loopholes are commercialization of human capacity to reproduce and its ill-effects in the society which can adversely affect the reproductive techniques but the price paid for this progress is the health of woman at risk.

2.4. Conclusion

The reproductive technologies, on one hand healed the wounds of infertile couples by giving them the chance to fulfill their desire for a biological child, on the other hand they have opened the possibilities for the state to intrude into the most private life of the people, their intimate experience i.e., sexuality and procreation. The technologies in this area have lead to the possibility of treating reproductive organs as commodities generating body products such as-sperm, egg, ova, womb for rent etc.

The quality of health care has not improved but rather it has become narrowly focused on population control. Women are still conceiving soon after marriage and spacing methods are not utilized to the extent. Women are providing care and support until they deliver the child, Sterilisation has been performed in women at their young age and sometimes forcefully.[112]

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[111] Nandita Das, *Law and Medicine* 138 (1st Edition 2007).

[112] G.Francis Raj and Vijay Lakshmi "Andhra Pradesh" in Shruti Pandey, Abhijit Das, Shravanti Reddy, and Binamrata Rani (eds) *Coercion versus Empowerment* 67 (2006).

To the end, Government documents claim that the large number of couples undergoing sterilization operations every year shows that there is a demand for these services. However, it is actually the state that is creating this demand by providing cash and other incentives for such services.[113]

[113] *Supranote* 112.

CHAPTER 3

ETHICAL DILEMMAS AND LEGAL ISSUES IN CASE OF REPRODUCTIVE RIGHTS

3.1. Introduction:

Technological innovations in the field of science and medicine have introduced the new processes of reproduction which enfold several burning issues. The science has touched every nook and corner of human life. Today, the scientific technology has made deep impact into the individual's life that it is no wrong to say that science is the reason for problems and solutions to many challenges before the people. One such challenge is that relating to reproductive rights of women brought by the reproductive technologies. In the complexities of problems and inadequacies of legal framework, it is imperative to study the legal, social and ethical issues of reproductive rights.

In traditional form of reproduction, there are natural mothers, natural fathers and natural children sharing biological relation with no intervension by any third party. On the other hand, there is a development of artificial reproduction through reproductive technology where there is intervension of a third party in the formation of a family. There are new challenges to the parenthood brought by these new reproductive methods, such as – In-Vitro Fertilization, surrogacy, cloning etc.[1]

It is a natural instinct of every human being to procreate. It is because of this universal truth that man and woman live together in the institution of marriage which has the recognition of law. The right to marriage and right to procreate have been recognized under human rights instruments also.

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

As long as procreation is complete by natural process there is no problem. However, if after the marriage, difficulties are created by either of the party to the marriage or their respective relatives causing obstruction to the process of natural consummation of the marriage then that amounts to matrimonial offence and therefore could be a case for judicial separation or divorce under the matrimonial laws applicable to the parties.[2] This is also violation of reproductive right of the parties.

But when the couple is not able to have children through the natural process, than, they may opt for the other methods of procreation (scientific/ reproductive technology). When procreation is conducted by any reproductive method, it raises various social, ethical and legal issues.

However, there is an estimate that out of 3.7 million babies born in 1990 in the United States, about 200,000 (about 18 percent) will owe their existence to infertility treatments. Nearly 200 infertility center performing in vitro fertilization are there. Half of infertile couple ends up with babies with such medical assistance.[3]

With the artificial reproduction, there are possibilities that a child would have five parents, an egg donor, a sperm donor, a surrogate mother who gestates the foetus and the couple who raise the child. However, there is an urgent need to determine the parenthood and legitimacy of children, as well as the rights and duties that flows from such status or relationship. Eventually, with these new methods of reproduction, there will be more visits to the courtroom than to the hospital.[4]

There is fear that these reproductive technologies may give rise to non traditional family units through homosexuals, unmarried single man/woman etc. There is question of

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[2] Non-consummation of marriage is a ground of voidable marriage under various personal laws and thus gets matrimonial relief for instance, the Hindu Marriage Act, 1955 provides under section 10 judicial separation and divorce section 13 and also under Special Marriage Act,1954 section 27.

[3] Warren Freedman,*Legal Issues in Biotechnology and Human Reproduction* 2 (1st Edition1991).

[4] *ibid* at pg. 29.

acceptance of babies procreated by homosexuals or by unmarried woman in the society. Whether society will accept those children as legitimate children? Or; whether unmarried women will have the acceptance in the society as legal mother? Whether homosexual are considered as husband and wife?

However, the developing community is also working on various aspect of sexual relationship. Like, Naz Foundation International (NFI) is an international non-governmental organization that advocates improving the sexual health, welfare and human rights for men who have sex with men. It aims at securing social justice, equity, health and well-being for socially excluded and disadvantaged males.[5]

Similarly, the highly ethical question has been raised before the judiciary when the *Naz Foundation case*, *Naz Foundation* v. *Government of NCT of Delhi*[6] came before it. The Delhi High Court's decision in this case has further advanced the right to privacy. It has strike down provisions criminalizing homosexual's sexual conduct on grounds of invasion of privacy.[7] Gay community comes under the cover of section 377[8] of IPC, as a result of which basic fundamental human rights of such groups or individuals have been denied and they were subjected to abuse, harassment and assault from the society.[9]

The artificial mode of reproduction, thus, throws up many moral and ethical issues. Many such issues on reproduction are discussed below:-

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[5] http://www.hivos.nl

[6] WP(C) No. 7455/2001.

[7] http://docs.google.com

[8] Section 377 provides "whoever voluntarily has carnal intercourse against the order of nature with any man, woman or against, shall be punished with imprisonment for life, or with imprisonment of either discriuption for a term which may extend to ten years and shall also be liable to fine".

[9] *Naz Foundation* v. *Government of N.C.T. of Delhi* (WP (C) No. 7455/2001.

3.2. Issues on Artificial Insemination (AI):

As already discussed in chapter III of this work, Artificial Insemination can be practiced in three ways. First, the artificial insemination homologous or husband (AIH) where the woman will be injected with the semen of her husband. Second is where the semen is used from the third party which is known as artificial insemination donor (AID). The third kind is where the seed of the husband and the third party is mixed together and called as Combined Artificial Insemination (CAI).[10]

As long as the first method is used where woman are injected with the semen of her husband, there is no problem but the use of other two methods bring new challenges. Artificial Insemination Homologous involves the three dimensional process of reproduction. Artificial Insemination Donor introduces third party in the role of a donor. It raises various questions relating to determination of paternity, matrimonial rights, the identity of a child etc. which are discussed as follows:

3.2.1. Adultery and Artificial Insemination:

The question may come about whether Artificial Insemination amounts to adultery or not. This issue has been raised for the first time in a Canadian case, *Oxford* v. *Oxford*[11].In this case the wife opted for artificial insemination without the consent of the husband. The court held that recourse to Artificial Insemination Donor without the consent of the husband amounted to adultery.

Also, in *Macilennan* v. *Macilennan*[12], the Scottish Court of Session provides that it is an offence by a wife to perform Artificial Insemination without the consent of the husband. The husband filed a petition for divorce on the ground of his wife's adultery. The wife alleged that the child she gave birth to was conceived by artificial insemination. *Lord Wheatley* contended that unilateral adultery is possible, as in the case of a married

[10] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of Indian Law Institute 283 (1977).

[11] 58 D.L.R.251 (1921) ; 49 Ontario L.R.15.

[12] 1958 Sess Case 105.

man who claims a woman not to be his wife. However, the court contended that the married woman committed a grave offence against the husband if she adopted for artificial insemination without the consent of her husband. In this case, the court granted the husband a divorce on the basis of the wife's adultery.[13]

For the offence of adultery the following contentions are necessary:-

1) There must be two parties physically present and voluntarily engaging in the sexual act.
2) To constitute the sexual act there must be an act of union involving penetration of the female organ by the male organ.
3) It is not a necessary concomitant of adultery that male seed should be deposited in the female's ovum.
4) If the placing of the male seed in the female ovum need not necessarily result from the sexual act, but is placed by another means, there is no sexual intercourse.

The logical argument therefore would be that if there is no voluntary sexual intercourse between a man and a woman who are not spouses to each other, then there is no adultery.

The court also provided that if AID is deemed as adultery, the question would come whether the donor whose seed has been used is also guilty of adultery? If so at what point of time adultery is committed? If adultery is deemed to take place at the time of the parting of the seed than, suppose the seed is never used? If the time is time when the seed is injected into the woman's body then suppose this is done after the donor's death (since the seed can be preserved for some time). In viewing all these, it was found that artificial insemination by donor does not constitute adultery.[14]

[13] *Supranote* 10 at pg.288.

[14] *Supranote* 10 at pg.289.

The main reason for adultery is carnal pleasure and emotional and physical satisfaction. These elements are not there in the medical-mechanical process of artificial insemination, it is opted for the purpose of begetting offspring.

Thus, this issue is almost settled and Artificial Insemination is no more amounted to adultery. In India also, the question of adultery does not arise as section 497 of I.P.C. clearly provides that there has to be sexual intercourse to commit the offence of adultery. Since penetration is a necessary element for a completion of sexual intercourse which is essential for adultery, therefore, Artificial Insemination Donor cannot be held to have committed adultery.[15]

3.2.2. Legitimacy of Assisted Reproductive Technology (ART) Child:

Another controversial issue that artificial Insemination poses is whether such a child is the legitimate child of the father or not and what are the father's rights and duties towards the child. Beside this, the interest of the child has also to be taken care of.

As long as there is use of husband's sperm is used for inseminating the wife, there is no problem in regard to the paternity of the offspring. But, the use of the sperm of the donor creates conflict with social and genetic truth. In the absence of any statutory guidelines the child is illegitimate, his rights being those enforceable against his genetic father i.e. a donor and his social father who is a legal stranger to him. This situation creates problems concerning inheritance rights.[16]

Under the English system, this problem has been resolved by enacting the Human Fertilization and Embryology Act, 1990. This Act provides that if a child is born as a result of artificial insemination or embryo transfer to a woman who was at the time of artificial insemination or transfer of embryo married, then her husband will be treated as the father of the child as held under section 28.[17]

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[15] K.R.Mythili *"Artificial Insemination –Legal Issues"* 39; 24 Journal of Indian Law Institute 348 (1997).

[16] *ibid* at pg. 349.

[17] *ibid*

In *Strnad* v.*Strnad*[18] the issue was of the custody of an AID child which was considered by the New York Supreme Court. It was held that the husband has a right of visitation although the child was not his offspring biologically. The court observed:

"The child has been potentially adopted or semi- adopted by the defendant. In any event, in so far as, this defendant is concerned and with particular reference to visitation, he is entitled to the same rights as those acquired by a foster parent who has fully adopted a child if not the same rights as those to which a natural parent under the circumstances would be entitled....." The court was of the opinion that the child in the said case is not illegitimate child.[19]

On the other hand, *Doornbas* v. *Doornbas*[20] took a different view. It provided that the act of AID is equal to adultery and it is opposed to the public opinion therefore any child born out of AID is called as an illegitimate child. Moreover, it lined that although artificial insemination is done with the consent of the husband yet he can not have rights to visit a child as the child not being his legitimate child.[21]

In, *People* v. *Sorensen*[22] here, a divorced woman sued her former husband for non-support of their AID son. In this case, the defendant after fifteen years of marriage and a medical determination of his sterility, allowed his wife to be artificially inseminated. AID was administered and a child was born. For about four years prior to their separation, the defendant represented that he was the child's father. The California Supreme Court held that the defendant was the lawful father of the child born to his former wife, that the child

[18] 78 N.Y.S.2d 390 (1948).

[19] Kusum *"Artificial Insemination and the Law"* 19; 3 Journal of the Indian Law Institute 291 (1977).

[20] 263 (1955); see also 23 U.S.L.W. 2308.

[21] *Supranote* at 19.

[22] 54 at 550 (1973-74)

was conceived by artificial insemination to which the defendant had consented and that his conduct carried with it an obligation to support.[23]

Taking the plea of equity and good conscience, it is absolutely injustice to the child to label him/her as illegitimate just because he/she is not born through natural process. Why would a child suffer for something which he was not responsible for? Why would an innocent child suffer the stigma of illegitimacy? A child born out of AI is not by its individual choice. At the same time, it is also necessary to protect a donor from any kind of liability against a child or parental responsibility against the child. Taking the note of the psychological impact on infertile couple, the law should be made so that the donor must not even be granted visitation rights.[24]

In the United States, every state that has legislation for AID has provided legitimacy to every AID child. As long as, there is consent to it of the husband, the child is legitimate. If the child is born out of the husband's sperm through insemination with the consent of the husband and to make the husband the legal father it would be necessary for the husband to adopt the child. Similarly, under English law, the Law Commission recommended that if there is consent of the husband for insemination, the child should not be deemed of the donor. The recommendation was partly adopted in the Family Law Reform Act, 1987, section 27(10) of the Act where it is provided that it will be deemed that the AID child is born with the consent of the father and thus the child be deemed as of the spouse. However, no clear law is there.[25] It is necessary to have written consent of the husband in case of insemination of the wife to avoid legal complications.

In India, there is neither statutory law nor case law to determine the legitimacy and the parentage of the AID child. Only this contention will be accepted that the child born during the subsistence of marriage will be deemed to be the legal child of the legally wedded spouses. There is also provision for acknowledgement by the father about the

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[23] *Supranote* 19 at pg. 292.

[24] Mrs. V. Rajyalakshmi "*Reproductive Technology versus Women*" 1 Supreme Court Journal 49 (1996).

[25] A.N.Ansari "*Artificial Insemination: Indian Perspective*" 1 Supreme Court Journal 18 (1995).

legitimacy of the child. But if the child is proved as illegitimate, there is no such provision which will make them legitimate.[26]

Nevertheless, legitimacy of children is governed by the personal laws in India. There is no provision for legitimacy under the Indian Legal system. The Hindu Marriage Act, 1955 and Special Marriage Act, 1954 confer legitimacy on children of void marriage enumerated under those Acts alone and denies legitimacy to children of other void marriages which fall outside the purview of these Acts. An AID child will not come under the provisions enumerated under any of the Acts mentioned above. Hence, they will be illegitimate in the absence of any legislation legitimizing the AID children.[27]

The same is the condition under the existing Muslim law where parentage is established only on Muslim parents and the child is born out of wedlock. Legitimacy cannot be conferred on an illegitimate child.[28]

There is no such law existing in India which deals with the legitimacy and illegitimacy of the child born out of wedlock or outside wedlock or also when the child is born out of new methods of reproduction.

3.2.3 Artificial Insemination and Consummation:

The vital legal question that comes before the court or the law-makers on Artificial insemination is whether it amounts to consummation of marriage, especially when later in life when the wife seeks for a divorce on the ground of non- consummation or impotency of the husband.

It seems that when both the parties had agreed to the insemination and especially, when the seed is that of the husband, there is no reason why the parties should not have been stopped to plea non- consummation. Apart from this, it is very unfair that a child

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[26] *Supranote* 25.

[27] K.R.Mythili *"Artificial Insemination-Legal Issues"* 39:24 Journal of Indian Law institute 350 (1997).

[28] *ibid*

who is in every manner legitimate being the biological offspring of both the parties and born within wedlock- should be labeled illegitimate by annulling such marriage on ground of non-consummation.[29]

It is, observed in *Slater* v. *Slater*[30] that such cases has to decide on case to case basis depending on the circumstances of each individual case and definitely, nothing can be said whether artificial insemination amounts to approbation of the marriage. It cannot be said that such a marriage is physically consummated, if such a marriage is liable to be annulled on the ground of non-consummation, then the very purpose of the insemination would be defeated.[31]

There is no legal framework to spell out the position of a husband and a wife after having a child through the process of insemination and later claim divorce on the ground of non-consummation. Logically, the marriage has been consummated and both the husband and wife should not be allowed to plea non-consummation and get out of the wedlock. The legal complication arises in such cases where the wife is inseminated without the consent of the husband.[32]

3.2.4 Right to know of Assisted Reproductive Technology (ART) Child:

Every child has a right to know about its origin which means that he must know about his parents. In artificial insemination by the donor's sperm, the identity of the donor being kept a secret, the biological father is kept out of the picture. If the donor's identity is revealed to the child there it will be opposing to the secrecy ascribed to the donation of gametes and it might also be unfavorable to the donor's interest.[33]

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[29] Kusum "*Artificial Insemination and the Law*" 19; 3 Journal of the Indian Law Institute 293 (1977).

[30] (1953)Probate Division 235

[31] *Supranote* 29.

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

[33] K.R.Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 350 (1997).

Various countries have law where an adopted child has right to know his parentage. As a child born by AID is not so different from an adopted child, can that child be given a right to know of its origin? If an AID child is treated equally as with the adopted child and granted the right to know of the donor's identity, it might be a host of complex problems. The right to know may be necessary in certain cases, like when the child wants to marry and also in cases where there is necessity to detect genetic diseases. So, whether the right to know can be given to an AID child and if given there under what circumstances has it to be determined by the legal system.[34]

Under the existing legal system in Sweden, it is now possible for an AID conceived child to trace its origin. But in Switzerland, France and Canada, there is total anonymity and secrecy of the donor which is done in the best interest of the child. The participants at the International round table on artificial procreation genetics and the law after pointing out the lack of psychological data to prove which system is really better for the child, felt that an analogy between an AID child and an adopted child should not be made in the matter of tracing parental origin and so donor secrecy has to be maintained. On the other hand, it was felt that important data should always be maintained, especially, in case it is needed to deal with medical problems.[35]

In United Kingdom, the Human Fertilization and Embryology Act, 1990[36] provides for access to knowledge as regards origin of a child conceived by artificial insemination from the authority. He is allowed to get information as to whether the person whom he is going to marry is related.

Under the Indian legal system, so far there is no statutory provision relating to right to know of a child of its origin. This area has been followed by the ethical principle of the inseminating physician. However, information is relevant to the child for medical and

[34] K.R.Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 350 (1997).

[35] *Supranote* 33.

[36] Section 31.

matrimonial reasons. In marriage, degrees of prohibited relationships under which a person who falls under that degree is not allowed to marry another in the same degree.[37]

There are no laws safeguarding the rights of a child to know his background or about his parents. It is necessary for the healthy development of a child to know his origin otherwise it will affect the psychological development of the child.

3.2.5 Issues on Liability for Negligence in Assisted Reproduction:

There are possibilities of negligence in the process of Artificial Insemination such as in the cases of[38] :

i) mixing of the sperms of the husband or donor with that of someone else;

ii) the transplant of gametes or embryo intended for someone else in the wrong patient;

iii) use of the gametes or embryo which are discarded for implant in the woman;

iv) The disposal of an embryo by mistake.

The super ovulatory drugs may develop hyper stimulation syndrome in a woman undergoing IVF. Other problems like contracting an injection are also always possible. Further, complication may arise in live births for both mother and child as a result of complications in premature delivery. The child might also suffer damages at birth or die in the pre-natal period.[39]

'Wrongful life' claims have been allowed under certain legal system. Similarly, 'wrongful birth' claims may also arise. Here, it means that a child is born, where a child would not have been born or would not have born in an unimpaired condition if there would not be the negligence of the physician. In such circumstances, the child can claim for wrongful life or wrongful birth.[40]

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[37] The degrees of prohibited relationship have been enumerated in section 2(f), Hindu Marriage Act, 1955.

[38] K.R.Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 351 (1997).

[39] *ibid*

[40] K.R.Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 352 (1997)..

The practicability of allowing the remedy to be claimed by a child who suffers a handicap due to the use of faulty gametes or an embryo is a debatable issue. For this purpose, it is essential for the donor to reveal his genetic diseases; otherwise the problem gets all the more difficult. By strict adherence to the principle of donor secrecy, the child's claim for *wrongful life* or non-disclosure becomes impossible. In such a case, can the remedy be allowed against the doctor for his failure to find out the disease by testing and thus resulting the deformities to the child or can there be a slight deviation from the strict adherence to donor secrecy and in case of wrongful life, the child be allowed to claim damages from the donor for his failure to disclose diseases?[41]

In the Indian legal system the whole area needs to be governed by the general law relating to the settlement of disputes. 'Wrongful life' claim have not yet been recognized in India. So the child may go without any remedy if anything goes wrong while treatment is provided using IVF or other artificial reproductive techniques.[42]

Though, the English System has dealt with the problem of the child for identity crisis for not being able to know his origin and provided for this remedy. That by *section 1A* the remedy available is against the medical staff and physician. Still, parents have to settle their disputes only under the general laws. Congenital Disabilities (Civil liability) Act 1976, sec 1 A inserted by section 44, Human Fertilization and Embryology Act, 1990 where Section 1 A (1) (b) states that *a child may sue under this Act if the child is born disabled and the disability results from an act or commission in the course of selection or the keeping or use outside the body, of the embryo, or the gametes used to bring about the creation of the embryo for a wrongful act against the person who was responsible for it.*[43]

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[41] *Supranote* 38.

[42] K. R. Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 348 (1997).

[43] *ibid*

In addition, remedy is also available against the donor in cases where he fails to reveal genetic diseases or infection as provided under Human Fertilization and Embryology Act. In cases where a condition or a defect cannot be exposed by testing, and the doctor is not at fault and the donor is answerable for it, the child might seek to have redressed from the donor. In such cases, the ambiguity or confidentiality of the donor might be unnecessary for the child applying to the court for an order under section 35 necessitating the Human Fertilization and Embryology Authority to disclose information regarding the donor so that the child may sue under sec 1 A of the Congenital Disabilities (Civil Liability) Act 1976.[44]

The availability of AI and IVF using donor gametes in India arouses various issues. Above all, non-existence of legislation on the said area makes the situation even worse. There is likelihood that the process might go wrong and result into disability, disease or deformity to the child. There is no remedy available to the child in case of any wrong done as a result of these practices. Hence, the situation justifies legislative intervention. Law should provide remedy to the child either from the donor or from the medical community whoever is on fault.

3.2.6 Artificial Insemination and the Donor:

The main issue is relating to the donation of gametes. Generally, the donor has to give their gametes free of charge but the fact is that donors always ask for money for the gametes. It is not unknown that donor demand a fee for their donation. The payment for gametes will certainly commercialise the whole thing and make donors of the sperm turn professional. On the other hand, non-payment of any gratification may lead to non-availability of people to come forward to donate gametes. These will obviously, affect the patient who goes for medically assisted conception. The Swiss Academy of Medical Sciences reverberates when it stated that the donation of gametes must be made free of charge (1990).[45]

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[44] *Supranote* 42 at pg. 353.

[45] *Supranote* 42 at pg 353.

On the other hand, one of the issues is to assist the inseminating physician in assessing whether he is a suitable donor or not. He should give details of his family history, especially, the genetic diseases of either self or genetically related persons. In case of voluntary non-disclosure, the donor has to undergo medical examination, if the physician asks for it.

It also has to tackle with many important matters like issue concerning the privacy of the donor. Here, the release of medical information constitutes a breach of confidentiality, however some legal and social interest permits physicians to release a patient's genetic information with the consent of the patient or when requested by an order of the court. The publishing of the medical information raises some important ethical principles. What is privacy of a donor and to what extent it can be taken as a defense against publishing ones genetic information given for artificial reproductive techniques are also sane concerns.

The rights of an individual to be protected against intrusion into his personal life or affairs or those of his family, by direct physical means or by publication of information is the clear violation of right to privacy. Privacy is a basic human right and the reasonable expectation of every person.[46]

At this juncture, the right to privacy of a donor shall be considered in connection with the right to know of the child.[47] Here the issue is regarding the following:-

(i) The right of the donor not to publish his genetic secrets.

(ii) The right of the artificially reproduced child to know about his parents. The donor of the egg or sperm has some rights not to publish their genetic secrets to any others.

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[46] Article 21 under Indian Constitution and various other International instruments also provides for Right to Privacy.

[47] Dr. George Joseph *"Artificial Reproductive Techniques-The New Horizon of the Right To privacy and Right to Know"* 4:98 Journal of Indian Legal Thought 103-4 (2006).

Every child has a right to know his or her parents. The President's Council on bioethics held at Washington D.C., March 2004, saw a number of powerful reasons in respect of the child's right to know:

1) The health and well being of children who are born with the aid of AI.
2) The foundational value of human life and the respect owed to it in its various stages.
3) The necessity to protect the freedom of children from improper attempts to manipulate their lives through control of their genetic make-up or from unreasonable expectations that could accompany such manipulations.
4) The protection of human body and its parts, the dignity of important human relationship.[48]

In India, the guidelines for the Bio-medical research of the Human Subjects have been drafted by the Indian Council of Medical Research. It evidently provides that the children who were begotten with the help of artificial reproductive techniques and their adopted or social parents have the right to know whatever medical or genetic information about the genetic parents that may be relevant to the child's health.[49]

It is clear from above that the genetic information of genetic parents can be published to the child and that of his adopted parents, if such disclosure is necessary for the health of the child. These guidelines can also be said to be in consonance with Article 39 (f) of the Constitution. But the code of Medical Ethics made by the Indian Medical Council provides that a medical practitioner: "*Do not disclose the secrets of a patient that have been learnt in the exercise of your profession*".[50]This shows the

[48] *Supranote* 47.

[49] http://www.bioethics.gov/

[50] Dr. George Joseph "*Artificial Reproductive Techniques-The New Horizon of the Right To privacy and Right to Know*" 4:98 Journal of Indian Legal Thought 105 (2006).

contradictory views for which only judicial intervention would give the appropriate solution taking into consideration nature and circumstances of the case.

Nevertheless, in case of any problem it can be disclosed only in front of the court with the order of the court. For this issue, it is pertinent to discuss a landmark decision of the Supreme Court i.e., *Mr. X* v. *Hospital Z.*[51] In this case, one Mr. X was diagnosed in hospital Z and found that X was HIV (+). The marriage of "X" was fixed with one "Y" but later called off due to the information from the Z hospital that X was found to be HIV(+). Against this, the appellant X approached the National Consumer Disputes Redressal Commission for damages against the respondent, on the ground that the appellant might seek his remedy in the civil court. The appellant contented that the principle of 'duty of care' as applicable to persons in medical profession includes the duty to maintain confidentiality and since the respondent violated this duty, they were liable for damages to the appellant. Furthermore, when the case came before the Supreme Court the information violates the right to privacy of X. Regarding this, court observed doctors are morally and ethically bound to maintain confidentiality. In such a situation, public disclosure of even true private facts might amount to an invasion of the right of privacy which may sometimes lead to the clash of one person's right to be informed.

This case clearly shows that even the discloser of true private facts has the inclination to disturb a person's serenity and harmony. It may create many difficulties to him and could also lead to psychological problems. He may there after, have a disturb life all through. Nonetheless, this right is not absolute and may be lawfully restricted for the prevention of crime, disorder or protection of health or morals or protection of right and freedom of others.[52]

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[51] AIR 1999 SC 495.

[52] Dr. George Joseph *"Artificial Reproductive Techniques-The New Horizon of the Right To privacy and Right to Know"* 4:98 Journal of Indian Legal Thought 106 (2006).

Thus, the right of a genetic father not to disclose the genetic secrets is not absolute and his right can be restricted for the preventing crime, disorder or protection of health or even for the protection of the rights and freedom of others. However, genetic information sometimes can serve additional functions that are not therapeutic and can be used to prevent crime.[53]

In England, the disclosure of genetic information for non- therapeutic purpose is possible with the help of the provision in the Human Fertilization and Embryology Act, 1990. Section 31(3) of the Act allows a person who has attained the age of 18 years to check records maintained by the authorities. In India, no such legislation is there authorizing a person to see his genetic records. On the other hand, in the light of the decision of the Supreme Court in Mr. 'X' versus Hospital 'Z', one can hope that such information can be obtained from the concerned authorities.[54]

The right of a child to know his genetic information and the right of another person to maintain secrecy of his genetic secrets are very important rights. One can rightly say that these rights have a correlative duty. In India, the law regarding the right of a child to know his genetic origin and the right of the donor to protect his genetic secrets are not directly settled either by legislation or by the judiciary.

The genetic information that pertains to an individual is something to be treated differently from any other personal information of a person. One thing is sure that the use of genetic information may raise multifarious issues, ethical and legal. Atleast, the most serious issue will be if an individual is subjected to a DNA test for reproductive purpose. This is not only affecting the particular individual but also his relatives.[55]

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[53] *Supranote* 52

[54] *Supranote* 52.

[55] Dr. George Joseph *"Artificial Reproductive Techniques-The New Horizon of The Right To privacy and Right To Know"* 4:98 Journal of Indian Legal Thought 107 (2006).

Confidentiality is a cornerstone of a patient- physician relationship. While the disclosure of genetic information constitutes a breach of confidentiality, well being of the child or the interest of the donor must be the only compelling situations that allow physicians to release a patient's genetic information. Modern Indian jurisprudence also considers the right to privacy not as an absolute right. For instance, the Constitution review Commission headed by Justice Venkatachaliah has suggested that though right to privacy is considered as basic right of a person, it should be reasonably restricted in the interest and the security of state, public safety, prevention of disorder or crime for the protection of health and morals and the protection of the rights and freedom of others.[56]

Another important point to be noted here is that the donor should be major. This is a mandatory provision.[57] It will be against the public policy to permit the Artificial Insemination to woman, if the husband or the donor as the case may be is a minor under the law to which they are subject.

The possibility of transmitting infections or genetic diseases by AI undoubtedly leads to careful scrutiny of screening procedure. The American Medical Association (AMA) in 1974 declared that there has to be "selecting and screening donor to control the transmission of infections and genetic diseases.[58]

This way the right of a child to know his genetic information and the right of another person to maintain secrecy of his genetic secrets are essentially important. There is a chance of tussle between the two where the judicial intervention is required.

3.2.7 Liability towards a Child:

One of the issues is also that the donor should have no liabilities towards the child like:

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[56] *Supranote* 55.

[57] A.H. Ansari "*Artificial Insemination: Indian Perspective*" 1 Supreme Court Journal 19(1995).

[58] Freedman Warren, *Legal Issues in Biotechnology and Human Reproduction* 27(1st Edition 1991).

i) Parental responsibility over the child.

ii) Maintenance of the child in case artificial insemination is done by an unmarried woman

iii) Claim of inheritance rights by the child,[59]

The gamete donor is normally divested of any liability towards the child. In United kingdom, it has been laid down by the statute that the sperm donor will not be treated as father of the child born out of the use of his sperm when he had given consent to such use under the Act.[60]

On the contrary, if the sperm donor is a person known to the woman who artificially inseminated herself without medical assistance, the issue of identity of the donor and his responsibility arise. It becomes more complicated if the woman is unmarried.

It is also prominent that the existing control caters only to the issues which arise when medical assistance is used in procreation. There is every possibility that artificial insemination will be done by the woman herself without medical assistance. In such cases, fixing of parental duties on the sperm donor will deter such prospective donors. Hence, in any case of Artificial Insemination either with or without medical assistance, the donor should be free from any responsibilities towards the child.[61]

3.2.8 Duties of Physician:

Usually, the physicians owe a duty of care towards their patients. In case of failure to take reasonable care doctors are liable under the existing legal system. But the propensity of the judiciary is that the better wisdom of the medical profession is to be respected and decision taken by them should not be questioned.[62]

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[59] K.R. Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 355 (1997).

[60] K.R. Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 356 (1997).

[61] *ibid*

[62] K.R. Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 357 (1997).

Many complications arise in the treatment of patients when they go for medically assisted procreation. Communication between the doctor and his patient needs to be confidential and privileged where AID is being done, though the doctor is to stick on to the confidentiality aspect, he is at times compelled to defer and give valuable information about the donor[63]:

i) the recipients; and

ii) Child at a subsequent stage.

Further, the duty of care and skill of the physician may be put to test when he selects the donors for artificially inseminating the woman. The duty of care of the doctor may be questioned when defective donor gametes are used for insemination.[64]

The doctors concerned must be satisfied before performing insemination about the consent of the husband and that the person who has given consent is the husband. Through the tests, if any required, he must be satisfied about the suitability of the donor for the recipient. For suitability he must also ascertain about the religion and the blood relationship of the wife, the husband and the donor as there is religious injunction against the inter-religious marriage and marriage within the prohibited degree.

3.2.9 Artificial Insemination and Unmarried Person:

In *C.M* v.*C.C*[65]., the unmarried couple conceived a child by semen of C.M. C.C. is denying the visitation right to C.M. just like a natural father. But the court found C.M. is the natural father and allowed the visitation right.[66]

According to Indian Council for Medical Research (ICMR) code, there is no legal bar on an unmarried women going for AID. But the child will be illegitimate. In this regard,

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[63] K.R. Mythili "*Artificial Insemination –Legal Issues*" 39; 24 Journal of Indian Law Institute 357 (1997).

[64] *Supranote* 62.

[65] 337 A 2d 821(N.J. Super 1997).

[66] Pranam Kumar Raut "*Futuristic Legal Aspects of Advanced Assisted Reproductive Technology*" 88 The Cuttack Law Times13 (1999).

ICMR code says *a child born to a woman with the sperm of her decease husband should be considered as legitimate despite the existing law.*[67]

In United States, all the State Statues (29 states have statutory law) sanction the use of AID by married woman. Several statues expressly limit it to the married women. Four of the states provide for situation in which AID is used in such a way that they can be interpreted as either disapproving it for the unmarried women or leaving the question open.[68]

In U.K. the Warnock Committee 1984 and the Law Commission recommended for prohibition of AID for unmarried or divorced or widow woman. The socialist countries have statutory prohibition for it.[69]

The reason which can be assumed for restricting the AID only to married women may be marriage institution, in the present set-up of the law and the society anywhere in the world is more important than right of a woman to have a child by any of the means. The child of an unmarried woman in all circumstances will be an illegitimate child. By law, legitimacy can be provided to him but will be least social acceptance of it and the child will be deemed as illegitimate child and he/she will have to bear rigors of the society because all the religions consider such a child as an illegitimate one.

When both husband and wife are present the child will not have psychological set-back as he will have a father too. It will be easy for them (husband and wife) to rear the child. Moreover, in absence of the male partner, the woman alone will have to bear the expenses of the child, which will be an uncalled burden upon the donor of the sperm.[70]

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[67] *Supranote* 66.

[68] A.N.Ansari "*Artificial Insemination: Indian Perspective*" 1 Supreme Court Journal 15 (1995).

[69] *ibid*

[70] *ibid*

There is a growing trend to become an unmarried mother, though there is no special acceptance of these phenomena. But the AID child of an unmarried mother will be illegitimate.

If the woman is unmarried but avails of treatment together with a man whose sperm is not used for artificial insemination, he is to be treated as the father of the child. It is provided that the donor of the sperm to be used for artificial insemination is not to be treated as the father of the child. If the sperm of a man or an embryo created by that man's sperm has been stored and is used after his death he will not be treated as the father of the child.

If an unmarried woman avails of treatment then the child born will be without any father as social parentage cannot be assumed.

However, there is no Act to prohibit treatment to single and unmarried person. But it states that while treatment is being provided the well being of the child including the presence of a father has to be taken into account by the inseminating physician. This does not solve the problem of legitimacy of the child.

