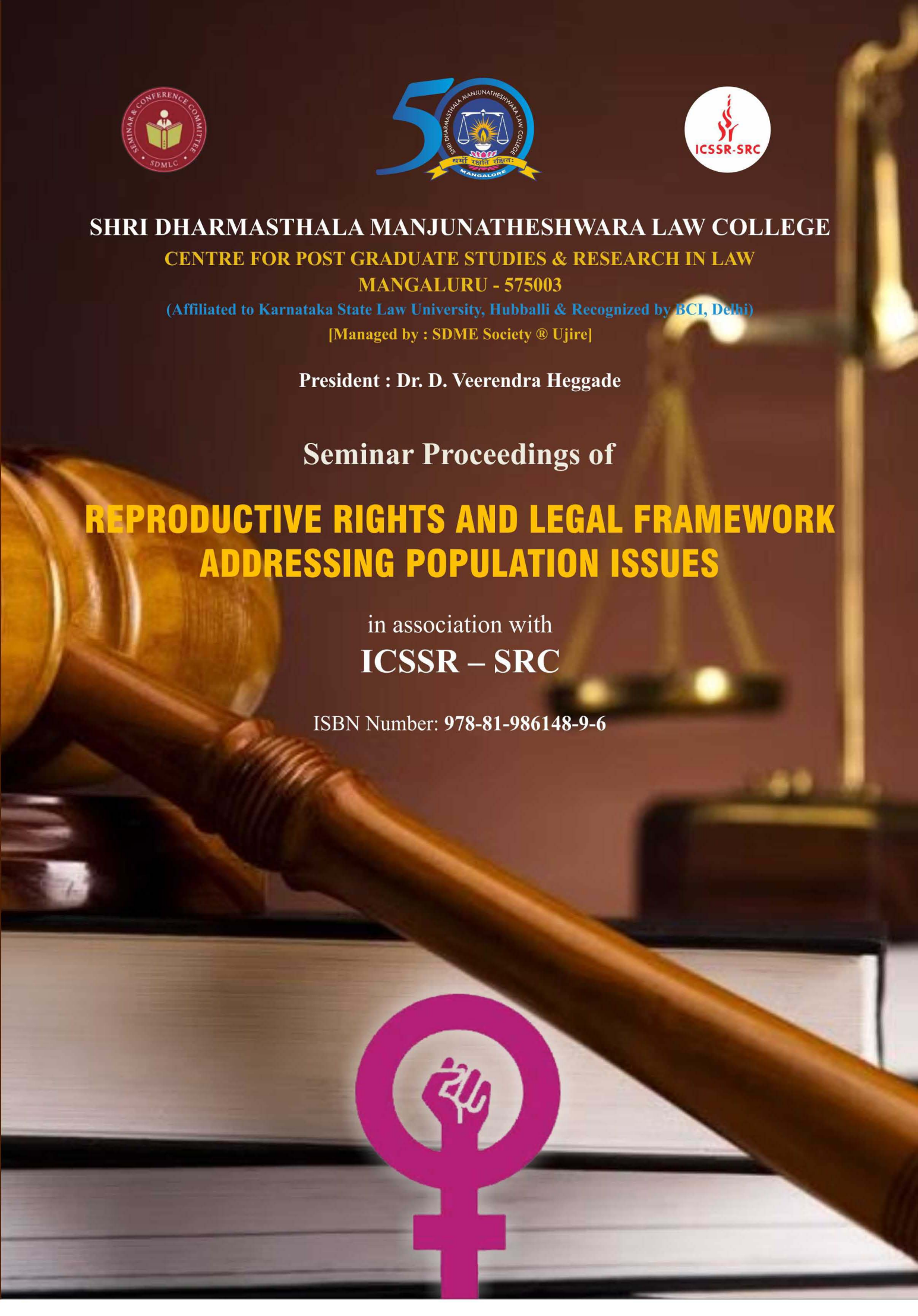

SHRI DHARMASTHALA MANJUNATHESHWARA LAW COLLEGE

CENTRE FOR POST GRADUATE STUDIES & RESEARCH IN LAW

MANGALURU - 575003

(Affiliated to Karnataka State Law University, Hubballi & Recognized by BCI, Delhi)

[Managed by : SDME Society ® Ujire]

President : Dr. D. Veerendra Heggade

Seminar Proceedings of

REPRODUCTIVE RIGHTS AND LEGAL FRAMEWORK ADDRESSING POPULATION ISSUES

in association with

ICSSR – SRC

ISBN Number: 978-81-986148-9-6

EDITORIAL BOARD

Disclaimer

The views/opinions expressed by the various contributors of the articles are their own views / opinions and do not represent the institute's opinion or the members of the Editorial Board.

ABOUT US

Shri DharmasthalaManjunatheshwara Law College Centre for Post Graduate Studies and Research in Law, Mangalore, is a professional college established in 1974 and is functioning under the aegis of the SDM Educational Society®Ujire. The college aims at imparting holistic knowledge of law and mould students to be competent legal professionals, committed to the cause of community development through sustained economic activities and research thereby, promoting empowerment through legal education for building ethical society.

Presently, the college has been affiliated to Karnataka State Law University, Hubballi and is recognized by the Bar Council of India.

The college offers Five Years integrated BA LLB, BBA LLB, Three Years LLB Course and Two Years LLM Programme. The college is the only Research Centre recognized by Karnataka State Law University, Hubballi.

The National Assessment and Accreditation Council (NAAC) in the year 2025 has inspected the institution online for the fourth cycle of re-accreditation. In the year 2025, the survey conducted for Top Eminent Law Schools in India by CSR (Competition Success Review), SDM Law College obtained 1st Rank in India. Our college has participated in GHRDC Law Schools Survey, 2025 and obtained 1st rank in the category of Eminent, 5th rank in the State of Karnataka and 6th rank in the Southern Region. The college has an outstanding alumnus in the judicial, administrative & host of other careers. The distinctiveness of the college is reflected in unique mooting events, law lab and functional arbitration centre. The year 2024 is observed as the golden jubilee year of the establishment of the college.

EDITORIAL

It gives me immense pleasure to present the proceedings of the National Seminar on "Reproductive Rights and Legal Framework Addressing Population Issues," hosted under the aegis of our institution. The theme is not only timely but also critical in the context of our nation's socio-economic development and public health strategy.

Reproductive rights are a fundamental subset of human rights, encompassing the right to access reproductive health care, the right to make decisions regarding reproduction free from discrimination, coercion or violence and the right to education and information on sexual and reproductive health. These rights are inextricably linked with broader issues such as gender equality, public health, social justice and population control.

