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Women and Healthcare in India: A Socio-Legal Analysis of the Contraceptive Burden on Women

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Abstract:

Healthcare is an unending and integral part of everyone's life- from birth to death. Sickness doesn't discriminate, but man does. Every patient expects a diagnosis from a doctor who they believe prescribes what is in their best interest. But, when the system is patriarchal, the institution it establishes, the education it imparts, and the treatment it provides are all tainted with gender, biased towards one and ignorant of the other. The present article uses MacKinnon's Social Construction to dissect the evolution of contraceptive burden on women. It begins by understanding how the burden of contraception fell on women using theoretical evidence. The second part of the article focuses on the materialization of the patriarchal structure in education and family unit. From exclusion of women as test-subjects and women specific maladies to construction of "appropriate feminine behaviour", patriarchy digs its roots deeper. The third part of the article explains how aptly social construction is successful in building a discourse that meets its purpose. The author concludes by suggesting a way to change the discourse and poison the roots of patriarchy. Thus, the present article discusses the how the burden of contraceptive care falls on women from a socio-legal perspective and suggests measures to change the status-quo.

Keywords: *Contraceptives, Women, Patriarchy, Medical Institutions, Family And Health.*

Introduction

Our society is shaped and guided by patriarchal notions and rules. Patriarchy pervades all institutional establishments, including the three limbs of the government which advances and preserves patriarchy by making policies and law (legislature), upholding and defending them (executive), and punishing those who violate it (judiciary), thereby maintaining the paternal ecosystem. A hospital/medical care is an inescapable part of human life, which a rare few (if any, bravo!) never encounter. In a woman's life, generally, a girl is born in a hospital, visits doctors/clinics in her adolescence, and later gynaecologists and obstetricians- for contraceptive care, menstrual issues, pregnancy related concerns or, for abortion. Later on, a woman may go to the doctor for geriatric related issues. Further, cosmetologists, nutritionists, and plastic surgeons conform women to societal standards they are told to conform with.

Women face many hurdles, from convincing doctors that something is wrong to bearing the consequences of a wrong or delayed diagnosis due to a ranging from a historical exclusion of women specific issues for research to outright denial of their symptoms as non-existent. Contraception is an essential commodity not only in the modern ages but

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since eons before. Abstaining from sex or use of certain herbs were the few recourses available to people. However, *women* now have a range of options to choose from to avoid pregnancy, unlike their male counterparts. Despite the lack of options, men seem to have accepted this inequality. The author found no evidence for protests from mens rights activists for birth control options for men. Shouldn't they have the choice to decide when they want to be a father?

It is important to highlight that the scope of the article is limited to cis-gendered women, and does not include transgender, or other gender identities. It is limited to women as *'patients'*, at the receiving end of medical institutions and not as *'practitioners'*, providing the care. Further, the article is limiting its focus on sexual health, namely 'contraceptives', and analysing gendered notions that exist in society and in institutions while treating women's contraceptive care. Patriarchy is an anti-thesis to feminism which has been aptly researched and agreed. The article does not delve into the concept of patriarchy and feminism, as is assumed that the meaning of those terms and related concepts is understood by the reader.

Katherine MacKinnon first coined the term social construction and how three aspects: Ideology, Materiality and Discourse shapes a society's reality. The article uses this theory as the basis for outlining the evolution of contraceptive burden on women. The purpose and scope of this article is to understand how the burden of contraception fell exclusively on women by using the social construction theory, and how legal precedents and governmental policies play a role in continuing to put the burden on women.

1. The Ideology

Although women have not had a significant part in the making of science, science has had a significant part in the making of women.

2.1Patriarchal Understanding of a *'Woman'* patient

Patriarchy is a geriatric man, stuck up in his ways, who is a stickler for doing things the *'right'* way. Let's call him Chad.[2] The right way is determined by Chad based on what *he* decides is right, which sadly does not include- *'women are equal'* or *'women are funny too'*, but is more on the lines of *'woman are inferior'* and *'women are incapable of making tough decisions.'* So, Chad thinks a woman must look like a woman, must act like a woman, and must speak like a woman, and anyone who fails, is a deviant, or not a woman at all. But unfortunately, transgressing the box within which a woman must stay in does not afford her the privilege of being considered a man, but rather, only an unnatural entity that needs to be corrected by punishment. Women are considered inferior to men, or as Aristotle put it *"mutilated men"*,[3] that are less intelligent, emotional, inaccurate reporters, and hysterical.[4]

2.1.1 You don't know what you want

[2] The name 'Chad' stems from an incel community- 4chan, where it refers to stereotypical alpha-males, idolised as the *"peak of masculinity"*. It is used to refer to *"arrogant, privileged man." See* Merriam-Webster, *chad*, CHAD Slang Meaning | Merriam-Webster (last visited June 28, 2025).