The most unique feature of Artificial Insemination is that AID makes the sexual intercourse separate from reproduction. This shows the way to the chance of the use of AI techniques by non traditional parties such as unmarried couple and lesbians giving scope for further complicated legal questions. Though, in India such situations are rare as legal specification allowing only the hetero- sexual couple to resort to AID would help as preventive measures in disallowing such deviant practices. Though, such legal situation may be attacked on the ground of being violation of right to equality (Article 14), such a measure can be justified on a biological urge as a social response and hence falls under the purview of reasonable restrictions clause.[71]

[71] Mrs.V. Rajyalakshmi "*Reproductive Technology vs. Women*" 1 Supreme Court Journal 49 (1996).

3.3. Legal and social implications on Surrogate Motherhood

In surrogate motherhood, the process of pregnancy depends upon the arrangement involved. As already discussed the three processes are:-

1) Total Surrogacy
2) Partial/Genetal Surrogacy
3) Commercial Surrogacy.

The surrogacy arrangement involves the crucial question as to what constitutes motherhood. Is it the process of gestation or bearing which constitutes the motherhood? This is an extremely problematic question that urgently require statutory framework.[72]

Very few nations have been successful in framing their laws on these issues. It is of vital importance to analyse the complexities arising due to surrogacy. It is also significant to consider the need for the appropriate legislation on the subject. Further, it is also necessary to see whether the process of procreation will lead to commercialization of the ability to give birth or not.[73]

Usually, in surrogate motherhood the most common form is where the woman in question is both the gestational and bearing mother, but, she gives up the child to the couple who has engaged her services for a pre-arranged fee. This process does not involve the difficult question of what constitute motherhood, but it brings in its own issues.[74]

The surrogacy arrangement elevates a query as to whether the contract amounts to contract of service or contract for service. In a contract of service where somebody is employed as part of the business, the surrogacy arrangement falls under the law of

[72] Mrs.V. Rajyalakshmi "*Reproductive Technology vs. Women*" 1 Supreme Court Journal 50 (1996).
[73] *ibid*
[74] *ibid*

contract category of service and hence would be out of the preview of the Consumer Protection Act, 1986.[75]

The surrogacy contract has led to the many matrimonial challenges. For e.g., if the husband of an infertile woman engages the services of surrogate mother who has been artificially inseminated with his sperm, does it amount to adultery if his wife is opposed to such an agreement? As the AI does not involve actual sexual intercourse, it does not amount to adultery but will certainly amount to the matrimonial cruelty. The similar response may be extended to a situation where the surrogate mother has agreed to the arrangement without the consent of her husband.[76]

Sometimes woman who has agreed to be a surrogate mother, refuses to be bind by the contract, than what will be the consequence of such a contract? Whether she will be guilty of breach of the contract? Can the man or couple involved claim upon the specific performance of the contract? This raises the essential question as to whether the contract is a valid contract or not? Public policy stresses that such contracts should be treated as void for two causes[77]-

1) Surrogate motherhood arrangement show the way to child trafficking.

2) Commercial surrogacy arrangements though offers respectable status comparing to prostitution, fosters physical, emotional and economic exploitation of women dropping their status further to be no more than being a commodity.

Here, it would be pertinent to refer New Jersey Supreme Court's statement in re *Baby M*[78] case where the court particularly held that the right to procreate very plainly is

[75] Mrs.V. Rajyalakshmi "*Reproductive Technology vs. Women*" 1 Supreme Court Journal 50 (1996).
[76] *Supranote* 72.

[77] *Supranote* 72.

[78] 100 N.J. at 448,537A zd at 1253.

the right to have natural children whether through sexual intercourse or artificial insemination. It is no more than that. The decision thereby had given sanction to AI but denied the same to surrogate motherhood. However, the distinction between AI and surrogate motherhood based upon 'naturalness' is deceptive. Both the techniques are equally natural or unnatural. The main reason for denial of legal sanction to surrogate motherhood arrangement is that it is opposed to public policy.[79]

Therefore, the trend is towards declaring the intended or genetic mother as having rights over and above that of the surrogate mother. This also obliges on the spouse of the natural father in the case of genetic surrogacy has no claims or parental rights over the child until she legally adopts it.[80]

Furthermore, there is apprehension that the surrogacy may turn out to be a profit making business especially in the light of the profit motivation, where the poor section of women may be attracted by offering huge amount of money. Thus, there is a need for the legal structure to balance between the technological innovations with that of the causes of human welfare.

There is a strong contention that paying someone to have a baby is equivalent to buying the baby. Whether the evil inherent in baby selling is present in surrogate motherhood? It is justified that surrogacy is no compare with baby selling. There has to be regulations in order to formulate the responsibilities arising out of surrogacy. In order to formulate such regulation, there is a need to understand the surrogacy.[81]

Another issue of concern is that women are often provided with false information regarding the success, the side effects or the treatment. There are also situations where women are unaware of the possible side effects and they go for a treatment as

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[79] Mrs. Rajyalakshmi "*Reproductive Technology vs. Women*" 1 Supreme Court Journal 51 (1996).

[80] Radhika Kolluru, Gitanjali Lakhotia "*Surrogacy :Legal and Social Issues*" 5 Law and Medicine 281 (1999).

[81] *ibid* at pg. 284

experimentation. Consequently, where the consent given by the woman for undergoing treatment is obtained due to the absence of accurate information or due to false information either intentional or unsure, such consent can never be treated as informed consent. There is always possibility that professional judgement may not be clear and accurate as many times information given by professionals are given just to hide true information. Hence, it is very much desirable that the fixation of the legal responsibility on medical profession should proceed with due precaution.[82]

In surrogate arrangement a woman accepts pregnancy and bears child either by way of artificial insemination or by way of implantation of in–vitro fertilized ova at the blastocyte state, till normal delivery for another woman who is incapable of carrying child.[83]

It has been reported in Times of India Report that a 30 years old woman from Chandigarh named Nirmala intends to bear a child for an infertile couple in exchange for Rs50, 000. Nirmala's unconventional plan to raise money for her invalid husband's medical bills has been the wake up call for every one to envisage the possible social, ethical and legal issues of new reproductive technologies. In India, there are 186 members in ART. It shows the growth of ART in India.[84]

Taking into consideration all the practical difficulties the Indian Council for Medical Research code has drafted through the Central Ethical Committee on Human Research of Indian Council for Medical Research under the chairmanship of former Supreme Court Chief Justice M.N. Venkatachalaia who has led down the following points regarding surrogate mother[85]:

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

[83] Pranam Kumar Raut "*Futuristic Legal Aspects of Advanced Assisted Reproductive Technology (A.R.T.)*" 88 The Cuttack Law Times 14 (1999).

[84] *ibid*

[85] *Supranote* 83.

i) Surrogate motherhood should be legal only when it is coupled with authorized adoption.

ii) It should be irrefutably presumed that a woman, who carries the child and gives birth to it, is its mother.

iii) The intending parents should have preferential right to adopt the child subject to six weeks post- partum delay for necessary maternal consent.

iv) Surrogate motherhood should be legal only if it is medically certified as the only solution to infertility or any other medical bar on pregnancy by the intending mother.

v) Abortion under the law (M.T.P. Act) on medical ground should be an inviolate right of surrogate mother and the adopting parents have no claim over the amounts already paid in the contract of surrogacy.

vi) Here the only remedy for the genetic father then would the claim for custody on the grounds of the best interest of the child.

It has been clearly stated in *re Baby M*[86]., that the surrogate mother is the legal mother but the surrogate contract is invalid.

Sometimes, contracting couple divorced after the start of pregnancy might pressurize the surrogate mother to abort. If the medical ground will not allow aborting, then what will be the status of the child? Sometimes surrogate mother may try to abort or harm the child after getting the proper payment. These are some issues still to be solved through visible legal framework.[87]

Surrogacy has aggravated the most intense opposition and the greatest public opposition, perhaps due to its very visible splitting of motherhood into genetic, gestational and social components.

[86] 537 A.2d-1227 CN. J 1988.

[87] Pranam Kumar Raut "*Futuristic Legal Aspects of Advanced Assisted Reproductive Technology (A.R.T.)*" 88 The Cuttack Law Times 15 (1999).

Surrogacy is the practice where one woman carries a child for another with the intention that the child should be handed over after the birth. The use of artificial insemination and the recent development of in-vitro fertilization have eliminated the necessity for sexual intercourse in order to have pregnancy.

As discussed, in surrogacy the confusion to the society is concerning what constitutes the motherhood? Is it the child bearing or child rearing? It's beyond the question that the woman who gives birth to the child is through the law as the mother. But with the advanced reproductive techniques, it is now possible for a woman to give birth to a child yet not genetically related, for example, when the egg and the semen has been placed in her body from the third person. This grows the question of whether the woman giving birth or the genetic mother is the legal mother. In India, there is no state regulation on this aspect till now.[88]

In England, section 27 of the Human Fertilization and Embryology Act, 1990 endow that the legal mother of a child is the woman who carries and gives birth to the child. This is the position even when the egg is being donated by another woman. So the genetic link is not implicated to the legal recognition of motherhood.[89]

There are many other issues also such as what if the embryos are transferred to a woman other than the one who contributed the ovum? What happens if the surrogate mother wants to keep the child? What is the status of the child with reference to the wife of the person who contributed the genetic material? Is she the step mother, social mother or the adoptive mother? Hence, the status of surrogate mother is still not clear.[90]

The additional intricacies occur with situation relating to biomedical research in embryos. Embryonic tissue itself can have therapeutic value. It has the capacity to relive Parkinson disease when transplanted into the brain of a sufferer. This raises a very

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[88] R.Anita Rao "*Surrogate Motherhood- Legal Perspective*" 2 Andhra University Law Journal 100 (1996).

[89] *ibid*

[90] R.Anita Rao "*Surrogate Motherhood- Legal Perspective*" 2 Andhra University Law Journal 101 (1996).

serious issue of how to regulate the scientific patents and turn reproductive services into market commodities. There are complicated issues that need to be faced by the society. The new technological implications have a direct bearing on the human reproductive system which has left considerable space between individual and the state. Till now, there is no explicit law to control and regulate these processes.[91]

So in surrogacy, surrogate mother is a woman who carries the pregnancy for another woman. She might furnish the egg and the womb and be artificially inseminated with the semen of the partners of another woman or she might provide the womb to an embryo obtained by IVF in which both the egg and sperm will be furnished by donors.[92]

Generally, law prevents any action that can be deemed to be dangerous to the well-being of the unborn child and thus any action of the woman trying to cause harm constitutes a breach and she will be forfeiting her fees. Various legal complications will arise after the birth of the child. On the birth certificate the name of the father and the mother will appear and the certificate will be destroyed many weeks later and the child will be later adopted by the potential step mother. The adoption cannot be taken straightway because it may amount to baby selling. After giving birth by the surrogate mother, the baby has to be legally adopted by the expected parents.[93]

The court while deciding the cases on surrogacy has to take into consideration, the intention of the surrogate mother. The father may sue her for the amount he paid or if the child is not received by the parents, she (the surrogate), can sue the parents for the expenses, till the adoption. The Indian Contract Act is also silent regarding these contractual obligations. Does it amount to personal service which is not enforced in the court of law? Hence, the position is not clear.[94]

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[91] *Supranote* 90.

[92] *Supranote* 90 at pg. 102.

[93] *Supranote* 90.

[94] R.Anita Rao "*Surrogate Motherhood- Legal Perspective*" 2 Andhra University Law Journal 102 (1996).

It is essential to clear the public image of a surrogate mother. She must be distinguished both from the sexual prostitution and body selling. Is the surrogate mother a prostitute? Or is she instead a modern extension of a wet nurse? Is the surrogate arrangement like donating the sperm or simply giving the women the right to sell their reproductive capacity as men have done for years? Can women sell her reproductive capacity the same way as old time prostitutes sold their bodies?

It is the need of the hour that a woman who is willing to surrogate her womb must be allowed to do it without the stigma of prostitution because there is no physical contract. The surrogate is being paid for giving the men what his wife can't, i.e. begetting a child. This way, there is a necessity to provide legal protection to the status of a surrogate mother.

The issue which creates a grave problem is the status and the relationship of the surrogate mother. What is her relation with the child she is carrying? It is nothing but womb leasing or womb for rent and what are the custodial rights she has over that child? After the child is born she has no right to keep the child because she is neither the mother (where both ova and sperm are from two different people) nor a contractor of the genetic maternal. She is only a contractor who is willing to give the end product once the contract between her and the person is fulfilled.[95]Can she be referring with any other contractor and can the child be referring as subject of contract under law? These questions have to be resolved by the law-makers and the judiciary.

Andra Dworein has placed surrogate motherhood in the centre of her elegant model of the systematic exploitation of women. Motherhood has become a new branch of female prostitution with the help of reproductive technology. Looking from one angle surrogate motherhood involves separating woman from the naturalness of conception, pregnancies and birth by intestifying the control over there processes largely by bio

[95] *Supranote* 94 at pg.103.

medical techniques and it undermines women's confidence as a biological reproductive technique of creating the new life.[96]

Is surrogacy an equivalent to organ- selling? Morally, comparing those who are needy to sell their kidneys to the rich patients and the surrogate mother who rent the womb to the infertile couple, can they be on equal footings?[97]

In a country like India, surrogacy insists on commercialization which may become a tool on the hands of the wealthy people to exploit poor women by attempting to manipulate to sell their womb for monetary benefits ignoring their emotions, physical well-being etc. It might have ill-effects on the child also including the social and legal status, psychological and emotional disturbance in the life of the child.[98]All these aspects have to be taken care of by the legal fraternity in order to avoid complications.

3.4. Controversies on Human Cloning

Clone is defined as an organism that has the same genetic configuration as another organism. It is the method of obtaining a genetically identical duplicate of an organism which is largely called as cloning. Human Genetics Advisory Commission (HGAC) and Human Fertilization and Embryology Authority (HFEA) define cloning as *"copying and propagation without altering the genome"*. When the genome complete genetic identity of any individual is cloned (or copied) a genetically identical individual is formed.[99]

While advances are being made in exploring the possibilities of human cloning, the host of questions of moral, ethical, emotional and legal aspects should be addressed

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[96] *Supranote* 94.

[97] *Supranote* 94.

[98] Radhika Kolluru, Gitanjali Lakhotia *"Surrogacy: Legal and Social Issues"* 5 Law and Medicine 295 (1999).

[99] S.K.Verma *"Cloning: Controversies and Law"* 21(1-3) Indian Journal of Criminology and Criminalisation 197 (2000).

urgently to reform the critical situations of human cloning which may arise in future. There are certain advantages that are stress upon on the following points[100]:-

1. Cloning can help those having problems of miscarriage, they can be treated by preparing effective new contraceptive by providing large number of morulas or ovums for medical experiment to be carried on.
2. Cloning can help those researching on cancer as cancer cells grow just like human morula cloning can lead cancer researchers to achieve success by providing large number of morulas for experiment.
3. Cloning can provide immense medical facilities-

    i) It helps in providing human cells which may provide tissues including blood cells and skin useful for surgical or grafting in burn cases of humans.
    ii) Treatment for damage to the brain or nervous system can be achieved by obtaining nerve cells through human embryo cloning.

4. Cloning helps to avoid hereditary disease providing cloned fertilized ovum to be tested.
5. Cloning can supply more eggs to IVF technology which will increase the possibility of pregnancy in case of infertility of women.
6. Reality of banks of organ for transplantation can be achieved only by various spare parts provided by cloning.

Cloning can be used as a new method of reproduction next to Artificial Insemination or In-Vitro Fertilization technology which may help humankind in various ways. However, this measure is also not free from side-effects. Some negative sides of cloning with relation to the questions of morality are[101]:-

i) Sex determination of foetus by genetic screening test can be easily done.

[100] Pranam Kumar Raut "*Human Cloning and the Law*" 88 The Cuttack Law Times 33 (1999).

[101] *ibid*

ii) Creation of perfect human or master race will be a curse to human civilization and competition to survive can wipe out entire human race.

iii) Genetic diversity will be seen. The general apprehension also arises that it could annihilate the animal kingdom one day.

iv) Emotional problem can be an issue in family and society. Society can discriminate between cloned man and natural born man.

v) a) Cloned man may be born with abnormality.
b) Cloned man may suffer in long run due to mutation.
c) Cloned man may prone to diseases.

vi) Ageing process of a clone reduce the life span when cloned from an aged cell as cloned cell's aged simply reflects the age of the cell from which it was originally cloned.[102]

It may be possible to clone human but it is offensive against the law of nature. It has been argued that human cloning shall be banned to avoid evil practices. But regarding researches are concerned, there is always more people favoring the same and thus there is always some relaxation on it.

According to Article 12 of the Universal Declaration on the Human Genome and Human Right which has accepted by the general conference on UNESCO in November 1997, *Freedom of Research which is necessary for the progress of knowledge is part of freedom of thought.* The application of research must be for the improvement of humankind, their health and other related factors such as advancement of medicine requires for the survival of human being, to provide them relief from suffering etc. So, if cloning is for the betterment of human being than there is no harm. But, however, in the

[102] *Supranote* 101 at pg. 34.

absence of statutory laws, it is difficult to regulate the research on human cloning and to prevent it from misuses.[103]

There has been effort on giving freedom to the scientists on the matter of cloning. Nobody has right to stop anyone from gaining knowledge in the process of research. Ban on human cloning will totally hamper their freedom of research. According to Dr. Wilmut's words *you cannot blame the scientist for making these kinds of discoveries ..... it is now up to society to decide how it should be used.*[104]

If there is fear on the creation of cloning than the problem lies with the society itself as it is not ready to accept the changes and misuses these scientific technologies. On the eve of modernization of 21st century the world claiming to be in scientific age should accept the cloning technology.[105]

Till 1997, it was not possible to produce a clone in higher animals and human beings, when a sheep (named Dolly) was cloned using a mammary cell of an adult ewe in Britain at the Roslin Institute in Edinburgh by Dr. Ian Wilmut. This initiated a debate and controversy that whether the research related to cloning should be allowed or not. The scientist in the United States have cloned a calf and thus in almost all the countries of the world including India, large number of projects are going on, to produce clones of various types of animals.

So far, no human clone has been created, but in early 1998 a Chicago physicist Richard Seed announced his intention to raise funds to clone a human. There are possibilities that in near future human clone can be created. The cloning experiments in animals imply that similar techniques might make it possible to clone humans. Such cloning would be used for many purposes such as- transferring a human ovum to a test tube removing its nucleus, replacing it with a somatic cell nucleus to differentiate to the blastula stage and

[103] *Supranote* 101at pg.38.

[104] *Supranote* 101at pg.39.

[105] *Supranote* 101 at pg.39.

than implanting it in a host uterus. The person using it on attaining maturity could be an identical genetic twin of the adult nuclear donor.[106]

Cloning process has the capability to provide a clone to those individuals/couples in which other methods of reproduction have failed to provide healthy children. It is also a technique to select, control or alter the genome of offspring. Cloning may be adopt by couple who because of infertility, a high risk of severe genetic disease or other factors can not or do not wish to conceive a child. In place of sperm, egg, or gamete donation to infertile couples, they may opt for cloning of either of them, as the child would biologically related to one of them, when this goal cannot be achieved through sexual reproduction.[107]Thus, cloning can help those unfortunate couple who even after adopting all the reproductive measures failed to have a baby or perhaps healthy baby.

Cloning can be used as an alternative to gamete donation. Sometimes couple has to remain childless because of complicated procedure of adoption or the couples at high risk of offspring with severe genetic diseases. If they already had a healthy child, they might choose cloning to create a later born twin of that child and in distant future it may also become possible to correct the genetic abnormality with gene therapy during cloning. Cloning may also be used to enable a couple to clone dead or dying child so that that child remain with them in closely related form.[108]

The usual controversial application of cloning relates to obtaining tissue or organs for transplantation. There may be a situation where a child who needed an organ or tissue transplants might lack a medically suitable donor. Couples in this situation can conceived a child coitally in the hope that the child born would have the correct tissue to serve e.g. as a bone marrow donor for elder sibling. Cloning a person's cells up to the embryo stage might provide a source of stem cells or tissue for the person cloned. Using cloning it may

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[106] S.K.Verma *"Cloning: Controversies and Law"* 21(1-3) Indian Journal of Criminology and Criminalisation 198 (2000).

[107] *ibid*

[108] *ibid*

also be possible to elucidate the mechanism that makes totipotent cells differentiate, which could allow diseased or damaged tissue to be encouraged to regenerate in vivo making transplantation; there is no risk of rejection of the organ.[109]This is highly useful purpose where cloning can be used for human transplantation.

A further probable area of use of cloning is in vaccine development. It has the chief advantage of not requiring cold chain which is a necessity for an effective present day vaccines. Efforts have been made to develop transgenic fruits which could be used as eatable vaccine. In India, attempts are being made to create the so called fertility control vaccine with cloned genes. Several labs are trying to isolate and then clone a gene from insect cells that would enhance cell life and thus make sure prolonged existence.[110]

Cloning has raised legal and ethical issues since early 1970s when Hans Jones noted that it does not matter whether an exact duplicate of an existing person is not possible. The important subject is that the person is chosen to be cloned because of some characteristic he or she possesses. He argued that cloning is necessarily a crime against the clone, the crime of depriving the clone of his or her right to existence relating to certain important phenomenon such as- the right of ignorance of facts about his or her origin that might affect him or her from becoming who he or she is.

Eugenic reproductive human cloning has been condemned all over the world as it is totally unethical and against the principle of nature. Various organizations and countries have started making legislation to ban/ regulate human cloning.[111]

Article 11 of the Universal Declaration on the Human Genome and Human Rights (UNESCO, 1997) utter that practices which are contrary to human dignity such as reproductive cloning of human beings shall not be permitted. In January 1988, the

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[109] S.K.Verma *"Cloning: Controversies and Law"* 21(1-3) Indian Journal of Criminology and Criminalisation 198 (2000).

[110] *ibid* at pg.199

[111] *ibid* at pg. 200

European Convention on Human Rights and Biomedicine was amended to include a total ban on human cloning. The preparatory resolution affirms that "*cloning of human being for any purpose whatsoever cannot under any circumstances be tolerated by any society*". It is a grave violation of fundamental human rights and contrary to the principle of equality. It is against human dignity and it requires experimentation of humans treating human being as spare parts or substitute.[112]

There is risk also if clones created are imperfect clones, who will take the responsibility of such clones is also a question to be answered.[113] These controversies have to be sorted out first before human cloning actually takes place. For that there is a need for the visible laws to regulate these issues.

Cloning challenges the present human kinship and family structure. Is the original of the clone, its parent, or sibling? The donor is not the clone's parent in the biological sense, but is simply an earlier offspring of the original parents. It challenges the traditional notions of reproduction and parenthood, and radically redefines them. The argument also fails to explain the social relationship of the clone with the earlier offspring. This has implications on the society.[114]

The question of individuality of the clone also comes. Though, the genome type of the clone is important, the environment in shaping personality cannot be underestimated. The nature of the parental motivation, the motives that people have for bringing a child a child into the world, these issues are underlying with the development of cloning.[115]It helps same sex couples in fulfilling their desire for biological offspring. The inability or unwillingness to involve in sexual intercourse does not prevent an individual from enjoying her procreative right which is fundamental human right.

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[112] *Supranote* 109 at pg. 200

[113] *Supranote* at pg.201.

[114] Naveen Sankaran "*Human Cloning – A Pandora's Box*" 5 Law and Medicine 259 (1999).

[115] *ibid*

3.5. Birth Control Measures and its Effects on Women

The use of contraceptive (birth preventive measure) creates many issues. What should be the level of knowledge of the doctor, if consulted and what degree of information is the woman consumer entitled to? Apparently, the doctor has to exercise reasonable care, that is to say, act in accordance with a due care and give medical opinion carefully, particularly when advice to be given to a woman about risks and benefits of various forms of contraception.[116]

In England, the Consumer Protection Act, 1987 made a drug company subject to strict liability for injuries consequential from any product released by it on the market.[117] Thereby, in case of any injuries from the use contraceptive, the drug company is made liable.

As the family planning programme is there in the health policies of the government with the propose to tackle with the population explosion campaigning about the various birth control measures such as contraceptive pills. But, to what extent these policies and programmes are analysed from a prospective of woman's right and woman's health. There are various issues on this subject matter, such as-who are the decision makers in use of contraceptive? To what extent do women have informed choice in determining the contraceptive of their use?[118]

When talking about contraception, it is necessary to look into the real life situation. Though, with government effort to balance population explosion, there is availability of contraceptive, but, to what extent women's voice has been heard-whether it is decision regarding consumption of such contraceptive or while making state policy or simply

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[116] P.M. Bakshi "*Contraception and Abortion: Some Legal Issues*" 11(1) Lawyers Collective 21 (1996).

[117] *ibid* at pg. 22.

[118] Gwendoline M.Alphonso "*Preventing Motherhood: The Medico-Legal &Ethical Dilemmas in Contraception*" 5 Law and Medicine 2(1999).

while dispatching it in the market. Does anyone consider women's choice and women's health in such matter?[119]

Needless to say, the present contraceptive debate analyses that it prevents all women from realizing their reproductive rights. This has been reflective from the attitude of the societies towards women's health. Contraception, itself have serious repercussions on women's health. To what extent is choice therein is informed? What are the side-effects of such contraceptive on women's health?

The contraceptive is used for various reasons. The main reason is the choice or preference of the users. How much choice exercised is informed choice in terms of information given about risks; its side effects and its effectiveness etc. Legally, choice refers to informed consent of the user.[120]If the birth control measures are adopted without informed consent would it amount to the tort or a criminal offence? In India, there is no law to regulate informed consent of the user and there is hardly any difference made between choice and consent. Here, it has to be examined whether women are the decision makers in contraception or whether their choice is informed by medical practitioners and health care providers? This reflects the fact, how much women have control over their reproductive and sexual lives?[121]

There are various reasons for the use of contraceptive like to prevent pregnancy, to space pregnancy and to avoid pregnancy. Generally, the risk to the user of controlling fertility is very less when simple method of contraception is used. But there are other contraceptive measures also, such as-IUDs, condom and diaphragms and coitus interrupts. The problem for women is that the more reliable methods the more they have lees control over the decision of reproductive rights.

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[119] Gwendoline M.Alphonso *"Preventing Motherhood: The Medico-Legal &Ethical Dilemmas in Contraception"* 5 Law and Medicine 2(1999).

[120] *ibid* at pg. 7.

[121] *ibid at pg. 8.*

The IUD introduced in India in the year 1965 and promoted widely, though at first popular, but later on failed because of the reasons stated below[122]:

- Careless insertions by para-medical staff;
- Women are not informed about the side effects;
- No proper back-up medical care.

Another important issue in this respect is the economic disparity in the society which has its effects on the use and acceptability of such measures. Those women with economic ability can opt for proper facilities in case those measures create any problems. They can assist with back up medical care in case of failure of such measures.

One more area of concern is how much information do a doctor provides to a person who choose the use of contraceptive best suited to her needs? This issue also needs to be addressed under proper legal framework. It is found that the doctors dismissed side effects as irrelevant as they are not life threatening to women. It is largely seen that women's health has been ignored when contraceptive is concerned. Though women are having unaccounted side effects because of such methods such as- nausea, vomiting tendency, weight loss/gain, bleeding, loss of fertility etc.

Even if woman is suffering from side effects doctors would not acknowledge it. No doctor would be held negligent if he/she did not take cognizance of side effects as told by the woman, even if those unattended side-effects later caused injury/harm to the woman concerned.[123]

The contraceptive is sometimes used not only by the married woman but unmarried adolescent girls also. The reason for the use of contraceptive by adolescent woman is totally different from that of the married woman. The awareness programme such as the

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[122] *Supranote* 118 at pg.12.

[123] Gwendoline M.Alphonso *"Preventing Motherhood: The Medico-Legal &Ethical Dilemmas in Contraception"* 5 Law and Medicine 15 (1999).

family planning programme of developing countries as a component of Mother and Child Health (MCH) programmes fails to reach out to youth who are not acknowledged to be sexually active.

The social structure of the society where it is presumed that sex and reproduction must be confined to the traditional family structure, which would ensure only after marriage, is the reason for the lack of knowledge on contraceptives. The level of educational attainment is also associated with the proper use of contraceptive and informed consent.

There are some new products has been arrived in the market known as "morning after pill". This new form of contraception has also crop up various issues before the society. This drug is approved for general use which is to be taken within 72 hours of sexual intercourse to ensure that any fertilized ovum will not implant in the womb. If more than 72 hours elapse after unprotected intercourse before the woman seeks help "menstrual extraction" can be used at or just after the due date of her next period to avoid chances of pregnancy.[124]

The question has been raised whether the morning after pill is a species of abortion. The answer should be in the negative for the following reasons[125]:

a) The fundamental concept of abortion contemplates that kind of conduct which leads to the expulsion of the foetus from the uterus before its full maturity.

b) From above, it is clear that the abortion requires three conditions to be satisfied:

i) There must be expulsion.
ii) There must be a conduct which acts on the foetus.
iii) There must be expulsion of the foetus from the uterus.

[124] P.M. Bakshi "*Contraception and Abortion: Some Legal Issues*" 11(1) Lawyers Collective 21 (1996).
[125] *ibid*

None of the requirements as stated above appears to be satisfied by a drug called as morning after pill as referred above and therefore that drug cannot be regarded as an abortifacient.[126]

Regarding other types of method, so far, no successful prosecution has ever been brought in respect of the use of an intra- uterine device, adopted as a means of births control after sexual relations. In 1983, in England, the Attorney General articulated his opinion that prior to implantation, there is no pregnancy and hence the means used to prevent implantation do not constitute the act of procuring miscarriage.[127] Thus before conceiving there is no abortion.

Although, the use of the morning after pill can be legitimately regarded as outside the sphere of abortion, a problem arises in regard to certain mere medical devices of family planning. One such device is known as menstrual extraction. By this technique, an instrument attached to a vacuum is used to remove the endometsuim within a few minutes, including, if it exists, the product of any unwanted conception. Firmly observing, by the time this procedure is utilized, the ovum will have an implanted embryo and the action taken to remove the embryo by the vacuum method seems to fulfill the essentials of abortion and thus constitute induced abortion.[128]

Another drug called as Mifepristone (RU 486), may render menstrual extraction obsolete. It is consumed orally in the first twelve weeks of pregnancy and in most women it is expected to induce a complete miscarriage within 48 hours. It is true that the development of the product cannot change the law of abortion and such a procedure can be lawful only if the requirements of the Medical Termination of Pregnancy Act, 1971 are satisfied.[129]Thus, in order to check use of contraceptive under this Act, there has to be amendment of the Act.

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[126] *Supranote* 124 at pg. 22.

[127] *Supranote* 124 at pg 22.

[128] P.M. Bakshi "*Contraception and Abortion: Some Legal Issues*" 11(1) Lawyers Collective 22 (1996).

[129] *ibid*

Generally, birth control is a measure which may be considered as embracing all the processes (scientific or otherwise) by which a child is only born if and when it is desired by its parents and not otherwise. As a national policy, it is a process of controlling population growth, with all the dynamics in order to ensure a healthy, enlightened population and a high standard of living for all people.[130]

3.6. New Horizon in Cases of Sterilization Operation

There are numerous complaints regarding failure of sterilization operation where the woman underwent tubectomy was unsuccessful and subsequently, she again become pregnant and gave birth to a child. In such cases, earlier there was no remedy before the law but now, court has set a new trend, the aggrieved party now go to the court to demand compensation for bringing up unwanted child.[131]

Medically, it is said that no method of female sterilization is absolutely reliable. All methods have a certain failure rate and the risk is inherent in the procedure.

Every doctor who enters the medical profession has a duty to act with reasonable degree of care and skill. This is what is known as the implied undertaking by a member of the medical profession that he would use a fair, reasonable and competent degree of skill. Thus, even after due care of the doctor if there is failure of sterilization operation than doctor will not be liable. Here, the question arises who will determine the liability of a doctor?

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[130] M. Adekunle Owoade *"The Legal Implication of Contraception in Contemporary Nigeria"* 14 Indian Socio- Legal Journal 68 (1988).

[131] Surya Malik *"Failure of Sterilisation Operation-Whether Medical Negligence?"* AIR Journal 292 (2004).

The doctors were not made liable for the failure of such operation for long time. The Medical experts have led down the following reasons of failure:[132]

a) slipping or tearing of the ring
b) recanalisation of the cut ends of the fallopian tubes by the natural process of union
c) Tubo-peritoneal fistula formation
d) Inappropriate application of the ring due to deep adhesion among the nearby structures, when identification of the tube becomes difficult
e) Diseased condition of the lower abdomen such as PID Endometriosis.

The court has in the case of *Archana Paul* v. *State of Tripura*[133], held that *"failure of sterilization is the nature's overpower on human conduct to maintain the nature's rule Of progency"*. The year 2000 saw a sea change in the trend- setting judgment of State of Haryana v. Smt. Santra.[134] The court has granted compensation for the birth of an unwanted child due to the failure of sterilization operation because of the negligence of the doctor.

Various case laws reveal that on failure of sterlisation operation, the claim of the complainant was rejected. The reason is obvious one. There are natural and unwanted and unavoidable circumstances that can lead to a failure of the operation, though done with due care and caution.[135]

In Santa's case there was prima facie negligence of the concerned doctor. Expert evidence confirmed this. The doctor should be held liable if[136],

i) Sterilisation operation is incomplete.

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[132] *Supranote* 131.

[133] AIR 2004 Gau 7.

[134] 2000 (3) SCALE 417.

[135] Surya Malik *"Failure of Sterilisation Operation-Whether Medical Negligence?"* AIR Journal 295 (2004).

[136] *ibid*

ii) The doctor fails to inform the patient that

a) Even though the operation was successful, there might be a conception (since every person has the right to decide if they wish to undergo this treatment where pain, inconvenience and at times, money are vital factors).

b) If the woman misses her monthly menstrual period, a medical check-up at the earliest opportunity is a must.

iii) Despite a medical check-up the doctor fails to detect the conception at a time when pregnancy could be medically terminated.

Thus, liability of the doctor/ hospital does not end with the operation. In fact it begins from the time when a couple comes to the hospital and is informed about the procedure and continues till the woman concerned reaches her menopause.[137]

Therefore, the legal issue is whether the 'proper guidance and due information' before as well as after sterilization is shown by the doctor or not. This is necessary to avoid liability. The crucial question is whether there was informed consent or not on the part of the doctor/hospital to the patient and the family concerned? It is the duty of the doctor to inform the patients elaborately about the procedure, alternatives and the success rate.

However, in India medical service providers do not lay much emphasis on taking an informed consent of the patients. The reasons are ample, chiefly being, lack of legal awareness of rights in the people and a primarily uneducated society.[138]

3. 7. A Socio-Legal Outlook on Abortion

Abortion is an issue clouded with the question of morality, ethics, religious beliefs and women's rights. Today, some 50 to 60 million abortions occur every year throughout

[137] *Supranote* 135.

[138] *Supranote* 135.

the world, up to half of them illegal and dangerous, killing about half a million women yearly. Apart from this, at least 500 million women around the world are placed at the risk of repeated pregnancies with serious health problems.[139]

To what extent abortion should be permitted, encouraged, restricted or severely repressed, is a social issue that has divided theologians, philosophers, legislators and general public. Today the most important reasons of abortion are as follows:-

a) To prevent the completion of a pregnancy that has resulted from rape.
b) To preserve the life or physical or mental well-being of the mother.
c) To prevent the birth of a child with serious deformity, mental deficiency or genetic abnormality,
d) To exercise birth control, that is to help from having a child for social or economic reasons.

