

Achieving The Way To Gender Justice By Remediating The Issues Surrounding Reproductive Health Of Women In India: An Analysis

Puneet Chander Joshi^{1*}, Dr. Ajay Kumar²

¹Ph.D. Scholar, Amity Law School, Amity University, Haryana

E-mail: pcjoshiadvocate@gmail.com

²Professor, Amity Law School, Amity University, Haryana

E-mail: Akumar16@ggn.amity.

ABSTRACT

Reproductive rights form an integral aspect of human rights. Exercising these rights allow women to make autonomous and informed decisions with regard to their reproductive lives. These rights encompass the freedom of access to contraception, menstrual hygiene, safe abortion, pre-natal and post-natal maternal healthcare, access to assisted reproductive technology etc. Such rights are vital for women's bodily autonomy, their health and equality. Despite the fact that reproductive rights are being recognized under Article 21 of the Constitution by the Apex court in several judgements, the existence of certain barriers like deeply engrained patriarchy, crippled and overwhelmed healthcare system, economic and gender inequality and cultural stigma still impede women's access to these rights.

KEYWORDS: Reproductive rights; Women's autonomy; Patriarchy; Safe sexual practices; Human rights

. How To Cite This Article: Joshi PC, Kumar A. Achieving the way to gender justice by remediating the issues surrounding reproductive health of women in india: an analysis. *Int J Drug Deliv Technol.* 2026;16(8s): 681-689; Doi: 10.25258/Ijddt.16.8s.75

1. INTRODUCTION

Reproductive rights denote rights to have information and access to affordable, safe, effective and legally acceptable means and methods of family planning as per one's choice. It includes the right of access to healthcare services enabling women to have safe pregnancy and child birth.¹ It also includes the women's rights to decide about reproduction without being influenced by any kind of coercion, violence and discriminatory practices.² Reproductive rights are the basis of women's health, dignity, their bodily autonomy and for achieving gender egalitarianism in real terms. In this modern world, basic measure of gender equality and empowerment lies in her ability to decide independently regarding her reproductive health. No doubt, India has made substantial progress, with an aim to safeguard reproductive rights of women, by incorporating significant changes and improvements in India's legal frameworks. But deeply ingrained social and cultural impediments still manage to restrict women's complete enjoyment to such rights.

Recent news (dated 5th and 20th January, 2026) related to two illiterate couples in Jind district of Haryana already having 9 daughters in one case (and 10 daughters in another case) giving birth to another child, a boy, amidst desire for male heir (to perform certain rituals)³ reflects the patriarchal norms and traditional beliefs still exist in

certain strata of society and dictating the role of women as mothers.

Enactment of Medical Termination of Pregnancy Act (MTP Act) in 1971 is considered as first major legal step towards recognition of reproductive rights of women in India as it legalized the act of abortion under certain stipulated circumstances and thereby expanded the access to safe and legal abortion services under medical supervision.⁴ In order to address the issue of sex determination and female foeticide, Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 was enacted. After amendment in 2003, it was renamed as Preconception and Prenatal Diagnostic (Prohibition of Sex selection) Act.

Also, such rights were enshrined in international platforms like Convention on the Elimination of All forms of Discrimination against Women (CEDAW) and International Conference on Population and Development, 1994 and thereafter same were recognized and adopted by various countries across the globe, but still the ground reality is different and women are still facing several barriers in exercise of their basic reproductive rights across the globe under the garb of traditional belief systems, economic inequalities and institutional incapacity. Moreover, in India, the evolution of legislative and regulatory framework

¹ Abhijit Das, "Reproductive rights and Community Action" in A.K. Shiva Kumar and Pradeep Panda, *Handbook of Population and Development* 145-151 (Oxford University Press, 2010)

² International Conference on Population & Development Program of Action, Para 7.3, Cairo, Egypt (1994)

*Author for Correspondence: pcjoshiadvocate@gmail.com

³ www.tribuneindia.com (last visited on January 25, 2026)

⁴ Prachi Mishra, "Abortion Laws in India: A look at the MTP Act and Legal Precedents" 5(3) *The Journal of Reproductive Health & Law* (2018)

surrounding reproductive rights have been influenced by various religious, cultural and societal norms.

This paper discusses about the reproductive rights and choices made available to women in India by legislature and about the challenges still encountered by females related to their sexual and reproductive autonomy. This paper also comments upon the judicial decisions, which laid down the cornerstone of jurisprudence of reproductive rights in India, thereby securing and advancing the reproductive rights of women. This paper also focusses on several societal, legal, cultural challenges that are still faced by women in India, thereby hampering their bodily autonomy and sexual choices. This paper further enquires upon the issue as to whether Indian legal framework related to women's reproductive rights aligns with international instruments like CEDAW etc. Finally, the paper talks about the need of measures and policies that are required to be formulated in order to create an inclusive and equitable framework leading to empowerment and emancipation of women.