[3] *Inclusive research: Women left out of drug research, clinical trials*, ET (Oct. 25, 2023) https://health.economictimes.indiatimes.com/news/industry/inclusive-research-women-left-out-of-drug-research-clinical-trials/104685037. (last visited Sept. 19, 2024)

[4] Ibid.

A woman *wants* to be married, *wants* to bear children. Again, she cannot decide to not want to have children, as such decisions are *'false'* or *'temporary.'*[5] Whereby her reproductive decisions regarding sterilisation or adoption, are restricted by both her family and her doctors. Wanting to preserve fertility is considered normal by doctors over other concerns, and given a higher preference disregarding a woman's choice.[6] As a consequence, the associated *emotional and mental work* surrounding fertility such as, researching which contraceptive is best suited for her body, making appointments with the doctors, travelling to the clinic, and the stress relating to the procedure, that she undertakes is also *socially constructed* to be normal.[7] Apart from the physical side-effects a woman has to deal with, contraceptive care is also a *financial burden* involving doctor visits and reinstallations based on the kind of contraceptive that is being used. This is another unpaid work or *'fertility work'* women have to undertake.

2.1.2 It hurts! (Stop overreacting!)

Women's behaviour that men deemed *'unwomanly'* or *'abnormal'* was categorised under *"hysteria"* by the Greeks and Romans in the 17th-18th century.[8] This diagnosis was used to club all those issues which Chad deemed problematic.[9] Women's accounts of the pain they experienced was assumed to be exaggerated[10] while those of men was assumed to be underplayed. Because men are strong and stoic, when they state their pain, it was always *'accurate and real'*, while women, who are believed to be inaccurate reporters, emotional and weak bodied, the pain they state to feel is *not actually that much.* Women were denied pain relief medications for childbirth as religion believed that women are to suffer during delivery.[11] There is also racial biasness where black people were believed to have higher pain tolerance, or feel less pain. Facial expressions were also used as a marker to determine the authenticity of pain stated, however, women are generally considered to be expressive are thought to over-react to pain, thereby undermining the pain they experience.[12] The reason behind the pain was linked to psychological disorders like stress, anxiety and depression rather than physical ailments.

2.2 Contraceptive Burden

The responsibility of preventing unwanted pregnancy largely falls on the woman. This is because Chad has relegated the issue of reproduction, and pregnancy as a *"woman's issue"*,[13] whereas ironically sexual intercourse falls in the *"man's sphere",* which is celebrated. As a result, male partners take lesser to no responsibility in preventing unwanted pregnancies. This has led to lesser research and demand of male contraceptives.

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[5] Malacrida, C., & Boulton, T., *Women's Perceptions of Childbirth "Choices": Competing Discourses of Motherhood,* Sexuality, and Selflessness, 26(5), GENDER & SOCIETY, 748, 751-772 (2012).

[6] Trivedi, D., Majumder, N., Bhatt, A., Pandya, M., & Chaudhari, S. P. (2021). Global research mapping on reproductive health: a bibliometric visualisation analysis. Global Knowledge, Memory and Communication, ahead-of-print(ahead-of-print). https://doi.org/10.1108/gkmc-08-2021-0131

[7] Ibid.

[8] Cohut M., *The controversy of 'female hysteria',* MEDICAL NEWS TODAY (Oct. 13, 2020) https://www.medicalnewstoday.com/articles/the-controversy-of-female-hysteria (last visited Sept. 21, 2024).

[9] Such diagnosis resulted in forced hospitalizations for women, and was included in the "*Diagnostic and Statistical Manual of Mental Disorders"* in America till 1980, when it was finally removed.

[10] Crystal Raypole, *Gender Bias in Healthcare is very real- and Sometimes Fatal,* HEALTHLINE (Jan. 20, 2022) https://www.healthline.com/health/gender-bias-healthcare (last visited Sept. 19, 2024).

[11] Ibid.

[12] Ibid.

[13] Ibid.

2.2.1 It's YOUR job

Self-sacrifice forms a core part of being a woman. Women are expected to sacrifice body to bear children and make sacrifices for their children. Since contraception falls within the sphere of reproduction, this responsibility is put on the women with the same expectation of being sacrificial.[14] Lisa Campo-Engelstein argues that though its empowering women by allowing them control and enhances autonomy, it is demanding sacrifice as well because it is a *"forced responsibility"*.[15] Katherine MacKinnon stated that women value care because women who care about men are valued by them according to the care received.[16] Women because of this social construction accept the responsibility that is expected of them, when contraceptive care/labour, doesn't actually have to be done alone.

According to the 5th National Family Planning Survey from 2019 to 2021, 56% of married women use modern contraceptives, of which female sterilization is top contraceptive used by 38%, followed by male condoms and pills, which are ten and five percent respectively.[17] Modern contraceptives include,[18]

1. Condoms for both sexes
2. Contraceptive pills
3. Intrauterine devices (IUDs/ PPIUDs)
4. Implants/ diaphragm
5. Emergency contraceptives
6. Injections
7. Male and female sterilizations
8. Lactational amenorrhoea method
9. Standard days method
10. Foam/jelly

A majority of the above are exclusively for women, and are invasive, causing pain during installation.