In India, it is illegal to terminate a pregnancy unless it is carried out under the terms of the Medical Termination of Pregnancy Act, (MTPA) 1971. The grounds are the same as stated above.[140]The MTP Act provides for termination of pregnancy upto 20 weeks. Thereafter, legal abortion is not allowed.

Recently, there has been the observation of a division bench of the Bombay High Court in a case where it is being heard by them concerning a pregnant woman of 25 weeks carrying a foetus in which an anomaly was discovered in the 24th weeks, the foetus was diagnosed with congential heart block.[141]Here, the most doctors refused to perform an abortion as it would be a clear violation of the MTP Act.

The gynecologist, this woman and her husband has challenged the provisions of the MTP Act or at best plead a case of exception with the Mumbai High Court for the basic

[139] Subhash Chandra Singh "*Right to Abortion: A new Agenda*" AIR Journal 129 (1997).

[140] *ibid*

[141] Anubha Rastogi "*Is Abortion Right?*" Jan-April Combat Law 100 (2009).

reason that a number of cases of similar nature were being observed. Since, a legal termination cannot be conducted after 20 weeks of pregnancy, in such cases these women were either go for illegal and unsafe abortions or carry the burden of unwanted child.[142]

The case was heard on the plea of emergency and was argued for a week. An expert committee of government doctors formed by the court observed both aspects of an existing anomaly that was likely to result in early death of the child, if born, and in that case the child would have to be dependent on medical support all its life. Unfortunately, the report concluded by saying that there is no specific indication that the child was not likely to survive if born.[143]

In view of the present development of technologies, MTP Act needs to be reviewed. The MTP Act does not cater to the modern technologies that are in existence and therefore, does not address an issue like the present one where the anomaly is detectable only after the 24th weeks of pregnancy and not before. Further, it is a well established medical stance that due to the technological and scientific advancement, safe abortions can be conducted way beyond the limit of 20 weeks.[144]

The rationale behind setting the 20 weeks limit in 1971, when the MTP Act was enacted, was the fact that at that time the methods of abortion available would pose a danger to the life of the pregnant woman if used beyond the second trimester, but now the situation has drastically changed. Today, with the amount of medical and technological advancement it is possible and preferred to regularly observe the growth and well-being of the foetus. Though, foetal growth can be detected minutely only at the 24th 26th week, it remains pointless, as the woman cannot opt for a safe legal abortion, it being in violation of the law.[145]

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[142] Anubha Rastogi *"Is Abortion Right?"* Jan-April Combat Law 100 (2009).

[143] *ibid*

[144] *ibid*

[145] *ibid*

Even though the Mumbai court denied pregnant woman liberty to abort the foetus with a fatal anomaly, uproar kick started publicly. But she had miscarriage due to the stress that she has gone through fighting for her right to decide whether to have child or not.

This case highlighted the harsh reality that women have no say whether she wants to have a child or not. The appeal has been made to the Supreme Court, the main issue of the petition was to raise the bar from 20 to 26 weeks by an amendment to the MTP Act. Notice has been issued to the State and the petitioner has been asked to produce progressive legislations from other countries.[146]

The decision to bear a child or when to bear it or whether to continue with pregnancy should primarily be that of the woman of the couple for the reason that it is the woman's life that gets altered with this decision, be that for the nine months of pregnancy or the lifetime that she spends in nurturing her offspring.

Another crucial question is should we allow a woman to make a unilateral decision for an abortion? Should not her father or husband have a right to say in the matter? It is settled principle that abortion cannot be forced upon an unwilling minor girl who wants to complete the terms of pregnancy and give birth to a child. A father's consent is necessary only when a minor decides to terminate her pregnancy.[147]

What about the spousal consent in terminating the pregnancy? In terms of the woman's right argument, which would leave the decision solely up to her, the husband would not have the right to make such a demand. But there are many family situations in which it would be the husband who would have to bear the economic support of the child to which she gives birth.

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[146] *Supranote* 142.

[147] Subhash Chandra Singh "*Right to Abortion :A new Agenda*" AIR Journal 129 (1997).

Forced pregnancy resembles in many ways a modified form of servitude, in which the body of a woman is owned by other for sexual and reproductive purposes. The Right to Abortion featured dominantly in the nine- day Cairo over the morality of abortion and other secondary issues instead of adopting any concrete resolution on adoption issue.[148]

The Medical Termination of Pregnancy Act has adopted very liberal and possibly vague criteria for abortion. As the concept of mental health or foreseeable environment of pregnant women are extremely vague and certain to be abused. Abortion is permitted if it fits into the circumstances laid down by section 3 (2) of the Act. While these circumstances appear to be questions of fact to be determined by the physician according to his medical knowledge, the other provisions seem require the doctor to take non-medical factors for example, Explanation I to section 3 provides that where pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman. Explanation II provides that where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. Thus, it is obvious that in the above two circumstances abortion is permitted. But, how it is asked, can a doctor decide about a pregnancy alleged to be the result of rape as required by Explanation-I to section 3. To make the abortion decision dependent on the proving of a serious criminal offence (rape) raises more problems than it solves.[149]

Further, no woman will approach doctors for abortion immediately after rape. They themselves come to know of pregnancy much later and by that time any evidence possible on the question of rape will have vanished. For all practical purposes, the

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[148] *Supranote* 147.

[149] Chidananda Reddy *"Does Abortion Law Need a Second Look?"* 14 Cochin University Law Review 128 (1990).

explanation enables a person to have abortion on the basis only of an allegation of rape.[150]

Again when doctor are asked to provide abortion in cases of contraceptive failure without there being any reliable medical test for it, the law is, in effect, making abortion available on demand. This may, doctors' fear, will increase the demand for abortion phenomenally.

Thus, the Act has conferred almost immunity to the unscrupulous professional medical abortionists. If commercialization is going on with increased demand for abortions, there will be more illegal abortion in the colour of failure of contraceptives. This Act will act as a protective cover to the criminal acts of medical abortionist.

The above conclusion is further protected by the blanket provision in section 8 of the Act which declares medical practitioner is not liable for any damage caused or likely to be caused by anything which is done or intended to be done in good faith under the Act.[151]

Thus, abortion in India has become available on demand, for, any abortion that is carried out can be given the colour of legality as discussed above. Why such a loose policy prone to abuse in every respect was adopted by the parliament? The Act has been systematically violated everywhere.

Another issue is that the exponents of right to privacy say that it is the right of the individual, married or single, to be free from unwarranted governmental intrusion in the matters fundamentally affecting a person such as whether to bear or beget child. It is argued that human being is a sociological concept before becoming a biological concept. A pregnant woman should not become the prisoner of the embryo which has no

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[150] *Supranote* 149.

[151] Chidananda Reddy "*Does Abortion Law Need a Second Look?*" 14 Cochin University Law Review 129 (1990).

sociological meaning when she has not accepted it. Thus she should be able to choose whether to have or not to have a child.[152]

Whether pregnancy is a relationship between two human beings, one dwelling within the other? Whether embryo determines the status of personhood or not is of ethical issue?[153]

There has been ethical debate going on the proposition that embryos are not persons in being for the purpose of the law but are recognized as enjoying a status deserving protection, requires justification. Embryos may not enjoy rights but duties are owed to them. Is this compromise rationally sustainable? Certain schools of thoughts have given there opinions which are as follows[154]:-

1) Embryos command moral respect as human reproductive products;
2) At the moment of fertilization when the sperm and ovum unite a unique individual is created with its own genetic pattern. From that point onwards the individual is arguably entitled to respect; and
3) Just as brain death is now generally accepted as marking the ending of life, so brain life marks the beginning of life.

If we believe on religious faith where human life as such, the human organism, commands respect necessarily must accept that an embryo within mother's womb enjoys a status equal to her own. But in a democratic society, no one has a right to compel freedom on the basis of a belief that she does not share. The proponents of the view that

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[152] *Supranote* 151 at pg. 131.

[153] *Supranota* 151 at pg.131

[154] Chidananda Reddy "*Does Abortion Law Need a Second Look?*" 14 Cochin University Law Review 141 (1990).

the embryo is human cannot force that view on women who reject it because of the disputed status of embryo.[155]

A foetus is treated in certain cases as a live child. In the context of dividing an inheritance, a foetus should be given the same constitutional protection as an infant. In the context of execution of death sentence, if the woman sentenced to death is found to be pregnant, a duty is imposed on the High Courts to order the execution to be postponed or to commute the sentence to imprisonment for life, if it thinks fit. In torts, in relation to pre-natal injuries, there is no law in India. Why the law should not protect the same person's interest when it comes to the point of abortion?[156]

If it is accepted that foetus has certain interest worthy of protection, the question will arise whether a foetus is a person or whether it should have legal protection. The judicial status of developing humans has historically depended upon their capacity for a separate and independent existence. It is not necessary to abondon that traditional understanding, we must only revise its application in the context of greater scientific knowledge.[157]

In the context of modernization and change through which the society is presently passing, one may ask the question whether M.T.P. Act which makes abortion available on demand has any justification to remain in the statute book. Thus, the prima facie ineffective M.T.P. Act is obviously in need of a second look.[158]

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[155] Chidananda Reddy *"Does Abortion Law Need a Second Look?"* 14 Cochin University Law Review 141 (1990).

[156] *ibid* at pg.143.

[157] *ibid* at pg. 143.

[158] Chidananda Reddy *"Does Abortion Law Need a Second Look?"* 14 Cochin University Law Review 144 (1990).

3.8. Legal and Moral Questions on Pre-Natal Diagnosis:

In India, there is a strong preference for a son everywhere whether remote or urban area. The sharp decrease in under seven sex ratio in the northern states of India is commonly assumed to be the result of the rapid spread of the use of ultrasounds and amniocentesis for sex determination/selection, followed by sex selective induced abortions. Haryana, a developed state has one of the lowest sex ratios as well as a decreasing trend in child sex ratio in the last two decades.[159]

In India, there is a lack of evidence on sex selective abortions because most of the abortions are illegal and not reported and there is hardly any documentation on the magnitude of sex selective abortions. One of the many key factors that influence the child sex ratio in our country is sex selective abortions through easy accessibility and affordable procedures for sex determination during pregnancy. Apart from accessibility of these services, socio- economic factors, domestic violence, prevalence of the dowry custom and financial pressure on parents further contribute to the scenario of increasing sex selective abortions. Therefore, it is no wrong to say that modern technologies have brought with them the creation of new hurdles for women.[160]

If abortion is conducted under safe, affordable and stigma-free conditions, it is neither a necessary evil nor a matter of private choice. Rather, it is a positive benefit that society has on obligation to provide to all who seek it, just as it provides education and health benefits.[161]

A preliminary look at the census data 2001 reveals a grim scenario of the worsening situation. The sex ratio of the child population (0-6 years) has declined by 18 points at the national level from 945 in 1991 to 927 in 2001. In fact all states and Union territories

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[159] Sayeed Unisa, Sucharita Pujari,R. Usha *"Sex Selective Abortion in Haryana* Jan 6 Economic and Political Weekly 60 (2007).

[160] *ibid*

[161] Anandhi S *"Women, Work and Abortion"* March 24 Economic and Political Weekly 1054 (2007).

except Kerela, Tripura and Mizoram have reported fewer girls than boys less than six years.[162]

In India, medical techniques developed to discover birth defects are increasingly used to determine the sex of the child before birth, so that the pregnancy can be terminated if the foetus is female.

The question of how extensively such techniques are used in India is important but difficult to answer conclusively. One indication is from estimates of the sex ratio at birth. However, the use of the modern techniques has been quite widespread amongst the well to do families in India as a trend towards pre-natal diagnosis for the purpose of sex selection techniques, such as, amniocentesis characteristics of an infant before birth such as certain genetic or developmental abnormalities. If the tests reveal severe malformation or gross malfunctioning in the foetus, an abortion is considered. These tests can also reveal the sex of the child in advance. There is now in India also use of IVF technology which will refine the sex pre-selection technique by removing genetic material from the fertilized pre-embryo eight cell stage and testing them for X-bearing spermatozoa which showed signs of female formation.[163]

If the finding of such tests reveals that a female child has been conceived, the foetus is being invariably terminated. According to the Indian Medical Association, for instance, five million female foetuses are aborted every year. The female selective abortion is a serious problem that deserves high priority from International and National policy makers.[164]

Various states has passed a law outlawing the use of pre-natal diagnosis for sex selection and made it illegal to reveal the sex of the foetus even when the procedure is

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[162] Dr. Subhash Chandra Singh *"New Reproductive Technology and Female –Selective Abortion"* All. L. Journal 86 (2003).

[163] *Supranote* 162.

[164] *Supranote* 162.

done for legitimate medical reason. At national level, the Pre-national Diagnostic techniques (Regulation and Prevention of Misuse) Act, 1994 was passed, which made sex determination or sex selection test a cognizable, non-bailable and non-compoundable offences.[165]

The Act has not helped much as there is hardly any condition where women may take decision of pre-natal sex determination on their own wish. In fact women in our society are the oppressed victims of tradition and patriarchy and are often forced to undergo abortion of a female foetus by their families. Sons are a major obsession throughout India. The rising levels of education, economic opportunities and the constitutional guarantees of equality have not helped to raise the status of women significantly.

From the ethical and human rights perspectives, female foeticide has led to a controversy surrounding the ethics of and right to opt for abortion. In India, the MTP Act, 1971 permits abortion under certain conditions. Here, the question arises that if abortion is legal in our country why should a democratic state interfere in a couple's decision to abort a female foetus? Clearly, the right to abortion and the right to end female foeticide are in a complex interrelationship within feminist discourse. It is argued that if abortion is a right over one's body, how are feminists to deny this right to women when it comes to the selective abortion of female fetuses?[166]

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 growing popularity of abortion raised many an eye-brow. Its moral and ethical aspects have been the topic of heated dialogue between social workers, medical men,

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[165] Dr. Subhash Chandra Singh *"New Reproductive Technology and Female –Selective Abortion"* All. L. Journal 87 (2003).

[166] *ibid*

administrators, politicians and also the commoners. The MTP Act is the only condition where a woman is allowed to take the decision solely on her own and it is a happy sign that she really makes use of this facility and at the hospital level the case is treated as most confidentially.[167]

There is little mention in the research literature of the right of women to determine for themselves how many children they wish to have and when they want to have them. The right to self determination is increasingly espoused throughout the world. For many women requesting abortion, this right is often sharply reduced for reasons relating to socio-economic status, personal conviction of physicians and the perceived mood of dominant segments of society. Unwanted pregnancy is not only a personal but also a social problem[168].

The question arises can a mother abort her child even when she has no grounds available under law? This is a very serious issue because life and death of a foetus depends upon the mother. It is the mother only who takes care of the child after birth as well as before birth because it is she only through whom a foetus gets nourishment while in womb. She must have the liberty to decide at what time she wants to get conceived that means she must be free to conceive as well as free to abort at any time.[169]

But there is a problem that if such a liberal attitude will be shown towards right to abortion of the mother, then what will happen of a right to birth of a foetus which is not recognized anywhere under law. Thus, a balance has to be maintained between there two rights i.e. right to birth of the foetus and right to abortion of the mother.[170]

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[167] V. Hemalatha Devi *"Abortion Law in India –Socio-Legal Implications"* Supreme Court Journal 53 (1990).

[168] *ibid*

[169] Dr.H.R.Jhingtaq, Kusum Chauhan *"Foetus,Abortion and Right to Life :Some Basic Issues"* X (II) M.D.U. Law Journal 2 (2005).

[170] *ibid*

3.9. Conclusion:

The advancement in medical science and awareness of the reproductive techniques made it possible to the couples to resort for various reproductive devices. These technologies pave the way for new family structures. With the emergence of these family structures many moral and legal issues might come (as discussed above). There are no guidelines to tackle those issues by the state mechanism.

Therefore, it is necessary to regulate these reproductive technologies through some regulations. In the absence of legal framework various technical difficulties might come. It may also disturb the peace and harmony of the society. Hence, it is required that suitable statutory framework is to be made to regulate the use of reproductive technologies and also other vital issues relating to reproductive rights of women.

CHAPTER 4

AN ANALYTICAL STUDY OF LAWS, POLICIES AND PROGRAMMES FOR THE PROTECTION OF REPRODUCTIVE RIGHTS

4.1. Introduction

There has been an International and National efforts for the protection of human rights. Over the years, International instruments have been working on various issues of women. However, women's life revolves around the reproduction and thus reproductive rights of women have invisibly occupied an important place in International and National legal framework.

A variety of rights were recognized at International level several times on the human rights of women. The United Nations ensures for the International co-operation in promoting and encouraging respect for human rights and fundamental freedom for all human beings without distinction as to race, sex, language and religion. The United Nation is firmly committed to gender equality and its charter is the first law-making treaty explicitly to mention the principle of equality between men and women. [1]

The recognition of the equality in dignity and human rights of men and women is a vital subject for the United Nation and its member states. The Preamble itself contains that people of United Nation "*to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women*".[2]

[1] Maja Kirilova Eriksson, *Reproductive Freedom in the Context of International Human Rights and Humanitarian Law* 22 (1st edition 2000).

[2] *ibid*

An issue of human rights of women is incomplete without discussing reproductive rights of women. Today, with the advancement of women's role and status in the society, reproductive rights have become an integral part of women's struggle for her position in the society. Thus, different International Instruments has explicitly and implicitly shown their concern on the protection of reproductive rights of women.

4.2. International Concern on Reproductive Rights

In 1970s, there was an emphasis on the equality of opportunity by the United Nation. This effort was made prominent in the World Plan of Action agreed upon in Mexico City in 1975 at the First Women's World Conference, the government delegations agreed that:

> *" the world community has proclaimed that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women as well as men in all fields".*[3]

International Instruments has profoundly stressed on the treatment of man and woman as equal in value and dignity. This principle enshrined under the Universal Declaration of Human Rights, 1948 which makes explicit reference of equality for women and children. Here, the idea of equality as a significant human rights object was replicated.[4]

The International Convention on Civil and Political Rights (1966) contains several provisions relating to women's Rights, such as Article 6 which provides that *"every human being has the inherent right to life"*. It has also provided right to liberty and security under Article 9. Again, Article 17 provides for the right to privacy. Similarly, the International Convention on Economic, Social and Cultural Rights (1966) recognizes the right to health under Article 10.[5]

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[3] *Supranote.* 2 at pg. 50.

[4] Palok Basu, *Law Relating to Protection of Human Rights* 92 (1st edition 2002).

[5] *ibid* at pg.69.

The Women's Convention[6] under Article 12(1) compels states parties to ensure individual's access to health care services, including those related to family planning. The International Covenant on Economic, Social and Cultural Rights also under Article 12(1) recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health.[7]

The Beijing Declaration highlighted on empowerment of women as primary need for gender equality. It was made more evident that by empowering women in taking decisions about their sexuality and fertility actually gives power to them in other domains, such as- household decision-making and participation in education and economic sphere.[8]

The Convention on the Rights of the Child, 1989 have a set of legal standards or norm for the protection of children. Every child has the right to survive, health, protection and developments. It stresses on the need for concerted efforts on specific problems, such as discrimination against girl child (among other discrimination) inheritance, early marriage, maternal health care, early pregnancies, family planning, education and services, the sale and trafficking of children, etc.

The Convention oblige the responsibility on the state parties to take effective measures to abolish traditional practices prejudicial to the health of children implicitly (including female circumcision) and to provide for rehabilitation to those children who are victims of neglect, abuse and exploitation (Article 28(3) and 39).[9]

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[6] The Convention on the Elimination of Discrimination Against Women, 1979 is called as Women's Convention as it deal only with discrimination against women where elaborate norms has been discussed for the causes of women.

[7] *Human Rights of Women National and International Perspective edited* by Rebecca J.Cook 528 (1st edition 1994).

[8] Maja Kirilova Eriksson, *Reproductive Freedom in the Context of International Human Rights and Humanitarian Law* 54(1st edition 2000).

[9] Ashok K.Jain,, *The Saga of Female Foeticide in India* 77(1st edition 2006).

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), 1979 is the most explicit United Nation documents on the rights of women. It requires state parties to eradicate all kinds of discrimination against women in all spheres of human life.

The Convention further provides that state parties shall take all appropriate measures to ensure for women, "the same right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to make possible for them to exercise these rights in all matters relating to marriage and family relations as held under Article 16".[10]

Thus, the Convention endow with an obligation on the state parties to eliminate discrimination against women in the area of health care in order to ensure "access to health care services" including those related to family planning (Article 12). Article 11(2) held that all state parties shall prevent discrimination against women on the grounds of marriage and ensure their effective right to work.[11]

It moreover, require the state parties to make sure that there are measures adopted for women to have access to specific educational information to help them ensure the health and well-being of families including an advice on the family planning as held under Article 10.The provision of Article 5 of the Convention provides that "family education includes proper understanding of maternity as a social function".[12]

However, the Convention also establishes a Committee on the Elimination of Discrimination against Women to monitor the progress made in its implementation that issued a General Recommendation No. 19 on Violence against Women. It provides that violence against women which is gender based violence which is intended against women because she is a woman and thus, invariably affects her fundamental human rights including right to be free from all forms of discrimination. It was found that

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[10] CEDAW, General Recommendation No.21&CEDAW/C/1995/7.

[11] *ibid*

[12] *Human Rights of Women National and International Perspective edited* by Rebecca J.Cook 517 (1st edition 1994).

violence against women in the form of coercion regarding fertility and reproduction places have led their health and lives at risk.[13]

In addition to these, there are number of key International policy documents relating to reproductive rights of women. For instances, the International Conference on Population and Development(ICPD) Programme of Action defines 'reproductive rights' as "..... *the right of all couples and individuals to decide freely and responsibility the number, spacing and timing of their children and to have information and means to do so and the right to attain the highest standard of sexual and reproductive health.....*".[14]It defines 'reproductive health' as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The International Conference on Population Development (ICPD) Programme of Action has identified various issues on reproductive and sexual health care such as family planning, pre-natal care, safe delivery and post natal care, infertility, abortion etc.

Besides, International law has also shown their concern on adolescents' reproductive rights. Adolescent means those who fall under the age group of 10 and 19 and are vulnerable segment of the population whose needs especially their reproductive health needs are largely neglected. It is seen that adolescents are increasingly becoming more sexually active consensually or not.

Thus, in 1990, Convention on the Rights of the Child for the first time gave the adolescents right to health, which includes reproductive health as well. The International Conference on Population and Development and Beijing Declaration establishes and declares the reproductive rights and concern on adolescent.[15]

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[13] *Supranote* 12.

[14] *Programme of Action of the International Conference on Population and Development*, Cairo Egypt, Para 7.3 Sept 5-13 (1994).

[15] www.reproductiverights.org

In many developing countries including India, a decrease in public health spending and in some cases, structural adjustment, contributes to the deterioration of public health systems. Especially, the system of privatization in health care without assurance of universal access to affordable health care reduces chances of universal health care system availability. This will directly hamper the health of girls and women as they do not receive enough social, economic and psychological support.[16]

The Programme of Action of the International Conference on Population and Development provides that in order to increase women's access to appropriate, affordable and quality health care, information and related services, the state parties are directed to take following actions[17]:

a) To implements the commitment made under CEDAW and other international instruments;

b) Reaffirm the right to the enjoyment, protection and promotion of the highest attainable standard of physical and mental health, and to incorporate it in national legislation and to review existing legislation;

c) Design and implement, in cooperation with women and community based organizations, health programmes so as to remove all barriers to women's health services and to provide a broad range of health care services;

d) Provide more accessible, available and affordable primary health care services of high quality including sexual and reproductive health care which includes family planning information and services;

e) Establish mechanisms to support and involve non-governmental organizations, particularly women's organizations, professional groups and other bodies working to improve the health of girls and women, in government policy making, programme design, as appropriate, and implementation within the health sectors and other related sectors;

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[16] *Beijing Platform for Action*. Chapter IV.C. Women and Health, Para 106. www.reproductiverights.org

[17] *ibid*

f) Allow women access to social security systems in equality with men throughout the whole life cycle, etc;

Taking into consideration above guidelines under International Instruments, India has also taken steps to constitute legal framework for implementing above discussed instruments.

4.3. National Concern on Reproductive Rights

The area of reproductive and sexual rights has not yet properly explored by the Indian government and has very few legislation on the subject. The judicial activism is also in its infancy stage. The Constitution of India also contains very few provisions relating to the protection of reproductive rights of women.

4.3.1. Constitution:

The Constitution is the guardian of a country, provides serious concern for the protection of the rights of women. A reproductive right of women is governed by the various outstanding provisions of the Constitution of India. The framers of the Indian Constitution were very much influenced by the Human Rights Instruments and have incorporated those provisions in the Constitution.[18] Health has been acknowledged as fundamental rights of the people. So, in various cases judges has decided cases taking the plea of various provisions of the Constitution for instance- fundamental rights, fundamental duties, directive principles of state policy etc.

Fundamental Rights:

The Constitution of India guarantees various rights under part III of the constitution such as; right to equality under Article 14-16 as fundamental rights. It prohibits discrimination among citizens on the ground of religion, race, caste, sex or place of birth (Article 15) and equal opportunity to them in matter of public employment (Article 16).Article 14 provides for equality before the law. Thus, the

[18] Lina Gonsalves, *Women and Human Rights* 22 (1st edition 2001).

constitution says that the state may make special provisions for the benefit of women and children.[19]

It guarantees right to life under Article 21 which lays down, "No person shall be deprived of his life or personal liberty except according to the procedure established by law." Right to life means right to live with human dignity and freedom from all kinds of exploitation.

With the liberal interpretation being given to the right to life, with passage of time, various new rights such as right to privacy, right to health etc which are basic human rights under international instruments hitherto not specifically granted under the constitution, were included in the plethora of rights available under Article 21 of the Indian Constitution. Since right to life includes right to enjoy life with all the limbs and faculties, it implies therefore that right to procreation and right to have control over reproductive organs are included in the broader concept of right to life. Every person including a girl has a right to marry and thereby to conceive a child which is absolute.[20]

Right to procreation and to have control over one's reproductive organs gives birth to another right i.e. right to abortion. This raises another peculiar problem of balancing the life and liberty of born and unborn more. So, in the present day social structure female- male sex ratio has deteriorated.[21]

By referring the term 'life' the Supreme Court has expounded that it means more than mere animal existence. The inhibition against its deprivation extends to all those limbs and faculties by which life is enjoyed as held in the case of *Munn* v. *Illinois*.[22]

The judicial activism has led to the emergence of one of the essential human right i.e., right to privacy under Indian Constitution. Justice Subba Rao, J held that right to

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[19] *Supranote* 18 at pg. 23.

[20] Manoj Sharma "*Right to Life vis-à-vis Right to Abortion: An Analytical Study*" 18 (3&4) Central India Law Quarterly 412(2005).

[21] *ibid.*

[22] 94 US 113 (1877).

privacy is an essential ingredient of personal liberty.[23] This has result in an enrichment of the status of women.

Directive Principles of State Policy:

Similarly, the Directive Principles of State Policy in part IV of the Constitution provides provision directing the government to eliminate inequalities in status, facilities and opportunities to ensure that the legal system promotes justice on the basis of equal opportunities, to secure a just and human condition of work and maternity relief and to regard the improving of nutrition, standard of living and public health as among its primary duties.[24]

Article 39 of Directive Principles of State Policy provides that "the state shall direct its policy towards securing[25]

1. That the men and women equally have the right to an adequate means to livelihood;
2. That there is equal pay for equal work for both men and women; and
3. That the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not guided by economic necessity unsuited to their age and strength.

Fundamental Duties:

The fundamental duties under Article 51 (A) include that every citizen has duty inter-alia by the Constitution to renounce practices derogatory to the dignity of women.[26] Also, Article 42 refers to just and human conditions of work and maternity relief.

By referring to the above Articles of the Constitution that is fundamental rights, Directive Principles of State Policy and Fundamental duties, judiciary has time and again filled the vacuum of inadequate laws on reproductive rights. In the case of

[23] *Kharak Singh* v.*State of U.P* (AIR 1963 SC 1295).

[24] Article 38(2), 39(A), 42 and 47 of the Constitution.

[25] *Supranote* 16 at pg 24.

[26] Article 51(A) (e)

Govind v. *State of Madhya Pradesh*,[27] the Court held that any right to privacy must include and protect the personal intimacies of the home, the family, marriage, **motherhood, procreation and child rearing.** In many cases, Supreme Court has also recognized an individual right to medical treatment.[28]

Conversely, despite equal rights as given by the Constitution women in India remain constantly a disadvantaged group .The reason for this is mainly social and cultural attitude of the society. Health is a fundamental human right and also guaranteed by the constitution to the citizens of India but its achievement is trivial only.

Not only this, the Constitution of India also made emphasis on prohibition of gender discrimination and enjoins upon every citizen, a duty to renounce practices that are against the dignity of women. With this liberal mind-set India has ratified the United Nations Convention on the Rights of the Child, 1989, and the Convention on the Elimination of All Forms of Discrimination against Women, 1979 etc.[29]

4.3.2. Indian Panel Code Provisions:

Indian Panel Code (herein after called as IPC) contains certain provisions relating to the reproductive rights though not so specifically. Section 312-318 of the Indian Panel Code, 1860 deals with miscarriage, injuries to unborn children, exposure of infants and concealment of births.

Section 312 makes the causing of miscarriage with the consent of the women and section 313 causing miscarriage without the woman's consent, punishable. Section 312 reads "as any one causing a miscarriage of pregnant woman except for the purpose of saving the life of the mother is guilty of causing miscarriage." In case of woman with child and woman quick with child, the punishment increases.[30] The legal interpretation is that a moment of conception which begins with the woman is

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[27] 3 S.C.R .946 at Para 24

[28] *Parmanand Katara* v.*Union of India* (1989) S.C.R.997, PARA 4.

[29] Ashok K. Jain, *The Saga Female Foeticide in India* 77 (1st edition 2006).

[30] K.D. Gaur, *The Indian Panel* 464 (2nd edition 1998).

considered in the former situation whereas quickening refers to an advanced stage of pregnancy.[31]

IPC has not defined the term miscarriage. However, it is commonly understood as expulsion of immature foetus at any time before it reaches full growth. In common parlance, miscarriage refers to abortion.

Section 312 allows abortion in such cases where it is necessary to save the life of the mother on medical grounds. The unborn child would be destroyed for the purpose of preserving the precious life of the mother.

If the act is done in good faith, the person is entitled to the protection of law. But good faith is ambiguous enough to protect most of the abortion whether therapeutic (medical) abortions or not. So long they are conducted ostensibly to preserve the mother's life but it is not punishable under Indian Panel Code. The good faith is to be decided on the basis of facts and circumstances of the case and not on the basis of law.[32]

Further, one who aids and facilitates a miscarriage is also liable for the abetment of the offence of miscarriage under section 312 read with section 109 IPC. Even though the abortion did not take place, a person is still liable for attempt to commit a criminal abortion under section 312 read with section 511 IPC even if he fails to succeed.[33]

Under section 313 it does not matter that the woman is quick with child or not. It provides for enhanced punishment in case of aggravating nature of the offence of miscarriage. Section 313 provides for the miscarriage without the consent of woman. So, section 312 held woman also liable for punishment whereas under section 313 women will not be held liable.

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[31] *Supranote* 30

[32] K.D. Gaur, *The Indian Panel* 464 (2nd edition 1998).

[33] *ibid* at pg.465.

Section 314 punishes when the death of a woman has occurred in causing miscarriage. It is not essential for the offender to know that the act is likely to cause death. He should have intent to cause the miscarriage of a woman with child and does any act which causes the death of such woman.[34]

Section 315 lays down that whoever before the birth of any child does any act with intent to prevent a child from being born alive or to cause it to die after birth and does so, be punishable unless the act is done in good faith for the purpose of saving the mother's life.[35]

Section 316 punishes the causing of death of a quick unborn child by an act amounting to culpable homicide. The punishment prescribed is imprisonment upto 10 years and fine. The offence is cognizable, non-bailable, and non-compoundable and is triable by a session's court.[36]

According to section 317 exposures and abandonment of a child under 12 years in any place by parents or persons having the care of the child with the intention of wholly abandoning such a child, is an offence. If the child dies in consequence of the exposure, the offender will also be guilty of murder or culpable homicide as the case may be (explanation to section 317).[37]

This section however covers the cases of female infanticide. In India, abandonment of a girl child is not unusual. Similarly, intentional concealment of the birth of a child by secretly buying or otherwise disposing of the dead body of the child, whether a child dies before, after or during the birth is an offence under section 318.[38]

It seems that an IPC provision is gender neutral making women equally liable for abortion. In a country like India, where woman has hardly any say in decision

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[34] *Supranote* 32 at pg. 468.

[35] *Supranote* 32 at pg.469.

[36] K.D. Gaur, *The Indian Panel* 469 (2nd ed.1998).

[37] *ibid* at pg. 370.

[38] *ibid at pg. 370.*

making process and there is cultural preference of son, such provision is very impractical. Sometimes pregnancy of a woman and child bearing is beyond the control and wishes of woman. So in such socio-cultural scenario, these provisions can hardly achieve the objects for which it has been enacted.

The IPC provision under section 312-316 have now become subject to the provisions contained in the Medical Termination of Pregnancy Act (MTPA), 1971. Till now, IPC provisions relating to miscarriage have not been amended or redrafted or repealed. However, abortion is now permissible under Medical Termination of Pregnancy ACT, 1971 in certain circumstances.

4.3.3. The Medical Termination of Pregnancy Act, 1971

In 1971, India saw a sea- change in abortion law by liberalizing the provision of section 312 of the Indian Penal Code, 1860 which sets rules for obtaining a legal abortion. With the enactment of the new abortion law, Medical Termination of Pregnancy Act, 1971 (herein after called as MTP), the features of the abortion law have change. The MTP Act has been modeled on the English Abortion Act of 1967.[39] This new abortion law was enacted on recommendation of a Committee appointed by the Central Government, known as *Shantilal Shah Committee* which is obliged under the Central Family Planning Board. The Medical Termination Pregnancy, Act was enacted in 1971 and enforced in 1972.[40]

Section 3 of the said Act provides for the termination of pregnancy by a registered medical practitioner in good faith under the following circumstances:-

a) *Therapeutics*: In case the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical and mental health.

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[39] Madhava Menon *"A Socio-Legal Inquiry into the Implementation of the Abortion Law in India"* 16 Journal of Indian Law Institute 626 (1974).

[40] B.B.L.Mathur *"Constitutional Limitations on Abortion Laws: A Study of the American and the Indian Law"* II The Indian Journal of Legal Studies 117 (1979).

b) *Pregnancy caused by rape*: In case the pregnancy results from rape or intercourse with a lunatic woman etc.[41]

c) *Failure of Contraceptive device*: In case the pregnancy has occurred as a result of the failure of a contraceptive device or method.[42]

d) Eugenic: In case there is substantial risk that the child born would suffer from physical or mental deformities or diseases.