2. LEGAL FRAMEWOK OF REPRODUCTIVE RIGHTS OF WOMEN IN INDIA

For last few decades, India's outlook towards women's reproductive rights have gradually evolved through wide spread public discussion on women's bodily autonomy and legislative and judicial endeavors. But deep-rooted traditional norms and cultural beliefs curb the liberty of women to exercise their reproductive rights. As reproductive rights have a direct bearing upon health and well-being of mother and her child, so they fall under the category of basic human rights. Women's reproductive rights have been recognized as part of fundamental right to life under article 21 of the Constitution in several judgements passed by Indian judiciary.

2.1 THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

Women's right "to have or not have a child" forms the foundation of her reproductive/bodily autonomy. As per section 312, Indian Penal Code, voluntary causing a miscarriage (unless done in good faith to save the woman's life) is punishable with imprisonment up to 3 years or with fine or both. In case of advanced stage of pregnancy, the punishment may extend up to 7 years of imprisonment and fine.⁵ So, basically abortion has been considered a criminal offence as per penal laws of India. On the recommendations of Central Family Planning Board, a committee was set up by Health ministry in 1964 with an aim to relax the abortion laws. The comprehensive report of this committee formed the basis of "The Medical Termination of Pregnancy Act, 1971". It was in alignment with the United Kingdom's Abortion Act, 1967. The main purpose of this Act was providing for termination of certain specified pregnancies under

the supervision of registered medical practitioners and also addressing the related matters. The Act provides for the circumstances/conditions under which abortion may be performed, (i) in case of any kind of risk/threat to life of pregnant woman or to her physical/mental health; (ii) if pregnancy is caused as a result of rape; (iii) if there is a risk that child, if born, would likely suffer from mental/physical deformity; (iv) in case of contraceptive failure; (v) if environmental conditions are such that it poses a risk to mother's health.⁶

The Act prohibited the termination of pregnancy beyond 20 weeks. The Act provides that pregnancy must be terminated with the help of registered medical practitioner. In case the duration of pregnancy is less than 12 weeks, the procedure is required to be approved by single registered medical practitioner.⁷ And, in case the duration of pregnancy is between 12 to 20 weeks, the procedure is required to be approved by at least 2 registered medical practitioners. Approval must contain an opinion related to risk to the woman's life or health (physical/mental) or related risk as to likelihood of child's physical/mental disability. Due to the precedence of the Act over section 312, IPC, no legal liability under this section arises, in case the conditions specified in section 3, MTP Act are fulfilled.

The Act was later amended in year 2021, wherein gestation limit was increased from 20 to 24 weeks for specific categories like rape survivors, minors etc.⁸ Also, unmarried women were allowed to have abortion under similar terms as laid down by the Act. And, in cases of pregnancy having duration more than 24 weeks, the concept of medical board was introduced to give an opinion regarding requirement and feasibility of termination of pregnancy.

2.2 PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 2003

This was enacted and then amended in 2003 to prohibit determination of sex and to curb the evil of female foeticide. It regulates the usage of scientific methods like ultrasound, amniocentesis by prohibiting its use for sex-determination. Usage of such techniques is allowed only for detection of genetic abnormalities, congenital disorders, sex-linked disorders, chromosomal abnormalities etc. Violations of provisions lead to suspension or cancellation of license of clinics/laboratories along with imposition of heavy penalties on them. Keeping in mind the long history of female infanticide, this act was enacted to prohibit and curb the abortions done after going through such pre-birth sex determination techniques.

2.3 ASSISTED REPRODUCTIVE TECHNOLOGY (ART) ACT, 2021

⁵ The Bharatiya Nyaya Sanhita, 2023 (Act 45 of 2023), s. 88

⁶ The Medical Termination of Pregnancy Act, 1971, s. 3

⁷ The Medical Termination of Pregnancy Act, 1971, s. 3(2)

⁸ The Medical Termination of Pregnancy (Amendment) Act, 2021, s.3(2)(b)

This law was enacted to regulate IVF (In-vitro Fertilization) clinics running across the country. It restricts the reproductive rights by limiting the access to IVF services exclusively for heterosexual married couples and single women (widows/divorcees). LGBTQ+ individuals, unmarried couples, live-in partners cannot avail such services legally. The Act prohibits commercial surrogacy and permits only altruistic arrangements i.e., surrogate needs to be a close relative (though it limits autonomy and may become a factor to create coercion within families). The very purpose behind the same is to prevent commercial exploitation of women. But simultaneously it restricts access to reproductive technology for many, thereby limiting their autonomy and reproductive choice. Altruistic and non-commercial nature of surrogacy is also mandated under Surrogacy (Regulation) Act, 2021 i.e., surrogate cannot be paid for carrying the child. But the intended parents are required to bear all medical expenses and insurance for surrogate during pregnancy and for 36 months after delivery. They are required to obtain written consent from the surrogate (so as to ensure that she is not being coerced into it) and are also bound to protect her safety and confidentiality. Contravention of the provisions of the act may lead to severe penalties (i.e., up to 10 years of imprisonment and fine up to Rs.10 Lacs).⁹