India, as one of the most populous countries in the world, faces a unique set of challenges. On one hand, we are witnessing rapid urbanization, increasing literacy and greater access to healthcare. On the other, disparities in access to reproductive health services, gender-based discrimination, early marriage and lack of awareness continue to persist in many regions. The legal framework in our country has evolved considerably from the MTP Act to laws against forced sterilization and child marriages but the implementation and public understanding often fall short of the intended outcomes.

As we step further into the 21st century, India continues to grapple with complex population dynamics. While advances in healthcare and education have contributed to increased awareness, A significant portion of our population particularly women and marginalized communities remains unaware or unable to exercise their reproductive rights freely.

This seminar brought together a wide spectrum of voices of academicians, legal experts, public health professionals, advocates and students to reflect upon and critically examine the challenges and opportunities within our legal and ethical framework.

The college is committed to encourage such intellectual inquiry that bridges academic theory with social application. We place on record our sincere gratitude to Poojya Dr. D. Veerendra Heggadeji and all distinguished members of the management for their active support in all our academic endeavours. I commend the seminar/ Conference and guest lecture Committee led by Dr Annapoorna Shet and the Student Co ordinators and Ms. Kavya, Co Ordinator of PG Centre for organizing a seminar in association with ICSSR (SRC) and I extend my heartfelt thanks to all the contributors whose research papers and presentations have enriched these proceedings.

I sincerely hope that this compilation will serve as a valuable resource for scholars, policymakers and students and it will inspire further research and action in the field of reproductive justice and population management.

Dr Tharanatha
Principal

ABOUT THE SEMINAR

S*DM Law College Seminar and Conference Committee and PG Department of Law in association with Indian Council of Social Science Research - SRC (ICSSR) has conducted One day National Seminar on "Reproductive Rights and Legal Framework addressing Population Issues" on 15-03-2025.*

The seminar explored the vital role of laws in protecting individual autonomy, focusing on women's reproductive rights. These rights encompass family planning, safe abortion, maternal healthcare and informed decision-making free from discrimination. Legal frameworks are crucial for upholding these rights, promoting gender equality and empowering women to make choices impacting their health, social and economic well-being. By granting reproductive rights, women can participate more fully in decision-making, leading to more equitable policy development. The seminar aimed to raise awareness about legal protections for reproductive health, including access to contraception, abortion and maternal care, enabling informed decisions and a deeper understanding of reproductive justice. We received 217 registrations from across India, where 143 authors presented the paper and selected papers presented in the seminar are published in this book.

I thank the Management in this respect. My deep sense of gratitude goes to Dr Tharanatha, Principal, SDM Law College, for allowing me to lead the Seminar and Conference Committee and also to organize a National Seminar in association with the Indian Council of Social Science Research - SRC (ICSSR) and for the support given in the publication process of this book. I extend my sincere gratitude to the Indian Council of Social Science Research - SRC (ICSSR) for providing partial assistance for conducting the seminar. I thank Ms. Kavya, LL.M Co-ordinator for her support in conducting the Seminar.

I also acknowledge the contribution of Ms. Sowparnika S. Hebbar, Secretary; Seminar and Conference Committee and Ms. Kadeejath Juviriya, Mr Anjan Krishna, Ms. Nagadarshini Naik, Ms. Deekshitha N, members of Seminar and Conference Committee in bringing out the conference proceedings. I sincerely thank all the authors who have submitted their papers for the conference proceedings.

Dr. Annapoorna Shet
(Faculty Editor)

Table of content

REGULATING WOMBS: A CONSTITUTIONAL INQUIRY INTO STATE CONTROL OVER SURROGACY IN INDIA

Ms. Shruti Tandon *
Mr. Sidharth Rathore **

Abstract

"Reproductive choices, including the right to procreate or abstain from procreation, are an essential facet of personal liberty under Article 21 of the Constitution."[1]

With these words, the Supreme Court in Suchita Srivastava v. Chandigarh Administration reaffirmed that reproductive autonomy is not merely a matter of personal preference but a constitutionally protected right. However, the Surrogacy (Regulation) Act, 2021 imposes stringent eligibility criteria, limiting access to heterosexual married Indian couples with medical necessity, while excluding single parents, LGBTQ+ individuals, and foreign nationals. Although framed to curb the exploitation of surrogate mothers and regulate assisted reproductive technologies, the Act raises fundamental concerns about state overreach into private reproductive decisions and its potential conflict with constitutional guarantees.

This paper critically examines the constitutional validity of these restrictions through the lens of equality, privacy, and reproductive autonomy under Articles 14 and 21. It explores whether these limitations constitute legislative overreach, disproportionately infringing upon personal liberties in the guise of public interest. Additionally, the study evaluates whether the state's regulatory control over surrogacy is a legitimate exercise of its parens patriae authority or an excessive restriction on individual choice.

While existing literature of work largely addresses the ethical and policy implications of surrogacy, there remains a critical gap in analyzing the Act's constitutional proportionality and reasonableness. This research fills that gap by conducting a doctrinal analysis of judicial precedents and statutory frameworks to determine whether India's surrogacy law strikes a just balance between state interest and reproductive rights. The study ultimately argues that while regulation is necessary to prevent exploitation, an unduly restrictive framework risks violating fundamental rights, necessitating a more inclusive and rights-based approach to surrogacy in India.

Keywords: **Surrogacy Law, Reproductive Autonomy, Constitutional Validity, State Regulation**

I. Introduction

Background and Significance of the Study

"Reproductive rights are not merely about having children but about having control over one's body and decision-making power over reproductive choices."[2]

Reproductive rights are central to personal liberty, bodily autonomy, and human dignity. Courts and legal scholars worldwide recognize reproductive choice as an essential aspect of individual freedom. In India, judicial pronouncements affirm that reproductive rights extend beyond biological functions to encompass decisional autonomy, privacy, and equality-all integral to constitutional protections under Article 21.[3] Courts have consistently upheld reproductive autonomy as a facet of personal liberty, as seen in *Suchita Srivastava v. Chandigarh Administration*, where the Supreme Court recognized the right to make reproductive choices

* **Junior Research Fellow, Dr. B.R. Ambedkar National University, Haryana.**

** **Assistant Professor, School of Law, Ideal Institute of Management & Technology, Guru Govind Singh Indraprastha University**

1 *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1, 11 (India).