The Act intended to eliminate the high incidence of illegal abortion, rather than to confer woman the right to decide about her own body. In fact, the main target was to control population explosion in India by allowing termination of an unwanted pregnancy in such situation where contraceptive device has failed.[43]

Here, by the enactment of the Medical Termination of Pregnancy, Act on certain conditions a woman can obtain a legal abortion. The Act provides under section 3(a) that pregnancy can be terminated by a registered medical practitioner where the pregnancy does not exceed 12 weeks and with the opinion of atleast two medical practitioners in case the pregnancy exceeds 12 weeks but not exceeding 20 weeks as under section 3(2) (b).[44]

At this point, one of the features is that there has been child marriage even after the enforcement of Child Marriage Restraint Act. In situation, where there is a need for the termination of pregnancy of a minor, the Act says, consent of woman is enough. But legally consent of minor is no consent at all. So in such cases along with the consent of minor girl, the consent of the guardian will also be taken. There is an apprehension that the Act may be misused if the consent of guardian only is made

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[41] Section 3 Explanation I MTP Act.

[42] Section 3Explanation II MTP Act.

[43] Madhava Menon *"A Socio-Legal Inquiry into the Implementation of the Abortion Law in India"* 16 Journal of Indian Law Institute 626 (1974).

[44] B.B.L.Mathur *"Constitutional Limitations on Abortion Laws: A Study of the American and the Indian Law"* II The Indian Journal of Legal Studies 121 (1979).

mandatory. If the right to take decision regarding termination of pregnancy is exercised by a woman exclusively than it could prevent her husband from having children always.[45]

Thus, it is only with the consent of pregnant woman that her pregnancy will be terminated. The Medical Termination of Pregnancy, Act has made a woman competent to give her consent to have her unwanted pregnancy being terminated. In case if she is below eighteen years of age or a lunatic, abortion can be done only with the written consent of her guardian. Here, the consent of a husband is not necessary. Only the consent of pregnant woman is made mandatory by the Act.

In *Sushil Kumar Verma* versus *Usha,*[46] the husband got divorce on the ground of cruelty within the meaning of sec 13 (1)(b) of the Hindu Marriage Act, 1955 for aborting the foetus at the very first pregnancy by a wife without the consent of the husband.[47]

This judgment has contradicted the Medical Termination of Pregnancy, Act and the purpose for which it has been enacted. As after this case woman are in constant threat of being divorced by her husband if she go for termination of pregnancy without her husband's consent. This has depreciated the decision making power of women in executing their reproductive rights (to limit their family and to protect themselves from any mental or physical health because of pregnancy). There is a need to rethink about the abortion laws taking into consideration present social and cultural development of the society and a new perspective of reproductive rights.

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[45] Abdel Rahman Tageldin Medani *"Right to Privacy and Abortion: Comparative study of Islamic and Western Jurisprudence"* XII Aligarh Law Journal 133-156 (1997).

[46] AIR 1987 Delhi 86.

[47] Abdel Rahman Tageldin Medani *"Right to Privacy and Abortion: Comparative study of Islamic and Western Jurisprudence"* XII Aligarh Law Journal 133-156 (1997).

The Act consists of eight sections which aims to confer on women the right to privacy, which includes the right to (1) space and limit pregnancies(i.e., whether or not to bear children) and (2) to decide about her own body.

Section 3 of the Medical Termination of Pregnancy, Act has liberated the strict provisions of abortion under section 312 of Indian Penal Code by permitting abortion in a number of situations. Above all, the Act has not clearly laid down whether foetus is a person or nor. It has been challenged on this ground in court of law several times.[48]

Section 5 of the Act deals with the situation where immediate urgency arises to save the life of the pregnant woman by the registered medical practitioner. Thus, section 5 makes exception to section 3 and 4 where termination shall be conducted only in Governmental hospitals or such places approved for the purpose of the Act by the Government on the grounds mentioned under section 3.[49] So, in case of urgency to save the life of pregnant woman abortion can be conducted in any other place also.

Section 7 of the Act empowers the Government to take necessary steps for its implementation. Section 7 provides for the provision of punishment with fine which may extend to one thousand rupees in case of contravention of the provision of the Act.[50]

Similarly, section 8 contains a provision where a registered medical practitioner absolve from any liability for any damage caused or likely to be caused by anything which in good faith done or intended to be done by him. The Act makes violation of the regulations framed under it by the States a panel offence.[51]

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[48] K.D. Gaur *"Abortion and the Law in Countries of Indian Subcontinent, Asian Region, United Kingdom, Ireland and United States of America"* 37 Journal of the Indian Law Institute (1995).

[49] Medical Termination of Pregnancy Act, 1971.

[50] *ibid*

[51] B.B.L.Mathur *"Constitutional Limitations on Abortion Laws: A Study of the American and the Indian Law"* II The Indian Journal of Legal Studies 121 (1979).

The Act highlighted that legally pregnant woman can abort whether she is married, single or widow. But however, illegal and unsafe abortion are performed due to lack of information about Medical Termination of Pregnancy, Act and the services available for the purpose.Nearly,21.7 per 1000 illegal abortion has done in Uttar Pradesh in 1995-96.[52]

No doubt, the Act has played a significant role in the modernization of the Indian society through the instrument of law. It has a direct impact on population control and in realizing social and economic development. On the other hand, the Act is a landmark in empowerment of women from the age old fear of abortion the same as considered as a sinful and criminal act.[53]

4.3.4. Pre-natal Diagnostic Techniques Act 1994:

In 1994, the Parliament passed the legislation banning sex- determination test except for certain purposes. The government has enacted The Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (hereinafter called as PNDT Act).

The Pre-Natal Diagnostic Techniques, (PNDT) Act provides for regulation of genetic counseling centers, genetic laboratories and genetic clinics and also regulates pre-natal diagnostic procedures. The medical professional running the genetic centre has to be registered under the Pre-Natal Diagnostic Techniques, Act.[54]

It allows the use of prenatal diagnostic techniques for the purpose of specific genetic abnormalities or disorders only and put down a prohibition on the use of these techniques for determining the sex of the foetus by any such person under the Act.[55]

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[52] Azim A. Khan Sherwani "*Illegal Abortion and Women's Reproductive Health*" 3 Supreme Court Cases Journal 120 (1997).

[53] K.D Gaur "*Abortion and the law in Countries of Indian Subcontinent, Asean Region, United Kingdom, Ireland and America*" 37:2 Journal of Indian Law Institute 306 (1995).

[54] Section 3, Pre-Natal Diagnostic Techniques, Act.

[55] Section 3A, inserted after amendment of the Act on 2003.

The Act also prohibits any kind of advertisements on pre-conception and pre-natal sex determination of foetus or sex selection of foetus is prohibited. The Act provides for upto three years imprisonment and fine upto ten thousand rupees as punishment in contravention of the Act.[56]

The Act further provides for the creation of a Central Supervisory Board consisting of concerned ministers, officials representing various ministries, departments, medical professionals and representatives of women's welfare organization to exercise the power and performs the functions conferred on the board under the Act.[57]

The Act was amended in 2002 and called as the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act. The amended Act confers a broader aspect so as to protect female foeticide in India which is seriously impairing the socio-cultural fabric of India. Section 3A of the Act prohibits sex determination test. This section has been inserted by Amended Act of 2002, provided that no person including a specialist or a team of specialists in the field of infertility shall conduct or cause to be conducted or aid in conducting by himself or by any other person, sex selection on a woman or a man or on both or on any tissue, embryo, conceptus, fluids or gametes derived from either or both of them.[58]

Likewise, section 3B has also been inserted under the Pre-Natal Diagonostic Techniques Act(Regulation and Prevention of Misuse) Act, 1994 which came into force on 1-1-1996.and the Act was renamed and amended in 2002 by the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002. The said Act came into force on 14-2-2003. The Act amended to prohibit sale of ultrasound machine etc, to persons laboratories, clinics etc, which are not registered under the Act.[59]

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[56] Section 22, the Pre-Natal Diagnostic Techniques, Act.

[57] Section 7, the Pre-Natal Diagnotic Techniques, Act.

[58] The Pre-Natal Diagnostic Techniques, Act.

[59] *ibid*

The object of the Act is mainly to prohibit the pre-natal sex determination test of a feotus so that the pre-natal diagnostic technique may not be misused for obtaining sex-selective abortion. It also aims to regulate pre-natal diagnostic technique for the useful purpose for which it has been intended, such as:-

(a) Where the age of the pregnant women is above 35 years (advance maternal age).
(b) Where the pregnant woman has undergone two or more spontaneous abortions or foetal loss.
(c) Where the pregnant woman had been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals.
(d) Where the pregnant woman has a family history of mental retardation or physical deformities such as spasticity or other genetic diseases.
(e) The Central Supervisory Board may specify any other conditions as required.

The Act as well provides to set up of the State Level Supervisory Bodies to look after the proper implementation of the Act at all levels. The Board shall meet at least once in four months. There has been provision on the constitution of the appropriate authority which includes efficient women member and a Legal expert.[60] The officers to be appointed under Appropriate Authority are as follows:

i) Joint Director of Health and Family Welfare as the chairperson.
ii) Eminent woman representing women's organization and
iii) Eminent legal expert.

The following functions are entrusted to the Appropriate Authority:

1) To create public awareness against the practice of pre-conception sex selection and pre-natal sex determination.
2) To supervise the implementation of the provision of the Act and Rules.

[60] Section 16A, amended Act of 2003.

3) To recommend to the Central Supervisory Board modification required in the Act or Rules in accordance with changes in technology or social conditions.

4) To send such reports to the State Board regarding the activities undertaken in the State under the Act.

The Act also provides for the punishment to any such medical geneticists, gynecologists, registered medical practitioners or any person who owns a Genetic clinic, Center or Laboratory or employed in it or renders his professional or technical services on an honorary basis or otherwise and who contravenes any of the provisions of the Act or rules made thereunder shall be punishable with imprisonment for a term upto 3 years and with fine upto Rs. 10,000/ and in case of subsequent conviction with imprisonment upto 5 years and fine upto Rs. 50,000/. Besides, name of the registered Medical Practitioner convicted by the court shall be reported to the State Medical Council for temporary cancellation of medical registration for a period of 2 years for the first time and permanently for the subsequent offence.[61]

Similarly, if any person like a husband or any other relatives compel pre-natal diagnostic on any pregnant women for the purpose other than those mentioned above shall also be punishable with similar punishment and fine.[62]

The court shall presume, unless, the contrary is proved that the pregnant woman has been compelled by her husband or relatives to undergo Pre Natal Diagnostic Technique and such person shall be liable for abetment of offence. Every offence under this Act shall be non-bailable, cognizable and non-compoundable under section 23.[63]

Though, the Act has been enacted by the government but there is no proper implementation of the Act. This has been shown from the "*declining sex- ratio of female child.*" There are as many as 50,000 female foetuses aborted every year after

[61] Section 23.

[62] Section 24, shall also be liable for abetment of offence.

[63] Dr.Snehal Fadnavis "*Right of a female child to be born vis-à-vis –the sex determination tests*" 6(2) Journal of the Institute of Human Rights 32 (2003).

pre-natal test. It is a saddest truth that this life saving techniques of ultrasonography and amniocentesis is more used to take life of an unborn child only because she is "*female*". India has a ratio of 927 females to 1000 males.[64]

Thousands of centers have grown up in all the parts of a country. This has increased the number of female foeticide in India. The Medical Termination Pregnancy, Act has been enacted over more than twenty years before even than it has not curbed the illegal abortions. In the same manner, even if the Pre-Natal Diagnostic Techniques, Act has been enacted and enforced from 1994 but, there are more and more cases coming up in regard to the sex determination abortion. The reason for the increase in the number of abortion is mainly because of the availability of sex determination and sex selection centers. If there is no strict implementation of the Pre-Natal Diagnostic Techniques, Act, it will be futile to have this Act. So there is a need for the proper implementation of the Act.[65]

To spell out the object of the Act was to (a) regulate pre-natal diagnostic technology and to restrict the detection of genetic or metabolic disorders, chromosomal abnormalities, congenital malformations or sex linked disorders. (b) To prevent misuse of technology for the purpose of pre-natal sex selection this led to sex selective abortions.[66]

It has been found from the survey conducted in 1992 in metropolitan city of Bombay that 7,999 out of 8,000 aborted fetuses were female. It has been reported in a national daily that as many as 50,000 female foetuses are aborted every year after determining the sex of the foetus. In Delhi 70 percent of abortion was to abort female foetuses only.[67]

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[64] Shakeel Ahmad "*Legalised Abortion: A Gender Sensitive Foeticide*" 31 Civil and Military Law Journal 235 (1995).

[65] *Supranote* 63.

[66] Asmita Basu "*Sex Selective Abortions*" November The Lawyers Collective 20 (2003).

[67] Shakeel Ahmad "*Legalised Abortion: A Gender Sensitive Foeticide*" 31 Civil and Military Law Journal 233 (1995).

In *CEHAT* v.*Union of India,*[68] public interest litigation was filed for the implementation of the Act. The Supreme Court issued an interim order in May 2001 to the Center and the State to take necessary steps to implement this law.[69]

The complexities lying for reasons of declining female sex ratio are many .The Pre-Natal Diagonoistic Technique Act has added fuel to the existing trend by providing sophisticated techniques to those who wants to get ride of burden of a female child. A lower sex ratio is said to be indicative of a lower status for women in the society.

4.3.5. Maternity Benefit Act, 1961:

The remarkable feature of the status of women in the society has its co-relation with the economic contribution that women made to the family through her participation in the workforce.[70]*Miller* finds that where female labour participation is high, there is always a high preservation of female life and where female participation is low, the status of women is low.

Since, women has always put into disadvantageous position because of her capacity to procreate. Earlier women labour/workers were paid less than that of men because of their physical incapacity. Constitution has now provided equal pay for equal work and women are paid equally for equal work.[71]

Again, in workplace women used to be thrown out of the work in case she becomes pregnant or if she happens to be married. This gender discrimination was checked by the Constitution in various cases. Earlier, she was forced to leave her job in case she becomes pregnant. This misfortune is today ensuring by the Maternity Benefit Act, 1961.

Here, any woman employee gets three months maternity leave with pay in case of delivery of child. This Act is the relief to all the working women. Again, after

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[68] AIR 2001 SC 2007.

[69] *Asmita Basu "Sex Selective Abortions"* November The Lawyers Collective 20-21 (2003).

[70] Ashok K. Jain, *The Saga of Female Foeticide in India* 33(1st ed.2006).

[71] Constitution of India Article 39(d).

amendment even father/ husband are also entitled paternity leave of one month to look after the wife during her delivery.

Recently, the Centre has increased maternity leave from three to six months, besides, introducing paid leave for two years to take care of their children. As per the notification which is yet to come into force (comes into force from 2009 September)where the concerned department ensured that women employee will now enjoy 180 days of Maternity leave as against the existing term of three months. The Child Care Leave shall also be provided as a paid leave period of maximum two years during the entire service of woman for taking care of upto two children(the child care leave can be taken for children upto the age of 18) whether for rearing or to look after any of their needs like examination, sickness etc.[72]

The Maternity Benefit Act aims to regulate the employment of women in certain periods before and after child-birth and to provide for maternity benefits including bonus, nursing breaks etc.

The existing ceiling of 90 days maternity leave provided under Rule 43(1) shall be enhanced to 135 days. All government employees with less than two surviving children may be granted paternity leave for a period of 15 days during the delivery of his wife on paid.

The Maternity Benefit Amendment Bill, 2007 provides that working women shall get more maternity benefits. The medical bonus paid to women as maternity benefit shall be increased if no pre-natal and post-natal care is provided by the employer free of charge.

It can also be available against a woman employee having just one child and can take in addition to the extended maternity leave and will in no way affect the seniority. Child care leave can be taken only for children upto the age of 18 years.

[72] Sikkim Express pg 6 Wednesday, 17 September, 2008 Gangtok.

The order stated that 'Child Care Leave' may also be allowed from the 3rd year as leave not due (without production of medical certificate). It may be combined with leave of the kind due and admissible.

The Maternity Benefit Act 1961 regulates the maternity benefit available to women in factories, mines, the circus..... plantation and shops on establishments employing 10 or more persons. It does not cover/ employees who are covered under the Employees State Insurance (ESI) for certain period before and after child birth.[73]

But, most women in rural areas and in urban in formal sector do not get this benefit. Even after the Recommendation of the National Commission on Rural Labour, an empowered governmental body has not acted upon in pursuance of the authority.[74]

4.3.6. Five Year Plan:

It is imperative to study how a human rights instrument has been implemented in India. It is seen that concern about population growth in India began late in the nineteenth century. But an effort towards policy and programme was made early. As a result, National planning Commission (NPC) was established in 1938. When no nation in the world sponsored a family planning programme, it was at that time Lakshmibai Rajwade forcefully argued for the inclusion of birth control provision of goods, instruments, demonstrations and consultations in maternal and child health services.[75]

During late 1980s and early 1990s, the concern about family planning contoured health sector development. India saw a reconsideration of its population policies starting from the first Five Year Plan (1951-56) till the last Ninth Five Year Plan (1997- 2002). A number of committees were formed to give reports and suggestions about the implementation of five year plan date back from the first Health Survey and development Committee, commonly known as Bhore Committee (1943) following

[73] Maternity Benefit September 2,1994 by Jonathon Porritt

[74] Lina Gonsalves, *Women and Human Rights* 25 (1st edition 2001).

[75] Mohan Rao, *From Population Control to Reproductive Health-Malthusian Arithmetic* 19(1st edition 2004).

Health Survey and Planning Committee popularly referred as the Mudaliar Committee report. Each of this committee gave their suggestions and recommendations.[76]

In the first year plan, health was recognized as a right of all citizens. In the second plan, allocation for family planning increased remarkably even a health sector expenditure declined. In the third plan, the Mudaliar Committee recommended that family planning should be an essential part of the activity of all health agencies. The primary health care system is extricably linked with the family planning rather than with the health of the people. The fourth plan held the programme of family planning as national importance. This plan proposed to set up the target of sterilization and IUCD insertions and to widen the acceptance of oral and injectable contraceptives. Various programmes, such as the All India Hospital Post – partum Programme, the intensive District Programme in collaboration with USAID were launched (especially for vasectomy). The fifth five year plan accorded the same priority as to fourth five year plan.

With the recommendation of the kartar Singh Committee, family planning was included in the Twenty Point programme devised by Prime Minister Indira Gandhi and the five point programme of her son Mr. Sanjay Gandhi. The working group on population policy was established by the planning commission, asserted in its report that population policy and general development strategy dealt with the same subject matter, the programme thus centered on women.[77]

The sixth Five year plan adopted the long term demographic goal of reducing the net reproduction rate to one by 1996 for the country as a whole and by 2001 in all states. The said plan emphasized on the problems of public health and proper co-ordination of activities of different department bearing family planning such as maternal and child care.[78]

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[76] *Supranote* 75 at pg 24.

[77] Mohan Rao, *From Population Control to Reproductive Health-Malthusian Arithmetic* 51(1st edition 2004)

[78] *ibid* at pg. 53.

The seventh plan reviewed the progress of the family – planning programme where it was found that the target was not fully achieved. Among many other factors, the main factors are underlying as follows: - lack of infrastructural facilities, the high infant mortality rates and high levels of maternal and child mortality. In view of the performances in the sixth plan, a goal of reaching a net reproductive rate of one was pushed forward from 2006 to 2011.

During eighth plan period, there was internal disturbance (demolition of Babri Masjid) because of which the plan took place only in 1992. In the health sector, there was a commitment not towards the health for all but health for the underprivileged. The plan noted that the death rates and disease rates were still unacceptably high and that the rural health services were still not fully operationalised. The plan further noted that containment of population is not merely a function of couple protection or contraception but is directly correlated, with female literacy, age at marriage of girls, status of women in community, the IMR quality and outreach of health and family planning services and other socio-economic dimensions.[79]

However in 1994, India committed itself to Reproductive and Child Health (RCH) approach at Cairo. In preparation for the Cairo conference the Central Government unveiled a draft National Population Policy which raised a storm.

The Ninth plan document, noted various factors responsible for health scenario, including lack of infrastructure, critical lack of manpower of equipment and drugs and so on. The plan announces the two important policy- National Population Policy (NPP) and National Health Policy.[80]

The National Population Policy has committed towards voluntary and informed choice and consent of citizens while availing of reproductive health care services and continuation of the target free approach in administering family planning services. It also acknowledges issues of child survival, maternal health and contraception etc.

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[79] Mohan Rao, *From Population Control to Reproductive Health-Malthusian Arithmetic* 65 (1st edition 2004).

[80] *ibid*

Various measures of National Population Policy are- empowerment of women for population stabilization, child health and survival, for the promotion of policies, measures such as rewarding of Panchyats and Zilla Parishad from exemplary performance in family welfare, maternity benefits for mother, family welfare linked social insurances to be given to couples with two or less children who undergo sterilization etc.

4.3.7. National Population Policy 2000(NPP):

The National Population Policy 2000 (NPP) was constituted under the chairmanship of the than Prime Minister on July 22nd 2000. The main purpose of the policy is to attain a stable population by 2045 at the level consistent with the requirement of sustainable economic growth, social development and environmental protection. This purpose has to be pursued in immediate terms by addressing the unmet needs for contraception, health care infrastructure and personnel including provision for integrated service delivery for basic reproductive and child health care by 2010.[81]

The numbers in the reproductive age groups has been expanded as (estimated) 58 percent, high infant mortality rate generate high "*wanted fertility*" which contribute 20 percent and high fertility rate due to unmet need for contraception contributes an equal percentage to high population growth.[82]

The National Population Policy is the affirmation and articulation of the India's commitment towards the International Conference on Population and Development (ICPD), 1994 which is the blueprint for population and development programmes in the country. The ICPD has successfully grown concern on population issue.[83]

The main goals of the said policy are improving people's quality of health, enhancing well being and providing opportunities for population stabilization. It aims at

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[81] Government of India, *National Population Policy*, 2000; http:/inotifw.nic.in Para 9.

[82] *ibid*

[83] A.R. Nanda "Indian Population Policy:An Overview" in Shruti Pandey, Abhijit Das, Shravanti Reddy and Binamrata Rani (eds.) *Coercion versus Empowerment* 14 (2006).

providing accessible and affordable reproductive health; widespread of primary and secondary education; availability of basic amenities like sanitation, safe drinking water and housing; access to education and employment to women for their empowerment. It further aims at achieving promotion of open information, awareness, empowerment and development based approach. It unequivocally rejects the target approach and calls for target free approach.[84]

This policy is a gender sensitive policy and incorporates within a comprehensive approach to the health needs of women, female adolescents and the girl child as a whole. The main purpose of this policy is to provide quality services and supplies choices in services: to enable women access to quality health care, informed choice and measures for fertility regulation that suits women.[85]

The Preamble of the NPP significantly states as follows:
"The National Population Policy, 2000(NPP) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services."[86]

The NPP has been stressing on the importance of empowerment of women for improving health and nutrition, promoting child health and survival, and meeting the unmet needs for family planning services which are also helpful in achieving population stabilization.[87]

The immediate objects of the National Population Policy is to address unmet needs in the field of contraceptive, health infrastructure and integrated service delivery for basic reproductive and child health care. Its long term objective is to stabilize population by

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[84] *Supranote* 83.

[85] A.R. Nanda "Indian Population Policy:An Overview" in Shruti Pandey, Abhijit Das, Shravanti Reddy and Binamrata Rani (eds.) *Coercion versus Empowerment* 14 (2006).

[86] Shruti Pandey "Introduction" in Shruti Pandey, Abhijit Das, Shravanti Reddy and Binamrata Rani (eds.) *Coercion versus Empowerment* xxvi (2006).

[87] *ibid*

2045 and at the same time fulfilling the requirement of sustainable economic growth, social development and environmental protection. There are some specific goals also for which National Population Policy is working which are as follows:[88]

- Access to information, counseling and services for fertility;
- Registration of births, deaths, marriages and pregnancies;
- Promotion of National AIDS Control Organization (NACO);
- Managing reproductive tract infections (RTI) and sexually transmitted infections (STI);
- Promoting small family norm which is not necessarily two child norm but on the basis f requirement of the family;
- Implementation of family planning measures for the lager welfare of the people.

The National Population Policy proposes for the constitution of a National and State Commission on population to implement the policy, to co-ordinate cell in the Planning Commission and a technology mission in the Department of Family Welfare. Broadly speaking, the National Population Policy provides for new directions in accordance with the Cairo and Bejing consensus.

The National Population Policy appears sensitive towards issues of reproductive health which fully addresses "*accessible affordable health- care*". Along with these, it also provides for the provision of primary and secondary education, provision for basic facilities such as sanitation, safe drinking water and housing ..... transport and communications.[89]

The most remarkable feature of the said policy is that it has regarded family planning as a people's affair and not the realm of sovereign control which is perhaps the most important characteristic of reproductive rights as well. As already discussed,

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[88] A.R. Nanda "Indian Population Policy:An Overview" in Shruti Pandey, Abhijit Das,Shravanti Reddy and Binamrata Rani(eds.) *Coercion versus Empowerment* 15 (2006).

[89] "*The Rights Framework in Reproductive Health Advocacy*" 8 Hastings Women's Law Journal 313.

India was the first country to launch a national program emphasizing on the family planning to stabilize the population in relation to the national economy (1952).

It was realized that there was no or delay in adoption of 'small family norm' which resulted into 48 percent of population increase. This can be controlled through voluntary and informed choice and consent of citizens and by the target free approach in administering family planning services. But in fact, state policy on family planning was always coercive.

The National Population Policy does not even once mention reproductive rights. There is no mention of the obligations assumed by India under human rights covenants (ICCPD and ICESC or the CEDAW). There is, however, no mention of reference even to fundamental Rights and Directive Principle of State policy. Although the language at times articulate the spirit of Cairo and Bejing Convention but there is no express reference to commitments arising from there or of the role of India in shaping reproductive rights of women.[90]

The vital zone of people's life such as – sexual relations, health and family planning should be taken seriously by the Government. The policy is silent on the Constitutional and legal changes necessary for achieving these strategic goals. There is a need for a suitable legislative framework.[91]

Above all, the National Population Policy is silence on the violence against women. As the Cairo and Bijing Conference recognized human rights to reproductive choice and health require determined efforts to combat organized state/ social violence against women. On the whole, violence against women is on the rise and thus, there is a need for the proper law, policy and programmes for the protection of women's rights as well as reproductive rights.

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[90] Government of India, *National Population Policy*, 2000; http:/inotifw,nic.in Para 9.

[91] *The Rights Framework in Reproductive Health Advocacy* 8 Hastings Women's Law Journal 313.

4.4. Implementation of International Instruments

The government of India is a signatory to the most of the International Instruments, such as International Covenant on Civil and Political Rights, Convention on the Rights of the Child, Convention on the Elimination of all Forms of Discrimination against Women (CEDAW),etc and has tried its best to give effect to those provisions under national legal framework.

The government of India reports on CEDAW has highlighted that there is intention and sincere efforts to implement the provisions of international human rights instruments through various mechanism.

Article 2 of CEDAW i.e. obligation to eliminate discrimination is under the Constitution of India itself. The right to equality under Article 14 and 16 (No distinction on the basis of caste, creed, colour, sex, language etc.) stated no discrimination on the basis of gender. Equality before Law means that amongst equals the law should be equal and should be treated alike. Various women organizations have been formed in pursuance of international instruments which campaign the cause of women who are ill treated by husbands solely for not producing son. It is now, scientifically proved that it is not the women who are responsible for giving birth to the female child but the male.[92] This information has been widely spread by the Government and by other Non governmental organizations.

Right to life which is basic human rights and also provides by the Constitution of India which implies right to live with human dignity under article 21. Many laws have also been enacted to enable women enjoy their fundamental rights fully. The Department of Women and Child Development and the National Commission for Women have reviewed these laws and suggested amendments to the discriminatory provisions, some of which have been accepted and some others are still pending and some are under the process of consideration.

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[92] H.L.Kapoor "*Foeticide an Inhuman and Brutal Act*" Oct- Dec The PRP Journal OF Human Rights 21(1997).

There is National Commission for Women which pursue its mandate through various activities viz, investigating individual complaints on atrocities, denial of rights, sexual harassment of women at work place etc, conducting parivarik/ Mahila Lok Adalat (alternate dispute resolutions), legal awareness programme etc. There is constitution of National Human Rights Commission and State Human Rights Commission for better protection of human rights and its enforcement as provided by the Protection of Human Rights Act, 1993. These commissions added to the protection of human rights by providing remedies and encouraging non-governmental organizations and institutions. It also helps women to protect their rights.

In furtherance to the implementation of the provision of Article 12 of CEDAW, India is committed to achieving the goal of Health for all by 2010 . A large network of institutions for health care has been established in both rural and urban areas. It was reported that there are total of 137,271 sub health centers, 22,975 primary health centers and 2,935 community health centres in rural areas. Several policies, programmes and schemes have been initiated and implemented.[93]

There are various policies and programs that has been implemented so far which are as follows:-

1) *National Health policy* 2002:- which stresses on the funding and an organizational restructuring of the National public health initiatives to facilitate equitable access to health care. It also provides for establishment of a network of primary health care service, extension and health education programme and encouraging private initiative for health care facilities.

2) *Reproductive and Child Health (RCH) Programmes*:- (first phase 1997-03, second phase from 2003 and ongoing) aims at reduction of maternal and infant mortality, creation of awareness on rights of population in health care and improvement in the health care

[93] *The unheard Scream-Reproductive Health and Women's lives in India* Mohan Rao (ed) (2004).

delivery systems. Interventions for reducing maternal mortality and morbidity include the promotion of safe deliveries in institutions and at home. The birth attendants are being trained for conducting clean deliveries under RCH. Along with this, efforts have been increased to address women's health issues and concerns related to HIV/AIDS, TB, Malaria, Leprosy and other communicable diseases. Visibility for men is also sought in the RCH programmes.

The Reproductive & Child Health Project was launched in the ninth plan which was funded by the World Bank. The project contains three components:[94]

a) Decentralised Participatory Planning,
b) Institutional Strengthening, and
c) Programme implementation enhancing.

3) *Integrated Child Development Services* (ICDS):- There has been a nation-wide program for the overall development of children below 6 years of age and expectant and nursing mothers. On March 2004, there were 5,267 projects in the country. It has large machinery for delivery of services. They includes 6, 36,105 anganwadi workers, 22,013 supervisors and 5,258 CDPOs/ ACDPOs. Supplementary nutrition for 21 days in a month has been provided by these anganwadi centers benefiting 16,798,824 children below 3 years, 17352,353 children between 3-6 years and 7,357,501 pregnant and nursing mothers. The education to 10, 1461 boys and 9,976,572 girls in the 3-6 years age group, thus making an average attendance of 17 boys and 16 girls per center.

4) *Family Welfare Programme*:- has adopted a Community Needs Assessment Approach (CNAA) since 1997, through a decentralized participatory planning strategy. The department of family Welfare

[94] Reema Bhatia "Health Policy, Plan and Implementation" in Tulsi Patel (ed) *Sex Selective Abortion in India* 208 (2007).

has taken several new initiatives in the Ninth and Tenth plan periods to shift the focus from individualized vertical intervention to a holistic and life cycle approach giving priority to reproductive health care. The program as a part of the RCH and maternal mortality rate to 100 per 100,000 live births by 2010. The major interventions reiterated in the 10th five year plan include 100 percent registration of pregnant woman received at least one antenatal checkup, 24 hour delivery services at PHCs and CHCs, screening for anemia, promotion of safe delivery by trained personal etc. Also efforts are being made for establishing male reproductive health centers to motivate men to accept family planning. No scalpel vasectomy project was launched in January 1998 to promote male participation in the family welfare programmes, due to which male sterilizations have gradually increased from 1.8 percent in 1997 to 2.46 percent in 2002. The project has been implemented in 20 states.[95]

This programme is sponsored by the Centre. It aims at establishing the growth of population and for that purpose the goals have been made to curtail both fertility and mortality to achieve an Net Reproductive Rate of unity. The government of India has implemented target free approach for famiy planning. There are programmes set to motivate the couples for family planning through spacing and the use of terminal methods in the age group of 20-29 years with low parity.[96]

5) *20-Point Programme*:- Despite five year plans and programmes, the government of India ,in 1975 initiated a special twenty –point programme. The main object of this programme is to eradicate poverty, to raise productivity, to reduce inequalities, to remove

[95] Mohan Rao "*The Unheard – Reproductive Health and Women's lives in India*" (2nd edition, 2004).

[96] Reema Bhatia Health Policy, Plan and Implementation in Tulsi Patel (ed) *Sex Selective Abortion in India* 206 (2007).

social and economic disparities and to improve quality of life. The three main programme relating to the health are:

a) Health for all;

b) Two child norm;

c) Expansion of education.

So, various programmes of twenty point id directly or indirectly related to health of women.

Other Such Programmes are- Janani Suraksha Yojana Scheme, the National Nutrition Policy (1993) and the National Plan of Action on Nutrition (1995), the National Nutritional Mission (2003), the National AIDS Control and Prevention policy (2002), Universal Health Insurance Scheme (2003) etc. which dealt with the maternal mortality, nutrition, problem of malnourishment, mass awareness programs, reimbursement of hospital expenses, protection of rights of HIV positive women in making decision and regarding pregnancy and child birth etc.

There are various health care programmes that has been carried out at all levels of the health care delivery system. The Centre and State government both are making efforts through various plans, programmes and policies to improve the health care delivery syctem. The establishment of various planning and advisory bodies, the allocation of resources, the setting of priorities and goalsare all articulated at the natinl and state level and than articulated to the district level.But unless and untill, these programme reached the people in the large scale , they are meaninglees. The people at the grass root level are the main beneficiary of these programme and thus make efforts to ensure that the programme is impleming for those people especially.The health care services are to be delivered through the network of Community Health Centres(chc), Primary Health Centres (PHC), Subsidairy Health Centres(SHC), and Sub-Centres(SC).The intention of the government is reflected through these programmes which aims at achieving all round health development of all women.[97]

[97] Reema Bhatia Health Policy, Plan and Implementation in Tulsi Patel (ed) *Sex Selective Abortion in India* 210 (2007).

4.5. Reasons for Lack of Implementation

However, inspite of all the plans, programs and policies on the women health, the health issues of women still remains to be an alarming concern to the nation. Giving importance at national level is not enough, the manner in which these programmes are implemented is also equally important .Is the implementation of these programmes are in the spirit of the noble intention of promoting equality of both sexes? Such an analysis is necessary to find out the causes for the lack of implementation of these programmes. Various reasons for lack of implantation of these programmes are as follows:

4.5.1. Gender Discrimination

The girl child is the most disadvantaged groups; she is more vulnerable to human rights abuses.[98] There has been decline in sex-ratio both in rural and urban areas because strong son preference, widespread prevalence of pre-natal sex determination and selection practices and existence of socio-cultural practices and low status of women in decision making are the main hurdles for the proper implementation of the human rights instruments.

The socio-economic status of women in society and household is predominantly affected by patriarchal set up.[99]A patriarchal set up means the consideration of males as superior to females. Medical Health services are not untouched by this gender biased value system which makes women victim of gender discrimination. Women and girls get a lesser share in the intra household distribution of health, goods and services as compared to men and boys. Women have lesser access to goods which causes various problems during pregnancy like anemia, low birth weight babies, miscarriage etc.

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[98] Preeti Misra "*Female Foeticide: A Violation of Human Rights*" 21&22 Law Review 71 (2001).