[14] AMY MULLIN, RECONCEIVING PREGNANCY AND CHILDCARE: ETHICS, EXPERIENCE, AND REPRODUCTIVE LABOUR 75-78 (Cambridge Univ. Press 2005).
[15] Campo-Engelstein L., *Contraceptive Justice: Why we need a Male Pill*, 14 VIRTUAL MENTOR 146 (2012).
[16] Campo-Engelstein L., *Gender norms and Contraceptive Trust*, 23 ALB. L.J. SCI & TECH. 581, 582-621 (2013).
[17] MINISTRY OF HEALTH AND FAMILY WELFARE, IIPS, NATIONAL FAMILY HEALTH SURVEY (NFHS - 5), 2019–21, 157 (March 2022). https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf (last visited Sept. 19, 2024) Though NFHS – 6 has been conducted, it is yet to be fully completed and published. Only the questionnaire of the survey is public, the statistics and data are yet to be published. *See* Nandlal Mishra and Pramit Bhattacharya, *Understanding India's National Family Health Survey*, DATA FOR INDIA (Jan. 30, 2025) https://www.dataforindia.com/nfhs-explainer/ (last visited June 29, 2025).
[18] Ibid. at 158. The average age for sterilization is 25.7 years.

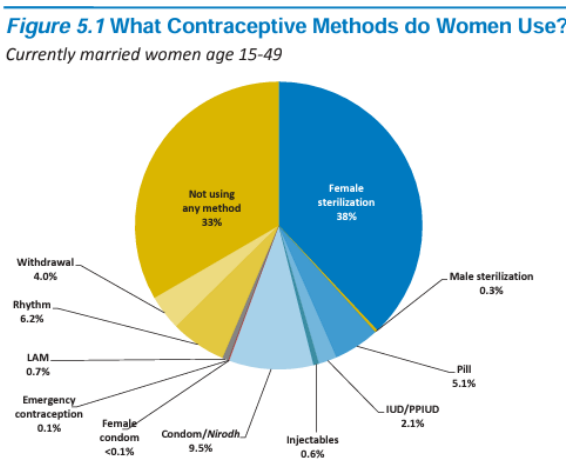


Figure 1: Contraceptives used by married women[19]

Male condoms and female sterilization were the top two amongst unmarried women.[20] The use of contraceptives increases with the number of children and with wealth. 62% of women were *informed* about the possible side-effects, while 54% were told *what to do* when they experienced side-effects. The major reason for discontinuation of contraceptives was for getting pregnant.[21] Female contraceptives also include traditional methods such as rhythm which tracks the menstrual cycle, calculating when ovulation will occur. From the survey it is clear that everyone is aware of what contraceptives are, as shown from figure 2 below. Despite this knowledge, the work of preventing pregnancies is still on the women as seen from the varied forms of contraceptives that is available for women to use. Compared to female contraceptives, there are only two for men- vasectomies and condoms, only one of which is invasive with no side-effects.[22] Depending on the contraceptives that women, they cause different side-effects. Birth control pills cause side-effects such as but not limited to nausea, changes in period, headaches, mood swings, acne, decreased libido, weight gain, etc.[23]

[19] Supra note 13.
[20] Ibid.
[21] Ibid. at 162.
[22] There are developments regarding male contraceptives which are under trials in the U.S., while in India RISUG an injectable contraceptive has passed clinical trials. *See* Rhythma Kaul, *ICMR's male contraceptive 99% effective: Report*, HINDUSTAN TIMES (Nov. 06, 2023) https://www.hindustantimes.com/india-news/icmrs-male-contraceptive-99-effective-report-101699210844793.html (last visited Sept. 20, 2024).
[23] Schrumpf, Leah A et al, *Side effect concerns and their impact on women's uptake of modern family planning methods in rural Ghana: a mixed methods study*, 20 BMC WOMEN'S HEALTH, 57 (2020).

Table 5.1 Knowledge of contraceptive methods—*Continued*

Percentage of all women and men, currently married women and men, sexually active unmarried women and men, and never married women and men who know any contraceptive method by specific method and residence, India, 2019-21