2 *Ibid*

3 *K.S. Puttaswamy v. Union of India*, (2017) 10 S.C.C. 1.

as part of individual dignity and autonomy. Similarly, in *Justice K.S. Puttaswamy v. Union of India*, the right to privacy was held to include bodily autonomy and decisional independence, reinforcing constitutional safeguards around reproductive rights.[4]

Despite this recognition, theSurrogacy (Regulation) Act, 2021 introduces a restrictive framework, limiting surrogacy access to heterosexual married couples with medical infertility, thereby excluding single parents, LGBTQ+ individuals, and foreign nationals.[5] This exclusion raises constitutional concerns under Articles 14 and 21, challenging its validity as a reasonable restriction.

Data from the *National Assisted Reproductive Technology and Surrogacy Board* (NARTSB) indicates that over *25,000 children were born through surrogacy in India between 2010 and 2020*, with a significant number involving single and LGBTQ+ individuals before the current restrictions were imposed.[6] These exclusions not only limit access but disproportionately impact marginalized groups.

While the Act aims to prevent the exploitation of surrogate mothers[7], it raises concerns about state overreach, discrimination, and infringement of reproductive autonomy. The doctrine of *parens patriae* is invoked to justify state intervention, arguing that such measures protect vulnerable women from exploitation and commodification.[8] The doctrine, which allows the state to act as a guardian for those unable to protect themselves, has been invoked in past rulings to justify restrictions in matters of personal autonomy.[9]

Yet, on the flipside, legal scholars argue that such regulation must be proportional to the harm it seeks to prevent.[10] This paper critically examines the legal and constitutional implications of India's surrogacy law and explores whether its restrictions align with constitutional guarantees.

Research Problem and Research Questions

The research critically evaluates whether the Surrogacy (Regulation) Act, 2021, violates fundamental rights by imposing arbitrary and discriminatory restrictions. The following questions guide this inquiry:

1. Does the exclusion of single parents, LGBTQ+ individuals, and foreign nationals from surrogacy violate the right to equality under Article 14?
2. Does the restriction on reproductive choices infringe upon the right to privacy and reproductive autonomy under Article 21?
3. To what extent does the doctrine of parens patriae justify state intervention in surrogacy regulations?
4. What reforms can be proposed to balance state regulation with reproductive rights?

Hypothesis

This study posits that the Surrogacy (Regulation) Act, 2021, imposes disproportionate restrictions that unconstitutionally infringe upon reproductive autonomy. While regulation is essential to prevent exploitation, the Act's exclusions violate fundamental rights, necessitating a more inclusive and balanced legal framework.

Scope and Limitations

This study primarily focuses on the legal and constitutional aspects of surrogacy regulations in India, with an emphasis on the Surrogacy (Regulation) Act, 2021. While *ethical, sociological, and economic considerations* are relevant, they remain secondary to the legal discourse. Although international perspectives provide valuable insights, the study primarily centers on India's legal framework while acknowledging global best practices for context.

Research Methodology

This study employs a doctrinal legal research methodology, drawing from primary sources such as

---

4 Ibid.

5 The Surrogacy (Regulation) Act, No. 47, Acts of Parliament, 2021 (India).

6 National Assisted Reproductive Technology & Surrogacy Board, *Annual Report on Surrogacy in India* (2021), https://artsurrogacy.gov.in.

7 J. Singh, *Commercial Surrogacy in India: Ethical and Legal Challenges*, 24 Ind. J. Gender Stud. 89 (2018).

8 Sama Resource Group for Women and Health, *Birthing a Market: A Study on Commercial Surrogacy* (2012), https://www.samawomenshealth.in (last visited Mar. 13, 2025).

9 *State of Maharashtra v. Madhukar Narayan Mardikar*, (1991) 1 S.C.C. 57; *Devika Biswas v. Union of India*, (2016) 10 S.C.C. 726.

10 J. Singh, *Commercial Surrogacy in India: Ethical and Legal Challenges*, 10(2) *J. Law & Soc. Policy* 45 (2018).

constitutional provisions, statutes, judicial precedents, and legal commentaries. It also incorporates secondary sources, including academic journals, law reviews, policy reports, and expert analyses, to ensure a comprehensive evaluation. Using an analytical approach, the research examines the proportionality of India's surrogacy restrictions while briefly referencing international legal frameworks for contextual insights.

II.Legal and Constitutional Foundations of the Surrogacy (Regulation) Act, 2021

The enactment of the *Surrogacy (Regulation) Act, 2021* by the Indian Parliament marked a significant shift in the legal landscape of assisted reproductive technologies in India. The Act aims to regulate surrogacy services in the country by prohibiting commercial surrogacy while allowing only altruistic surrogacy under specific conditions. The primary objectives of the Act, as outlined in its provisions, include preventing the exploitation of women, particularly those from economically weaker sections, ensuring the rights of surrogate children, and upholding ethical standards in the practice of surrogacy.[11]

Key Provisions of the Act:

1. Prohibition of Commercial Surrogacy: As per Section 3 of the Act, commercial surrogacy is strictly prohibited, criminalizing monetary transactions beyond basic medical expenses and insurance coverage for the surrogate mother.[12]
2. Eligibility Criteria for Intended Parents: Section 4(iii)(c)(I) limits surrogacy to legally married Indian heterosexual couples who have been married for at least five years, are infertile, and do not have any biological or adopted children (with some exceptions for disabled or deceased children).[13]
3. Conditions for Surrogate Mothers: Under Section 4(iii)(a) & (b), a surrogate mother must be a close relative of the intending couple, married, have at least one biological child, and be between the ages of 25-35 years.[14]
4. Ban on Foreign Nationals and Certain Groups: Section 4(iii)(c) prohibits foreign nationals, single men, unmarried women, same-sex couples, and live-in partners from accessing surrogacy in India, restricting its use to married heterosexual couples only.[15]
5. Regulation and Authorization: The Act establishes the National Assisted Reproductive Technology and Surrogacy Board at the national and state levels to oversee surrogacy practices and ensure compliance with ethical guidelines.[16]

The stated objectives of the Act, as outlined in its preamble and *Statement of Objects and Reasons*, include preventing the exploitation of surrogate mothers, ensuring the welfare of the child, and regulating surrogacy clinics to prevent commercialization and unethical practices.

The stated intent behind these provisions, as outlined in its preamble and *Statement of Objects and Reasons*, is to curb the commercial exploitation of women and prevent the unethical commodification of the surrogacy process. However, critics argue that instead of providing a balanced approach to regulation, the law imposes overly restrictive measures that *infringe upon individual autonomy, reproductive rights, and the right to equality.*

Legislative Intent: Balancing Exploitation Prevention and Reproductive Autonomy

The primary rationale for the Act is to prevent the economic exploitation of vulnerable women in commercial surrogacy arrangements. The Law Commission of India, in its 228th Report, highlighted the risks of commodification and coercion in surrogacy contracts, particularly for women from socio-economically disadvantaged backgrounds.[17]

However, a blanket prohibition on commercial surrogacy fails to account for the agency of surrogate mothers

---

[11] Surrogacy (Regulation) Act, No. 47, Acts of Parliament, 2021 (India).