2.4 MATERNITY BENEFITS ACT, 1961 (Amended in 2017)

With a view to support the right to health during pregnancy and post child birth, the mothers were provided the paid maternity leaves. This act was amended in year 2017 under which paid maternity leaves were increased from 12 to 26 weeks for first two children.¹⁰ Adoptive mothers are also provided with provision of 12 weeks of paid leaves. Establishments with more than 50 employees are mandated to provide creche facilities. Nursing mothers are also provided with the option of work from home. This act applies to every establishment with 10 or more employees. If an employer fails to provide maternity benefits provided hereunder this act, they may be sentenced to imprisonment of 3 months extending up to 1 year with fine between Rupees two to five thousand.¹¹

2.5 PROHIBITION OF CHILD MARRIAGE ACT, 2006

This act prohibits the marriage of girls below 18 years of age thereby protecting them from unsafe pregnancies at very young age. In developing nations, harmful practices like dangerous abortions, female genital mutilations,

female foeticide etc. tend to threaten female lives, thereby leading to alarmingly high global maternal mortality rate i.e., 197 deaths per 1 lac live births (though it declined by 40 percent between year 2000 to 2023).¹² In India, the Maternal Mortality Ratio (MMR) dropped from 130 (between 2014-2016) to 93 (between 2019-2021) per 100,000 live births.¹³ Despite all these legislations and initiatives on the part of government, the sexual and reproductive health problems still rank among the leading health concern for women (aged between 15 to 44 years) in developing nations.

3. INTERNATIONAL PERSPECTIVE ON REPRODUCTIVE RIGHTS OF WOMEN

Globally reproductive rights fall under the category of basic human rights and are considered as an integral part of right to health. International organizations like United Nations, through its several conventions and treaties, explicitly or impliedly ensure women's reproductive rights and their bodily autonomy. Based on these conventions, the member states have framed their legislations, regulations and policies to enable the women to exercise their reproductive rights free from any type of discrimination, coercion or violence.

3.1 THE UNIVERSAL DECLARATION OF HUMAN RIGHTS (UDHR),1948

The UDHR, 1948 does not explicitly mention the term "reproductive rights" but it laid down the foundational principles for it. Right to health and well-being under Article 25 can be interpreted to include sexual and reproductive health services in addition to various other aspects of health. Special care and assistance of both motherhood and childhood was recognized in this article. Similarly, right to life and liberty under article 3 can be inferred to enjoy bodily autonomy and security thereby enabling females to make decision about their reproductive choices.¹⁴

3.2 PROCLAMATION OF TEHRAN, 1968

It was adopted during the UN International Conference on Human Rights. It was the first instrument wherein reproductive rights were recognized as a part of human rights. The proclamation states that parents have the right to decide about the number and spacing between their children. The proclamation shifted the perspective of population control from demographic or economic approach towards individual and parental rights. It proved to be a cornerstone of international agreements like Cairo Program of Action, 1994.¹⁵

⁹ The Surrogacy (Regulation) Act, 2021, ss. 38, 39

¹⁰ The Maternity Benefits (Amendment) Act, 2017

¹¹ The Maternity Benefits Act, 1961, s. 21(1)

¹² www.data.unicef.org/topic/maternal-health/maternal-mortality (last visited on January 23, 2026)

¹³ www.mohfw.gov.in (last visited on January 31, 2026)

¹⁴ www.un.org/en/udhrbook/pdf/udhr-booklet-en-wen.pdf (last visited on February 1, 2026)

¹⁵ Roland Burke, "From Individual Rights to National Development: The First International Conference on Human Rights, Tehran 1968" 19(3) *Journal of World History* 275-296 (2008)

3.3 CONVENTION ON ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, 1979

This convention was adopted by UN General Assembly in 1979. It is also referred to as International Bill of Rights for Women. Its sole purpose was to end discrimination in all areas like education, employment, health, family etc. it aimed to ensure equality in practice, not just law. The convention also targeted traditions and culture, under the influence of which, gender roles and family relations are affected and molded.¹⁶ All forms of rights of women including their reproductive rights were dealt with in this convention. Reproductive rights are being dealt with under articles 10 to 12. Member states were tasked with the responsibility to ensure the access of women to the information related to family planning so that their health is not being compromised because of gender discrimination.¹⁷ Measures related to maternity leaves with pay/social benefits are being introduced. Discriminatory practice of dismissal on the ground of pregnancy or marital status was prohibited.¹⁸ Healthcare services related to pregnancy like pre-natal and post-natal care, family planning services etc., were made accessible to females.¹⁹

3.4 INTERNATIONAL CONFERENCE ON POPULATION & DEVELOPMENT (ICPD), CAIRO, 1994

Total 179 countries adopted the ICPD Program of Action. It aimed at placing dignity and rights of people at the heart of sustainable development. It gave priority to human rights including reproductive rights and empowerment of women and girls. United Nations defined the term 'Reproductive Health' at this conference. Its main agenda was to address the sexual and reproductive health issues. Under its program of action, definition of sexual and reproductive health and rights included providing services and information relating to family planning, safe pregnancy and abortion, prevention and treatment of sexually transmitted diseases (STDs) and that too without any coercion, violence or discrimination.²⁰ Primary objectives of ICPD were universal education, reduction of infant/child mortality/maternal mortality across the globe and access to reproductive healthcare.