	Women				Men			
Method	All women	Currently married women	Sexually active unmarried women[1]	Never married women	All men	Currently married men	Sexually active unmarried men[1]	Never married men
	TOTAL							
Any method	98.8	99.7	99.9	95.9	98.9	99.6	99.8	97.8
Any modern method	98.8	99.7	99.8	95.9	98.8	99.6	99.7	97.7
Female sterilization	97.2	98.8	98.0	92.0	91.8	95.5	96.0	86.0
Male sterilization	81.1	86.0	86.6	65.7	84.3	88.3	90.1	78.2
Pill	89.7	93.1	91.6	79.7	83.9	87.9	91.4	77.9
IUD or PPIUD	79.5	86.0	82.8	59.8	47.8	54.2	54.1	38.4
Injectables	79.1	83.7	78.9	66.3	65.8	70.5	73.4	58.9
Condom/*Nirodh*	87.1	90.3	92.0	78.4	96.2	96.9	98.3	95.4
Female condom	24.4	25.8	26.8	20.9	39.6	41.3	46.0	37.2
Emergency contraception	47.6	52.2	48.6	34.6	47.2	51.8	62.1	40.3
Diaphragm	8.9	9.5	8.7	7.2	12.7	13.6	16.2	11.4
Foam or jelly	7.0	7.5	8.7	5.8	10.5	11.2	13.2	9.5
Standard days method	31.1	35.4	32.3	18.2	26.5	31.7	26.8	18.7
Lactational amenorrhea method (LAM)	45.2	52.4	41.9	23.2	22.3	27.0	22.7	15.3
Other modern method	1.3	1.5	1.4	0.8	4.8	5.4	4.9	3.9
Pill, IUD/PPIUD, and condom/*Nirodh*[2]	73.2	80.1	77.3	52.8	45.5	51.9	51.4	36.1
Any traditional method	74.6	84.4	84.8	44.8	74.5	81.8	85.3	63.6
Rhythm	62.7	71.4	65.0	36.4	47.4	56.4	57.7	33.8
Withdrawal	64.0	74.6	78.3	31.6	69.6	76.2	80.6	59.6
Other traditional method	1.6	1.9	1.5	0.8	1.0	1.1	1.7	0.7
Mean number of methods known by respondents age15-49	8.1	8.7	8.4	6.2	7.5	8.1	8.4	6.7
Number of respondents age 15-49	724,115	521,352	835	172,075	93,144	55,475	3,420	36,503
Mean number of methods known by respondents age15-54	na	na	na	na	7.5	8.0	8.3	6.6
Number of respondents age 15-54	na	na	na	na	101,839	63,739	3,463	36,648

IUD = Intrauterine device; PPIUD = Postpartum intrauterine device
na = Not applicable
[1] Had sexual intercourse in the 30 days preceding the survey
[2] All three methods

Figure 2: Knowledge of contraceptive methods[24]

2.2.2 Don't burden the country when you can't be a good mother

The national policy for introducing and promoting contraceptives in India around the 1970s was linked to the issue of *'family planning'*, *'population control'*, and reducing the rate of maternal mortality,[25] than on providing women the *'choice to decide'* when to get pregnant. Now, the emphasis has shifted to maternal and child health, and protective reproductive rights of women majorly related to *'access to contraceptives* and *'abortion'*, instead of focussing on women's *'reproductive health'*.

Even so, Lisa Cassidy, a feminist scholar argues that the emphasis is on ensuring unwanted pregnancies are avoided, because if the adults are not ready, the environment the child

[24] Supra note 13.
[25] UNFPA India, *Insights from a Changing India: The UNFPA India Storybook*, 4 (Oct. 2024) https://india.unfpa.org/sites/default/files/pub-pdf/2025-03/Final%20UNFPA%20Report%20Feb%202025_for%20website.pdf (last visited Oct. 23, 2024).

grows up in won't be *'right.'*[26] The importance is on ensuring that the *'right'* people will be parents who will bring up their children in the right manner. On the other hand, she presents a contradictory view, where there is an expectation of abstinence from women - who are believed to have a lower libido which when they violate are deserving of punishment through unwanted pregnancy because they are *'bad women'*.[27]

Medical research has now begun for contraceptives for men, however when they will be in the market is yet to be seen.[28] Since, preventing pregnancy is a burden on woman, as they want to prevent negative societal repercussions, and are willing customers of contraceptives, there is hardly any research to look in to alternatives, leaving women with no other choice but to deal with the side-effects of contraceptives.

3 Materiality

The above ideologies spearheaded by Chad are adopted by the medical establishment which affects future medical research, policies and decisions. A gender bias which favours men, structures the whole concept of care around the *'male body'* and according to male *'needs.'*

3.1 Default setting: Male

Differential treatment based on classifications is a justified when the rationale for doing so is reasonable. Chad also agrees that men and women are biologically different, because of which they cannot be treated at par with each other. But these rational biological differences lead to few irrational gendered stereotypes.