[12] *Baby Manji Yamada v. Union of India*, (2008) 13 SCC 518.

[13] Surrogacy (Regulation) Act, 2021, § 4(ii).

[14] Ibid, § 4(iii)(c).

[15] Supra Note 1

[16] Surrogacy (Regulation) Act, 2021, § 38.

[17] Law Commission of India, 228th Report on the Need for Legislation to Regulate Assisted Reproductive Technology Clinics and Surrogacy, (Aug. 2009).

who may willingly engage in compensated surrogacy arrangements. Legal scholars argue that protectionist policies often serve to curtail, rather than enhance, women's autonomy. As noted by Martha Nussbaum, "*protective legislation often masquerades as benevolence but, in effect, limits women's agency by restricting their choices.*"[18]

Further, the Act fails to distinguish between exploitative and consensual surrogacy, imposing rigid restrictions rather than adopting a regulatory framework that ensures fair compensation and informed consent. The jurisprudence established in *Suchita Srivastava v. Chandigarh Administration* emphasizes that reproductive choices, including the decision to act as a surrogate, are protected under Article 21's right to privacy and bodily autonomy.[19] The Act's excessive restrictions conflict with this precedent, raising concerns of constitutional overreach.

Parens Patriae: The State's Justification for Regulatory Control

The invocation of the *parens patriae* doctrine in the context of surrogacy regulation represents a broader tension between state intervention and individual autonomy. While historically deployed to safeguard vulnerable populations, its application to reproductive rights raises the question of whether the state is acting as a benevolent guardian or an overreaching regulator. The Surrogacy (Regulation) Act, 2021, ostensibly premised on protecting surrogate mothers from exploitation, effectively curtails their autonomy by restricting who may act as a surrogate and under what circumstances.

Understanding Parens Patriae: State as a Guardian

The doctrine of *parens patriae*, meaning "*parent of the nation,*" is rooted in the state's obligation to protect those who are unable to safeguard their own interests. This principle, drawn from English common law, has been expansively interpreted by Indian courts. In *Charan Lal Sahu v. Union of India*, the Supreme Court underscored that:

"*Under the doctrine of parens patriae, the State, as a guardian of its citizens, is entitled to take necessary measures to protect those who, due to their conditions, are unable to act in their own best interest.*"[20]

Similarly, in *State of Gujarat v. Hon'ble High Court of Gujarat*, the Court held that:

"*The doctrine of parens patriae is invoked by the State to protect the rights and well-being of those who cannot advocate for themselves, including minors, persons with disabilities, and those in situations of vulnerability.*"[21]

However, the application of this doctrine in reproductive rights jurisprudence is a matter of contestation. Unlike children or mentally incapacitated individuals, surrogate mothers are capable of informed consent. To assume their inherent vulnerability and impose a restrictive legal framework on that basis risks infantilizing women and disregarding their agency. As Sharmila Rudrappa notes, "*State paternalism often cloaks itself in the language of protection, but it is ultimately a mechanism of control.*"[22]

Application to Surrogacy: Protection or Overreach?

The Surrogacy Act's blanket prohibition on commercial surrogacy is predicated on the assumption that all surrogacy arrangements inherently commodify women. This assumption, however, ignores the distinction between exploitative arrangements and consensual compensated surrogacy. As the Supreme Court recognized in *Suchita Srivastava v. Chandigarh Administration* where it observed that "*The right to make reproductive choices is a dimension of personal liberty as understood under Article 21 of the Constitution of India. It includes a woman's entitlement to carry a pregnancy to its full term, to give birth, and to raise children.*"[23]

This recognition is at odds with the Act's pre-emptive interference in women's reproductive decisions. The doctrine of *parens patriae* cannot be used as a carte blanche justification for infringing upon bodily autonomy, particularly when less restrictive regulatory alternatives exist.

---

[18] Martha C. Nussbaum, Women and Human Development: The Capabilities Approach, 128 (2001).

[19] Supra Note 1

[20] Charan Lal Sahu v. Union of India, (1990) 1 SCC 613.

[21] State of Gujarat v. Hon'ble High Court of Gujarat, (1998) 7 SCC 392.

[22] Sharmila Rudrappa, *Discounted Life: The Price of Global Surrogacy in India* (NYU Press 2015) https://nyupress.org/9781479825325/discounted-life/ .

[23] Supra Note 1

Comparative Analysis: State Regulation of Surrogacy in the U.K., U.S., and Canada

A comparative analysis reveals that other jurisdictions have adopted a more nuanced approach to surrogacy regulation:

- United Kingdom: The Surrogacy Arrangements Act, 1985, prohibits commercial surrogacy but allows reasonable reimbursement of expenses. Notably, the U.K. does not impose arbitrary restrictions based on marital status or sexual orientation.[24]
- United States: Surrogacy laws vary across states, but jurisdictions such as California recognize and enforce compensated surrogacy agreements under comprehensive legal protections.[25]
- Canada: Canada's Assisted Human Reproduction Act, 2004, permits altruistic surrogacy while ensuring surrogate mothers are reimbursed for pregnancy-related expenses, thus striking a balance between protection and autonomy.[26]

By contrast, India's approach is both overbroad and underinclusive—overbroad in its sweeping restrictions and underinclusive in its failure to recognize and accommodate diverse family structures.

Critical Evaluation of the Act's Restrictions

While the Surrogacy (Regulation) Act, 2021, is framed as a protective measure against the exploitation of surrogate mothers, its provisions impose restrictions that not only curtail reproductive autonomy but also raise serious constitutional concerns. The Act's rigid framework disproportionately burdens those it claims to safeguard, reinforcing structural inequalities rather than mitigating them.

First, the Act denies reproductive autonomy by imposing state control over an individual's right to make reproductive choices. This is in direct conflict with the Supreme Court's recognition of reproductive autonomy as an essential aspect of personal liberty and privacy in *Justice K.S. Puttaswamy v. Union of India*.[27] The Act effectively reduces women's agency by assuming that surrogacy, even when entered into voluntarily, necessitates state intervention.