3.5 BEIJING DECLARATION & PLATFORM OF ACTION, 1995

In this 4th world conference on women, out of 12 key areas, where urgent action was sought to ensure equality and opportunities for males and females, one pertained

to 'Women and Health' wherein their mental health, proper nutrition and sexual and reproductive rights were taken into consideration to ensure greater equality and opportunity.

3.6 SUSTAINABLE DEVELOPMENT GOALS (SDGs)

To address the issues like inequality, climate change, hunger, education etc., 17 global goals were adopted by the United Nations in 2015. It was an urgent call for action by all countries (developing and developed) to eradicate poverty, protect the planet and ensure prosperity for all by 2030. Moreover, women's reproductive rights are primarily addressed through SDG-5 and SDG-3.

SDG-3 relates to ensuring good health and well-being for all. It has a goal to reduce the global maternal mortality ratio to less than 70 per 1,00,000 live births. By 2030, it aims to provide the access of sexual/reproductive healthcare services to all.

SDG-5 aims to achieve gender equality and empower all women and girls. Its main target includes elimination of harmful practices like forced child marriage and female genital mutilation. To ensure universal access to reproductive rights as agreed in accordance with ICPD and Beijing Platform for Action.²¹

4. IMPEDIMENTS TO REPRODUCTIVE RIGHTS IN INDIA

While India has enacted several legislations and passed variety of rules/policies to ensure the swift accessibility of reproductive rights by women of all ages but significant impediments still persist preventing women from exercising their bodily autonomy and reproductive rights.

4.1 PATRIARCHAL SETUP

Main reason behind the restriction of women's autonomy worldwide still remains the deeply ingrained patriarchal system. Patriarchy often curbs women's exercise over their sexual/reproductive choices. Because of prevalence of patriarchal structure, male members of family still dictate regarding timing and number of children a woman/wife/daughter-in-law shall have, thereby denying her the control over her reproductive choices. In patriarchy setup, women are still blamed for infertility. Also, the obsession of having a male child often leads to coercive measures like forced/repeated pregnancies, thereby causing higher risk for maternal health.²² Social stigma and partner's consent generally

¹⁶ www.un.org/womenwatch/daw/cedaw/ (last visited on February 2, 2026)

¹⁷ Convention on Elimination of All Forms of Discrimination against Women, 1979, art. 10

¹⁸ *Id.*, art. 11

¹⁹ *Id.*, art. 12

²⁰ M.J. Roseman, L. Reichenbach, "International Conference on Population & Development at 15 years:

Achieving Sexual and Reproductive Health and Rights for All?" 100(3) *American Journal on Public Health* 403-406 (March, 2010)

²¹ www.unwomen.org/en/node/36060 (last visited on February 5, 2026)

²² A. Radkar, "Is Son Preference Weakening?" 53(12) *Economic & Political Weekly* 101-106 (March, 2018)

hampers women's access to safe abortion and contraceptive methods.

As certain articles of CEDAW relates to personal laws and community practices of various countries including India. So, legislature showed hesitation in implementing and enforcing laws based on such articles due to prevailing societal norms.

4.2 UNEQUAL ACCESS TO HEALTHCARE SERVICES

In terms of mobility, decision making and access to resources the women's independence is not absolute rather constrained.²³ In India, access to healthcare services during pregnancy is quite hampered due to prevalent gender-bias.²⁴ Women's access to contraceptives, abortion services and health care seeking behavior during pregnancy/delivery is determined by the position of woman in household (nuclear/joint). Women in nuclear household are more likely to get services, thereby positively affecting their maternal health.²⁵ As pre-marital sexual relations are considered a taboo in Indian society, hence adolescents face difficulties in accessing contraceptives, safe abortions and other reproductive health services.²⁶

4.3 ABORTION: LEGAL BUT STIGMATIZED

Abortion, though legally allowed, is still considered a social taboo in India. This deep-rooted socio-cultural stigma forces unmarried females, rural women and those belonging to marginalized communities to adopt unsafe and dangerous methods of abortion, thereby putting their life/health at risk. Unsafe abortions are one of the major factors behind maternal mortality across the globe. Around two-third abortions in India falls under this unsafe category.²⁷ Based on women's role as child-bearers and caregivers, forcing them to continue with unwanted pregnancies, is in reality a severe kind of injustice.²⁸

4.4 ECONOMIC BARRIERS

Women's access to reproductive health services is notably obstructed by economic disparity. It disproportionately hit women from economically backward strata, thereby contributing to adoption of unsafe and dangerous abortion methods or lower access to necessary pre-natal care, finally resulting in poorer health conditions. In developing countries, millions of women still lack the means to prevent unwanted pregnancies and to get the medical aid in case of any complication/disease during pregnancy.²⁹ Women with meagre financial resources generally lack the education and autonomy to take decisions related to their reproductive health, which further worsen their financial capacity, thereby compounding their vulnerability. Hence, denying abortion increases poverty among such economically vulnerable groups.