3.1.1 Huh? Women's bodies react differently?

Implicit personal biases presuppose biased assumptions while undertaking research. Since Chad favours men, the scientific field is predominantly male. While undertaking medical research, the male specimen- be it an animal or a human is preferred as there is a lack of variations, unlike the female body which has hormonal, and menstrual cycles causing variations.[29] This rationale excluded women from research trials. However, the results from those male tested trials were extrapolated to women without testing them on women.[30] There is a flawed assumption that women will react similar to the male body. This leads to misdiagnosis or late diagnosis of the same disease present in women, as symptoms that were experienced by women weren't *'typically'* seen in the clinical trials.[31]

For example, in heart attacks, women experience symptoms that aren't considered symptoms for heart attacks and are dismissed. This includes symptoms like disturbed sleep, nausea, back and abdominal pain instead of chest-pain, fatigue, and

[26] Campo-Engelstein L., *That Many of Us Should Not Parent*, 21(4) HYPATIA, 40, 42-57 (2006).
[27] Ibid.
[28] Supra note 20.
[29] Sengupta A., *Clinical Trials in India: A Way towards Impoverishment*, 11 NALSAR STUD. L. REV. 1 (2017).
[30] Ibid. In U.S., Ambien a drug used for sleeping disorders was tested on male rats. It was approved and sold in the market. Later, when women complained of disorientation and there was a rise in road accidents, it was found that women required half of the prescribed dosage. *See* Crystal, *supra* note 8.
[31] Crystal, *supra* note 8. However, the contrary needs to be pointed out where men's symptoms which are more commonly seen in women are discounted. It takes more time to diagnose men with depression or hyperthyroidism as their symptoms are different for men or culturally not masculine.

breathlessness.[32] U.S.'s National Institutes of Health prescribes that both male and female animals should be used in research.[33] While the medical institution in Europe and Canada requires researchers to answer whether their research is inclusive of gender/sex.[34] Such guidelines for gender/sex inclusive research or trials have not yet been prescribed by the National Medical Commission, the Indian Medical Association, or the Clinical Trials Registry till now. Furthermore, there are no reports that substantiate that female subjects are *excluded* from clinical trials; however, a lack of guidelines and economic and social exclusion causes the author to believe there is no adequate representation.

Further, the female reproductive health is another area which is under researched. The mysticism that still surrounds the menstrual cycle, results in issues merely dismissed as cramps or pain, where the underlying problem remains unaddressed. For example, pelvic pain was considered to be caused by cramps. However, research later revealed that there could be multiple reasons behind the pain such as, cervical cancer, endometriosis or ovarian cysts.[35]

Such instances cause a distrust towards doctors, who are dismissive of their issues, or incorrectly treating them. Further, non-diagnosis may not only cause emotional distress but can also lead to the problem being ignored until it's too late.

4 Discourse

Looking back informs how to look forward

4.1 Indian Legal Scenario

Present laws related to women's reproductive rights include those for surrogacy, abortion, IVF and maternity leave.[36] The driving force for abortion was a means to achieve the State's partial objective of population control and the other partial objective of protecting women's lives which were lost due to illegal, unsafe abortions. The Ministry of Health and Family Affairs regulates contraceptive services and disburses contraceptives free of cost through its centres and hospitals. None of the present legislations touch upon contraceptive care. Neither are there any resolutions or directives which discuss measures to remedy the one-sided burden on women.

4.1.1 Judicial Decisions on Reproductive Rights

The legislature has supported the choice of women regarding contraceptives, in line with the ideology of the State which places it on the women to use contraceptives. A woman's autonomy to choose contraceptives was upheld by the Supreme Court [referred as, "SC"] in

[32] Ibid.

[33] *Sex as a Biological Variable*, NIH (Apr. 16, 2024) https://orwh.od.nih.gov/sex-gender/orwh-mission-area-sex-gender-in-research/nih-policy-on-sex-as-biological-variable#:~:text=Adequate%20consideration%20of%20both%20sexes,is%20disabled%20in%20your%20browser (last visited Oct. 23, 2024).

[34] White, Jamie et al, *The Integration of Sex and Gender Considerations into Biomedical Research: Lessons From International Funding Agencies*, 106(10) THE JOURNAL OF CLINICAL ENDOCRINOLOGY AND METABOLISM 3034, 3037-3048 (2021).

[35] Crystal, *supra* note 8.

[36] The Surrogacy (Regulation) Act, 2021, The Medical Termination of Pregnancy (Amendment) Act, 2021, The Assisted Reproductive Technology (Regulation) Act, 2021 and, The Maternity Benefit (Amendment) Act, 2017.