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

In India, the Maternal Mortality Rate (MMR) has been estimated as 340 per 1, 00,000 births which are very high, further 15 percent of death among women in the reproductive age group (13-44 years) are maternal deaths. Maternal deaths due to complications in pregnancy and childbirth are the main causes of death among women in India. It is estimated that for every maternal death, 73 to 100 women face severe life threatening complications. The cause of maternal deaths include- hemorrhage (both anti and post parton) sepsis, obstructed/prolonged labour, puerpal sepsis, unsafe abortion, anemia etc. The factors responsible are poor health care facilities, lack of access to health care units, limited access to family planning services and safe abortion services, poor nutrition, early marriage, frequent and closely spacing pregnancies etc. These problems are not yet checked by the government even after various programs and policies.[100]

There are various National Nutritional Policies missions and action plans but the incidence of malnourishment among women and children continues to be widespread. The NFMs-II survey shows in 1997-98 shows that more than 50 percent of married women and 75 percent of children suffered from anemia. Women still lack access to the daily per-capita requirement of the recommended minimum nutrition. Nearly 60 percent of the women particularly pregnant and lactating women suffer from anemia.[101]

Another reason for the lack of acknowledgement of the reproductive rights and implementation of the legal instrument is the socio-cultural practices in the country. Women have to work outside the household and at the same time managed the household work also. This has resulted into competing demands on their time and energy and thus results into neglect to their health. Various social and cultural practices in the society has made women subordinate member in the household and thus lacks decision- making powers which includes decision-making in limiting and spacing children, bearing and not bearing of child and to conceive or not to conceive etc.

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[100] *CEDAW Committee Report-Government of India*;www.reproductiverights.org

[101] *ibid*

Despite various efforts made by the government and non-governmental organizations there are striking disparities in the health status of women and children, particularly girl children.

There seems that government is more interested in controlling population growth than in general health of the people (especially of women and children). There are many incidences in various states of India like Utter Pradesh, Rajasthan and Bihar where targeted sterilization was adopted. The existing growth rate of population was expected to cross 1,000 million by the end of the twentieth century. It is increasing by about 17 million per year.[102] India is a signatory to the Cairo Conference on Population and development (ICPD) which put emphasis on target- free family planning which is oppose to Indian government targeting sterilization which put population control before development.

Above all, lack of education of women also affects the health policy as this not only led woman to live in poverty with no income but also makes them ignorant of their own personal needs such as health needs.

Though, government has taken all the possible steps to address the challenges of these disadvantages but the result of such approach is still unsatisfactory. The Tenth plan- which envisages erecting of an enabling environment by adopting various affirmative policies and programmes for development of women and facilitating their easy and equal access to all minimum basic services of privacy, health care and family welfare with a special focus on the underserved and under-privileged segment of population through universalizing *Reproductive and Child Health Services* is yet to see the light of the day.

4.5.2. Failure of Pre-Conception and Pre-Natal Diagnostic Techniques Act

The Pre-Conception and Pre-Natal Diagnostic Techniques Act (PNDT), 1994 has failed to achieve its objectives because of many reasons. The machinery required to enforce the Act at the State and District levels was not taken seriously by the governing bodies entrusted to enforce it. Not a single pre-natal Diagnostic Center had been

[102] K.D.Gaur "*Abortion and the Law*" 37:2 Journal of the Indian Law Institute 299 (1995).

registered until 2001 in Punjab even though it was the first State to provide sex selection facilities as early as in the 1970s and the sex ratio in the age group of 0-6 years has been on the deadline. A warning was issued to the general people for the prohibition of the use of sex selection of unborn to stop female foeticide.[103] It was difficult to identify the purpose for which an ultra-sound test has been done due to non-maintenance of adequate records by clinics. Further the insistence of family planning programmes on the small family norm coupled with the son-preference bias in India added pressure on families to look at sex- selection as a via media for their desired family composition. That is before amendment of 2002 Pre-natal Diagnostic Technique Act.

Section 4 (2) of the Act provides that no pre-natal diagnostic technique shall be conducted except for the purpose of detection of any of the following abnormalities:

1) Chromosomal abnormalities.
2) Genetic metabolic disease.
3) Haemoglobinopalties.
4) Sex linked genetic diseases
5) Congenital abnormalities and
6) Any other, abnormalities or diseases as may be specified.

But the purpose of these life saving technique is sometimes used for denial of life to an unborn person only on the basis of gender.Nearly, 50,000 female foetuses are aborted every year after such test. As amniocentesis is an important clinical procedure and it is not desirable to ban it but what is required is the ban on sex determination and sex selective abortion.[104]

[103] Preeti Mishra "*Female foeticide :A Violation of Human Right*" 21&22 Law Review 76 (2001).

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

4.5.3. Reproductive and Child Health Policy

Women bear their health problems in a cultural norm of silence and do not seek timely health care, they often cannot travel beyond the area of their normal activities to obtain services, they cannot usually approach male health providers; in general, families, including women themselves, spend less time, effort and money seeking health care for women and girls than for men.

The delivery system that views women primarily as reproducers which means two things (i) the health delivery system tended to ignore the provision of general health care for women and (ii) the system tended to overlook women who did not fall into the reproductive age category for instance, adolescent girls, unmarried women, post menopausal and infertile women.

The documents recognize that the knowledge and use of reproductive health services is in extricably tied to the level of social development within a community and therefore gives importance to issues of women's empowerment especially through education.

The programme has extended its services from family planning and maternal health to include the treatment of women specific diseases like RTIs. The programme further recognizes that the Indian Family Welfare Programmes have focused on women in reproduction to the extent of exclusion of male responsibility. Therefore a key project under the programme has been to en-gender the reproduction process that is to make men visible in the process of reproductive decision making and contraceptive use.

Over and above this provision, under the decentralized participatory planning there is an emphasis on enhancing the process of participation between Auxiliary Nurse Midwives (ANMS) and individuals and the community respectively.

4.5.4. Health Programmes and its implementation

The sphere of health has been intervened through health programme especially for the women under Maternal and Child Health Services, Reproductive and Child Health Project (RCH) and the Family welfare programme. The said programmes aim at

providing complete and adequate care to women in terms of their reproductive health. Similarly, the Universal Immunisation Programme (UIP) aims at achieving Universal immunization and reducing the mortality and morbidity resulting from vaccine preventable diseases. From 1992 the child survival and safe motherhood programme, with the assistance of World Bank and UNICEF has been introduced to supplement the gains of the UIP. Iron and folic acid tablets are being regularly supplied to mothers and children. The World Bank Project aided to improve the quality of Family services.[105] The RCH project looks after the reproductive health of women and encouraging the women to participate for planning their own health has taken various steps.

An initiative was also taken to provide health education to the people under the programme called the Information, Education and communication Activities (IEC). The programme aims to intervene in improving the status of women in the sphere of family planning and maternal and reproductive health.[106]

An analysis of the programme shows that in India, the Programme gets implemented in the field of Family Welfare programme. The other programme that gets implemented are those for which target has been set. The entire structure of health services is confined to the achievement of targets- targets of family planning, immunization and malaria slides. The entire effort is made towards meeting target at the cost of rest of the health services.[107]

The health of women is not of any concern to anyone, including women themselves. Only in one situation woman's health was taken care of and that is in case of son bearing. If suppose, a daughter is born, she starts her chores the very next day may be out of guilt of having borne a daughter. It is only after bearing son she can rest physically as well as mentally.[108]

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[105] Reema Bhatia "Health Policy and Implementation" in Tulsi Patel (ed.) *Sex –selective Abortion in India* 205 (2007).

[106] *ibid.*

[107] M.K.Premi *"The Missing Girl Child"* 36(21) Economic and Political Weekly 1875-1880 (2001).

[108] Mohan Rao, *The Unheard Screa-Reproductive Health and Women's Lives in India* (2nd edition 2004).

In a way the only programme that actually gets materialized is the Family Planning programme. For the government, it means controlling fertility by limiting the number of children to two, irrespective of the sex of the children. For the people and the workers too it means planning families, but in a different way.

Initiatives and efforts taken to address women issues have been inadequate, distorted, vertical and top down and have rarely emerged out of concern for women's health. The only solution being offered for women's health is for maternal health. This too is extremely limited and is restricted to the distribution of iron and folic acid tablets and to tetanus toxoid injections.

There is a lack of support system to empower women. That can only be materialized through cooperation of government and different departments and the involvement of the people themselves. Reproductive health should be the prime concern to empower women.[109]

Besides, approaches to the small family norm as an ideal family, has been propogated from 1951 onwards and several measures adopted by the Family Planning Programme (FPP), sponsored by the government of India through the means of mass media and the widespread network of the country's health care programme. This has lead to the increase in the adoption of family planning measures such as- use of contraceptive, abortion of unwanted foetus or sterilization, etc. Many times these measures have affected the health of women immensely. The leaders of a country and an official of a country saw population as a problem and wanted a policy to control population immediately to solve the country's problem.[110]

4.5.5. Inadequacy of Law to Protect Illegal Abortion

One of the difficulties, rather factors that has been resulted into lack of prosecution and successful convictions of abortion offences, has been the obtaining of adequate evidence to prove the fact of pregnancy and its termination in a court of law.

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[109] *Supranote* 108.

[110] Tulsi Patel "Foeticide,Family Planning & State-Society Intersection" in Tulsi Patel (ed) *Sex Selective Abortion in India* 325 (2007).

It is only a medical examination soon after the termination of pregnancy that can reveal the fact of pregnancy and its termination. As per the criminal procedure code of 1898 which was in vague till 1973, an accused could not be compelled to submit to a medical examination. And a woman who happened to be an accused would never submit to it. However, under the code of 1973 the prosecuting agency can compel a woman suspected of an offence to undergo medical examination.[111]

Another factor is lack of adequate and proper law enforcement authorities in such cases in the non-cognizable nature of offences relating to illegal abortions. A police officer can neither arrest an accused without a warrant, nor investigate the alleged offence of miscarriage without the order of an authorized Magistrate. Such a complicated procedure involves a lot of exercise on the part of the police which generally they would avoid due to obvious reason.[112]

On humanitarian ground also abortion are generally pregnant unmarried girls or widows caught in a difficult situation. Any procedure would mean more harassment, torture and agency to the unfortunate woman rather than give her relief.[113]

Therefore, to liberalise abortion laws Government of India constituted Medical Termination of Pregnancy Act, 1971.The object of the Act is to eliminate the high incidence of illegal abortions, which perhaps confer on women right to privacy which also include the right to space and limit pregnancies and the right to decide about her own body. Another silent feature of the Act is to encourage a reduction of population growth by permitting termination of unwanted pregnancy of a woman on the ground of failure of contraceptive device.[114]Similarly, abortion is permitted if the pregnancy is caused by rape.

However, abortion is not conducted on demand except under certain condition. The reason for not allowing abortion on demand is because of subservient status of

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[111] K.D.Gaur "*Abortion and the Law in India*" March Cochin University Law Review 129 (1991).

[112] *ibid*

[113] *ibid*

[114] Ashok K.Jain, *The Saga of Female Foeticide in India* 101(1st edition 2006).

women in the society where she may be forced to abort against her will and the health of the women. Abortion policies are made with the intention to safeguard the women's life from the consequence of unsafe abortion.[115]

Another major concern for the country as a result of legal abortion is that it has lead to the large number of female foeticide in India. There are evidences which show that termination of pregnancy was resorted not for the reason stated under MTP Act but because there is strong preference for son leading to female – selective abortions. The gender bias nature of the society was aided with by the medical technology that can detect the sex of the foetus in womb and further liberal abortion law that helped the couples to abort foetus if it is found as female foetus. Though, PNDT Act, 1994 is there but it still fails to curb the problem because of non implementation of the Act.[116]

There is no doubt that there is demand for pre-natal test and apperantly it leads to female foeticide. But with the enforcement of PNDT Act the demand for such test is done secretly and the practice of foeticide is still going on.

4.6. Conclusion

Despite all the laws, policies, programmes and measures adopted as well as efforts made by the government the problems of women are still remain as they are. The majority of the women are still denied freedom to control their fertility because of ignorance, religious prohibition or husband's desire. The serious implication of this denial is on her health and life expectancy. Denial of sexual and reproductive rights including free choice with regard to pregnancy and child bearing added to the widespread discrimination and violence of human rights against women.

However, the government is unable to enforce laws especially in area where culture is deeply rooted. In reality, there is a visible gap between the law as it stands

[115] *Supranote* 114 at pg.105.

[116] Leela Visaria "Deficit of Girls in India" in Tulsi Patel (ed) *Sex Selective Abortion in India* 70 (2007).

and the law as it operates, which is regularly marred by incidents of overwhelming injustice.

In analyzing the legal basis for the protection of reproductive rights and keeping pace with the advanced reproductive technologies, there is a need to enact and enforce legal structure on the basis of the women's needs. The existing legislative framework is very encouraging, while the difficulty lies with the pragmatic use of the law and making it reachable to the mass population. Though, only law cannot guarantee protection of reproductive rights of women, proper implementing machinery and proper environment for the implementation is also very important.

CHAPTER 5

ROLE OF THE JUDICIARY IN PROTECTION OF REPRODUCTIVE RIGHTS OF WOMEN

5.1 Introduction

In the absence of adequate legal framework for the protection of reproductive rights of women an inevitable task has been left to the judiciary to solve the issue of reproductive rights. Today, with new reproductive technologies, the face of reproduction has changed totally. The matter of reproductive rights not only deals with legal questions but also with ethical and moral issues.

In India, very few cases have come before the judiciary concerning reproductive rights. But, there is no doubt that in future judiciary will have to face new challenges on variety of these aspects. There are many reported and unreported cases which obviously thrash the heart of the academicians, law makers, judiciary etc. There is a need to be prepared for the critical issues which underlie with the reproductive rights and the reproductive technologies. Furthermore, there is host of complex issues embedded with these new trends of reproduction. Therefore, there is a call for a multi-pronged policy and programme within which judiciary and other organs have imperative task to occupy for themselves.

The Supreme Court being the caretaker of the public rights and the High Courts established in every state have been empowered to issue appropriate directions/ orders etc. It has shown its concern towards women's rights dealing with various issues that are important part of women's life. Rights of women can be guaranteed only in an atmosphere where women will be treated equally and when women will acquire equal position in the society.

Among various women's rights, today, reproductive rights occupies significant place in achieving all other rights. As woman's life revolve around mostly with the role she

plays in reproduction and it is a woman who has to take the hardship in reproduction. Therefore, no other rights can be achieved without having or guaranteeing reproductive rights. However, in India issues on reproductive rights has been so scanty and issues on reproductive technologies has been hardly dealt with by the judiciary. The reasons for very few cases on reproductive rights of women are various. Such as-

i) Women's subordinate position in the society.
ii) Cultural attitude of the society.
iii) Son-preference
iv) Lack of legal awareness
v) Illiteracy and ignorance.
vi) Limited exercise of informed choice
vii) Limited access to Health care

Reproduction is fundamental to the very existence and survival of mankind. Consequently, any questions related to human reproduction are of crucial importance and involve both the family unit and society as a whole. Ever since, time immemorial, human being has endeavoured to protect the most uncomplicated impulse to reproduce. In primitive societies and subsequent civilizations this desire have been gradually transformed into rights and obligations, materialized and protected by customary, religious norms and later on by legal system.[1]

Women's problems in the context of reproduction are rooted in their status of being dependent from the very beginning of her life. They are in the custody of their father till their marriage and than in the custody their husband after marriage. Their individuality, rights and needs are always subject to their father, husband and later son. Despite laws to provide some relief to them in case of marital or other violence they are still silent victim of social and religious norms. Inspite of the avenues open to them to seek redressal of grievances in the Court of Law, practically they are constantly urged to submit, adjust and to have patience.

[1] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights* 166 (1st edition 2000).

5.2. New Emerging Issues on Reproductive Rights and the Role of the Judiciary

5.2.1 Response of Judiciary on Gender Issue

The debate on gender issue is the recognition of the equality in dignity and human rights of women and men. The concern of gender equality comes from the protection of women from sexual harassment and the right to work with dignity which is recognized as basic human rights and has been accepted almost by all the countries of the world.[2]

The Supreme Court of India has always shown positive attitude towards the issue of gender equality. It has actually taken various bold steps to eradicate the menace of gender biases from the society. Various reforms have been made by the judiciary to protect the dignity of women, such as – protection of woman against sexual harassment at the workplace.[3]

The Supreme Court of India has always responded to the issues of gender discrimination in an optimistic manner. There are many cases where the court has significantly advance the cause and dignity of women. In C.*B. Muthama v. Union of India*[4] a service rule whereby marriage was a disability for appointment to Foreign Service was declared unconstitutional. Similarly, in the case of *Air India Nargesh Meerza*[5]ere the court declared pregnancy as a disqualification to continue in public employment was ultra vires under Article 14 and 16 (1) of the Constitution.

In the case of *Bodhisatwa Gautam* v. *Subhra Chakraborty,*[6] the Supreme Court observed that rape in criminal law is not only an offence but also violation of fundamental right to life and liberty under Article 21 of the Constitution. Also, the

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[2] J. Palok Basu, *Law relating to Protection of Human Rights* 92 (1st edition 2002).

[3] *ibid* at pg. 95.

[4] AIR 1979 SC 1868.

[5] (1981) 4 SCC 335: AIR 1981 SC 1829.

[6] AIR 1966 SC 922

Vishaka v. *State of Rajasthan*[7] where the Supreme Court has given landmark judgment forwarding application of international law and gender equality in India.

The decision pronounced by the Supreme Court is based on the provisions of the International law instruments, Conventions and Declaration of which India is the party and has ratified it. The Supreme Court has done every possible effort to implement the provisions of international law and constitutional law for securing the equality of women.

Despite the fact that the Supreme Court has shown dynamic attitude in ensuring gender equality, judicial activism is yet to flourish to the lower levels of the judicial system. Moreover, some of the much talked about reforms are safeguards to working women against sexual harassment at work place, women's right to privacy, equal pay for equal work, prohibition of dowry system etc. which has been achieved through judicial intervention. But, women's access to gender justice is still difficult especially because of the age old cultural barriers rooted in male dominated society.[8]

In *Madhu* kishwar v. *State of Bihar*[9], the court has considered the provisions of the Convention on the Elimination of all Forms of Discrimination against Women, 1979 (CEDAW) and marked that the Fundamental Rights and the Directive Principles of State Policy of Indian Constitution contains all the elements of the Convention and will be applied with the same spirit.[10]

If gender bias is identified in all its shade and colour which would be a major step in dealing with this dilemma. There is no need of special treatment for woman as for man because such special treatment is not required. Instead, there is a need for the sensitive ways to examine the attitude of the society towards man and woman which has affected the decision making power of both man and woman. Once, this sensitivity is achieved and it is accepted with openness than and only than will the litigants be able to explain

[7] AIR 1997 SC 3011

[8] AIR 2001 Journal section 149 at 152.

[9] AIR 1996 SC 1864.

[10] AIR 2001 Journal section 149 at 152.

their circumstances to a court that is both willing to learn and to judge to achieve a gender neutrality in its judicial system.[11]

Inspite of the Supreme Court's efforts, there are lack of concern in certain areas of women's rights and one of such area is women's health especially reproductive health of women. Gender equality as guaranteed by Constitution under Article 14 and 16 (1) and the efforts of the judiciary to realize this right is meaningless without having women's right to health particularly reproductive health.

5.2.2 Justification of right to Procreation

The family formation begins either with marriage or parenthood, or both. The element of right to found or establish a family is related to individual's right to procreate. The new assisted reproductive technologies brought new challenges to the traditional concept of procreation.

As one of the main ends of marriage is the 'procreation of children'. In *White* v. *White,*[12] a husband insisted on a particular sexual practice which practice would ensure that the wife could not get pregnant. The court held that it amounts to cruelty on his part as the wife was very interested to have a child.[13]

The marriagble age of the girl and a boy has been fixed by law as 18 years for girls and 21 years for boys[14]. In *Leela Gupta* v. *Lakshmi Narain*[15], the Supreme Court held that breach of minimum age condition does not render the marriage void. The Child Marriage Restraint Act, 1929 also does not invalidate the marriage even in case of violation of the minimum age provision but punishes the persons responsible for such violation. Therefore, a girl minor or major possesses equal right to marriage and ultimately thereby to conceive a child.[16]

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[11] AIR 2001 Journal section 149 at 153.

[12] (1948) 2 ALI ER 141.

[13] J. Palok Basu, *Law relating to Protection of Human Rights* 124 (1st edition 2002).

[14] Section 5 (3), Hindu Marriage Act, 1955.

[15] AIR 1978 SC 1351.

[16] J. Palok Basu, *Law relating to Protection of Human Rights* 125 (1st edition 2002).

In English law, the view of parents or natural guardian in the matter of abortion is irrelevant when the minor was capable of understanding the implications of her opinion. So, if a girl whether minor or major with sufficient understanding desires to marry, there is no impediment on her choice. The consummation of marriage naturally may lead to pregnancy. The State cannot interfere and compel a girl not to conceive. The family planning laws are only advisory but not mandatory.[17]

Even the Indian Panel Code permits cohabitation by a husband with his wife when she is below 16 years of age. Woman got an absolute freedom and discretion under law whether to conceive or not. But, when once exercised this option to conceive, termination of the foetus is an offence under the Indian Panel Code under section 312. The Medical Termination of Pregnancy Act (MTP), 1971 at this stage interferes and allows a woman to go voluntarily for abortion. When the woman is major her decision is final under MTP Act. Nevertheless, when she is a minor she has to come up through guardian for abortion.

In *Danforth Planned Parenthood of Central Missourie, In Re*[18] held that State might not constitutionally require a married woman to have husband's consent to abortion nor might they impose a parental consent requirement for unmarried minors. The State does not possess any authority to give a third party an absolute authority to terminate the pregnancy.[19]

In India, the High Court of Madras delivered a landmark judgement in *Krishna* v. *G. Rajan*[20] and upheld the validity of minor girl's consent in the matter of retaining pregnancy. The court held that a minor girl cannot be forced to abort her child much against her desire.[21]

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[17] *Supranote* 16.

[18] 1976 49 L Ed zd 788.

[19] J. Palok Basu, *Law relating to Protection of Human Rights* 125 (1st edition 2002).

[20] 1994 (10) W Cri 16 Mad (DB).

[21] *Supranote* 19

The increased concern for women's health and gender equality as contained in various international documents has moved the focus towards the means necessary to exercise reproductive freedom. In other words, the right to procreation will enable the right to take decision as to when to conceive and how to conceive, to limit the number of children and to space the number of children as to one's desire.[22]

Here, it is necessary to mention the case of *Javed and others* v. *State of Haryana and others*[23] where the constitutionality of a population control provision in the Haryana Panchayat Raj Act, 1994 was challenged on the ground of being violative of Article 14 and Article 21 of the constitution. The Act disqualifies those having more than two children from holding Panchayat office.

The court held that the object of enactment is to popularize the family planning taking into consideration population growth in a country. Fundamental rights are not to be read in isolation. They have to read along with the chapter of Directive Principles of State Policy which provide for the welfare of the people and developing a social order empowered at justice-social, economic and political.

Though, the court focuses on the population problem but it failed to issue any direction to ensure that the state helps citizens to practice family planning. The *Javed* decision shows the reality of women's lack of reproductive decision making power because the social, cultural and economic obstacle is not reluctantly taken into consideration by the Judiciary.

The judiciary seems to be not informed of the Indian position in the demographic transition that the growth rates have declined the fertility rate as well. Moreover, such coerced policy will only add misery to women's problems relating to reproductive health.

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[22] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights* 240 (1st edition 2000)

[23] AIR 2003 SC 3057.

5.2.3 Right to Abortion

Abortion is an issue misted up with the question of morality, infanticide, suicide, ethics, religious belief and women's rights. Today some 50 to 60 million abortions occur every year throughout the world, up to half of them illegal and dangerous killing about half a million women annually. Apart from this, at least 500 million women around the world are placed at the risk of repeated pregnancies with serious health problems. However, it is shocking that such a basic right as the right to help with planning or preventing the birth of an unwanted child has been denied to women.[24]

It emerges that the clash for gaining this right would be earned through the courts rather than Parliament or State Legislation. Sooner or later, the right to life and personal liberty as guaranteed by Article 21 of the Constitution would have to interpret in such a way as to include the right to abortion also.[25]

In *Satya (smt)* v. *Shri Ram,*[26] the High Court of Punjab and Haryana held that termination of pregnancy at the instance of wife but without the consent of her husband amounts to cruelty. In *Deepak Kumar Arora* v. *Sampuran Arora*[27] a division bench of Delhi High Court has observed that if a wife undergoes abortion with a view to spite the husband, it may, in certain circumstances be contended that the act of getting herself aborted has resulted into cruelty.[28]

In an English case Forbes v. *Forbes,*[29] it was held that if a wife deliberately and consistently refuses to satisfy her husband's natural and legitimate craving to have children and the deprivation reduces him to despair and affects his mental health, the

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[24] J. Palok Basu, *Law relating to Protection of Human Rights* 126 (1st edition 2002).

[25] *ibid* at pg. 127.

[26] AIR 1983 P&H 252.

[27] (1983) 1 DMC 182.

[28] J. Palok Basu, *Law relating to Protection of Human Rights* 126 (1st edition 2002).

[29](1955) z All ER 311.

wife is guilty of cruelty. In *Sushil* Kumar v. *Usha*[30] the Delhi High Court held that aborting the foetus without the consent of the husband would amount to cruelty.[31]

However, judiciary has denied right to abortion of woman if there is no consent of the husband by declaring it as cruelty which is one of the grounds of divorce under personal law. Such a decision discourages woman to exercise her right to take decision to abort child if she is not physically or mentally ready for it. The MPT Act has allowed woman to take decision without the consent of her husband. But such right cannot be exercised by a woman freely if court marked it as matrimonial cruelty. Here, court is required to have wider viewpoint taking into consideration the reproductive right of woman.

5.2.4 Implementation of the Pre-Conception and Pre-Natal Diagnostic Technique Act (PNDT)

The use of sex-determination technology by parents for the purpose of sex-selective abortion has been the prime concern of the country. Internationally, the UN Special Rapporteur on Violence against Women among others has condemned such practices. Similarly, in India, there is enactment and enforcement of the Pre-natal Diagnostic Techniques Act, 1994 to prohibit sex determination or sex-selection of the foetus. The use of these new technologies has resulted into the killing of female fetuses and sex-selective abortions.[32]

The reproductive right does not include a freedom of the couples to decide on their child's sex if that is for the devaluation of any of the sexes. There has been great number of sex-selective abortions of females in India and China as a sign of devaluation of women. There has been world wide son preference but it is so grave in South Asia and the Middle East. The obvious reason for son preference in these societies is historically rooted in the patriarchal system. Another reason for such practice is the social and cultural stigma attachés to the daughter or a girl child because

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[30] AIR 1987 Del 86.

[31] J. Palok Basu, *Law relating to Protection of Human Rights* 126 (1st edition 2002).

[32] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights* 268 (1st edition 2000).

of the dowry system where considerable costs of marrying off a daughter have to pay. Also, if the daughter does not marry she will remain dependent upon her family. Thus, pre-natal tests meant to detect the abnormalities of the foetus are being widely used to determine the gender of the child.[33]

There has been, therefore, prohibition of sex determination or selection through government initiative where the pre-natal diagnostic technique including ultrsonography for the purpose of determining the sex of a foetus is prohibited under the PNDT Act. However, in India, the situation of sex selective abortion resulted into female foeticide continues to worsen even after the introduction of the PNDT Act. The reason could be non-implementation of the Act as well as the growing misuse of reproductive technologies.[34]

In 1998, a Public Interest Litigation was filed in Supreme Court in a case of (Centre for Enquiry into Health and Allied Themes) CEHAT v. *Union of India*[35] for direction to implement Pre-natal Diagnostic Act. The Hon'ble Court passed a constructive interim order in May 2001 directing the Central Government and States to take all necessary steps to realize this law. Compliance with the Act in serious note, therefore, initiate with the passing of this order.[36]

Here, while executing the Act the Court has revealed loopholes and problems inherent in the Act. The main shortcomings highlighted were that there were no clear provisions regulating pre-conception techniques in the Act. Further, it was asserted that the Act drafted at the time when amniocentesis was considered to be the main threat which was incorrectly drafted as far as the use of ultrasound tests were concerned. Moreover, that the Appropriate Authorities constituted under the Act were abusing their powers and harassing practicing doctors. Thus, the prenatal test meant to discover

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[33] *Supranote* 32.

[34] Ashok K. Jain, *The Saga of Female Foeticide in India* 143 (1st edition 2006).

[35] AIR 2001 SC 2007.

[36] Asmita Basu "*Sex Selective Abortion*" The Lawyers Collective 20-21 (2003).

abnormalities of the foetus are being used to determine the sex of the child, effecting abortion if it is a female.[37]

Although, it is appropriate to spot out at this crossroads that the compliance affidavits filed by the States in the Centre for Enquiry into Health and Allied Themes (CEHAT) case shows that most of the actions taken against doctors is on the ground of non-maintenance of proper records. There are very few cases where doctors have been caught in the act of disclosing the sex of a foetus.[38]

The Supreme Court issued a series of directions during 2001-2003 to the following authorities (i) Central Government, (ii) Central Supervisory Board (iii) State Government/ Union Territories Administration, and (iv) other appropriate authorities.[39]

The Apex Court directed all the States to confiscate ultrasound equipment from clinics that are being run without licenses. It was found that many Genetic counseling centers, laboratories or clinics were not registered and no action has been taken as per the provision of the Act, besides issuing warning.[40]

The Centre assured the Supreme Court that it will set up a National Inspection and Monitoring Committee for the implementation of the Act. In 2003, the Court was informed that the PNDT Act has been amended in pursuance of the direction of the Supreme Court taking necessary steps to achieve the object of the Act.[41] But the saddest truth is that sex selective abortion is still prevalent in the country.

5.2.5 Reproductive Health and Abortion services

Of a variety of factors necessary for women's ability to have their own choice in procreation, access to abortion services is also a decisive factor. The abstract right to

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[37] Asmita Basu "*Sex Selective Abortion*" The Lawyers Collective 20-21 (2003).

[38] *ibid*

[39] Ashok K. Jain, *The Saga of Female Foeticide in India* 144 (1st edition 2006).

[40] *ibid* at pg.146.

[41] Ashok K. Jain, *The Saga of Female Foeticide in India* 147 (1st edition 2006).

make a decision is meaningless if the conditions needed to carry it out do not exist.[42] In reality, safe and affordable abortion services are out of reach of the common people. A legal right to abortion might in reality be of lesser importance for women if abortion services are not accessible.

There is ample example that short-term 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 subject of reproductive health of women. Under such situation, access to the services is determined by social, cultural, economic and political conditions. The status of women and their decision making ability plays an important role in their opportunity to receive adequate reproductive health care.[43]

Maternity leave is provided to working women during post delivery in India by the Maternity Benefits Act, 1961. The labour legislation also provided for breast feeding intervals and crèche facilities in work places. The Supreme Court in *B. Shah* v. *Labour Court Coimbatore*[44] stated that the Maternity Benefits Act is intended to achieve the object of social justice to women workers. It is an example of a legislative provision specifically designed to make women's reproductive roles into account and ensure security to women and that they are not discriminated in employment as a result of their reproductive roles.[45]

5.2.6 Changing Outlook towards Abortion Right

There has been the recent observation of a division bench of the Bombay High Court in a case being heard by them concerning a pregnant woman of 25th weeks carrying a

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[42] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights* 292 (1st edition 2000).

[43] Malini Karkal "*Family Planning and Reproductive Health*" The Indian Journal of Social Work LIV.No.2 297 (1993).

[44] AIR 1978 SC 12 at 16.

[45] Subash Chandra Singh "*Reproductive Rights as Human Rights: Issues &Challenges*" 31(1&2) Indian Socio-Legal Journal 64-65 (2005).

foetus in which an anomaly was discovered in the 24th weeks. The foetus was diagnosed with congenital heart block.[46]

The MTP Act clearly states that unless it is necessary to save the life of the pregnant woman, a pregnancy can be terminated only up to 20th weeks. In this case, even though, the foetal anomaly was detected only in the 24th weeks, most doctors refused to perform an abortion, as it would be a clear violation of the MTP Act. The gynecologist was also keen on challenging the provisions of the exception with the Mumbai High Court for the basic reasons that a number of cases of similar nature were being observed. Since a legal abortion cannot be carry out after 20th weeks of pregnancy so, there is no option left to the couples than turning towards illegal and unsafe abortions.[47]

The case was than heard on the plea of emergency and was argued for a week. An expert committee of the government doctors formed by the court observed both aspects of an existing anomaly that was likely to result in early death of the child, if born, and in that case the child would have dependent on medical support all its life. Alas, the report finished by saying that there is no specific sign that the child was not likely to survive, if born.

The court passed an order to re-submit the report to the petitioner. The MTP Act does not cater to the modern technologies that are in existence and therefore does not address an issue like the present one where the anomaly is detectable only after the 24th week of pregnancy and not before. Further, it is a well-established medical stance that due to the technological and scientific advancement, safe abortions can be conducted even after the limit of 20th weeks.[48]

Today, with the quantity and the quality of medical and technological advancement, it is possible and preferred to regularly observe regularly the growth and well-being of the foetus. But the fact remains that even though there are number of phase of foetal growth that can be detected only at the 24th and 26th weeks of pregnancy, it becomes

[46] Anubha Rastogi *"Is Abortion Right?"* Jan-Apr Combat Law 100 (2009).

[47] *ibid*

[48] *ibid* at pg. 101

useless as the woman cannot choose for a safe and legal abortion for the reason that it is in violation of law.[49]

Even though, the Mumbai High court denied the pregnant woman liberty to abort the foetus with fatal anomaly at that stage. Many social activists and intellectuals were of the view that the MTP Act should now be amended to accommodate cases like these, while there were others who were offering to take care of the child after it was born and bear the medical expenses.

This case highlighted the harsh truth that women have no say whether she want a child or not. In this case, notice has been issued to the State and the petitioner has been asked to produce progressive legislations from other countries.[50]

5.2.7 Liability in Case of Medical Negligence

Recently, a city court in Delhi has summoned a widow of a Delhi policeman along with her parents and brother for having aborted her husband's only heir to be for his negligent act.[51]

In *Indian* Medical *Association* v. *V.P. Santha Kumar*[52] a three member bench of the Supreme Court placed the controversy that if the services rendered by a medical practitioner is service within the meaning of Consumer Protection Act (CPA) or not.[53]

The court has come to the various conclusions inter-alia, the following[54]:

a) services rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service) are covered under the definition of 'service' under CPA.

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[49] Anubha Rastogi "*Is Abortion Right?*" Jan-Apr Combat Law 101 (2009).

[50] *ibid*

[51] Reported in Hindustan Times, 27 June 2005.

[52] AIR 1996 SC 550.

[53] Surya Malik "*Failure of Sterilisation Operation-Whether Medical Negligence?*" AIR Journal 292 (2004).

[54] *ibid*

b) In case of hospital/nursing homes/ health centers where some patient are treated free of cost while charges are required to be paid by others, everyone undergoing treatment including those who have not made any payment, would be a consumer under the Act.

c) Services provided by hospital/health centre of government or non-governmental hospital free of charge would not be covered under CPA even if there is payment of a token amount for registration purpose.