Second, its arbitrary exclusions-which bar single parents, LGBTQ+ individuals, and foreign nationals from accessing surrogacy-raise fundamental concerns under Article 14 of the Constitution. As established in *State of West Bengal v. Anwar Ali Sarkar*,[28] classifications under the law must be based on intelligible differentia and have a rational nexus with the objective sought to be achieved. The exclusions in the Surrogacy Act, however, appear to be grounded more in societal conservatism than in legitimate state interests, creating an impermissible classification that fails constitutional muster.

Third, the Act's punitive stance on commercial surrogacy reflects an overcriminalization of reproductive decisions. By failing to distinguish between exploitative practices and consensual compensated arrangements, the law enforces an absolute prohibition that disproportionately penalizes both intended parents and potential surrogates. This heavy-handed approach is not only legally questionable but also inconsistent with global best practices that seek to regulate, rather than prohibit, compensated surrogacy.

These inherent contradictions in the law set the stage for a deeper constitutional inquiry. The next portion of the Research paper will critically examine the Act's compatibility with constitutional guarantees, analyzing whether its restrictive provisions withstand judicial scrutiny under Articles 14 and 21. It will also explore whether the Act meets the proportionality test-a fundamental standard in evaluating the reasonableness of state-imposed restrictions. In doing so, the following chapter will assess whether the Surrogacy (Regulation) Act, 2021, aligns with evolving reproductive rights jurisprudence or stands as a regressive barrier to fundamental freedoms.

III. Constitutional Challenges to the Surrogacy (Regulation) Act,2021

The Surrogacy (Regulation) Act, 2021, while framed as a protective measure, raises serious constitutional

---

[24] Surrogacy Arrangements Act 1985, c. 49 (UK).

[25] California Family Code § 7960 (U.S.).

[26] Assisted Human Reproduction Act, S.C. 2004, c. 2 (Canada).

[27] *Justice K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1.

[28] *State of West Bengal v. Anwar Ali Sarkar*, AIR 1952 SC 75.

concerns regarding its compliance with Articles 14 and 21 of the Indian Constitution. The Act's rigid exclusions and blanket prohibitions create a framework that disproportionately burdens individuals seeking to exercise their reproductive rights, failing to strike a balance between state regulation and personal autonomy. This chapter examines the constitutional infirmities of the Act through the lens of equality, privacy, and proportionality.

Discriminatory Exclusions and Violation of Article 14

The Right to Equality and Non-Arbitrariness

Article 14 guarantees equality before the law and prohibits arbitrary classifications that lack a reasonable nexus with the objective sought to be achieved. The Supreme Court in *State of West Bengal v. Anwar Ali Sarkar*[29] held that classification must not be arbitrary or oppressive. The Act's selective recognition of surrogacy for only a specific subset of individuals—married heterosexual couples with medical infertility—imposes an exclusionary framework that lacks a constitutionally sound rationale.

In *Navtej Singh Johar v. Union of India*,[30] the Supreme Court reaffirmed that discrimination based on sexual orientation is unconstitutional. By excluding LGBTQ+ individuals and single parents, the Surrogacy Act disregards this jurisprudence and enforces a heteronormative model of family formation that is inconsistent with evolving constitutional norms. Similarly, in *Deepika Singh v. Central Administrative Tribunal*,[31] the Court recognized diverse family structures, underscoring the need for legal frameworks that accommodate rather than exclude.

International Perspectives on Equality in Surrogacy Laws

A comparative analysis highlights how restrictive surrogacy laws in India diverge from global best practices. In Canada, the *Assisted Human Reproduction Act, 2004*, permits altruistic surrogacy without restrictions based on marital status or sexual orientation, ensuring that regulation does not devolve into exclusion. The United Kingdom's *Surrogacy Arrangements Act, 1985*, while prohibiting commercial surrogacy, does not impose arbitrary exclusions on intended parents. The European Court of Human Rights, in *Mennesson v. France*,[32] ruled that restrictive surrogacy policies should not undermine children's right to family life, illustrating how excessive regulation can infringe upon fundamental rights.

Violation of Reproductive Autonomy and Privacy Under Article 21

The Right to Make Reproductive Choices

Reproductive choices, as reaffirmed in *Suchita Srivastava case* are an essential facet of personal liberty under Article 21. The Supreme Court held that "*reproductive rights include the right of a woman to make a choice regarding reproduction free of unwarranted state interference.*"[33] The blanket prohibition on commercial surrogacy disregards this precedent by treating all compensated surrogacy arrangements as exploitative, rather than distinguishing between coercive practices and informed, consensual agreements.

Legal scholar Prabha Kotiswaran argues that *"prohibitionist laws on surrogacy reflect moral paternalism rather than an evidence-based approach to preventing exploitation."*[34] Instead of imposing categorical bans, a regulatory framework ensuring fair compensation and strong consent mechanisms would better align with constitutional guarantees.

State Regulation of Reproductive Decisions: Necessity vs. Overreach

The Supreme Court in *Common Cause v. Union of India*[35] recognized that autonomy and dignity must inform state intervention in deeply personal decisions. If individuals have the right to refuse life-sustaining treatment, they should logically have the right to enter into surrogacy arrangements under a framework that prioritizes informed consent.

---

29 Ibid.

30 *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1.

31 *Deepika Singh v. Cent. Admin. Trib.*, (2022) 7 S.C.R. 557 (India).

32 *Mennesson v. France*, App No. 65192/11, ECHR (2014).

33 Supra Note 1

34 Prabha Kotiswaran, *Surrogacy, Law, and Women's Agency in India*, 44(2) Journal of Law and Society 317, 329 (2017).

35 *Common Cause v. Union of India*, (2018) 5 SCC 1.

The Act's restrictions disproportionately impact women who may wish to act as surrogates under fair and regulated conditions. As Martha Nussbaum has argued, "*protective legislation often masquerades as benevolence but, in effect, limits women's agency by restricting their choices*."[36] The assumption that all compensated surrogacy is exploitative denies women the ability to make informed economic and reproductive decisions.

Judicial Scrutiny and the Proportionality Test

The constitutional validity of legislative restrictions is often assessed using the proportionality test, which serves as a safeguard against excessive state intervention in fundamental rights. The Supreme Court of India, in *Modern Dental College v. State of Madhya Pradesh*,[37] established that any law restricting fundamental rights must satisfy four prongs:

1. The measure must have a legitimate state aim.
2. There must be a rational nexus between the restriction and the aim.
3. The measure must be the least restrictive means to achieve the objective.
4. There must be proportionality between the extent of the restriction and the benefit derived.

Applying this test to the Surrogacy (Regulation) Act, 2021, reveals significant constitutional infirmities.