2009, where the court said that women have the free choice to choose their birth control. There can be no restriction either in use of contraceptives or choosing not to engage in sexual activity.[37] Whereas the Puttaswamy judgement included women's reproductive choices as a constitutional right under Article 21.[38] In 2016, the SC held that reproductive rights encompass the right to choose sterilization provided there is informed consent without any coercion.[39] In Laxmi Mandal case,[40] The Delhi High Court held that maternal mortality is a violation of human rights. Through the above decisions, reproductive rights of a mother are underpinned in Article 21 of the constitution. Apart from autonomy over ones' body, the court has also placed reproductive rights in the sphere of equality and non-discrimination. This shift from personal liberty to focussing on women in marginalised groups was seen in cases like Devika Biswas,[41] where the court condemned forced sterilization of marginalised groups which harmed the *"reproductive freedoms of the most vulnerable groups of society"*. The court also recognised that a reproduction is also political as it is bound to social structures as a women's familial and societal status is linked to whether they can give birth to a son and thereby ensure the continuity of the future generations.[42] The court also extended the right of abortion to unmarried women in X v. NCT.[43]

So, although the judiciary is protecting and upholding women's reproductive rights, these decisions do not assist in lessening the contraceptive burden on women. The decisions do cater to women's well-being, primarily the right to choose- to get pregnant or to abort. They have a control over their fertility. However, the conversation on the effect of contraception on a women's well-being is absent. If an individual is given an option to drink muddy water or to drink water with faeces, is that really providing a good choice? Both will have harmful effects on the body. Furthermore, targeted sterilizations[44] and gender-skewered contraceptive programs violate fundamental rights under Articles 14, 15 and 21, as interpreted in light of the above-mentioned judicial precedents.

A man has not had to demand the such rights from the court. A court is said to be a reflection of society, upholding what the society believes is right and needs to be protected. Thus, the perception that contraceptive is majorly taken by women is accepted by the society as well.

4.2 International Legal Scenario

There are no international legal documents focussing on contraception. They majorly relate to human rights, which include under them sub-category of rights like equality, dignity, freedom, health and so on. The following principles from international conventions and guidelines showcase how contraceptive burden on women is a violation of human rights and international obligations.

A. Convention on the Elimination of All forms of Discrimination Against Women [referred as, "CEDAW"]:

[37] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 3 SCC (Civ.) 570.
[38] Justice K S Puttaswamy v Union of India, (2017) 10 SCC 1.
[39] Devika Biswas v. Union of India, (2016) 10 SCC 726.
[40] Laxmi Mandal v. Deen Dayal Harinagar Hospital (2010) 172 DLT 9 (Del).
[41] Supra note 37.
[42] X4 v. State (NCT of Delhi), (2023) 14 SCC 615.
[43] Ibid.
[44] Supra note 37.

It was adopted by the United Nations General Assembly in 1979 and is also known as the *"international bill of rights of women"*. India is party to the Convention. Article 2 obligates States to eliminate discrimination against women through law, institutions, and societal change.[45] Article_12 states that a state must *"take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"*.[46]

Further, Article 5 states that the State has to take appropriate measures to *"modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women"*[47]

A gendered focus on contraception is a violation of these Articles.

B. International Covenant on Economic, Social and Cultural Rights [referred as, "ICESCR"]:

ICESCR is a multilateral treaty enforced by the United National General Assembly in 1976. India acceded to the covenant in 1979. Article 12 of the Covenant states that state parties must *"recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*.[48] This encompasses reproductive health within it and thus, also contraceptive care. Harm resulting from contraceptive burden both mental and physical is a violation of this Article.

C. International Conference on Population and Development [referred as, "ICPD"]:

ICPD was held in Cairo in 1994. 179 governments adopted the Programme of Action shifting the focus from population control to reproductive rights, gender equality and sustainable development. India joined ICDP in 2011. One on its principles states the reproductive health includes the right to highest standard of reproductive healthcare. It recognizes the importance of equitable sharing of contraceptive responsibility.[49] It highlights that reproductive health care must not only address women's needs, including adolescents, but also actively involve men through education. Men must be enabled and encouraged to take shared responsibility in contraception, family planning, domestic duties, and STD prevention.[50] Further, reproductive health services should be delivered through the primary healthcare system, which should dispense access to contraception, counselling for family planning, and gender-sensitive outreach programs.[51]

[45] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13, art. 2.
[46] Ibid. at art. 12.
[47] Ibid. at art. 5.
[48] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, art. 12.
[49] Report on the International Conference on Population and Development, Programme of Action, U.N. Doc. A/CONF.171/13/Rev.1 (1995), Chp. VII.
[50] Ibid.
[51] Ibid.