4.5 RELIGIOUS AND CULTURAL IMPEDIMENTS

Traditions like child-marriage and other strict gender norms lead to high-risk unwanted pregnancies and other health related complications for women and girls. Due to early marriage, the girls are forced to take part in sexual relations and child-bearing. Because of their under-developed bodies, young girls face greater risk of several life-threatening conditions because of pregnancy and childbirth (For example, obstetric fistula and hemorrhaging). In certain sections of society, particularly rural and marginalized communities, due to immense pressure for early marriage and child-bearing, voluntary and informed reproductive decision making by women takes a backseat, thereby constraining women's agency.³⁰ Moreover, taboos related to menstruation still exist and hence lead to use of unsafe practices rendering women vulnerable to physical and mental traumas. In India, 42.5% of women use old cloth pieces during menstruation. Re-use of such old cloth is a cause of reproductive tract infection among women.³¹

²³ S.J. Jejeebhoy, Z.A. Sathar, "Women's Autonomy in India and Pakistan: The Influence of Religion & Region" *27 Population & Development Review* 687-712 (2001)

²⁴ G. Sen, A. Iyer, "Who gains, Who Loses & How: Leveraging Gender & Class Intersections to Secure Health Entitlements" *74(11) Social Science & Medicine* 1802-1811 (June, 2012)

²⁵ N. Saikia, A. Singh, "Does type of Household Affect Maternal Health? Evidence from India" *41(3) Journal of Biosocial Science* 329-353 (2009)

²⁶ L. Sanneving et.al., "Inequity in India: The Case of Maternal & Reproductive Health" *Global Health Action* (2013)

²⁷ EPW Editorial, "Right to Safe Abortion Care" *53(9) Economic & Political Weekly* (2017)

²⁸ D. Jain, "Time to Rethink Criminalization of Abortion? Towards a Gender Justice Approach" *12 NUJS Law Review* 21 (2019)

²⁹ Lozano R, Naghavi M. et.al., "Global & Regional Mortality from 235 cause of Death for 20 age groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010" *380 The Lancet* 2095-2128 (2012)

³⁰ S. Sinclair, P. Nanda et.al., "Child Marriage in South Asia: Context, Evidence and Policy Options for Action" *AFPPD, Australian Government Overseas Aid Program and UNFPA, Asia Pacific Regional Office* (October, 2012)

³¹ I. Mostafa, "The Real Period Stain: Menstrual Stigma & its Pressure in South-Asia" *Celebration of Learning* (2019) available at: digitalcommons.augustana.edu/celebrationoflearning/2019/presentations/3

5. JUDICIAL APPROACH TOWARDS REPRODUCTIVE RIGHTS OF WOMEN IN INDIA

In India, reproductive rights of women are shaped by combination of statutory laws/legislations, guarantees provided under constitutional provisions and judicial interpretations by various High Courts and Supreme Court. The right to reproductive autonomy is not explicitly provided in any of the constitutional provision, but the same has been interpreted (in a series of landmark judgements) from Article 21 (Right to Life and Personal Liberty) read with other rights under Article 14 (Right to Equality), Article 15 (Prohibition of Discrimination based on Sex /Gender) and Article 19 (Right to Freedom of Speech and Expression). Reproductive rights encompass variety of rights within itself. The key ingredients of reproductive autonomy in India includes as follows: -

5.1 RIGHT TO HAVE CHILD OR NOT TO HAVE CHILD

Reproductive autonomy includes the choice of women to take decision as to reproduce or not to reproduce. Right to not have a child has been recognized under MTP Act, 1971. Moreover, in case of *Suchita Srivastava v. Chandigarh Administration*³² the court held that women's right to make reproductive choices falls under the dimension of 'Personal Liberty' as described under article 21 of the Constitution. The Apex court stated that reproductive choices can be exercised both to procreate as well as to abstain from it. The main factors to be considered includes respect towards women's right to bodily integrity, dignity and privacy. In case of termination of pregnancy, women's consent is important. In the absence of her consent, the women's right to liberty and reproductive choice get violated. Similarly in High Court on its own motion v. State of Maharashtra³³, the Bombay High Court opined that due to the profound effects of pregnancy on the physical and mental well-being of a woman, the choice related to fertility, motherhood, bodily autonomy should be given to the woman alone.