Legitimate State Aim and Rational Nexus

The stated objective of the Act is to prevent the exploitation of surrogate mothers and regulate surrogacy practices. The Supreme Court has recognized the prevention of exploitation as a legitimate state interest in multiple cases, including *State of Punjab v. Devans Modern Breweries Ltd.*,[38] where the Court held that *"legislative restrictions must be rooted in a pressing social need, not mere moral considerations."*

However, for a law to withstand constitutional scrutiny, it must also demonstrate a rational nexus between the restriction and the objective. In *Anuj Garg v. Hotel Association of India*,[39] the Supreme Court invalidated a law that barred women from working in bars, holding that paternalistic protectionism cannot justify absolute exclusions. The Court observed that "*state-imposed restrictions must be based on empirical evidence rather than stereotypes about vulnerability*."[40] Similarly, the assumption that all commercial surrogacy is inherently exploitative lacks empirical backing. Research indicates that rather than eliminating exploitation, blanket bans often drive practices underground, exacerbating risks for surrogate mothers.[41]

Least Restrictive Means: Is a Blanket Ban Justified?

The proportionality test requires that the state adopt the least restrictive means to achieve its objective. The Supreme Court in *K.S. Puttaswamy v. Union of India*[42] emphasized that *"a measure that restricts fundamental rights must not go beyond what is necessary to achieve the legitimate aim."* The Surrogacy Act's absolute prohibition on commercial surrogacy does not satisfy this requirement.

Legal scholar Prabha Kotiswaran argues that "*prohibitionist regimes reflect a moral panic rather than a nuanced regulatory approach*."[43] Instead of a total ban, the state could have opted for:

- A robust regulatory framework with licensing requirements, consent mechanisms, and compensation guidelines.
- Judicial oversight to review surrogacy agreements and prevent coercion including Ethical guidelines for surrogacy agreements, similar to models in the UK and Canada.[44]
- Legal safeguards against exploitation, including contracts that ensure fair compensation and informed decision-making.

---

36 Martha Nussbaum, *Sex and Social Justice* 285 (Oxford University Press 1999).

37 *Modern Dental College v. State of Madhya Pradesh*, (2016) 7 SCC 353.

38 *State of Punjab v. Devans Modern Breweries Ltd.*, (2004) 11 SCC 26.

39 *Anuj Garg v. Hotel Association of India*, (2008) 3 SCC 1.

40 Ibid.

41 Sital Kalantry, *Women's Human Rights and the Need for Regulation of Surrogacy: An International Perspective*, 28(1) Harvard Journal of Law & Gender 59, 73 (2017).

42 *Justice K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1.

43 Prabha Kotiswaran, *Surrogacy, Law, and Women's Agency in India*, 44(2) Journal of Law and Society 317, 329 (2017).

44 Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* 256 (Oxford University Press, 2001).

In *Internet and Mobile Association of India v. Reserve Bank of India*,[45] the Supreme Court struck down a complete ban on cryptocurrency trading, holding that "*a total prohibition is disproportionate when regulatory safeguards can suffice.*"[46] A similar regulatory rather than prohibitory approach to surrogacy would be less restrictive yet equally effective in preventing exploitation.

Comparatively, in the United Kingdom, surrogacy is regulated rather than prohibited, ensuring surrogate mothers are not financially coerced while still allowing intended parents to access the procedure.[47] The European Court of Human Rights, in *Paradiso and Campanelli v. Italy*,[48] warned against blanket prohibitions, emphasizing that state intervention in surrogacy must be tailored to protect rights rather than suppress them.

Proportionality Between Restriction and Benefit

The final prong of the test examines whether the benefit derived from the restriction is proportional to the harm inflicted on fundamental rights. The Act's exclusionary framework disproportionately impacts:

- Women who wish to act as surrogates under fair compensation models.
- Intended parents—particularly LGBTQ+ individuals and single parents—who are denied access to surrogacy.
- Surrogate-born children, whose legal status remains precarious due to restrictive regulations.

The Supreme Court, in *Shayara Bano v. Union of India*,[49] observed that laws must not "*impose an undue burden on fundamental rights in the name of social reform*."[50] The Surrogacy Act, by imposing absolute exclusions rather than targeted protections, fails this test.

International Judicial Approaches to Surrogacy Rights

International jurisprudence supports a balanced approach to surrogacy regulation. In the U.S., courts have upheld surrogacy agreements where they comply with principles of informed consent and fairness. The New Jersey Supreme Court, in *In re Baby M*,[51] struck down a surrogacy contract on coercion grounds but did not impose a blanket ban, emphasizing case-by-case scrutiny.

In Canada, courts have upheld surrogacy agreements within a framework of ethical regulation, ensuring surrogate mothers' rights while allowing intended parents legal recognition.[52] The European Court of Human Rights, in *Mennesson v. France*,[53] ruled that restrictive surrogacy policies should not undermine children's right to family life, further illustrating that an outright ban is disproportionate.

Therefore, it can be concluded that The Surrogacy (Regulation) Act, 2021, fails the proportionality test, imposing absolute restrictions where regulatory safeguards would suffice. The Supreme Court has consistently held that paternalistic laws must be justified by evidence rather than moral assumptions. The Act's overbroad exclusions and punitive framework suggest that the state has exceeded its constitutional limits, necessitating a reconsideration of its approach to surrogacy regulation. Moreover, by adopting an exclusionary framework rather than a balanced regulatory approach, the Act undermines reproductive autonomy, disregards established jurisprudence on privacy and equality, and enforces moral paternalism at the expense of individual rights. The final portion of the paper will explore potential reforms to develop a legal framework that ensures protection without sacrificing autonomy.

IV. The future of reforming Surrogacy Laws – A Rights-Based Framework

The Surrogacy (Regulation) Act, 2021, imposes severe restrictions on surrogacy access, effectively excluding single parents, LGBTQ+ individuals, and foreign nationals while criminalizing commercial surrogacy. These exclusions raise *serious constitutional concerns*, particularly in light of established jurisprudence on

---

45 *Internet and Mobile Association of India v. Reserve Bank of India*, (2020) 10 SCC 274.

46 Ibid.

47 Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* 256 (Oxford University Press, 2001).

48 *Paradiso and Campanelli v. Italy*, App No. 25358/12, ECHR (2017).

49 *Shayara Bano v. Union of India*, (2017) 9 SCC 1.

50 Ibid.

51 *In re Baby M*, 537 A.2d 1227 (N.J. 1988).

52 Vanessa Gruben, *Surrogacy in Canada: Ethical and Legal Perspectives*, 49 McGill Law Journal 60, 77 (2019).

53 *Mennesson v. France*, App No. 65192/11, ECHR (2014).

reproductive autonomy, privacy, and equality. The research problem identified in Chapter 1 questioned whether such exclusions and prohibitions amount to *arbitrary and disproportionate restrictions* on fundamental rights under Articles 14 and 21.