A noticeable implication of judgement in *Indian Medical Association* v. *V.P. Santha Kumar's* case is that there has been a burst in complaints of medical negligence under the CPA. These complaints pertains to medical negligence due to erroneous diagnosis, inaccurate pathological reports resulting in wrong medication and lapse while performing surgery as treating gynae patients etc.[55]

In *Bolam* v. *Friern Hospital Management Committee,*[56] *M.C. Nair,J.* thus laid down that the test in such cases is the standard of ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill, it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular skill. In the case of a medical person, negligence means failure to act in accordance with the standards of a reasonably competent medical person at the time. There may be one or more perfectly proper standards and if he conforms to one of these proven standards, then he is not negligent.[57]

Lord Denning in *Hucks* v. *Cole*[58] clarified the distinction between negligence and medical negligence, "a charge of professional negligence against a medical person was severe. It stood on a different footing to a charge of negligence against the driver of a motor car. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater. As the charge was so

[55] *Supranote* 53.

[56] (1957) 2 All E R 118.

[57] *Supranote* 53 at pg.293.

[58] (1968) 118 NLJ 469.

grave, so should proof be clear. With the best skill in the world, things sometimes went wrong in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong. He was not liable for mischance or mishappening or an error of judgment. He was not liable for taking one choice out of two. He was only liable when he fell below the standard of a reasonably competent practitioner in his field so much so that his conduct might not be excusable.[59]

Spring Meadows Hospital v. *Harjot Ahluwalia*[60] give further details about the distinction between a bona-fide mistake which may be excusable and a mistake which is tantamount to negligence. While in the former, a court can accept that ordinarily human shortcoming preclude the liability; in the latter, the conduct of the defendant is considered to have gone beyond the bounds of what is expected of the reasonable skill of a competent doctor.[61]

In essence the true test to determine whether in a particular case there is medical negligence or not is the nature of the error.

A bulk of the judgments on failure of sterilization operations (and as a result, the birth of an unwanted child) has not gone in favour of aggrieved party due to the medically proved failure rates.

In *Smt.* Shanti v. *Post- Graduate Institute of Medical Education and Research,*[62] it was held that such operations were not hundred percent successful and no compensation could be given unless there was substantial evidence to show negligence.[63]

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[59] Surya Malik *"Failure of Sterilisation Operation-Whether Medical Negligence?"* AIR Journal 293 (2004).

[60] AIR 1998 SC 1801.

[61] *Supranote* 59.

[62] 1998 (1) CLT 257 (UT).

[63] Surya Malik *"Failure of Sterilisation Operation-Whether Medical Negligence?"* AIR Journal 293 (2004).

In *Smt.* Jaiwati v. Parivar *Sewa Sanstha,*[64] Delhi State Consumer Redressal Commission, while giving reference to a number of treaties and books on laparoscopic operations concluded. The above said extracts from reputed medical texts clearly prove that the risk of failure is inherent in female sterilization. That risk cannot be obviated despite due care and caution. Risk of failure, being a risk inherent to procedure and therefore, it cannot be said that the opposite parties were in any way guilty of negligence merely because the procedure has failed.[65]

In Pushpabai v. *S. Joseph,*[66] it was observed that in the absence of expert evidence that there no negligence on the part of the respondent. Further, it was not possible to record a finding of deficiency of service.[67]

The decision in *Dr. N. Sandhya* Rani v. *M. Kalpana,*[68] also exonerated the doctor for medical negligence holding that there is some percentage of failure of tubectomy operations by pomeroy's technique which is an approved method and has a failure rate of 0.2%. Further, no negligence could be proved since the doctor was assisted by a doctor and a nurse and there were good facilities in the operation theater. The patient did not make any attempt to get the pregnancy terminated when it could be safely done. Therefore, the case of the patient and she had unwanted pregnancy and suffered mental agony, hardship and inconvenience could not be accepted. The court rejected the claim concluding that the complainant willingly bares the child and suffered the burden.[69]

Similarly, in *Premlata Dhakonia* v. *Dr. Dheeraj Garha,*[70] the National Commission found that if the sterilization operation failed, it could not be attributed to negligence and each case depended on the circumstances of that case. If the appellants did not want a third child, they could have got the pregnancy terminated. However, they thought it

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[64] 1999(3) CPJ 167.

[65] *Supranote* 63.

[66] 2000 (2) CPJ 566 (MP).

[67] *Supranote* 63.

[68] 2000 CTJ 504 (CP) (SCDRC) AP.

[69] *Supranote* 63 at pg.294.

[70] 2002 CTJ 357(CP) NCDRC.

fit to file a complaint only when girl child was born. Thus, they willfully chose to have a child. The question of expiry of period of limitation was also settled, that the cause of action would start from the date of knowledge of pregnancy. In this present case, the complainant had conceived after ten years of the tubectomy operation.[71]

Shikha v. *Ashoka Jindal*[72] lay down that no expert evidence had been brought to show that sterilization operation was not carried out as it should have been done and there could be cases of stray pregnancy since there was a failure rate of 0.4%. The National Commission concluded, "It was imperative that expert evidence should have been led to show lapse on the part of the doctor concerned". No relief could be granted if nothing have been done.

In *Archna Paul* v. *State of Tripura,*[73] the hospital has made clear before the operation that the success of the operation was not guaranteed. The petitioners were advised for checkup by the medical officer on regular intervals but none of the petitioners have followed the instructions of the medical officer.

Justice P.K. Sarkar in *Arahana* Paul v. *State of Tripura*[74] rightly remarks, "*the failure of sterilization is the nature's overpower on human effort to maintain the nature's rule of progeny*".

The year 2000 saw a trend- setting judgment granting compensation on the birth of an unwanted child due to the failure of sterilization operation in the case of *State of Haryana* versus *Smt. Santra.*

The recent Delhi High Court judgment in *Smt.* Shobha v. *Government of NCT of Delhi*[75] is also apt to discuss here where two cases were decided simultaneously.

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[71] Surya Malik "*Failure of Sterilisation Operation-Whether Medical Negligence?*" AIR Journal 294 (2004).

[72] 2003 CTJ 775 (CP) NCDRC.

[73] AIR 2004 Gau 7.

[74] *ibid*

[75] AIR 2003 Del 399.

Smt. Shobha underwent a tubectomy on February 23rd 1999 in Hospital. She was assured that it was a complete and successful operation and she will not bear any more children. However, she conceived in Janauary 2000 and when she contacted the Chief Medical Officer and other doctors of the hospital, she was informed that she was not pregnant. Two months later, when her pregnancy became apparent she again approached those doctors, who then told her that the operation was not successful. Shobha requested for an abortion which was refused as it would be dangerous to her life. In October 2000, she gave birth to a female child.[76]

Sikri J. concluded that the respondents had not at all informed the petitioner that despite reasonable care in performing the operation and the apparent success of the operation there could still be a conception. It was held that the consent was not informed. Thus, compensation was granted.[77]

In another case, petitioner was informed that the sterilization operation could fail and the doctor would not be liable. The petitioner was also informed verbally and in writing that if she misses her menstrual period, she had to report to the nearest hospital or the doctor and chose to proceed with the pregnancy of their free will.[78]

When they reached the hospital in the advanced stage of pregnancy (18- 20 weeks) it was not safe to terminate it. Sikri J. concluded that the birth of the unwanted child could be prevented had the petitioner being vigilant. Contributory negligence cannot be ruled out.[79]

In *Achutrao Haribhav Khodua and others* v. *State of Maharashtra and others*[80] the deceased was admitted to the hospital where she delivered the child through normal

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[76] Surya Malik "*Failure of Sterilisation Operation-Whether Medical Negligence?*" AIR Journal 296 (2004).

[77] *ibid*

[78] *ibid*

[79] *ibid*

[80] (1996) 2 SCC 634.

delivery. She went for sterilization operation and thereafter, she developed high fever and abdominal pain. When her condition deteriorated the doctor opened the sterilasition operation where mop towel was found inside the peritoneal cavity of the deceased. Though, it was removed but ultimately she died. The court on appeal held the state and the respondent liable for negligence.

5.2.8 Right to Birth and Right to Life of Foetus

The American Supreme Court for the first time in *Roe* v. *Wade*[81] recognized woman's right to terminate her pregnancy. The court found this right to be rooted in the constitutional right to privacy. In brief, the Supreme Court of America held that a woman's right to terminate her pregnancy is such that the state may not prohibit abortion until the foetus reaches viability. But, in a later case, *Webster* v. *Reproduction Health Services,*[82] the Hon'ble Supreme Court of America reversed its earlier judgment and upheld a Missouri Statute which declared that the life of each human being begins at conception and that unborn children have protectable interest in life, health and well-being.[83]

The court maintained that state can pass any regulation of abortion on the ground of preserving and protecting the health of the pregnant woman. The next is to protect the potential human life personified in the foetus, prior to *Webster,* the foetus had no 'protectable interest' until it had reached viability. Thus, the American Supreme Court recognized the right of a foetus to grow and born.

In *Davis* v. *Davis*[84] case where a divorced wife and husband disputed on claiming of right on Frozen Pre-embryos for implantation to have a child, the judge concluded that as a matter of law, human life begins at conception and the legal provisions governing a human being existing as embryo in-vitro to be those of child custody law, dominated by the obligation to seek, protect and advance the best interest of the child.[85]

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[81] 1973 USA.

[82] 1989 USA.

[83] G.V. Ramaiah "*Right to Conceive vis-à-vis Right to Birth*" AIR Journal 138 (1996).

[84] (1989) 15 FLR 2097.

[85] G.V. Ramaiah "*Right to Conceive vis-à-vis Right to Birth*" AIR Journal 138 (1996).

In an English case *R* v. *Tait,*[86] the Court of Appeal quashed the conviction of a burglar on the ground that "threat to kill a foetus" is not an offence directed against the another person. The foetus in utero was not in the ordinary sense another person distinct from its mother.[87]

In another case *R* v. *Sullivan,*[88] midwives who attended the delivery of a foetus that failed to survive birth was charged with the offence of criminal negligence of causing death to another person (foetus). The conviction by the trial court was set aside by British Columbia court of Appeal on the ground that a foetus that was not living on complete removal from its mother's body was not a 'person' but the court substituted a verdict of guilty of criminal negligence causing bodily harm to another person namely the pregnant woman. The foetus in the birth canal was found to be part of the mother, so that injury to the foetus constitutes injury to her. This view was rejected in a later case *Bonbrest* v. *Kotz*[89] and the unborn child was recognized as a human being. The unborn child need not reach the stage of viability to maintain an action for recovery of damages under the law of torts. Thus, unborn child to whom live birth never comes is held to be a person who can be the subject of an action for damages for his death.[90]

Is the foetus to be recognized as a separate entity or a part of its mother? The European Convention on Human Rights recognizes the right of everyone to life, however, it does not define the term 'everyone'. In *X* v. *United Kingdom,*[91] doubted that whether the term 'everyone' in Article 2 of the Convention included foetus but held that even if the right to life begins at conception it was subject to the implied restriction to permit abortion in order to protect the mother's life or health. The issue again arose in *Paton* v. *U.K,*[92] where the Commission conclusively decided that Article 2 of the Convention applies to only people who have been born because if Article 2 were to

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[86] 1989 3 WLR 891.

[87] *Supranote* 85 at pg. 140.

[88] (1988) 43 CCC 3d 65.

[89] 05 F. Supp 138 d.d.c 1946.

[90] *Supranote* 85 at pg.140.

[91] 8416/780 DR 19,244.

[92] (1980) 3 EHRR 408.

apply to foetus, abortions would have to be prohibited at the cost of the mother's health. Further, this would give the life of the foetus a higher value than that of the mother. Requiring a person to be deliberately killed in order to save the life of another would be contrary to Article 2 of the Convention.[93]

The United Sates Supreme Court indirectly in the case of *Roe* v. *Wade*[94] where a Texas abortion statute prohibited abortion except under medical advice to save the life of the mother. An unmarried pregnant woman who wished to terminate pregnancy by abortion challenged the statute as unconstitutional. The Supreme Court of United States accepted the contention that the right of pregnancy a woman possesses her right to take decision as to termination of pregnancy but disallowed an absolute right of the woman to terminate pregnancy. The court in this case developed the trimester test of pregnancy. However, when the foetus became viable, the state may regulate, even prescribe abortion in promoting its interests in the potentiality of human life.[95]

As already discussed, the Supreme Court modified its stand in Roe and thus contented in *Webster* v. *Reproduction Health Services*[96] that it was constitutional for the state to declare an interest in human life at all stages of pregnancy. Further, Webster unequivocally lay down that life begins from the time of conception and not viabile as laid down in Roe.

Likewise in India, in *Bandhu Mukti Morcha* v. *Union of India*,[97] the Hon'ble Supreme Court held that it is a fundamental right of everyone in this country assured under the interpretation of Article 21 to live with human dignity. Thus, it must include within it the tender age of children to develop in a healthy manner and in conditions of freedom and dignity.

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[93] S.J. Prashanth "*Right to Life of Foetus*" AIR Journal 209 (2005).

[94] *Supranote* 81.

[95] *Supranote* 93 at pg. 210.

[96] *Supranote* 82.

[97] AIR 1984 SC 802.

According to Ramaiah G.V. Article 21 of the Indian Constitution may be interpreted to mean that the word 'person' applies to all human beings including the unborn offsprings at every stage of gestation[98].

Kerela High Court ruled that if a pregnant woman dies in an accident, her husband can claim compensation separately for the unborn child too. A foetus can not be equated with or considered as a part of the mother's body, the court said setting aside earlier judgements.[99]

The eternal conflict of right to born of a foetus has never been resolved, although it appears that courts generally favour foetus as part of mother's life. There has been debate going on moral, ethical, religious and legal view points and frequently the life of the mother has been recognized as more valuable than the foetus. Undoubtedly, a pregnant woman's decision will affect her own life, as well as the life of the foetus she is carrying.[100] Advocates of women's rights demanded among other things that the fertility control should be included in the category of women's human rights.

Like Justice Sandra Day O' Connor said in *Akron* v. *Akron*[101] *"as medical science becomes better able to provide for the separate existence of the foetus, the point of viability is moved further backs towards conception"*.[102]

Today, with the help of modern medical science, it has become possible to build an artificial womb and nurture an embryo from fertilization to 'birth' without it even being inside a woman. It will, in effect, mean that every foetus is viable at any stage during pregnancy. If the viability will be recognized as the start of human life and therefore,

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[98] S.J. Prashanth *"Right to Life of Foetus"* AIR Journal 214 (2005).

[99] Wed 22 Oct 2008, Telegraph.

[100] Warren Freedman, *Legal issues in Biotechnology and Human Reproduction* 141 (1st edition 1991).

[101] 103 Supreme Court 2481 (1983).

[102] Subash Chandra Singh *"Reproductive Rights as Human Rights: Issues &Challenges"* 31(1&2) Indian Socio-Legal Journal 63 (2005).

line at which abortion will be illegal, then life will begin at conception and it will be wrong to kill the foetus at any time after conception.[103]

5.2.9 Right to Privacy

The proponents of right to privacy said that it is the right of the individual married or single, to be free from unwarranted governmental intrusion, in the matters fundamentally affecting a person such as whether to bear or beget children. It is argued that human being is a sociological concept before becoming a biological concept. A pregnant woman should not be bound by the embryo which has no sociological meaning when she has not accepted it. Thus, she should be able to choose whether or not to have children.[104]

In *Doe* v. *Bolton*[105] believed that the decision of the woman to continue or discontinue a pregnancy is an integral part of the right to privacy and affirmed abortion as a constitutional right. It rejected the argument that a foetus becomes a person upon conception and thus is fully entitled to due process and equal protection guarantee under the constitution. In fact, the court explicitly stated that the foetus was not a person within the meaning of the Fourteenth Amendment of the constitution. There is no case decided by the Supreme Court of India on this point. However, relying on the United States Supreme Court ruling some writers said that for the purpose of Article 21, a foetus or unborn child will not come within the definition of person.[106]

The United States Supreme Court expanded the right of privacy in *Eisenstndt* v. *Baird*[107] who was not a doctor was convicted under a Massachusetts law prohibiting distribution of contraceptives to unmarried persons but allowing such access to married persons. In *Baird*, the court followed an equal protection approach and held that the

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[103] *Supranote* 102.

[104] C.L. Anand "*A Critical Examination of Laws Relating to Abortion and Access to all forms of Contraception*" 24 Civil and Military Law Journal 253 (1988).

[105] 410 US 179 (1973).

[106] C.L. Anand "*A Critical Examination of Laws Relating to Abortion and Access to all forms of Contraception*" 24 Civil and Military Law Journal 255 (1988).

[107] 405 US 438 (1972).

statutory distinction between married and unmarried persons violated the equal protection clause of the Fourteenth Amendment. Although, the court in *Baird* based its holding on an equal protection theory, it expanded the protection, the right of privacy to all individuals regardless of marital status. The court observed:

> *It is true that in Griswold the right to privacy in question inherent in the martial relationship. Yet, martial couples is not an independent entity with mind and heart of its own but an association of two individuals each with a separate intellectual and emotional make up. If the right of privacy means anything, it is the right of the individual married or single to be free from unwanted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.*[108]

The holding of the United States Supreme Court in *Baird* case has been interpreted by some courts and commentators as affirming a general right to sexual privacy. In fact, the court in *Baird* did question the legitimacy of the state's law regulating fornication, sodomy and adultery. It is clear that the court in this case invalidated a Massachusetts statute prohibiting distribution of contraceptives to unmarried persons because the means chosen were not effective, nor rationally related to achieving the goal and eliminated merely an insignificant amount of premarital sexual activity.[109]

The code of medical ethics made by the Indian Medical Council provides that a medical practitioner; "do not disclose the secrets of a patient that have been learnt in the exercise of their profession. Those may be disclosed only in a court of law under orders of the presiding judge". The problem raised by these two codes can be solved only in the light of the decision of the Supreme Court in *Mr. X* v. *Hospital Z.*[110] In this case, one Mr X was diagnosed in hospital 'Z' and found that 'X' was HIV (+). The marriage of 'X' was fixed with one 'Y' but later called off due to the information from the 'Z' hospital that 'X' was found to be HIV (+). Against this the appellant 'X'

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[108] Medani Abdel Rahman Tageldin *"Right to Privacy and Abortion: A Comparative Study of Islamic and Western Jurisprudence"* xii Aligarh Law Journal 136 (1997).

[109] *ibid*

[110] AIR 1999 SC 495.

approached the National Consumer Disputes Redressal Commission for damages against the respondents who were made liable to pay damages. But the commission dismissed the petition on the ground that the appellant might seek his remedy in the civil court.

Appellant contended that the principle of "duty of care" as applicable to person in medical profession includes the duty of care and in case of infringement they were liable for damages to the appellant. When the case came before the Supreme Court, the main issue was whether the disclosure of the information violates the right to privacy of 'X'. Regarding this, court observed, doctors are morally and ethically bound to maintain confidentiality. In such a situation, public disclosure of even true private facts amount to an invasion of the right of privacy which may sometime lead to the clash of one person's "right to be let alone" with another person's right to be informed..... Disclosure of even true private facts has the tendency to disturb a person's tranquility.[111]

In a country that lives in different cultural values, the role of the judiciary is brought sharply into focus. The court confronted with an intellectual and moral dilemma in Delhi High Court stating that the sphere of privacy deals with persons not places. In *Naz Foundation* v. *Government of NCT of Delhi and others*[112] the petitioner NGO has been working for the intervention and prevention of HIV/AIDS. This requires interaction with the vulnerable sections of the society which includes gay community or homosexuals. The litigation has been filed on the ground that HIV/AIDS prevention efforts were found to be severely impaired by discriminatory attitude exhibited by the state towards gay community. They are being covered under section 377 of Indian Panel Code under unnatural offences.

The petitioner held that right to privacy is implicit in the right to life and liberty and guaranteed to the citizen human dignity, autonomy and the need for intimate personal sphere including consensual sexual relations also afforded protection within

[111] Dr. George Joseph "*Artificial Reproductive Techniques-The New Horizon of The Right to Privacy and Right to Know*" 4:98 Journal of Indian Legal Thought 105-106 (2006).

[112] WP(C) NO.7455/2001.

the ambit of the said fundamental right to privacy under Article 21. In addition, section 377 IPC has a damaging impact upon the lives of homosexuals perpetuating it as social stigma and police or public abuse; thereby compelling homosexual activity underground jeopardizing HIV/AIDS prevention efforts and thus making them more vulnerable to contracting HIV/AIDS.[113]

The right to privacy is an essential component of right to life envisaged by Article 21 under Indian Constitution. This right however, is not absolute and may be lawfully restricted for the prevention of crime, disorder or protection of health or morals or protection of rights and freedom of others.[114]

5.2.10 Consent of Husband in Relation to Family Planning

The UN Conferences confirm that access to contraceptives and a free and informed choice of methods for family planning have been accepted world-wide as fundamental human rights.[115] Women shall have the right to obtain contraceptives without spousal consent. Professor Cook has, in addition, argued that denial of access to means of fertility control for women constitute a violation of the liberty of persons as defined in human rights instruments.[116]

A case decided in *Griswold* v. *Connecticut,*[117] a Connecticut law which forbade the use of any drug, medicinal article or instrument for the purpose of preventing conception. It also forbade dissemination of information of contraceptive devices was struck down by the Supreme Court, here, as being violation of the right to privacy embodied in the Fourteenth and Fifth Amendments of the American Constitution. Speaking through Douglas J., the Supreme Court held that such laws operated directly on the intimate relationship of husband and wife and unconstitutionally intruded upon

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[113] *Supranote* 112.

[114] Dr. George Joseph "*Artificial Reproductive Techniques- The New Horizon of the Right to Privacy and Right to Know*" 4:98 Journal of Indian Legal Thought 108 (2006).

[115] Maja Kirilova Eriksson, *Reproductive Freedom in the context of International Human Rights* 240 (1st edition 2000).

[116] *ibid*

[117] 381 U.S. 479 (1965).

the right of marital privacy. It was said that the right of privacy which the court was dealing with, was even older than the Bill of Rights – older than the political parties, older than the school system. The court apprehended that if such laws were held to be valid, that would mean that the police could "search the sacred precincts of marital bedrooms in the use of contraceptives". The court found this idea to be repulsive to the notion of privacy connected with marriage relationship.[118]

However in India, in *kalpana* v. *Surendra Nath,*[119] termination of pregnancy by the wife without the consent of the husband, inter-alia, was accepted as a ground for granting divorce to the husband. It was held by the court that such an act amounted to marital cruelty and deprived the husband of the pleasure and pride of being a father.

This judgment presents an interesting instance of battle between two values-women's absolute and exclusive choice in the matter and the harmony of the martial life.[120]

Similarly, in *Sushil Kumar Verma* v. *Usha,*[121] the Hon'ble Delhi High Court held that aborting the foetus in the very first pregnancy by a deliberate act without the consent of the husband amounts to cruelty within the meaning of sec 13 (1) (a) of the Hindu Marriage Act, 1955 and granted a divorce. In effect the husband's consent is mandatory in matter of pregnancy.[122]

Moreover, the United State Supreme Court in *Planned Parenthood* v. *Danforth,*[123] held that the constitution protects a minor's right to privacy to abort her pregnancy. However, the United State Supreme Court's determination to extend the right to privacy protection to encompass a woman's right to abortion was received with heavy

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[118] C.L. Anand "*A Critical Examination of Laws Relating to Abortion and Access to all forms of Contraception*" 24 Civil and Military Law Journal 254 (1988).

[119] AIR 1985 All 253.

[120] *Supranote* 118 at pg.258.

[121] AIR 1987 Delhi 86.

[122] *ibid.*

[123] 428 U.S. 52 1976.

criticism by many commentators because the court declined to recognize during the first trimester the right of the husband to participate in the abortion decision and the interest of the state in protecting the life of the foetus.[124]

In 1992, the United State Supreme Court in *Planned Parenthood of Southern Pennsylvania* v. *Casey*[125] held that the State is empowered to impose medical or emotional barriers to abortion, so long as these do not become an undue burden in opting for abortion.[126]

In *Skinner* v. *Oklahoma,*[127] the court held that marriage and procreation is fundamental to the very existence of survival of the race. Marriage is not only two couples finding pleasure in one another but two people approaching together towards a value which exists in common life –tasks. This life task is accomplished in the begetting and rearing of children.[128]

The significant development in the law regarding abortion came with the case of *R* v. *Bourne.*[129] The defendant was an eminent obstetric surgeon. He informed the police of his plan to perform an abortion on a 14 years old girl who had been raped, and having done so, was duly prosecuted. He was charged under the Offences against the Person Act, 1861 for unlawfully unless termination of foetus is done in good faith in order to save the life of the mother. It was further held that the surgeon had not to wait until the patient was in peril of immediate death, but was his duty to perform the operation if on reasonable grounds and with adequate knowledge he was of the opinion

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[124] Medani Abdel Rahman Tageldin *"Right to Privacy and Abortion: A Comparative Study of Islamic and Western Jurisprudence"* xii Aligarh Law Journal 137 (1997).

[125] 112 S.C.2791 (1992).

[126] *Supranote* 124.

[127] 316 U.S. 535 (1942).

[128] Medani Abdel Rahman Tageldin *"Right to Privacy and a Abortion: a Comparative Study of Islamic and Western Jurisprudence"* xii Aligarh Law Journal 143 (1997).

[129] Decided in 1939.

that the probable consequence of the continuance of the pregnancy would be to make the patient a physical and mental wreck. The surgeon was found not guilty.[130]

In an Indian case the father of a minor girl filed a writ petition before the Madras High Court for a direction from the court to terminate the pregnancy of his minor daughter. The High Court dismissed the writ petition and held that abortion cannot be forced on a minor girl when she is willing to bear the child.[131]

In *Loving* v. *Virginia,*[132] the court recognized the freedom to marry as one of the vital personal rights as essential to the orderly pursuit of happiness by the freeman. If right to terminate pregnancy is given to women absolutely than it will certainly disrupt the purpose of marriage and family life.[133]

5.2.11 Artificial Insemination and the Judiciary

Artificial insemination as already discussed, is an old technique because of which various legal and ethical issues have arise. Though, litigation in the Artificial Insemination (AI) is minimal, the highly emotional circumstances and the experience of infertility has led to the AI as a boon but there is distinct possibility that in future many people will approach the judiciary in order to resolve various issue. There is no such issues arise in India, so far, but in various other parts of the world such issues has come before the judiciary. Those issues are issue whether artificial insemination amounted to adultery or not? Whether AI child is legitimate child of the couple or not? Whether introduction of semen through AI amounted to consummation or not?, etc.

Introduction of something spurious is adulteration. Since Artificial Insemination Donor has the potentiality of introducing into the husband's family a spurious child, it has been argued by some that it amounts to adultery.

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[130] Medani Abdel Rahman Tageldin "*Right to Privacy and a Abortion: a Comparative Study of Islamic and Western Jurisprudence*" xii Aligarh Law Journal 147 (1997).

[131] Subhash Chandra Singh "*Right to Abortion*" AIR Journal 129 (1997).

[132] 410 US 113(1973).

[133] Medani Abdel Rahman Tageldin "*Right to Privacy and a Abortion: a Comparative Study of Islamic and Western Jurisprudence*" xii Aligarh Law Journal 133-156 (1997).

In *Rutherford* v. *Richardson,*[134] adultery was said to have been committed even tough there was no penetration but some lesser act of sexual gratification. In *Sapsford* v. *Sapsfort and Furtado,*[135] the court recognized that voluntary submission to or participation in intimate 'physical contacts' may be inconsistent with the duties of a wife towards her husband. Karminiski J. stated; "I have no doubt that if whole penetration was not achieved, some lesser act of sexual intercourse was performed and granted a divorce on proof of such act. Though, these cases had nothing to do with artificial insemination, yet, the effect is the demolition of the concept of sexual intercourse with penetration as an ingredient of adultery.[136]

The Indian position, however, continues unchanged and penetration whatever the extent, irrespective of ejaculation is a necessary ingredient. In *W.J. Philips* v. *Emperor*[137] the court held that sexual intercourse is a necessary ingredient of the offence of adultery (under section 497 IPC). Nothing short of it would justify a conviction under that section. Similarly, in *re Anthony*[138] where a boy of fifteen years was accused of committing rape on a girl of seven and a half years, the court held that "while there must be penetration in the technical sense, the slightest penetration would be sufficient and a completed act of sexual intercourse is not at all necessary.[139]

The issue whether artificial insemination amounts to adultery was raised for the first time in a Canadian court in *Oxford* v. *Oxford.*[140] The marriage was not consummated because of some physical affliction of the wife. The wife however, gave birth to a child. The husband accused the wife of adultery. While he stayed in Canada and she was in England. According to the wife, she had resorted to artificial insemination as the doctors had advised her that the only way she could be cured of the affliction was by

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[134] 1923 A.C. 1

[135] (1954) 2 All E.R. 373.

[136] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 285 (1977).

[137] AIR 1939 Oudh 506.

[138] AIR 1960 Mad 308.

[139] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 285 (1977).

[140] (1921) 49 Ontario LR 15.

bearing a child and that it might be done artificially. The court disbelieved the story and came to the finding that the wife had sexual intercourse in the ordinary way. It however, observed:

> *That no authority can be found declaring directly or indirectly that "artificial insemination" would constitute adultery is not to be wondered at. This is probably the first time in history that such a suggestion has been put forward in a court of Justice. But can any one read the mosaic law against those sins which, whether of adultery or otherwise, in any way affect the sanctity of the reproductive functions of the people of Israel, without being convinced that had such a thing as" artificial insemination entered the mind of the law giver, it would have been regarded with the utmost horror and detestation as an invasion of the most sacred of the marital rights of husband and wife and have been the subject of severest penalties.*[141]

The court continued further that the essence of the offence of adultery consists, not in the moral turpitude of the act of sexual intercourse, but in the voluntary surrender to another person of the reproductive powers or faculties of the guilty person, and any submission of those powers to the service or enjoyment of any person other than the husband or the wife comes within the definition of adultery.[142]

Similarly, in the Scottish Court of Session at Edinburgh in *Maclennan* v. *Maclennan,*[143] the husband filed a petition for divorce on the ground of his wife's adultery. The wife alleged that the child she gave birth to was conceived by artificial insemination. The husband contended that AID was adultery in the eye of law and also that he did not consent to his wife's impregnation. The court, however, conceded that a married woman committed a grave and heinous offence against the marriage contract by submitting to artificial insemination without her husband's consent, nevertheless, this according to the court, was a matter in respect of which the legislature should

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[141] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 286 (1977).

[142] *ibid*

[143] (1958) Sess.Cas. 105.

determine an appropriate remedy. The wife declined to provide the necessary information and the court held that she had committed adultery.[144]

The decision of *Lord Wheatly* in the above case was the subject of debate in the House of Lords in February 1958 as a result of which a departmental Committee expressed the view that a clear distinction has to be drawn between artificial insemination and adultery. It endorsed the view of the Royal Commission on Marriage and Divorce 1951-1955 that artificial insemination of the wife without the consent of her husband must be made new and separate ground of divorce or judicial separation.[145]

The object of an adulterous act is carnal pleasure and emotional and physical satisfaction. These are missing in artificial insemination which is resorted to for the purpose of begetting offspring. Whereas in artificial insemination the only purpose is procreation, in adultery it is sexual pleasure alone.

Similarly, the legitimacy of AI children is an issue that courts have grappled with ever since the years. In *Strnad* v. *Strnad*[146], the question of custody of AID child was considered by the NewYork Supreme Court. It was held that the husband had a right of visitation although, the child was not his offspring biologically. The Court observed:

> *The child has been potentially adopted or semi-adopted by the defendant. In any event, in so far, as this defendant is concerned and with particular reference to visitation, he is entitled to the same rights as those acquired by a foster parent who has formally adopted a child, if not the same rights as those to which a natural parent under the circumstances would be entitled .....In the opinion of this court .....this child is not an illegitimate child.*[147]

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[144] *Supranote* 141 at pg.288.

[145] *Supranote* 141 at pg. 289.

[146] 78 N.Y.S. 2d (1948).

[147] *Supranote* 141 at pg. 291.

In *Doornbas* v. *Doornbas,*[148] however, the court took a different view. It was held that AID was adultery and contrary to public policy and that the child born through this process was illegitimate. It further ruled that although the husband had consented to artificial donor insemination of his wife, yet he had no visitation rights to the child. The court said:

> *Heterogonous artificial insemination with or without the consent of the husband is contrary to public policy and good morals and constitute adultery on the part of the mother. A child so conceived is not a child born in wedlock and therefore, illegitimate. And as such it is the child of the mother and the father has no right or interest in said child.*[149]

In a later case, *Gursky* v. *Gursky*[150] again the New York Supreme Court found that a child born through AID is not a legitimate child of the husband. In this case, the wife, defendant in her husband's unsuccessful action for annulment, counterclaimed for an annulment of the marriage for impotency of her husband and for custody of and support of a child born through artificial insemination with semen from a third party donor. The husband had given his written consent for the insemination, nevertheless, the court when granting annulment refused to recognize the child as husband's legitimate child.[151]

Similarly, in *Anonymous* v. *Anonymous,*[152] a husband had consented to his wife's therapeutic impregnation. In a claim by the wife for alimony the husband asserted that such a child was illegitimate. The court refused to accept this argument and awarding alimony held that the written consent carried an implied promise to furnish support for the child if born.[153]

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[148] 1954 p.41.

[149] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 292-293 (1977).

[150] 39 Misc. zd 1083.

[151] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 292 (1977).

[152] 41 Misc. zd 886;246 N.Y.S. Zd 835 (Sup.Ct.1964).

[153] *Supranote* 151.

In *People* v. *Sorensen*[154] a divorced woman sued her former husband for non-support of their AID son. In this case, the defendant had consented, after fifteen years of marriage and a medical determination of his sterility, to allow his wife to be artificially inseminated. AID was administered and a child was born. For about four years prior to their separation the defendant represented that he was the child's father. The California Supreme Court held that the defendant was the lawful father of the child born to his former wife, that the child was conceived by artificial insemination to which the defendant had consented, and that his conduct carried with it an obligation to support.[155]

Another such burning issue is that of consummation in Artificial Insemination. In *R.E.L.* v. *E.L.*,[156] a wife whose husband was unable to consummate the marriage because of psychological infirmity was artificially inseminated with her husband's seed. This process spread over a period of twelve months. A few weeks after an insemination, the wife, unaware that she was pregnant left the husband. The child was subsequently born. The wife filed a suit for nullity of the marriage. The court held that the conduct of the wife in allowing herself to be artificially inseminated with her husband's seed and the conception of the child did not necessarily amount to an approbation of the marriage; nor was the court prevented on any ground of public policy from pronouncing a decree even though the result of that decree would be to bastardize the child. The court observed: "If the child should be made illegitimate it is most regrettable but the stigma of birth are of less effect that they were, and sons are not judged by the errors of their parents".[157]

The issue whether artificial insemination amounted to consummation or not was raised again in *Slater* v. *Slater*.[158] In this case, AID was resorted to but was unsuccessful and ultimately, a child was adopted. It was held that the attempted

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[154] 68 Cal zd 280 1973.