5.2 ACCESS OF CONTRACEPTION AND FAMILY PLANNING

Women must have free will to decide and access the method of birth control. There should be no restriction on the contraception choice of the woman. 'Birth control' is an individual choice of woman to control her fertility, while 'Family Planning' is state's endeavor to control/restrict the population of state. In India, family planning services are implemented through administrative policies. Also, the manufacture and sales of material related to contraceptives is also regulated by

government. But factors like poverty, illiteracy, poor health infrastructure etc. led to lack of information and access to contraception methods, thereby increasing number of unwanted pregnancies and risk of maternal mortality. In India, unsafe abortion is 3rd main cause of maternal mortality. 8% of maternal deaths are caused by such abortions.³⁴ In *Meera Santosh Pal v. Union of India*³⁵ and *Z v. State of Bihar*³⁶, the Supreme Court held that women's right to reproductive autonomy includes her right to refuse participation in sexual activity, and her right to choose an appropriate contraceptive/birth control method.

5.3 FREEDOM FROM COERCION & VIOLENCE

Reproductive autonomy can be fully exercised by women only if there is complete absence of any kind of coercion or violence in cases of impregnation, abortion or sterilization. State should refrain from exercise of coercion while implementing family planning measures. In a bid to control the population, India always had bad reputation for implementing forced sterilization policies especially in rural areas. After incidents of mass forced sterilization in the states of Bihar and Chhattisgarh in year 2012 by an NGO accredited by the District Health Society without following any formal transparent process in unhygienic conditions, a public interest litigation was filed as informed consent was not obtained from patients before conducting the procedures. The court held the respondents liable for violation of right to health and reproductive rights under article 21 of the constitution. The court held that freedom to exercise reproductive rights by women includes the right to make choice regarding sterilization on the basis of informed consent and without any kind of coercion.³⁷ State was directed to follow Standard Operating Procedures related to sterilization process.

5.4 RIGHT TO HAVE ADEQUATE PRE-NATAL & POST-NATAL REPRODUCTIVE HEALTHCARE

Reproductive health includes ability to have safe sex life, capability to reproduce with freedom to decide about spacing between children, having access to safe and affordable family planning methods of their choice, having safe pregnancy and child-birth. In *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others*³⁸, the High Court observed that death of women because of refusal of adequate maternal healthcare despite being qualified for free services under State-sponsored schemes is unfortunate. The court stated that right to healthcare including right to access public health facilities, enforcement of reproductive rights of mother, medical care of new born child falls under the umbrella of Right

³² (2009) 9 SCC 1

³³ 2017 ALL MR (Cri) 3 250 Bombay HC

³⁴ S. Mishra, S.K. Rath, "Unsafe Abortion: Combating the Silent Menace" 8(2) *Indian Journal of Obstetrics & Gynecology Research* 146-149 (2021)

³⁵ (2017) 3 SCC 462

³⁶ (2018) 11 SCC 572

³⁷ *Devika Biswas v. Union of India* (2016) 10 SCC 726

³⁸ (2010) 172 DLT 9

to Life and Personal liberty under article 21 of the Constitution. Hence, lack of implementation of health and nutrition schemes amount to denial and violation of right to life. Similarly, in *Kali Bai v. Union of India*³⁹, high maternal mortality rates were highlighted due to poor health infrastructure at Gaurela Community Health Centre in Bilaspur, Chhattisgarh. The court held that state's failure to provide timely medical treatment to a person in need of such treatment amounts to violation of fundamental rights under article 21.

5.5 RIGHT TO SAFE AND LEGAL ABORTIONS

In India abortion is legal i.e., termination up to 20 weeks of pregnancy is permitted with one doctor's approval. And in certain categories (like rape victims, minors, disabled) termination of 24 weeks of pregnancy is permitted with 2 doctors' approval.⁴⁰ In *Murugan Nayakkar v. Union of India*⁴¹, the Supreme Court allowed abortion at 32 weeks to a 13-year-old rape survivor, thereby giving priority to her bodily autonomy. The court emphasized that mental trauma of pregnancy caused due to rape outweighs fetal rights. In *X v. Principal Secretary, Health & Family Welfare Department, Government of NCT of Delhi*⁴², the Supreme Court expanded the scope of section 3B of MTP Act, 1971 (amended in 2021) and included unmarried women, thereby ensuring equality and non-discrimination. It held that access to abortion cannot be determined solely by female's marital status. In *K.S. Puttaswamy v. Union of India*⁴³, the Hon'ble Supreme Court affirmed privacy as a fundamental right under Constitution of India. The bench recognized privacy as an inalienable right covering personal autonomy (relating to body and mind) in its wide domain.

These judicial decisions helped in securing and advancing the reproductive rights of women, thereby keeping the soul of concerned legislations and policies intact along with laying down of emerging jurisprudential substructure of reproductive rights of women in a developing country like India. In a recent judgement by Hon'ble Supreme Court, access to menstrual hygiene is recognized as a fundamental right under article 21 (Right to Life) and 21A (Right to Education). In order to address high dropouts and absenteeism among menstruating girls, the apex court directed all the states and union territories to ensure availability of toilets and menstrual absorbents in every school (Government and private schools in rural and urban areas). Moreover, with a view to break stigma and taboo associated with menstrual health and hygiene, the court directed the National and State Councils of Educational Research and Training (i.e., NCERT & SCERTs) to incorporate gender responsive curricula on menstruation, puberty and other related health concerns (PCOS, PCOD etc.). Also, training and sensitization on