The hypothesis posited that the Act fails the proportionality test by imposing absolute restrictions where regulatory safeguards would suffice. As demonstrated in Chapter 3, a blanket ban on commercial surrogacy and categorical exclusions from altruistic surrogacy are neither the least restrictive means nor justified by compelling state interest. The law prioritizes state paternalism over individual agency, invoking *parens patriae* without demonstrating proportionality. This chapter proposes an alternative rights-based framework that balances reproductive autonomy with ethical safeguards, aligning surrogacy regulation with constitutional principles and the research objectives set out in Chapter 1.

Expanding Eligibility Criteria While Ensuring Safeguards

A fundamental flaw of the Act is its arbitrary exclusion of certain groups, which conflicts with the equality principle under Article 14. The Supreme Court in *Navtej Singh Johar v. Union of India* held that laws based on "*majoritarian morality*" cannot override individual rights.[54] Similarly, *Deepika Singh v. Central Administrative Tribunal* reaffirmed that constitutional protections extend beyond *heteronormative, marital relationships*.[55] By limiting surrogacy to legally married heterosexual couples, the Act violates the non-arbitrariness principle outlined in *State of West Bengal v. Anwar Ali Sarkar*.[56]

A proportionate regulatory framework must:

- Expand access to surrogacy for single parents, LGBTQ+ individuals, and foreign nationals under state-regulated mechanisms.
- Introduce mandatory counselling and informed consent requirements to protect surrogate mothers.
- Establish independent review boards to assess eligibility and ethical compliance, replacing the current blanket exclusion approach.

Such reforms would align India's surrogacy laws with constitutional mandates and global best practices while mitigating exploitation risks.

Regulating Commercial Surrogacy Without a Blanket Ban

The Act presumes that commercial surrogacy is inherently exploitative, justifying a complete prohibition. However, this presumption lacks empirical backing. In *Anuj Garg v. Hotel Association of India*, the Supreme Court emphasized that *legal restrictions on individual liberty must be based on evidence, not abstract moral assumptions.*[57] The outright criminalization of commercial surrogacy ignores the agency of surrogate mothers, many of whom willingly participate in surrogacy agreements as a means of economic empowerment.

A regulated commercial surrogacy framework would be more constitutionally sound. Such a framework should include:

- A licensed surrogacy model under strict medical and ethical oversight.
- Ensuring fair compensation for surrogate mothers to prevent economic coercion while safeguarding autonomy.
- Clear contractual provisions that establish the rights and obligations of all parties to prevent disputes and ensure accountability.

Comparative legal models-such as *California's regulated surrogacy laws*-demonstrate that commercial surrogacy can function within a well-structured ethical framework without exploitation.[58] The Indian government could adopt similar best practices instead of relying on an overbroad prohibition.

Balancing *Parens Patriae* with Individual Autonomy

Shifting from State Paternalism to Individual Choice

---

[54] *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1.

[55] *Deepika Singh v. Central Administrative Tribunal*, (2022) 4 SCC 731.

[56] *State of West Bengal v. Anwar Ali Sarkar*, AIR 1952 SC 75.

[57] *Anuj Garg v. Hotel Association of India*, (2008) 3 SCC 1.

[58] *Johnson v. Calvert*, 851 P.2d 776 (Cal. 1993).

The doctrine of *parens patriae*, while invoked to justify state intervention, must be applied in a proportionate and evidence-based manner. In *Common Cause v. Union of India*, the Supreme Court ruled that "*state intervention in personal autonomy must be justified by compelling state interests and cannot be based on abstract notions of morality.*"[59] The absolute prohibitions imposed by the Act fail to meet this standard, as they eliminate the possibility of consensual, ethical surrogacy arrangements.

A rights-based framework would involve:

- Recognizing reproductive autonomy as a constitutionally protected right while ensuring ethical safeguards.
- Establishing independent review mechanisms rather than imposing blanket prohibitions.
- Allowing surrogate mothers to exercise full agency over their reproductive choices within a well-regulated framework.

Establishing an Independent Surrogacy Ethics Committee

To balance state oversight with individual choice, an independent Surrogacy Ethics Committee should be instituted. This body would:

- Oversee surrogacy arrangements to ensure compliance with ethical and medical standards.
- Adjudicate disputes arising from surrogacy contracts to prevent legal uncertainties.
- Establish uniform guidelines for compensation, consent, and medical care to safeguard the rights of all stakeholders.

By replacing blanket prohibitions with structured ethical oversight, the state can achieve its legitimate regulatory objectives without infringing upon fundamental rights.

Strengthening Legal Protections for All Stakeholders

The current law fails to clearly define legal rights, leading to uncertainty and potential legal conflicts. A comprehensive framework should include:

- Recognizing surrogacy contracts as legally enforceable to protect all parties.
- Introducing pre-birth parentage orders to prevent custody disputes.[60]
- Imposing strict penalties for coercion and forced surrogacy, while ensuring due process safeguards.

International legal precedents highlight the importance of robust contractual protections in ensuring legal certainty in surrogacy arrangements.

V. Policy Recommendations for a Balanced Surrogacy Framework

Based on the constitutional concerns and regulatory gaps identified, the following policy recommendations are proposed:

1. Expanding surrogacy eligibility criteria to ensure access is based on ethical and medical considerations rather than arbitrary exclusions.
2. Replacing the blanket ban on commercial surrogacy with a regulated model that allows ethical compensation.
3. Strengthening contractual protections through legally enforceable surrogacy agreements and pre-birth parentage mechanisms.
4. Establishing an independent Surrogacy Ethics Committee to oversee ethical compliance and prevent exploitation.
5. Enhancing financial transparency in surrogacy transactions to prevent economic coercion.

The Future of Surrogacy Regulation in India

As constitutional jurisprudence in India evolves, the restrictive framework of the Surrogacy (Regulation) Act, 2021, appears increasingly incompatible with fundamental rights. The Supreme Court's rulings in

[59] *Common Cause v. Union of India*, (2018) 5 SCC 1.

[60] *In re Marriage of Buzzanca*, 61 Cal.App.4th 1410 (1998).

Puttaswamy, *Navtej Singh Johar*, and *Suchita Srivastava* reflect an expanding recognition of reproductive autonomy.

This research hypothesized that the Act imposes disproportionate and unconstitutional restrictions, and the preceding chapters have demonstrated that the law fails to meet the proportionality standard. A more inclusive and balanced surrogacy law would better align with constitutional mandates, ensuring reproductive choice while addressing ethical concerns.