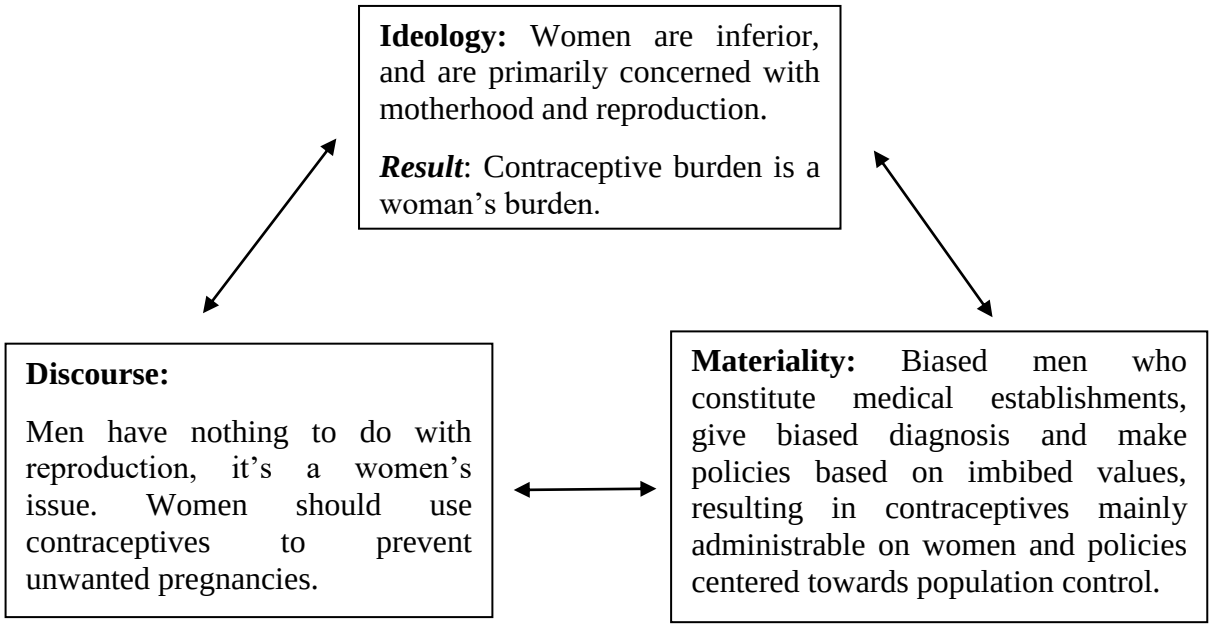
ICPD shifted the focus from family planning to a gender-balanced, rights-based approach that includes men as equal partners in reproductive decision-making.

4.3 Social Construction

'Discourse' relates to the prevalent discussion about a topic going on in the society. It is the continuation of the reality which may be changed for the better or worse.[52] This in turn shapes the 'ideology' which then materializes through norms, accepted as facts or truths.[53] 'Materiality' refers to a created reality where the ideology becomes a fact.[54] Ideology, discourse and materiality are interdependent on each other and also mutually exclusive. For example, doctors whose are experts in their field are respected and their opinion is followed. Now, a doctor who believes a woman is faking the pain she is feeling, or judges that there is nothing wrong with her, lead not only the woman but also her family to come to the same belief. Then any further complaints about the same are dismissed as false. On the flip side, if the discourse in the society is that women are reliable and rational then the same beliefs will be carried forward by people which eventually will become the truth. Then based on that truth, medical establishments will adjudge the pain communicated by female patients at face value.

These three aspects form the prongs of social construction which are cyclic in nature. What is 'normal' is constructed.[55] Our perceptions, behaviour, ideas are shaped by social structures which are shaped by the discourse which again is influenced by materiality and ideology and vice versa. In the present case, *'contraceptive burden of women'* is the ideology, the *'medical establishment'* materializes that ideology and the *'society/family'* units continues that reality.

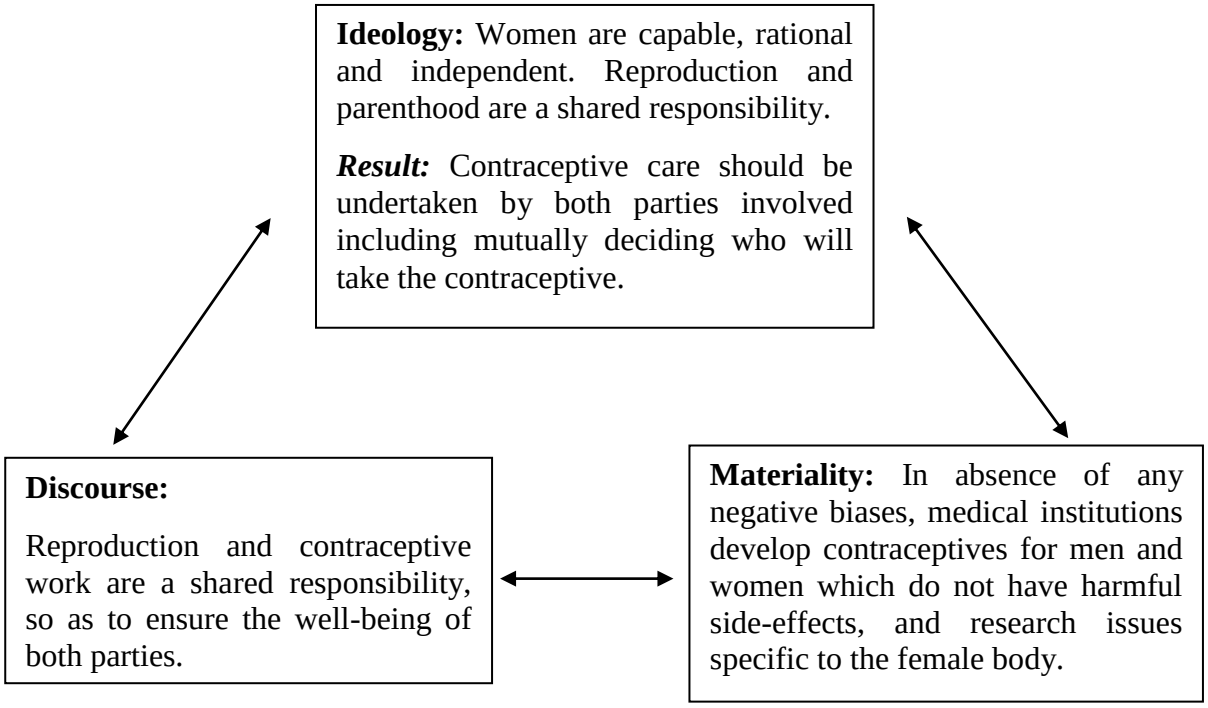
Present cycle:



[52] Nancy J. Hirschmann, *Freedom, Power and Agency in Feminist Legal Theory*, in THE ASHGATE RESEARCH COMPANION TO FEMINIST LEGAL THEORY, 51 (Margaret Davies and Vanessa E. Munro eds., Ashgate Publishing 2013).
[53] Ibid.
[54] Ibid.
[55] Ibid.

In order to take away Chad's influence, the discourse about women patients and women's health needs to change. There is also a need to see women differently which is a harder expectation to fulfil.

Potential Cycle:



The pressure to use contraceptives is therefore socially constructed. Through the three prongs of social construction, it is established how the burden of contraceptives falls on the woman. Once the ideology changes, the reality changes. There is a need to change the discourse. Men need to be more involved in sharing the burden. But gendered notions have constructed their identity in such a manner that first they need to realise the flaws in their constructed reality after which they can make changes. The same applies to women, who need to take a stand, but will face harsher reactions from the society, or their own family wherein they might be told to compromise and make use of the contraceptives available.

When the notions of masculinity and femininity are deconstructed and viewed more fluidly irrespective of gender, there will be more openness to venture into territories outside of the box designated by Chad. Contraceptive burden unfortunately is here, till Chad is dead. One of the ways to make Chad weak is to poison him, through fighting his social constructions, by passing laws that overrule his laws, raising the next generation gender-neutrally, opposing gender norms, permeating the patriarchal structures and breaking them to create new structures, to name a few.

Further, there is also a general disregard to the problems faced by women while using these contraceptives which are accepted as bound to happen. A higher standard should be adhered to by medical researchers, where female contraceptives have little to no side-effects when used. Which relates to the other point where research relating to the female body should be adequately funded, and encouraged, to ensure that a woman's health is duly recognised, given importance and counted, instead of being seen as an extension of a

man. A woman's unique biology should be properly understood to prevent misdiagnosis, and properly address symptoms.

The following steps can be taken to counter the contraceptive burden on women-

- Change through research- non-harmful contraceptive options: Since contraceptive burden largely arises due to sociological stigma, a societal change is necessary. Law and governmental intervention are tools to bring about a social change. There is a need for inclusive and equitable policy making. The government can support and adequately fund research initiatives relating to harmless contraceptive choices, non-invasive contraceptives, or contraceptives for men to reduce the burden on women and provide contraceptive choices which do not negatively affect women's health. In line with this, the research departments should ensure that 'sex' is used as a variable in the studies/testing.
- Change through policy: Men should be equally be a part of family planning campaigns as women are so that unwanted pregnancy does not solely fall on women. Governmental policies should be drafted in a manner which puts a shared responsibility on family planning. Furthermore, information on they type of contraceptives and their respective side-effects should be thoroughly explained so that a woman can make an informed choice. Contraceptive care must be included in national policies and schemes.
- Promoting shared responsibility: Proper counselling prior to permanent sterilization and taking informed consent is important. Incentivizing male sterilization, which has almost no side-effects compared to female sterilization, by providing compensation or post-operational benefits will shift societal perceptions of responsibility in family planning. Rebranding vasectomies to responsible fatherhood will bring about behavioural changes in society. Community-led events for men and boys should be supported to reduce stigma and improve reproductive literacy.
- Setting National Rules: The government should clearly lay down enforceable national standards for informed consent in sterilization and contraception. Sufficient budgetary allocation for reproductive healthcare will boost the progress for gender neutral contraception.

A woman's bodily autonomy might seem empowering with the availability of contraceptives, but in reality, it's a necessary evil due to a lack of alternative choices. There is a long way to go for women to receive fair and equal healthcare that is focussed exclusively on their well-being, without roping in a woman's spouse, potential child, or family. Reproductive autonomy can thrive when all reproductive choices are safe and non-discriminatory.