menstrual hygiene is to be imparted to all teachers (males and females both).⁴⁴

6. CONCLUSION & SUGGESTIVE MEASURES

All the international instruments related to human rights like CEDAW, UDHR, ICPD etc. have repeatedly affirmed that reproductive autonomy of women is a non-negotiable part of their bodily integrity, dignity and equality. And, India being a signatory to these instruments bears an obligation to frame and harmonize domestic legislations and policies with stipulated international standards. The in-depth analysis of India's legal and policy framework shows that though the country has made commendable progress in granting access to reproductive rights to all ages of women, but still a lot to be done to ensure the full realization and protection of reproductive rights across all age groups, castes, strata of female society. Basically, variety of social impediments like patriarchy, budgetary constraints, economic disparity, cultural and religious stigma continue to hamper women's right to fully enjoy their reproductive bodily autonomy. In order to make full realization of their reproductive rights by women, the legislative reforms and policies need to be implemented effectively in their real terms and spirit. To ensure the same, following measures are required to be implemented: -

Firstly, certain legal and policy reforms are required to be undertaken on urgent basis. A legislation related to 'Protection of Reproductive Rights' needs to be enacted wherein scope of reproductive rights need to be specifically defined. Agencies responsible for ensuring women's reproductive health must be made accountable (by way of penalty etc.) in case of any kind of deficiency on their part. Right to abort the foetus (without determination of gender) must be given to the women of all ages carrying the same in her womb based on her prudent choice/decision. Gestational limits for the purposes of abortion should be removed especially in cases where there is a chance of physical/mental risk to mother or child. Any kind of coercion, allurements, undue influence, mis-representation etc., caused by any person for the purposes of altering women's decision related to her reproductive autonomy or choice must be made punishable.

Secondly, based on the population of our country, healthcare infrastructure needs to be revamped keeping in mind the rural and economically weaker section of the society across the country. Health centres and government hospitals in the rural and semi-urban areas of the country are still in miserable condition with chronic shortage of staff and infrastructure. Trained professionals with fully equipped mobile clinics for treatment of medical conditions related to reproductive health of women are required to be launched along with

³⁹ (2017) SCC OnLine Chh. 1081

⁴⁰ *Supra* note 8

⁴¹ (2017) SCC OnLine SC 1092

⁴² 2022 INSC 740

⁴³ (2017) 10 SCC 1

⁴⁴ *Dr. Jaya Thakur v. Govt. of India & Ors.* 2026 INSC 97

upgradation of government hospitals and health centres based on latest medical techniques/equipment. Similar to registration of births in the country, a database related to pregnant women and lactating mothers must be maintained so as to keep track of physical and mental health related needs of such women.

Thirdly, there is an urgent need of introduction of policies related to reproductive health, keeping in mind the reproductive rights (right to fertility, surrogacy, adoption etc.) of LGBTQ+ persons. Policies related to promotion of safeguards against forced sterilization must also be framed. With an aim to curb the practice of forced sterilization, women must be made aware of their reproductive rights by means of distributing pamphlets, spreading short and informative videos, performing street plays in rural areas etc. In order to address the violation of reproductive rights of women/LGBTQ+, a centralized complaint redressal mechanism must be built by Central and State governments. Such complaints must be tackled and disposed of in time bound manner.

Fourthly, in order to challenge the patriarchal norms, gender-based discrimination and the stigma/taboo associated with abortion, menstruation, fertility etc., there is an urgent need to sensitize the teenagers, grown-ups, religious leaders, educators etc. Knowledge related to equal status of women, reproductive system and health, menstruation, abortion and fertility, contraceptive methods etc. must be imparted in an informative and entertaining way. Health-workers need to be trained on the topic and issues of gender sensitivity, human rights etc. Government must launch platforms for open dialogues related to reproductive health of women at every level (school, colleges, offices etc.). To dismantle the stigma and misconception, science based accurate information must be imparted. Online platforms and social media must be utilized to share the facts, information and real-life stories. To build support and reduce stigma, men/boys must be involved in conversation related to topics like menstruation and reproductive health of women.

Fifthly, India must make initiatives to align its laws and policies related to reproductive health with best practices followed across globe. Like, WHO guidelines (2022) and countries like South Africa and Canada supports concept of abortion on demand for up to 12 weeks pregnancy as opposed to India's conditional and doctor-approved abortions. Moreover, in India surrogacy is not allowed to single parents, LGBTQ+ community etc. But ICPD, Cairo program (1994) and European Commission of Human Rights and countries like USA, Cyprus, Canada, Mexico support inclusivity and hence made surrogacy open to all including single parents, same sex couples, thereby offering robust legal protection for intended parents. Government must implement rules/regulations to prevent forced/coerced sterilization under the garb of incentives to Dalit and poor women, though such practices are condemned by CEDAW and UN Human Rights Council. Hence, a monumental shift is urgently needed as reproductive rights of women in

our country lag behind global best practices. We must adopt a rights-based inclusive approach.