[155] *Supranote* 151.

[156] 1970 (1943) 2 All E.R. 540.

[157] Kusum "*Artificial Insemination and the Law*" 19:3 Journal of the Indian Law Institute 293(1977).

[158] (1953) Probate Division 235.

insemination could not constitute consummation and that the doctrine of approbation could not constitute consummation and that the doctrine of approbation could not be applied to defeat the wife's claim despite the insemination and adoption. However, it all depends on the circumstances of each case and nothing can be said categorically as to whether the act of artificial insemination – whether AID or AIH- would or would not amount to approbation of the marriage. By the very nature of the process of the device, in the absence of organic intercourse, it would be hard to believe that such a marriage is physically consummated, nevertheless, if such a marriage is easily liable to be annulled on the ground of non-consummation, then, the very purpose and object of the insemination would be defeated, viz, the purpose of relieving the parties of the frustration of not bearing a child and removing a principal cause of disharmony in the family.[159]

However, in India there is still no cases have come before the door of the judiciary. In case such issue comes before the judiciary than obviously, it will have to take the help of the above judgments for reference in the absence of any visible legislation.[160]

5.2.12 Landmark Judgments on Sterilisation Operation

The Supreme Court judgement in *Haryana* v. *Santra*[161] assumes special significance. A mother of seven, a labourer under the sterilization scheme has opted for sterilization operation launched by the Haryana government as one of the programmes for family planning. Despite the operation, a female child was born. The mother filed a suit for recovery of Rs 2 lakhs as damages for medical negligence. The Hon'ble court came to a finding that it was a clear case of medical negligence by a doctor of the government hospital where the woman had gone for sterilization operation. The doctor after having operated only on one fallopian tube gave her a certificate of complete and successful sterilization with no chance of pregnancy thereafter.[162]

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[159] *Supranote* 157 at pg. 293.

[160] Supranote 157 at pg. 293.

[161] 2000(3) SCALE 419.

[162] Kusum "*The Unwanted Baby: A Comment on Haryana v. Santra*" 42:1 Journal of Indian Law Institute 74 (2000).

According to the Trial court the medical officer who conducted the operation threw the care and caution to the winds and focused attention to perform as many operations as possible to build record and earn publicity. High Court has dismissed the case and the Supreme Court shown its concern on the alarming population growth where the population is increasing by the tick of every second on the clock. According to the court, the medical officers entrusted with the implementation of the family planning programme cannot by their neglect acts in performing complete sterilization operation, sabotage the scheme of national importance. The court remarked:

> *The people of the country who co-operate by offering themselves voluntarily for sterilization reasonably expect that after undergoing the operation they would be able to avoid further pregnancy and consequent birth of additional child.*[163]

After going through moral and statutory obligations of the parents to maintain their minor children, contained in the provision under section 125 of the Code of the Criminal Procedure, 1973 and section 20 of the Hindu Adoptions and Maintenance Act, 1956 the court assessed the amount of damages for the unwanted child at Rs 54,000 payable by the State Government on account of negligence by the doctor. This covered the expenses at the rate of Rs 3,000/ per annum, which the claimant would have to incur in bringing up the child till she attains puberty. Though, the statutory liability extends till the age of majority which is 18 years.[164]

This judgment being the first one delivered by the highest court needs to be viewed from various perspectives, specially public policy and demographic needs of the country. Should the birth of a normal healthy child, albeit- unwanted be a subject matter of the court litigation for grant of damages?

In the West, the courts seemed to be lost in ideological and moral issues. Some courts refused to allow such claims on ground of public policy, while in many others the claim was offset against the benefits derived from having a child and the pleasure in rearing up that child. In many others where sterilization was undergone on account of

[163] *Supranote* 162.

[164] *Supranote* 162 at pg. 75.

social and economic reasons, particularly, in a situation where the claimant already had several children, the court allowed the claim for rearing up that child. For eg, in *Shaheen* v. *Knight*[165] where a wife gave birth to a fifth child despite husband's vasectomy a claim for the additional expenses of supporting education and maintaining the said child until maturity was denied on grounds of public policy. However, in *Benarr* v. *Kettering Health Authority,*[166] the court went to the extent of awarding damages even to cover the private education of the child. In *Allen* v. *Bloomsbury Health Authority*[167], damages were awarded in a case involving negligence in termination of pregnancy. This covered general damages for pain and discomfort associated with the pregnancy and birth as also damages for economic loss being the financial expenses for the unwanted child in order to feed, cloths, care and educate the child till the age of majority. In *Allan* v. *Greater Glasgow Health Board*[168] policy consideration were rejected and cost of rearing the child was also awarded.[169]

The effect of such claims on a child's psychology was considered in a case from Canada in *Dolron* v. *Orr.*[170]The judge stated that he would have been prepared to award damages from mental anguish caused to the plaintiff but refused to accept that in such a case there could be liability for the cost of bringing up an unwanted child.

In a case from South Africa damages were awarded for the cost of maintaining the child where the woman had undergone sterilization operation because of financial conditions. The courts in New Zealand and Australia *in L* v. *M*[171] *and CES* versus *Superclinies Australia Pty. Ltd*[172] respectively refused to award expenses involved in rearing the child.[173]

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[165] C.ZD 41,45 (1957).

[166] (1988) 138 NL J 179.

[167] (1993) 1 All E.R. 651

[168] (1998) SLT 580

[169] *Supranote* 162 at pg. 75.

[170] 86 DLR 719

[171] (1979) 2 NZLR 519.

[172] (1995) 38 NSWLR 47.

[173] *Supranote*162 at pg. 74.

Thus, we see that there is no unanimity amongst the courts in the matter and naturally so for the social, cultural and economic conditions of each country vary. The Supreme Court very aptly pointed in Santra case.

More recently in 1997 in *State of M.P.* versus *Asharam*[174] the high court allowed damages for medical negligence in the performance of a family planning operation on account of which a daughter was born after 15 months of the operation.[175]

5.2.13 The Judicial Activism in the Surrogate Motherhood

Surrogate motherhood is one of the many old reproductive techniques that have enabled infertile couples to have children. A surrogate mother is a woman who agrees to be artificially inseminated generally with the sperm of a man whose own wife is incapable of fertilizing his wife's egg and/or where the wife is incapable of conceiving or carrying a child to term. A surrogate mother will enter into a formal contract relationship with the infertile couple to provide for her medical and living expenses in addition to a fee.

The surrogate motherhood becomes the burning issue when the news of Nirmala case was known. A 30 year old woman called Nirmala from Chandigarh intends to bear a child of an infertile couple for the sum of Rs 50,000 in order to pay for her invalid husband's medical bills.[176]

The New York Times[177] reported that a Michigan surrogate mother had refused to surrender the twins whom she bore for an Arkansas couple under a properly drawn and executed contract and the Michigan court, had, despite her breach of the contract, temporarily permitted her to retain custody but authorized the infertile couple to see the new born twice a week. The defense of the surrogate mother was coercion in having

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[174] 1997 Accident Claim Journal 1224.

[175] Kusum *"The Unwanted Baby: A Comment on Haryana v. Santra"* 42:1 The Journal of Indian Law Institute 77 (2000).

[176] Radhika Kollure Gitanjali Lakhotia *"Surrogacy: Legal and Social Issues"* 5 Law and Medicine 277 (1999).

[177] Sept 16, 1987.

succumbed to seven inseminations of the legal father's sperm, also she argued that the contract itself violated the Thirteenth Amendment, which outlaws slavery. The famed *Baby M*[178] *case* in 1987 in New Jersey, upholding the validity of the contract, prompted *New Jersey* Supreme Court opposing the practice of surrogate motherhood which was therein delineated of surrogate motherhood, which was therein delineated as promoting the exploitation of women and infertile couples and the dehumanization of babies. In short, it traffics for profit in human lives. In Isreal, according to 1987 regulations of Health Ministry precludes a woman from "renting out" under contract her uterus to carry a foetus and then handing it over to another couple; also a foetus produced by IVF may not be implanted in a relative of the donor.

The right of a married couple to engage in collaborative techniques such as surrogate parentage is constitutionally protected. The United State Supreme Court has repeatedly upheld the individual right to make personal decisions relating to procreation, conception and the rearing of children- free from governmental interference. This procreative liberty encompasses even the right of the surrogate mother to abort the child she is carrying for another. Procreative liberty includes the right of married couples to reproduce through noncoital sexual intercourse. In *Skinner* v. *Oklahoma*, the highest court recognized that procreation is one of the basic civil rights and the government cannot infringe thereupon, absent a most compelling interest. It would appear that all persons participating in the collaborative reproduction are also constitutionally protected especially where such parties are essential to the reproductive process.[179]

The United State Supreme Court in *Carry* v. *Population Service International Ltd.*[180] declared that where a decision as that whether to bear or beget a child is involved regulations imposing a burden on it may be justified only (a) by compelling State interest, and must be (b) narrowly drawn to express only those interest. It is submitted that a State law against baby selling in the surrogate relationship would not

[178] 525 A. 2d 1127 (1988).

[179] NLJ Nov &1987.

[180] 431 U.S. 678 (1977).

be compelling unless the constitutional right of privacy was also involved, as illustrated by the Michigan Court of Appeals holding in *Dae* v. *kellay.*[181]

A total ban on surrogate parenting would be unwise restraint on choices that childless couples and willing surrogates should be permitted to make. It is an unreasonable interference with personal autonomy.

5.3. Conclusion

The concept of reproductive health is gaining importance slowly but steadily motivating a shift from demographic to meeting the needs of individuals for access to reproductive services. In this environment, a new approach by the judiciary while dealing with such issues is the need of the hour. It is through the judiciary the gaps in legal framework have to be filled.

There are very few occasions where the issue of reproductive rights has been raised. However, there is a need to frame health care policies and rules in the light of the present challenges of reproductive rights .As there is no visible law on the issue, most of the cases has gone unregistered and therefore, there are very few case lying before the judiciary . The issue itself is very sensitive and thus requires wider perspective of the legal guardian i.e. - Court.

According to a global survey that looked at where mothers fare best and where they face the greater hardships. India is ranked a dismal 66th among 71 "less development countries"- slightly better than countries like Switzerland, Papua New Guinea and Nigeria.[182]

While China occupies the 15th position, Pakistan (69) is among the only five countries in that list, which is worse off than India. Bangladesh figures in a separate list

[181] 307 N.W.ZD 438 1981.

[182] October 22 Telegraph 2008.

that looks at maternal care in 34 "least developed countries" and ranks 13th while Nepal is 11th.

The State of the world's Mother report 2008 brought out by American humanitarian organization 'save the children', says that in India, one in 70 women face a lifetime risk of dying during childbirth. In comparison, it is one in 1300 women in China and one in 74 women in Pakistan.

The survey that documents condition for mothers in 146 countries – 41 developed nations and 105 in the developing world- also throws poor light on the number of institutional deliveries taking place in India and the level of female education. While the report found that over 53% of births in India are not attended by skilled health personal, only 43% Indian women were using modern contraceptives.

Shockingly the expected number of years for formal female schooling was 10 in the country compared to 17 in the United State and UK and 16 in Israel.

The report estimates that annually, 50 million women in developing countries give birth at home with no professional care and about 533,000 women die during childbirth.

When, mothers die their children are 3- 10 times more likely to die. Every year, four million new born babies die in the first month of life mostly from preventive causes. The majority of these deaths occur in settings where there is also a high rate of maternal mortality, the report says.[183]

Thus, when appearing before the judiciary in the trial court, the judges must have sympathetic attitudes towards women. The Indian women particularly, less privileges women look at judiciary in despair and suspension. It is the duty of the judges to assure such women fairness and justice.

[183] October 22 Telegraph 2008.

The Naz Foundation case is the expansion of the idea of privacy in India by the judiciary as it did in establishing the right of women to terminate their pregnancy in Roe v. Wade. This case emerged at a time when many feminists and women's rights activists were encouraging State legislature to liberalise their abortion laws. After success in the arena of legal reform, the next step was to shift the battle to the court. The main feature of cases like Wade is the use of the judiciary and innovative interpretations of the Constitution to settle a controversial area and establish rights for unpopular minorities or to establish a ruling against public morality as defined by the majority. Thus, Naz Foundation is rightly called as welcome arrival of the Roe v. Wade of India for new beginning.

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.

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ADDENDUM AND CORRIGENDUM

CLARIFICATION WITH REFERENCE TO POINTS MARKED AS 'A' & 'B'

A) Clarification with reference to point 'A'

1. ART Bill [THE ASSISTED REPRODUCTIVE TECHNOLOGIES (REGULATION) BILL – 2010]

At the out set attention is drawn to the fact that the above bill is dated 2010 and my theses was submitted in 2009 and as such the question of mentioning the Bill did not arise at that point of time. There was ART Bill 2008 also which I have mentioned in my thesis in page 15. I hereby submit ART Bill 2010 in Appendix 'A' in compliance with the requirement of addendum and corrigendum area marked as 'A'. A Critique of ART Bill 2010 is given below.

THE ASSISTED REPRODUCTIVE TECHNOLOGIES (REGULATION) BILL – 2010: A CRITIQUE

Although, ART Bill 2010 is a milestone in the area of reproductive rights but it has its drawback as well. The bill is to regulate the practice of surrogacy. This will make women vulnerable to exploitation in the name of money especially poor women are more likely to be exploited since they may be in need of money particularly in a country like India.

Firstly, it is stated that donor, at the time of donation and surrogate mother after delivery of the child, shall relinquish all parental rights (section 33(3)). It will raise many ethical and moral questions. Human being is an emotional being and relinquishing all the rights at once may affect the mother's and child psychology.

The bill allows individual and unmarried couples to avail of this route to have children. There is also a provision (section 20(10)) that conception by surrogacy shall not be considered by any clinic if it would normally be possible to carry a baby to term. The disparate impact is obvious; a woman desiring a child would thus have to show that she is not capable of bearing one. This is also issue of debate.

There is a restriction on ART clinics for providing any information about surrogate mothers or potential surrogate mother to any person (section 34(14). That means parties who are looking for

surrogate mothers thus, have to either advertise (permitted under section (34(7)) or approach middlemen. The parties seeking for surrogate mother would have benefit if they have reliable source of information regarding candidates as they are investing so much for it. They must have chance to select someone who they think fit to be surrogate. Moreover, the strict confidentiality requirements of section 34 (12) and section 34 (14) would made it difficult for the parties to access information even for verification purposes.

Similarly, the bill does not have provision to save the interest of gay couple. As they also want to have children but there is no provision in the bill for a gay couple to have a child.
Another, criticism of this bill is that section 2 (h) says "couple" means two persons living together and having a sexual relationship that is legal in India. The gender neutral terminology is used and the only requirement is legality of sexual relationship, so this will include same sex-couple within the definition of 'couple'. This will bring problem in future implementation of law as the status of couple is probably left to the judiciary to decide in future.

Similarly section 2 (v) defined "married couple" means two persons whose marriage is legal in the country/countries of which they are citizen. Again, gender neutral language, which means same sex married abroad can legally use ART but an unmarried couple can only be heterosexual. The status of civil union is perhaps left to the court to interpret in future.

There may arise several lacunas in the bill in future during implementation, like any foreign couple would be required to appoint a local guardian to be legally entrusted with the surrogate mother's welfare until the baby is handed over to them after delivery. They are also required to establish to the clinic through documents that they are able to take the child back with them (section 34 (19). In fact, several infirmities may arise in the arrangement including the absence of a legal contract between the parties. It is also a subject of worry that there is potential for exploitation of native surrogates.

With the enormous advances in medicine and medical technologies use of ART is not unknown. The bill detailed procedure for accredition and supervision of ART clinics within a recognized framework of ethics and good medical practice. However, the bill has some loopholes which

might create difficulties in future. Thus, it is suggested that bill must be passed amending all the probable lacunas that may knock in future.

2) Case index

The examiner has pointed out that the case index is missing however it is pointed out that the case index is in page 303 to 304 of my theses.

B) Clarification with reference to point 'B'.

1. Methodology

Regarding methodology, the examiner has suggested for empirical observation. I have adopted doctrinaire research and not empirical research, the reasons for adopting doctrinaire research is that the issue of reproductive right is very private and no one including women is willing to talk about it. The area is new and no statistics is available especially in the state of Sikkim where Medical Termination of Pregnancy Act,1961 is not even adopted by the State. The nature of the topic is such that it is impossible to get data on the subject-matter. So, it is not possible to adopt empirical method for research.

2. Subject Index:

A detailed index is given already in contents of thesis so it was thought that a subject –index is not needed. However, as an addendum a subject-index is submitted below:

SUBJECT INDEX

3. Hypothesis

My conclusion chapter runs from page No. 254 to 289 and hypothesis has been indicated in pages 256-266, 268,277 and 287 clearly and elaborately.

4 Research methodology

About remark on the legal research methodology it is submitted that the methodology has been properly followed. The research is library bound being doctrinaire research and studied theoretically using all the available research materials. Primary data and secondary data are used. Howsoever, Primary data is in the form of case laws.

5 Foot Note

I have used Harvard Blue Book Method. Instead for abbreviations I have used full name and in case of books name of the publisher is mentioned in bibliography.

APPENDIX – A

Draft

THE ASSISTED REPRODUCTIVE TECHNOLOGIES (REGULATION) BILL - 2010

MINISTRY OF HEALTH & FAMILY WELFARE
GOVT. OF INDIA, NEW DELHI

INDIAN COUNCIL OF MEDICAL RESEARCH
NEW DELHI

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THE
ASSISTED REPRODUCTIVE TECHNOLOGY
(REGULATION) BILL - 2010

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Contents

ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) BILL – 2010

PREAMBLE

It is estimated that 15 percent of couples around the world are infertile. This implies that infertility is one of the most highly prevalent medical problems. The magnitude of the infertility problem also has enormous social implications. Besides the fact that every couple has the right to have a child, in India infertility widely carries with it a social stigma. In the Indian social context specially, children are also a kind of old-age insurance.

With the enormous advances in medicine and medical technologies, today 85 percent of the cases of infertility can be taken care of through medicines, surgery and/or the new medical technologies such as *in vitro* fertilization (IVF) or intracytoplasmic sperm injection (ICSI). It may be recalled that the birth of the first child, Louise Brown in 1978, through the technique of in vitro fertilization by Robert G Edwards and Patrick Steptoe, was a path-breaking step in control of infertility; it is, in retrospect, considered as one of the most important medical advances of the last century.

Most of the new technologies aimed at taking care of infertility, involve handling of the gamete – spermatozoa or the ooctye – outside the body; they also often involve the donation of spermatozoa or oocyte, or the use of a surrogate mother who would be carrying a child with whom she has no biological relationship. These technologies not only require expertise but also open up many avenues for unethical practices which can affect adversely the recipient of the treatment, medically, socially and legally.

The last nearly 20 years have seen an exponential growth of infertility clinics that use techniques requiring handling of spermatozoa or the oocyte outside the body, or the use of a surrogate mother. As of today, anyone can open infertility or assisted reproductive technology (ART) clinic; no permission is required to do so. There has been, consequently a mushrooming of such clinics around the country.

In view of the above, in public interest, it has become important to regulate the functioning of such clinics to ensure that the services provided are ethical and that the medical, social and legal rights of all those concerned are protected.

The bill details procedures for accreditation and supervision of infertility clinics (and related organizations such as semen banks) handling spermatozoa or oocytes outside of the body, or dealing with gamete donors and surrogacy, ensuring that the legitimate rights of all concerned are protected, with maximum benefit to the infertile couples/individuals within a recognized framework of ethics and good medical practice.

STATEMENT OF OBJECTS AND REASONS

An act to provide for a national framework for the accreditations, regulation and supervision of assisted reproductive technology clinics, for prevention of misuse of assisted reproductive technology, for safe and ethical practice of assisted reproductive technology services and for matters connected therewith or incidental thereto.

BE IT ENACTED by the Parliament in the 60th year of the Republic of India as follows:

CHAPTER - I

PRELIMINARY

1. **Short title, extent and commencement –**

   (1) This Act may be called the Assisted Reproductive Technology (Regulation) Act, 2010

   (2) It applies, in the first instance, to the whole States of ..... and ..... and the Union Territories; and it shall apply to such other States which adopt this Act by resolution passed in that behalf under Clause (1) of Article 252 of the Constitution.

   (3) It shall come into force at once in the States of ..... and ..... and the Union Territories, on such dates as the Central Government may, by notification appoint, and in any other States which adopt this Act under Clause (1) of Article 252 of the Constitution, on the date of such adoption; and any reference in this Act to the commencement of this Act shall, in relation to any State or Union Territory, mean the date on which this Act comes into force in such a State or Union Territory.

2. **Definitions** — In this Act, and in any rules and regulations framed hereunder, unless the context otherwise requires –

   a. "ART bank", means an organisation that is set up to supply sperm / semen, oocytes / oocyte donors and surrogate mothers to assisted reproductive technology clinics or their patients;

   b. "artificial insemination", means the procedure of artificially transferring semen into the reproductive system of a woman and includes insemination with the husband's semen or with donor semen;

   c. "assisted reproductive technology" (ART), with its grammatical variations and cognate expressions, means all techniques that attempt to obtain a pregnancy by handling or manipulating the sperm or the

oocyte outside the human body, and transferring the gamete or the embryo into the reproductive tract;

d. "assisted reproductive technology clinic", means any premises used for procedures related to assisted reproductive technology;

e. "biological parent(s)", means genetic parent(s);

f. "child", means any individual born through the use of assisted reproductive technology;

g. "Commissioning parents/couples/individuals", means parents, couples or individuals, respectively, who approach an ART clinics or ART bank for providing a service that the ART Clinic or the ART bank is authorized to provide.

h. "couple", means two persons living together and having a sexual relationship that is legal in India;

i. "cryo-preservation", means the freezing and storing of gametes, zygotes and embryos;

j. "Department of Health Research", means Department of Health Research, Ministry of Health and Family Welfare, Government of India;

k. "donor", means the donor of a gamete or gametes but does not include the husband who provides the sperm or the wife who provides the oocyte to be used in the process of assisted reproduction for their own use;

l. "egg", means the female gamete (that is, oocyte)

m. "embryo", means the fertilized ovum that has begun cellular division and continued development up to eight weeks;

n. "fertilization", means the penetration of the ovum by the spermatozoon and fusion of genetic materials resulting in the development of a zygote;

o. "foetal reduction", means reduction in the number of foetuses in the case of multiple pregnancies;

p. "foetus", means the product of conception, starting from completion of embryonic development until birth or abortion;

q. "gamete", means sperm and oocyte (that is egg);

r. "gamete donor", means a person who provides sperm or oocyte with the objective of enabling an infertile couple or individual to have a child;

s. "Indian Council of Medical Research", means the Indian Council of Medical Research (ICMR) as registered under the Societies Registration Act, 1860;

t. "implantation", means the attachment and subsequent penetration by the zona-free blastocyst, which starts five to seven days following fertilization;

u. "infertility", means the inability to conceive after at least one year of unprotected coitus; or an anatomical / physiological condition that would prevent an individual from having a child;

v. "married couple", means two persons whose marriage is legal in the country / countries of which they are citizens;

w. "oocyte" and "ovum", mean, respectively, the female gamete (that is, egg) present in the ovary, and an ovulated oocyte in which the first polar body has been released;

x. "patient(s)", means an individual / couple who comes to an infertility clinic and is under treatment for infertility;

y. "Pre-implantation Genetic Diagnosis", includes the technique in which an embryo formed through in-vitro fertilisation is tested for specific disorders prior to the transfer;

z. "sperm", means the male gametes produced in the testicles and contained in semen;

aa. "surrogacy", means an arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong to her or her husband, with the intention to carry it and hand over the child to the person or persons for whom she is acting as a surrogate;

bb. "surrogate mother", means a woman who is a citizen of India and is resident in India, who agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to viability and deliver the child to the couple / individual that had asked for surrogacy;

cc. "surrogacy agreement", means a contract between the person(s) availing of assisted reproductive technology and the surrogate mother;

dd. "unmarried couple", means two persons, both of marriageable age, living together with mutual consent but without getting married, in a relationship that is legal in the country / countries of which they are citizens;

ee. "zygote", means the fertilized oocyte prior to the first cell division.

CHAPTER - II

CONSTITUTION OF AUTHORITIES TO REGULATE ASSISTED REPRODUCTIVE TECHNOLOGY

3. Establishment of National Advisory Board –

(1) With effect from such date as the Central Government may, by notification, appoint, there shall be established a Board to be known as the National Advisory Board for Assisted Reproductive Technology, hereafter referred to as the National Board, to exercise the jurisdiction and powers and discharge the functions and duties conferred or imposed on the Board by or under this Act.

(2) The National Board shall consist of such number of members, not exceeding twenty one, as may be prescribed by the Central Government and, unless the rules otherwise provide, the National Board shall consist of the following –

(a) Secretary, Department of Health Research, Government of India, who shall be the Chairman of the Board;

(b) A senior scientist having knowledge of assisted reproductive technology, from the Department of Health Research or the Indian Council of Medical Research, who shall be the Member-Secretary of the Board;

(c) A representative, not below the rank of Joint Secretary, from the Ministry of Health and Family Welfare;

(d) The nominee of an Indian professional society concerned primarily with assisted reproduction;

(e) Up to sixteen other experts – of whom one each shall be a nominee of the Ministry of Health and Family Welfare and Indian Council of Medical Research, and at least six of whom shall be women – in the fields of assisted reproduction, gynaecology, embryology, andrology, bioethics, mammalian reproduction, medical genetics, social science, law, or human rights, to be nominated by the Central Government.

(3) The Chairman of National Board shall nominate a Vice Chairman from among its members.

4. Meetings of National Advisory Board –

(1) The National Board shall meet as and when necessary, not less than two times a year, and at such time and place in the country as the Chairperson of the National Board may think fit.

(2) The Chairperson of the National Board shall preside over the meetings of the National Board.

(3) If, for any reason, the Chairperson of the National Board is unable to attend any meeting of the National Board, the Vice-Chairperson of the National Board shall preside over the meeting.

5. Functions of National Advisory Board –

(1) The National Board may recommend modification from time to time in the attached rules and schedules where relevant in regard to the following, and perform any other functions and tasks assigned to it by the Central Government:

(a) minimum requirements related to staff and physical infrastructure for the various categories of assisted reproductive technology clinics;

(b) regulations in respect of permissible assisted reproductive technology procedures;

(c) regulations in respect of selection of patients for assisted reproductive technology procedures;

(d) encouragement and promotion of training and research in the field of assisted reproduction;

(e) encouragement of the establishment and maintenance of a national database in respect of infertility;

(f) guidelines for counselling and providing patients with all necessary information and advice on various aspects of assisted reproductive technology procedures;

(g) ways and means of disseminating information related to infertility and assisted reproductive technologies to various sections of the society;

(h) regulations in respect of research on human embryos;

(i) proformae for obtaining information from donors of gametes and surrogate mothers, consent forms for various procedures, and contracts and / or agreements between the various parties involved, in all of the languages listed in the Eighth Schedule of the Constitution;

(j) policies from time to time on assisted reproduction;

6. Establishment of State Boards –

(1) Every State Government shall, within 180 days of the issue of the notification under sub-section (1) of section 3, by notification in the Official Gazette, establish a State Board for Assisted Reproductive Technology to exercise the jurisdiction and powers and discharge the functions and duties conferred or imposed on the State Boards by or under this Act.

(2) The State Boards shall consist of such number of members, not exceeding twelve, as may be prescribed by the State Government and, unless the rules otherwise provide, the State Boards shall consist of the following members, namely –

(a) The Secretary of the Department of Health and Family Welfare, who shall be Chairperson, *ex officio;*

(b) The nominee of an Indian professional society concerned primarily with assisted reproduction who shall be the Vice Chairperson, ex officio;

(c) An officer not below the rank of a Joint Secretary, who shall be the Member-Secretary of the Board;

(d) Up to nine other members – of whom at least four shall be women – who shall be experts in the fields of assisted reproduction, gynaecology, embryology, andrology, bioethics, mammalian reproduction, medical genetics, social science, law, or human rights, to be nominated by the State Government.

(3) The Chairman of the State Board shall nominate a Vice Chairman from among its members.

7. Meetings of State Boards –

(1) The State Board shall meet as and when necessary, but not less than three times a year, and at such time and place as the Chairperson of the State Board may think fit.

(2) The Chairperson of the State Board shall preside over the meetings of the State Board.

(3) If for any reason the Chairperson of the State Board is unable to attend any meeting of the State Board, the Vice Chairperson of the State Board shall preside over the meeting.

8. Powers and functions of State Boards –

(1) Subject to the provisions of this Act and the rules and regulations adopted thereunder, the State Board shall have the responsibility for

laying down the policies and plans for assisted reproduction in the State.

(2) Without prejudice to the generality of the provisions contained in sub-section (1) of this section, the State Board, taking into account the recommendations, policies and regulations of the National Board, may –

(a) advise the State Government to constitute a Registration Authority or Authorities as required, at least of six experts in assisted reproduction technology or a related field, for the use of assisted reproductive technology in the State;

(b) monitor the functioning of the Registration Authority subject, in particular, to the guidelines laid down by the National Advisory Board;

(c) coordinate the enforcement and implementation of the policies and guidelines for assisted reproduction;

(d) constitute advisory committees consisting of experts in the field of assisted reproduction and related fields at the State or district level, to make recommendations on different aspects of assisted reproduction;

(e) perform such other functions prescribed under this Act;

(3) Notwithstanding anything contained in section 12 of this Act, the State Board may, *suo moto*, whether on the basis of a complaint or otherwise, examine and review any decision of the Registration Authority.

(4) In the exercise of its functions under this Act, the State Board shall give such directions or pass such orders as are necessary, with reasons to be recorded in writing.

9. Term of office, conditions of service, etc., of Chairperson and other members of State Boards –

(1) Before appointing any person as the Chairperson or other member, the appropriate Government shall satisfy itself that the person's integrity is such that his / her professional interest shall not affect prejudicially his functions as such member.

(2) The Chairperson and every other Member shall hold office for such period, not exceeding five years, as may be specified by the appropriate government in the order of his appointment, but shall be eligible for re-appointment.

(3) Notwithstanding anything contained in sub-section (1) of this section, a member may by writing under his / her hand and addressed to the appropriate Government resign his / her office at any time;

(4) A vacancy caused by the resignation or removal of the Chairperson or any other member shall be filled by fresh appointment.

(5) In the event of the occurrence of a vacancy in the office of the Chairperson by reason of his / her death, resignation or otherwise, such one of the members as the appropriate Government may, by notification, authorise in this behalf, shall act as the Chairperson till the date on which a new Chairperson, appointed in accordance with the provisions of this Act to fill such vacancy, takes charge of the office.

(6) When the Chairperson is unable to discharge his / her functions owing to absence, illness or any other cause, the Vice Chairperson shall discharge the function of the Chairpersons, till the date on which the Chairperson resumes his duties.

(7) The salaries and allowances payable to and the other terms and conditions of service of the Chairperson and other members shall be such as may be prescribed: provided that neither the salary and allowances nor the other terms and conditions of service of the Chairperson or any other member shall be varied to his disadvantage after his appointment.

(8) The Chairperson and every other member shall, before entering upon his / her office make a declaration of fidelity and secrecy in the form set out in the Schedule.

(9) The Chairperson ceasing to hold office as such shall not hold any appointment or be connected with the management or administration in any company, hospital, clinic, society, trust or other undertaking in relation to which any matter has been the subject matter of consideration before the State Board, for a period of three years from the date on which he ceases to hold such office.

10. Procedure of State Boards –

(1) Subject to the provisions of this Act, the State Board shall have powers to –

(a) regulate the procedure and conduct of the business;

(b) delegate its powers or functions to such persons or authorities as prescribed in the rules or regulations made under this Act.

(2) The State Boards shall, for the purposes of any inquiry or for any other purpose under this Act, have the powers to –

(a) summon and enforce the attendance of any witness and examine him / her on oath;

(b) order the discovery and production of document or other material objects producible as evidence;

(c) receive evidence on affidavit;

(d) requisition any public record from any court or office;

(e) issue any order for the examination of witnesses;

(f) any other matter which may be prescribed.

11. Constitution and functions of the Registration Authority –

(1) The State Government shall constitute the Registration Authority as per the advise of the State Board, within a period of three months of the advise.

(2) The Registration Authority shall have a full-time Chairman of the level of a Secretary to the State Government, who shall be a recognised expert in assisted reproductive technology or a related field.

(3) The other members of the Registration Authority shall be part-time members, and shall be adequately compensated for their services.

(4) Before appointing any member of the Registration Authority, the Government shall satisfy itself that his / her integrity is such that his / her professional interest shall not affect prejudicially his / her functions as a member.

(5) The Registration Authority shall be provided by the State Government with adequate supporting staff and secretarial assistance, and suitable accommodation.

(6) The Registration Authority shall issue an appropriate letter granting or rejecting registration to an assisted reproductive technology clinic.

12. Proceedings before State Boards to be judicial proceedings –

(1) Every State Board shall be deemed to be a civil court and when any offence as is described in this Act is committed in the view or presence of the State Board, the State Board may, after recording the facts constituting the offence and the statement of the accused as provided for in the Code of Criminal Procedure, 1973, forward the case to a Magistrate having jurisdiction to try the same, and the Magistrate to whom any such case is forwarded shall proceed to hear the complaint against the accused as if the case has been forwarded to him under section 346 of the Code of Criminal Procedure, 1973.

(2) Every proceeding before a State Board shall be deemed to be a judicial proceeding within the meaning of sections 193 and 228, and for the purposes of section 196 of the Indian Penal Code, and the Board shall be deemed to be a civil court for all the purposes of section 195 and Chapter XXVI of the Code of Criminal Procedure, 1973.

CHAPTER - III

PROCEDURES FOR REGISTRATIONS AND COMPLAINTS

13. Registration and accreditation of clinics –

(1) All assisted reproductive technology clinics shall, within such period and in such form and manner as may be prescribed, register themselves with the Registration Authority.

(2) An application for registration by an assisted reproductive technology clinic under sub-section (1) of this section shall contain the particulars of the applicant including all details of techniques and procedures of assisted reproductive technology practiced at such clinic.

(3) The State Board may, subject to such terms and conditions as may be prescribed, register any assisted reproductive technology clinic on the basis of the techniques and procedures of assisted reproductive technology practiced at such clinic, such as –

(a) infertility treatment, including Intra-Uterine Insemination (IUI), Artificial Insemination with Husband's semen (AIH), and Artificial Insemination using Donor Semen (AID), involving the use of donated or collected gametes;

(b) infertility treatment involving the use and creation of embryos outside the human body;

(c) processing or storage of embryos;

(d) research.

(4) Notwithstanding anything contained in this Act or any of the Rules made thereunder, no assisted reproductive technology clinic performing any of the functions under sub-section (3) of this section, or any other advanced diagnostic, therapeutic or research functions, shall practice any aspect of such diagnosis, therapy or research without a certificate of accreditation issued by the State Board.

(5) The practice of any aspect of assisted reproductive technology in contravention of the provisions of this section shall constitute an offence under this Act.

(6) Assisted reproductive technology clinics registered under this Act shall be deemed to have satisfied the provisions of the PC & PNDT Act, 1994 [amended in 2002], and shall not be required to seek a separate registration under the said Act.