REFERENCES

ARTICLES/BOOKS

1. Abhijit Das, "Reproductive rights and Community Action" in A.K. Shiva Kumar and Pradeep Panda, *Handbook of Population and Development* 145-151 (Oxford University Press, 2010)
2. A. Radkar, "Is Son Preference Weakening?" 53(12) *Economic & Political Weekly* 101-106 (March, 2018)
3. D. Jain, "Time to Rethink Criminalization of Abortion? Towards a Gender Justice Approach" 12 *NUJS Law Review* 21 (2019)
4. EPW Editorial, "Right to Safe Abortion Care" 53(9) *Economic & Political Weekly* (2017)
5. G. Sen, A. Iyer, "Who gains, Who Loses & How: Leveraging Gender & Class Intersections to Secure Health Entitlements" 74(11) *Social Science & Medicine* 1802-1811 (June, 2012)
6. I. Mostafa, "The Real Period Stain: Menstrual Stigma & its Pressure in South-Asia" *Celebration of Learning* (2019) available at: digitalcommons.augustana.edu/celebrationoflearning/2019/presentations/3
7. International Conference on Population & Development Program of Action, Para 7.3, Cairo, Egypt (1994)
8. Lozano R, Naghavi M. et.al., "Global & Regional Mortality from 235 cause of Death for 20 age groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010" 380 *The Lancet* 2095-2128 (2012)
9. L. Sanneving et.al., "Inequity in India: The Case of Maternal & Reproductive Health" *Global Health Action* (2013)
10. M.J. Roseman, L. Reichenbach, "International Conference on Population & Development at 15 years: Achieving Sexual and Reproductive Health and Rights for All?" 100(3) *American Journal on Public Health* 403-406 (March, 2010)
11. N. Saikia, A. Singh, "Does type of Household Affect Maternal Health? Evidence from India" 41(3) *Journal of Biosocial Science* 329-353 (2009)
12. Prachi Mishra, "Abortion Laws in India: A look at the MTP Act and Legal Precedents" 5(3) *The Journal of Reproductive Health & Law* (2018)
13. Roland Burke, "From Individual Rights to National Development: The First International Conference on Human Rights, Tehran 1968" 19(3) *Journal of World History* 275-296 (2008)
14. S.J. Jejeebhoy, Z.A. Sathar, "Women's Autonomy in India and Pakistan: The Influence of Religion & Region" 27 *Population & Development Review* 687-712 (2001)
15. S. Mishra, S.K. Rath, "Unsafe Abortion: Combating the Silent Menace" 8(2) *Indian Journal of Obstetrics & Gynecology Research* 146-149 (2021)

16. S. Sinclair, P. Nanda et.al., “Child Marriage in South Asia: Context, Evidence and Policy Options for Action” *AFPPD, Australian Government Overseas Aid Program and UNFPA, Asia Pacific Regional Office* (October, 2012)

JUDGEMENTS

1. Devika Biswas v. Union of India (2016) 10 SCC 726
2. Dr. Jaya Thakur v. Government of India & Others 2026 INSC 97
3. High Court on its own motion v. State of Maharashtra 2017 ALL MR (Cri) 3 250 Bombay HC
4. Kali Bai v. Union of India (2017) SCC OnLine Chh. 1081
5. K.S. Puttaswamy v. Union of India (2017) 10 SCC 1
6. Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others (2010) 172 DLT 9
7. Meera Santosh Pal v. Union of India (2017) 3 SCC 462
8. Murugan Nayakkar v. Union of India (2017) SCC OnLine SC 1092
9. Suchita Srivastava v. Chandigarh Administration (2009) 9 SCC 1
10. X v. Principal Secretary, Health & Family Welfare Department, Government of NCT of Delhi 2022 INSC 740
11. Z v. State of Bihar (2018) 11 SCC 572

STATUTES

1. The Bharatiya Nyaya Sanhita, 2023 (Act 45 of 2023), s. 88
2. Convention on Elimination of All Forms of Discrimination against Women, 1979, art. 10
3. The Constitution of India, Art. 14, 21
4. The Maternity Benefits (Amendment) Act, 2017
5. The Maternity Benefits Act, 1961, s. 21(1)
6. The Medical Termination of Pregnancy Act, 1971, s. 3
7. The Medical Termination of Pregnancy Act, 1971, s. 3(2)
8. The Medical Termination of Pregnancy (Amendment) Act, 2021, s.3(2)(b)
9. The Surrogacy (Regulation) Act, 2021, ss. 38, 39

WEBSITES

- www.data.unicef.org/topic/maternal-health/maternal-mortality (last visited on January 23, 2026)
- www.mohfw.gov.in (last visited on January 31, 2026)
- www.tribuneindia.com (last visited on January 25, 2026)
- www.un.org/en/udhrbook/pdf/udhr-booklet-en-wen.pdf (last visited on February 1, 2026)
- www.un.org/womenwatch/daw/cedaw/ (last visited on February 2, 2026)
- www.unwomen.org/en/node/36060 (last visited on February 5, 2026)