14. Who may apply for registration –

(1) Assisted reproductive technology clinics, ART banks and research organizations using human embryos, operative on the date of notification of this Act, shall obtain a temporary registration within six months of the notification of the State Registration Authority by the State Board, and regular registration within 18 months of the above notification. If an assisted reproductive technology clinic that has applied for temporary registration under this clause to the State Registration Authority does not receive the registration or hear from the above Authority within 60 days of the receipt of the application by the Authority, the clinic would be deemed to have received the temporary registration.

(2) No assisted reproductive technology clinic, ART bank or research organisation using human embryos, other than the ones specified above, shall practice any aspect of assisted reproductive technology, or carry out any research on or using human embryos, or use any premises for such purposes, without a registration under this Act.

(3) Any assisted reproductive technology clinic or ART bank or research organisation using human embryos, by whatsoever name called, may apply to the Registration Authority for registration to operate the clinic, ART bank or research organisation in accordance with the procedure and criteria laid down in this Act.

(4) Every application under sub-section (2) of this section shall be in such form and shall be accompanied by such fee and such documents as may be prescribed by the State Government.

15. Grant of registration –

(1) The Registration Authority may, if it is satisfied that the criteria specified in the Rules have been met, grant registration to the applicant for a term of three years under such terms and conditions as it thinks fit.

(2) The Registration Authority shall, within one month of a registration being granted under this section, report such registration to the State Board.

(3) The State Board shall maintain a record of all registrations applied for and granted under this section.

(4) No registration shall be granted unless the Registration Authority, or such authorised person or persons acting on its behalf, have inspected the premises of the applicant.

16. **Renewal, suspension or revocation of registration –**

(1) The Registration Authority may, on an application made to it in such form and manner as may be prescribed, renew a registration granted under the provisions of this Act with effect from the date of its expiry if it is satisfied that the criteria prescribed in the Schedule continue to be met.

(2) The Registration Authority may at any time suspend the operation of a registration and call upon the holder of the registration to produce such documents or furnish such evidence as may be required if it has reasonable grounds to believe that the terms and conditions of the registration have not been met.

(3) When acting under sub-section (2) of this section, the Registration Authority shall either revoke the registration or continue the registration, as the case may be, after giving the holder of the registration adequate opportunity to be heard.

(4) The Registration Authority shall inform the concerned State Board of every assisted reproductive technology clinic in respect of which it has granted, renewed, revoked or denied a registration under this Act within one month of such an action being taken.

(5) The Registration Authority shall be deemed to have granted renewal for three years to the applicant if the applicant does not receive a definitive communication from the Registration Authority regarding the renewal application within sixty days of the receipt of the application in the office of the Registration Authority.

17. **Registration Authority to inspect premises** – In the exercise of its powers under this Act, the Registration Authority shall have the power to inspect, with or without prior notice on a working day during working hours, any premises or call for any document or material in the discharge of its powers and functions.

18. **Applicability to ART banks and research organisations** – The provisions of sections 13 to 16, as relevant, shall apply also to ART banks and research organisations using human embryos.

19. **Appeal to the State Board –**

(1) Any person aggrieved by the decision of the Registration Authority made under this Act may, within such period and in such manner and form as may be prescribed, prefer an appeal to the State Board.

(2) On receipt of an appeal under sub-section (1) of this section, the State Board may, after giving an opportunity to the appellant to be heard, and after making such further inquiry as it thinks fit, confirm, modify or set aside the decision of the Registration Authority, within three months of the receipt of the appeal.

CHAPTER - IV

DUTIES OF AN ASSISTED REPRODUCTIVE TECHNOLOGY CLINIC

20. General duties of assisted reproductive technology clinics –

(1) Assisted reproductive technology clinics shall ensure that patients, donors of gametes and surrogate mothers are eligible to avail of assisted reproductive technology procedures under the criteria prescribed by the rules under this Act and that they have been medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed and all other communicable diseases which may endanger the health of the parents, or any one of them, surrogate or child.

(2) It shall be the responsibility of an assisted reproductive technology clinic to obtain, from ART bank(s), all relevant information, other than the name, personal identity and address, of possible gamete donors, and assist the couple or individual desirous of the donation, to choose the donor.

(3) When an ART bank receives a request from an assisted reproductive technology clinic for a donor oocyte, a responsible member of the staff of the ART bank will accompany the particular donor to the assisted reproductive technology clinic, and obtain a written agreement from the authority designated for this purpose by the clinic, that the clinic shall, under no circumstances (except when asked by a court of law), reveal the identity of the donor to the recipient couple or individual or to anyone else; the clinic shall also ensure that all its staff is made aware of the fact that any step leading to disclosure of the identify (i.e., name and address) to the recipient couple or individual or to anyone else, shall amount to an offence punishable under this Act.

(4) Either of the parties seeking assisted reproductive technology treatment or procedures shall be entitled to specific information in respect of donor of gametes including, but not restricted to, height, weight, ethnicity, skin colour, educational qualifications, medical history of the donor, provided that the identity, name and address of the donor is not made known.

(5) Assisted reproductive technology clinics shall obtain donor gametes from ART banks that have ensured that the donor has been medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed and all other communicable diseases which may endanger the health of the parents, or any one of them, surrogate or child.

(6) Assisted reproductive technology clinics shall provide professional counselling to patients or individuals about all the implications and chances of success of assisted reproductive technology procedures in the clinic and in India and internationally, and shall also inform patients

and individuals of the advantages, disadvantages and cost of the procedures, their medical side effects, risks including the risk of multiple pregnancy, the possibility of adoption, and any such other matter as may help the couple or individual arrive at a decision that would be most likely to be the best for the couple or individual.

(7) Assisted reproductive technology clinics shall make couples or individuals, as the case may be, aware of the rights of a child born through the use of assisted reproductive technology.

(8) Assisted reproductive technology clinics shall explain to couples or individuals, as the case may be, the choice or choices of treatment available to them and the reason or reasons of the clinic for recommending a particular treatment, and shall clearly explain the advantages, disadvantages, limitations and cost of any recommended or explained treatment or procedure.

(9) Assisted reproductive technology clinics shall ensure that information about clients, donors and surrogate mothers is kept confidential and that information about assisted reproductive technology treatment shall not be disclosed to anyone other than a central database to be maintained by the Department of Health Research, except with the consent of the person or persons to whom the information relates, or in a medical emergency at the request of the person or persons or the closest available relative of such person or persons to whom the information relates, or by an order of a court of competent jurisdiction.

(10) No assisted reproductive technology clinic shall consider conception by surrogacy for patients for whom it would normally be possible to carry a baby to term. Provided that where it is determined that unsafe or undesirable medical implications of such conception may arise, the use of surrogacy may be permitted.

(11) Assisted reproductive technology clinics shall provide to couples or individuals, as the case may be, a pre-stamped self-addressed envelop to inform the clinic of the results of the assisted reproductive technology procedure performed for the couple or the individual.

(12) No assisted reproductive technology clinic shall obtain or use sperm or oocyte donated by a relative or known friend of either of the parties seeking assisted reproductive technology treatment or procedures.

(13) Every assisted reproductive technology clinic shall establish a mechanism to look into complaints in such manner as may be prescribed.

(14) No assisted reproductive technology procedure shall be performed on a woman below 21 years of age, and any contravention of this stipulation shall amount to an offence punishable under this Act.

(15) All assisted reproductive technology clinics shall issue to the infertile couple / individual a discharge certificate stating details of the assisted reproductive technology procedure(s) performed on the couple / individual.

(16) Only a registered ART bank (and no other organization) shall be authorised to advertise for, procure or provide semen, oocyte donor or surrogate mother.

21. Duty of the assisted reproductive technology clinic to obtain written consent –

(1) No assisted reproductive technology clinic shall perform any treatment or procedure of assisted reproductive technology without the consent in writing of all the parties seeking assisted reproductive technology to all possible stages of such treatment or procedures including the freezing of embryos.

(2) No assisted reproductive technology clinic shall freeze any human embryos without specific instructions and consent in writing from all the parties seeking assisted reproductive technology in respect of what should be done with the gametes or embryos in case of death or incapacity of any of the parties.

(3) No assisted reproductive technology clinic shall use any human reproductive material to create an embryo or use an in vitro embryo for any purpose without the specific consent in writing of all the parties to whom the assisted reproductive technology relates.

(4) The consent of any of the parties obtained under this section may be withdrawn at any time before the embryos or the gametes are transferred to the concerned woman's uterus.

22. Duty of the assisted reproductive technology clinic to keep accurate records –

(1) All assisted reproductive technology clinics shall maintain detailed records, in such manner as may be prescribed, of all donor oocytes, sperm or embryos used, the manner and technique of their use, and the individual or couple or surrogate mother, in respect of whom it was used.

(2) All assisted reproductive technology clinics will, as and when such central facilities are established, put on line all information available to them in regard to progress of the patient (such as biochemical and clinical pregnancy) within seven days of the information being available, withholding the identity of the patient.

(3) Records maintained under sub-section (1) of this section shall be maintained for at least a period of ten years, upon the expiry of which

the assisted reproductive technology clinic shall transfer the records to a central database of a, national ART registry to be set up by the Department of Health Research at the Hqrs of the ICMR.

(4) In the event of the closure of any assisted reproductive technology before the expiry of the period of ten years under sub-section (2) of this section, the assisted reproductive technology clinic or ART bank shall immediately transfer the records to a central database of a, national ART registry to be set up by the Department of Health Research at the Hqrs of the ICMR

23. Duties of assisted reproductive technology clinics using gametes and embryos –

(1) Assisted reproductive technology clinics shall harvest oocytes in accordance with such regulations of the National Board or concerned State Board or any rule as may be prescribed under this Act.

(2) The number of oocytes or embryos that may be placed in a woman in any one cycle shall be according to the rules and regulations provided under this Act.

(3) No woman should be treated with gametes or embryos derived from the gametes of more than one man or woman during any one treatment cycle.

(4) An assisted reproductive technology clinic shall never mix semen from two individuals before use.

(5) Where a multiple pregnancy occurs as a result of assisted reproductive technology, the concerned assisted reproductive technology clinic shall inform the patient immediately of the multiple pregnancy and its medical implications and may carry out foetal reduction after appropriate counselling.

(6) The collection of gametes from a person whose death is imminent shall only be permissible if such person's spouse intends to avail assisted reproductive technology to have a child.

(7) No assisted reproductive technology clinic shall use ova that are derived from a foetus, in any process of in vitro fertilisation.

(8) No assisted reproductive technology clinic shall utilise any semen, whether from an ART bank or otherwise, for any aspect of assisted reproductive technology unless such semen is medically analysed in such manner as may be prescribed.

(9) Any contravention of stipulation under sub-section 3, 4, 7 and 8 of this section shall amount to an offence under this Act.

24. Pre-implantation Genetic Diagnosis –

(1) Pre-implantation Genetic Diagnosis shall be used only to screen the embryo for known, pre-existing, heritable or genetic diseases or as specified by the Registration Authority.

(2) Destruction or donation (with the approval of the patient) to an approved research laboratory for research purposes, of an embryo after Pre-implantation Genetic Diagnosis, shall be done only when the embryo suffers from pre-existing, heritable, life-threatening or genetic diseases

(3) The State Board may lay down such other conditions as it deems fit in the interests of Pre-implantation Genetic Diagnosis.

25. Sex selection –

(1) No assisted reproductive technology clinic shall offer to provide a couple with a child of a pre-determined sex.

(2) It shall be a criminal offence and it is prohibited for anyone to do any act, at any stage, to determine the sex of the child to be born through the process of assisted reproductive technology.

(3) No person shall knowingly provide, prescribe or administer any thing that would ensure or increase the probability that an embryo shall be of a particular sex, or that would identify the sex of an in vitro embryo, except to diagnose, prevent or treat a sex-linked disorder or disease.

(4) No assisted reproductive technology clinic will carry out any assisted reproductive technology procedure to separate, or yield fractions enriched in sperm of X or Y variations.

(5) Any contravention of stipulation under sub-section 1, 2, 3 and 4 of this section shall amount to an offence under this Act.

CHAPTER - V

SOURCING, STORAGE, HANDLING AND RECORD KEEPING FOR GAMETES, EMBRYOS AND SURROGATES

26. Sourcing of gametes –

(1) The screening of gamete donors and surrogates; the collection, screening and storage of semen; and provision of oocyte donor and surrogates, shall be done by an ART bank registered as an independent entity under the provisions of this Act.

(2) An ART bank shall operate independently of any assisted reproductive technology clinic.

(3) ART banks shall obtain semen from males between twenty one years of age and forty five years of age, both inclusive, and arrange to obtain oocytes from females between twenty one years of age and thirty five years of age, both inclusive, and examine the donors for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the parents, or any one of them, surrogate or child.

(4) All ART banks shall have standard, scientifically established facilities and defined standard operating procedures for all its scientific and technical activities.

(5) All ART banks shall cryo-preserve sperm donations for a quarantine period of at least six months before being used and, at the expiry of such period, the ART bank shall not supply the sperm to any assisted reproductive technology clinic unless the sperm donor is tested for such diseases, sexually transmitted or otherwise, as may be prescribed.

(6) An ART bank may advertise for gamete donors and surrogates, who may be compensated financially by the bank.

(7) An ART bank shall not supply the sperm of a single donor for use more than seventy five times.

(8) No woman shall donate oocytes more than six times in her life, with not less than a three-month interval between the oocyte pick-ups.

(9) Eggs from one donor can be shared between two recipients only, provided that at least seven oocytes are available for each recipient.

(10) All unused oocytes would be either appropriately preserved by the assisted reproductive technology clinic for use on the same recipient(s), or given for research to a bonafide organisation.

(11) One sample of semen supplied by an ART bank shall be used by the assisted reproductive technology clinic only once on only one recipient.

(12) An ART bank shall obtain all necessary information in respect of a sperm or oocyte donor or a surrogate, including the name, identity and address of such donor or surrogate, in such manner as may be prescribed, and shall undertake in writing to the donor to keep such information confidential.

(13) No ART bank shall divulge the name, identity or address of any sperm or oocyte donor to any person or assisted reproductive technology clinic except in pursuance of an order or decree of a court of competent jurisdiction.

(14) Any person or ART bank who divulges the name, identity or address of a sperm donor in contravention of subsections 11 and 12 of this section shall be guilty of an offence under this Act.

(15) An ART bank may, for such appropriate fee as may be prescribed, store any semen obtained from a donor for the exclusive use of the wife or partner of the donor.

27. Storage and handling of gametes and embryos –

(1) The highest possible standards should be followed in the storage and handling of gametes and embryos in respect of their security, and with regard to their recording and identification.

(2) No donor gamete shall be stored for a period of more than five years.

(3) An embryo may, for such appropriate fee as may be prescribed, be stored for a maximum period of five years and at the end of such period such embryo shall be allowed to perish or donated to an approved research organization for research purposes with the consent of the patients. If during the period of five years, one of the commissioning partners dies, the surviving partner can use the embryo for herself or for her partner, provided an appropriate consent was taken earlier.

Provided that where the persons to whom such embryo relates fails to pay the fee, or both the commissioning persons die, the assisted reproductive technology clinic may, subject to such regulations as may be prescribed, destroy the embryo or transfer the embryo to any accredited research organisation under section 18 of this Act.

28. Records to be maintained by the ART bank –

(1) The ART bank shall keep a record of all the gametes received, stored and supplied, and details of the use of the gametes of each donor.

(2) The records shall be maintained for at least ten years, after which the records shall be transferred to a central database of the Department of Health Research, Government of India.

(3) Where an ART bank closes before the expiry of the ten year period, the records shall be immediately transferred to the central database of the Department of Health Research, Government of India.

(4) If not otherwise ordered by a court of competent jurisdiction, all ART banks shall ensure that all information about clients and donors is kept confidential and that information about gamete donation shall not be disclosed to anyone other than the central database of the Department of Health Research.

29. Restriction on sale of gametes, zygotes and embryos –

(1) The sale, transfer or use of gametes, zygotes and embryos, or any part thereof or information related thereto, directly or indirectly to any party outside India is prohibited and shall be deemed to be an offence under this Act except in the case of transfer of own gametes and embryos for personal use with the permission of the National Board.

(2) The sale of gametes, except for use by an assisted reproductive technology clinic for treating infertility, and the sale of zygotes and embryos, or of any information related to gametes, zygotes or embryos, within India, is prohibited and shall be deemed to be an offence under this Act.

CHAPTER - VI

REGULATION OF RESEARCH ON EMBRYOS

30. Permission of the Department of Health Research for research –

(1) The sale of any gametes and embryos or their transfer to any country outside India, for research is absolutely prohibited and shall constitute a criminal offence under this Act.

(2) Research shall only be conducted on such gametes and embryos that have been donated for such purpose.

(3) No research shall be conducted using embryos except with the permission of the Department of Health Research.

(4) Any person or organisation, by whatsoever name called, may apply to the Department of Health Research for registration as a research institution permitted to conduct research on embryos.

(5) While granting permission on an application for registration made under sub-section 4 of this section, the Department of Health Research may prescribe, and the applicant shall be bound by such terms and conditions as it thinks fit.

(6) The Department of Health Research may, if it has reasonable grounds to believe that any of the terms and conditions prescribed under sub-section 5 of this section have not been met, –

(a) call for the production of such documents or the furnishing of such evidence as may be required;

(b) inspect, or order any officer authorised in this behalf to inspect, any premises related to the grant of registration;

(c) suspend the registration of the research institution, after giving all concerned parties adequate opportunity to be heard.

(7) The Department of Health Research may make such regulations as it thinks fit to provide for research on embryos.

(8) Any act or thing done or omitted to be done in contravention of the provisions of this Chapter shall be deemed to be an offence under this Act.

31. Regulation of research –

(1) In exercising its powers under this Chapter, the Department of Health Research shall ensure that –

(a) no research is conducted on any human embryo unless such research is necessary in public interest;

(b) no research is conducted on any human embryo created *in vitro* unless such research is necessary in public interest to acquire further scientific knowledge;

(c) no research is conducted on any human embryo, other than embryos given for storage to an ART bank under sub-section (3) of section 27, unless full and informed consent in writing is obtained from the persons from whom such embryo was created;

(d) no advertisement is issued, and no purchase, sale or transfer is made, of any human embryo created *in vitro* or any part thereof, except in accordance with this Act;

(e) no human embryo *created in vitro* is maintained for a period exceeding fourteen days or such other period as recommended by the National Advisory Board;

(f) no work is done leading to human reproductive cloning;

(g) such other terms and conditions that may be prescribed by the ICMR, are adhered to.

(2) Any assisted reproductive technology clinic or other research institution or person conducting any research in contravention of the provisions of this Act or any rules or regulations prescribed hereunder shall be an offence under this Act.

CHAPTER - VII

RIGHTS AND DUTIES OF PATIENTS, DONORS, SURROGATES AND CHILDREN

32. Rights and duties of patients –

(1) Subject to the provisions of this Act and the rules and regulations made thereunder, assisted reproductive technology shall be available to all persons including single persons, married couples and unmarried couples.

(2) In case assisted reproductive technology is used by a married or unmarried couple, there must be informed consent from both the parties.

(3) The parents of a minor child have the right to access information about the donor, other than the name, identity or address of the donor, or the surrogate mother, when and to the extent necessary for the welfare of the child.

(4) All information about the patients shall be kept confidential and information about assisted reproductive technology procedures done on them shall not be disclosed to anyone other than the central depository of the Department of Health Research, except with the consent of the person or persons to whom the information relates, or by a court order.

33. Rights and duties of donors –

(1) Subject to the other provisions of this Act, all information about the donors shall be kept confidential and information about gamete donation shall not be disclosed to anyone other than the central database of the Department of Health Research, except with the consent of the person or persons to whom the information relates, or by an order of a court of competent jurisdiction.

(2) Subject to the other provisions of this Act, the donor shall have the right to decide what information may be passed on and to whom, except in the case of an order of a court of competent jurisdiction.

(3) A donor shall relinquish all parental rights over the child which may be conceived from his or her gamete.

(4) No assisted reproductive technology procedure shall be conducted on or in relation to any gamete of a donor under this Act unless such donor has obtained the consent in writing of his or her spouse, if there, to such procedure.

(5) The identity of the recipient shall not be made known to the donor.

34. Rights and duties in relation to surrogacy –

(1) Both the couple or individual seeking surrogacy through the use of assisted reproductive technology, and the surrogate mother, shall enter into a surrogacy agreement which shall be legally enforceable.

(2) All expenses, including those related to insurance if available, of the surrogate related to a pregnancy achieved in furtherance of assisted reproductive technology shall, during the period of pregnancy and after delivery as per medical advice, and till the child is ready to be delivered as per medical advice, to the biological parent or parents, shall be borne by the couple or individual seeking surrogacy.

(3) Notwithstanding anything contained in sub-section (2) of this section and subject to the surrogacy agreement, the surrogate mother may also receive monetary compensation from the couple or individual, as the case may be, for agreeing to act as such surrogate.

(4) A surrogate mother shall relinquish all parental rights over the child.

(5) No woman less than twenty one years of age and over thirty five years of age shall be eligible to act as a surrogate mother under this Act.

Provided that no woman shall act as a surrogate for more than five successful live births in her life, including her own children.

(6) Any woman seeking or agreeing to act as a surrogate mother shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and must declare in writing that she has not received a blood transfusion or a blood product in the last six months.

(7) Individuals or couples may obtain the service of a surrogate through an ART bank, which may advertise to seek surrogacy provided that no such advertisement shall contain any details relating to the caste, ethnic identity or descent of any of the parties involved in such surrogacy. No assisted reproductive technology clinic shall advertise to seek surrogacy for its clients.

(8) A surrogate mother shall, in respect of all medical treatments or procedures in relation to the concerned child, register at the hospital or such medical facility in her own name, clearly declare herself to be a surrogate mother, and provide the name or names and addresses of the person or persons, as the case may be, for whom she is acting as a surrogate, along with a copy of the certificate mentioned in clause 17 below.

(9) If the first embryo transfer has failed in a surrogate mother, she may, if she wishes, decide to accept on mutually agreed financial terms, at

most two more successful embryo transfers for the same couple that had engaged her services in the first instance. No surrogate mother shall undergo embryo transfer more than three times for the same couple.

(10) The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of individual / individuals who commissioned the surrogacy, as parents.

(11) The person or persons who have availed of the services of a surrogate mother shall be legally bound to accept the custody of the child / children irrespective of any abnormality that the child / children may have, and the refusal to do so shall constitute an offence under this Act.

(12) Subject to the provisions of this Act, all information about the surrogate shall be kept confidential and information about the surrogacy shall not be disclosed to anyone other than the central database of the Department of Health Research, except by an order of a court of competent jurisdiction.

(13) A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy.

(14) No assisted reproductive technology clinic shall provide information on or about surrogate mothers or potential surrogate mothers to any person.

(15) Any assisted reproductive technology clinic acting in contravention of sub-section 14 of this section shall be deemed to have committed an offence under this Act.

(16) In the event that the woman intending to be a surrogate is married, the consent of her spouse shall be required before she may act as such surrogate.

(17) A surrogate mother shall be given a certificate by the person or persons who have availed of her services, stating unambiguously that she has acted as a surrogate for them.

(18) A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple/ individual. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.

(19) A foreigner or foreign couple not resident in India, or a non-resident Indian individual or couple, seeking surrogacy in India shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after the pregnancy as per clause 34.2, till the child / children are delivered to the foreigner or foreign couple or the

local guardian. Further, the party seeking the surrogacy must ensure and establish to the assisted reproductive technology clinic through proper documentation (a letter from either the embassy of the Country in India or from the foreign ministry of the Country, clearly and unambiguously stating that (a) the country permits surrogacy, and (b) the child born through surrogacy in India, will be permitted entry in the Country as a biological child of the commissioning couple/individual) that the party would be able to take the child / children born through surrogacy, including where the embryo was a consequence of donation of an oocyte or sperm, outside of India to the country of the party's origin or residence as the case may be. If the foreign party seeking surrogacy fails to take delivery of the child born to the surrogate mother commissioned by the foreign party, the local guardian shall be legally obliged to take delivery of the child and be free to hand the child over to an adoption agency, if the commissioned party or their legal representative fails to claim the child within one months of the birth of the child. During the transition period, the local guardian shall be responsible for the well-being of the child. In case of adoption or the legal guardian having to bring up the child, the child will be given Indian citizenship.

(20) A couple or an individual shall not have the service of more than one surrogate at any given time.

(21) A couple shall not have simultaneous transfer of embryos in the woman and in a surrogate.

(22) Only Indian citizens shall have a right to act as a surrogate, and no ART bank/ART clinics shall receive or send an Indian for surrogacy abroad.

(23) Any woman agreeing to act as a surrogate shall be duty-bound not to engage in any act that would harm the foetus during pregnancy and the child after birth, until the time the child is handed over to the designated person(s).

(24) The commissioning parent(s) shall ensure that the surrogate mother and the child she deliver are appropriately insured until the time the child is handed over to the commissioning parent(s) or any other person as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy.

35. Determination of status of the child –

(1) A child born to a married couple through the use of assisted reproductive technology shall be presumed to be the legitimate child of the couple, having been born in wedlock and with the consent of both spouses, and shall have identical legal rights as a legitimate child born through sexual intercourse.

(2) A child born to an unmarried couple through the use of assisted reproductive technology, with the consent of both the parties, shall be the legitimate child of both parties.

(3) In the case of a single woman the child will be the legitimate child of the woman, and in the case of a single man the child will be the legitimate child of the man.

(4) In case a married or unmarried couple separates or gets divorced, as the case may be, after both parties consented to the assisted reproductive technology treatment but before the child is born, the child shall be the legitimate child of the couple.

(5) A child born to a woman artificially inseminated with the stored sperm of her dead husband shall be considered as the legitimate child of the couple.

(6) If a donated ovum contains ooplasm from another donor ovum, both the donors shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and the donor of both the ooplasm and the ovum shall relinquish all parental rights in relation to such child.

(7) The birth certificate of a child born through the use of assisted reproductive technology shall contain the name or names of the parent or parents, as the case may be, who sought such use.

(8) If a foreigner or a foreign couple seeks sperm or egg donation, or surrogacy, in India, and a child is born as a consequence, the child, even though born in India, shall not be an Indian citizen.

36. Right of the child to information about donors or surrogates –

(1) A child may, upon reaching the age of 18, ask for any information, excluding personal identification, relating to the donor or surrogate mother.

(2) The legal guardian of a minor child may apply for any information, excluding personal identification, about his / her genetic parent or parents or surrogate mother when required, and to the extent necessary, for the welfare of the child.

(3) Personal identification of the genetic parent or parents or surrogate mother may be released only in cases of life threatening medical conditions which require physical testing or samples of the genetic parent or parents or surrogate mother.

Provided that such personal identification will not be released without the prior informed consent of the genetic parent or parents or surrogate mother.

CHAPTER - VIII

OFFENCES AND PENALTIES

37. Prohibition of advertisement relating to pre-natal determination of sex and punishment for contravention –

(1) No assisted reproductive technology clinic shall issue or cause to be issued any advertisement in any manner regarding facilities of pre-natal determination of sex.

(2) No assisted reproductive technology clinic, or agent thereof, shall publish or distribute or cause to be published or distributed any advertisement in any manner regarding facilities of pre-natal determination of sex.

(3) Any person who contravenes the provisions of this section shall be punishable with imprisonment for a term which may extend to five years and with fine which may be specified.

Explanation - For the purposes of this section, "advertisement" includes any notice, circular, label wrapper or other document and also includes any visible representation made by means of any light, sound, smoke or gas.

38. Offences and penalties –

(1) Any medical geneticist, gynaecologist, registered medical practitioner or any person who owns or operates any assisted reproductive technology clinic, or is employed in such a facility and renders his professional or technical services to such facility, whether on an honorary basis or otherwise, and who contravenes any of the provisions of this Act or rules made thereunder, shall be punishable with imprisonment for a term which may extend to three years and / or with fine which may be specified, and on any subsequent conviction, with imprisonment which may extend to five years and / or fine which may be specified.

(2) The name of the registered medical practitioner who has been convicted by the court under sub-section 1 of this section shall be reported by the State Board to the respective State Medical Council for taking necessary action including the removal of his name from the register or the Council for a period of two years for the first offence and permanently for any subsequent offence.

(3) Any person who seeks the aid of assisted reproductive technology or of a medical geneticist, gynaecologist or registered medical practitioner for conducting pre-natal diagnostic techniques on any pregnant woman for purposes other than those specified in clause (2) of section 4 of the Pre-natal Diagnostic Techniques (Regulation and Prevention of

Misuse) Act, 1994 [Act 57 of 1994], shall be punishable with imprisonment for a term which may extend to three years and with fine which may be specified, and on any subsequent conviction with imprisonment which may extend to five years and with fine which may be specified.

(4) The transfer of a human embryo into a male person or into an animal that is not of the human species shall be an offence under this Act and shall be punishable with imprisonment for a term which may extend to three years and with fine which may be specified.

(5) The sale of any embryo for research is absolutely prohibited and shall be an offence under this Act punishable by imprisonment for a term which may extend to three years and with fine which may be specified.

(6) Use of individual brokers or paid intermediaries to obtain gamete donors or surrogates shall be an offence under this Act, punishable by imprisonment for a term which may extend to three years and fine which may be specified.

39. **Presumption in the case of conduct of pre-natal diagnostic techniques** – Notwithstanding anything in the Indian Evidence Act, 1872, the court shall presume, unless the contrary is proved, that the pregnant woman has been compelled by her husband or the relative to undergo pre-natal diagnostic technique.

40. **Penalty for contravention of the provisions of the Act or rules for which no specific punishment is provided** – Whoever contravenes any of the provisions of this Act or any rules made thereunder, for which no penalty has been elsewhere provided in this Act, shall be punishable with imprisonment for a term which may extend to three years, or with fine which may be specified, or with both, and in the case of continuing contravention, with an additional fine which may be specified.

41. **Offences by companies –**

(1) Where any offence, punishable under this Act has been proven to be committed by a company, every person who at the time the offence was committed was in charge of, and was responsible to, the company for the conduct of the business of the company, as well as the company, shall be deemed to be guilty of the offence and shall be liable to be proceeded against and punished accordingly:

Provided that nothing contained in this sub-section shall render any such person liable to any punishment, if he proves that the offence was committed without his knowledge or that he had exercised all due diligence to prevent the commission of such offence.

(2) Notwithstanding anything contained in sub-section (1) of this section, where any offence punishable under this Act has been committed by a

company and it is proved that the offence has been committed with the consent or connivance of, or is attributable to any neglect on the part of, any director, manager, secretary or other officer of the company, such director, manager, secretary or other officer shall also be deemed to be guilty of that offence and shall be liable to be proceeded against and punished accordingly.

Explanation – For the purposes of this section,

(a) "company" means any body corporate and includes a firm or other association of individuals, and

(b) "director", in relation to a firm, means a partner in the firm.

42. Offence to be cognizable – Every offence under this Act shall be cognizable.

CHAPTER - IX

MISCELLANEOUS

43. Maintenance of records –

(1) All records, charts, forms, reports, consent letters and all other documents required to be maintained under this Act and the rules shall be preserved for a period of ten years or for such period as may be prescribed

Provided that, if any criminal or other proceedings are instituted against any facility using assisted reproductive technology, the records and all other documents of such facility shall be preserved till the final disposal of such proceedings.

(2) All such records shall, at all reasonable times, be made available for inspection to the concerned State Board or to any other person authorised by the concerned State Board in this behalf.

44. Power to search and seize records etc. –

(1) If the State Board has reason to believe that an offence under this Act has been or is being committed at any facility using assisted reproductive technology, such Board or any officer authorised thereof in this behalf may, subject to such rules as may be prescribed, enter and search at all reasonable times with such assistance, if any, as such authority or officer considers necessary, such facility, and examine any record, register, document, book, pamphlet, advertisement or any other material object found therein and seize the same if the State Board or officer has reason to believe that it may furnish evidence of the commission of an offence punishable under this Act.

(2) The provisions of the Code of Criminal Procedure, 1973, relating to searches and seizures shall, so far as may be, apply to every search or seizure made under this Act.

45. Power to remove difficulties –

(1) If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order published in the Official Gazette, make such provisions not inconsistent with the provisions of this Act as may appear to be necessary for removing the difficulty:

Provided that no order shall be made under this section after the expiry of three years from the commencement of this Act.

(2) Every order made under this section shall be laid, as soon as may be after it is made, before each House of Parliament.

46. **Protection of action taken in good faith** – No suit, prosecution or other legal proceeding shall lie against the Central or the State Government or the National Board or State Boards or Registration Authority or any officer authorised by any of them, for anything which is in good faith done or intended to be done in pursuance of the provisions of this Act.

47. **Power to make regulations** – The National Advisory Board may, with the previous sanction of the Central Government, by notification in the Official Gazette, make regulations not inconsistent with the provisions of this Act and the rules made thereunder, to provide for –

(a) the time and place of the meetings of the Board and the procedure to be followed for the transaction of business at such meetings, and the number of members which shall form the quorum;

(b) the conditions for the transfer of embryos and gametes to research institutions;

(c) regulation of Pre-implantation Genetic Diagnosis;

(d) research on embryos;

(e) the efficient conduct of the affairs of the Board;

(f) any other purpose that may be prescribed.

48. **Power of the Central Government to make rules –**

(1) The Central Government may make rules for carrying out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for –

(a) categories of assisted reproductive technology clinics;

(b) the minimum requirements regarding staff in assisted reproductive technology clinics;

(c) the minimum physical infrastructure requirements for an assisted reproductive technology clinic;

(d) the various assisted reproductive technology procedures to be adopted by an assisted reproductive technology clinic;

(e) the criteria for selecting patients for an assisted reproductive technology procedure;

(f) the criteria for selecting an assisted reproductive technology procedure for a patient;

(g) information and advise to, and counselling of patient;

(h) the eligibility of couples and individuals to use assisted reproductive technology;

(i) the eligibility of donors;

(j) the eligibility of surrogate mothers;

(k) the number of embryos that can be implanted in a woman;

(l) the number of times that a patient can be given a procedure;

(m) the maintenance of records;

(n) procedure to search and seize;

(o) the criteria to be fulfilled for a license;

(p) the effective implementation of the Act.

(3) Every rule made by the Central Government under sub-section (1) of this section shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive sessions aforesaid, both Houses agree in making any modification in the rule or regulation or both Houses agree that the rule or regulation should not be made, the rule or regulation shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule or regulation.

49. **Power of State Government to make rules** – Subject to the provisions of this Act and the rules and regulations made thereunder, the State Government may make rules to carry out the purposes of this Act.

50. **Act to have effect in addition to other Acts** – The provisions of this Act shall be in addition to, and not in derogation of, the provisions of any other law, for the time being in force, except for the following:

a) Provision made in Section 13(6) of this Act;

b) Inapplicability of the provision of the Right to Information Act in regard to provision made in Section 20(9) and 26(13) of this Act.

ADDENDUM AND CORRIGENDUM

Title: A STUDY OF THE LEGAL FRAMEWORK FOR THE PROTECTION OF THE REPRODUCTIVE RIGHTS OF WOMEN IN INDIA

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