The future of surrogacy regulation in India must move beyond paternalistic overreach, embracing a rights-centric framework that upholds dignity, autonomy, and equality. Only through evidence-based, proportionate regulation can the law effectively balance individual rights with ethical safeguards in the evolving landscape of reproductive rights.

* * * *

MATERNITY BENEFITS:
A CRUCIAL ASPECT OF REPRODUCTIVE RIGHTS

Dr. Dipa Gautalair *

Abstract

Maternity benefits from work are crucial for ensuring job security and protecting the economic rights of the female workforce. It is a much-needed facility provided by employers that allows working women to perform their maternal duties without any stress or work pressure which consequently ensure reproductive rights to women which is a fundamental right guaranteed under Article 21 of the Indian Constitution. Unfortunately, most of the working women are deprived of such important support during their crucial period of life. This is mainly due to the nature of contract of employment they have entered into and mandates of all social security legislations which lay down certain essential criteria to be fulfilled to avail social security benefit including maternity benefit such as qualifying period, nature of contract of employment and continues period of service. Hence, the effort has been made to explore reproductive rights, a fundamental right under Article 21, maternity benefits and role of judiciary in extending the maternity benefit to women employed on contract basis in formal sectors and government departments.

Key words: **Reproductive rights, Maternity benefits, social security, contractual employees, government department, formal sector and informal sector.**

I. Introduction

Women, who form the integral part of human kind, their contribution in all sectors of employment are very significant in this modern world. Women's partaking in economic sector is vital fortheir economic empowerment.The globalization and modernization have led to the economic development around the world which demands huge labour force. This has in fact paved a means for women to come forward as one of the significant sources of labour force. There is remarkable participation of women on par with men at workplace. On the other hand,to become a mother is the most natural phenomenon in the life of a woman. Therefore, whatever is needed to facilitate the birth of child to a woman who is in service, the employer has to be considerate and sympathetic towards her and must realise the physical difficulties which a working woman would face in performing her duties at the workplace while carrying a baby in the womb or while rearing up the child after birth.[1]The Maternity Benefit Act, 1961 aims to provide all these facilities to a working woman in a dignified manner so that she may overcome the state of motherhood honorably, peaceably, undeterred by the fear of being victimized for forced absence during the pre-or post-natal period[2]and enable them to exercise their reproductive rights, a fundamental right guaranteed under Article 21 of the Indian Constitution.[3]

Unfortunately, most of the working women are deprived of such important support during their crucial period of life. This is mainly due to the nature of contract of employment they have entered into. Formal sectors generally employ wage workers and contract basis employees. In government departments Contractual appointments can be of three kinds - firstly, appointments of routine nature like housekeeping, maintenance, data entry, etc.[4]; secondly, contractual appointments for certain posts wherein certain specific skills are

* **Assistant Professor, Karnataka State Law University's Law School, Navanagar, Hubballi, Karnataka.**

1 *Municipal Corporation of Delhi* v. *Female Workers (Muster Roll) & Another* (2000) 3 SCC 224 para no.33

2 *Ibid*

3 *Suchita Srivastava* v. *Chandigarh Admin.*, (2009) 9 SCC 1

4 Such kinds of jobs are usually outsourced to agencies which depute people to do the task. These labourers are controlled by the contractors

required and, thus, suitable persons are selected upon negotiations for salary; thirdly, the appointments of retired government employees considered useful due to their expertise garnered during their period of service. Though there is no unanimity in such contractual appointments, in the absence of specific legislations, departments under the Central Government has formulated their guidelines and rules to address the issues of informal employment and the rights of the employees and liabilities of the employer accruing thereto.[5]

Women particularly employed as unprotected wage workers and employed oncontract basis in formal sectors and government department are deprived of maternity benefit under the Maternity Benefit Act,1961 due the dilemma that the Act is confined and appliable to those who are employed on regular basis in the formal sectors and employed as permanent employees in government departments.This is mainly due to the reason that for any social security benefit there is a qualifying period for which the employees are required to serve a minimum continues period of service. Similarly, working women are required to be service to avail maternity benefits under the Maternity Benefit Act, 1961.

Therefore, this research paper aims at exploring reproductive rights of women and maternity benefits guaranteed in India andanalyse whether, maternity benefits should be perceived as any other social security benefit such as disability, old age, death, etc. to fulfil qualifying periods and other eligibility criteria. Further, explore the tremendous role played by the judiciary in extending the maternity benefit to women employed on contract basis and other unprotected workers employed in formal sectors and government department eradicating the barrier of temporary nature of employment.

II. Reproductive Rights of Women in India: An Overview

Reproductive rights are a part of a woman's right to health, dignity, and autonomy. In India, these rights are protected under both the Constitution and various laws and Supreme Court judgments.Every woman has the right to make decisions about her own body, namely the right to use contraceptives; the right to access safe abortion; and the right to access reproductive healthcare.Women are entitled to terminate a pregnancy up to24 weeks of pregnancy if continuation of pregnancy poses a risk to the woman's life or health, or if there are fetal abnormalities.[6]The Supreme Court of India has held that the right to make reproductive choices is a part of the right to personal liberty under Article 21 of the Constitution.[7]Though India does not criminalize marital rape under general law, the Supreme Court has recognized that reproductive rights include the right to say no to sex, even within marriage.[8]with regard to access to health service in case of pregnancy, Indiabeing a signatory to international treaties like Convention on the Elimination of All Forms of Discrimination Against Women, 1979,wherein the emphasis is being made on reproductive health rights.[9]

III. Maternity Benefit: A Key Part of Reproductive Rights of Women in India

Maternity benefits are an important part of a woman's reproductive rights. These rights protect a woman's health, well-being, and dignity during and after pregnancy.Maternity benefits include, paid leave before and after childbirth, protection from being fired due to pregnancy, medical bonuses, and nursing breaks at work. These benefits enable women recover from childbirth and care for their newborns without the fear of losing their job or income.In *Suchita Srivastava* v. *Chandigarh Admin*,the Supreme Court of Indiaheld that reproductive rights include not just the right to have or not have children, but also the right to have access to health and safety during pregnancy and after childbirth. Maternity benefits help women exercise these rights by ensuring they are supported during this important time.[10]

Under the Maternity Benefit Act, 1961women are entitled for26 weeks of paid maternity leave[11] employed in an establishment in which 10 or more employees are employed.[12]The benefits are also extended for adoptive

---

5 Bishwanath Goldar and Suresh Chand Aggarwal, "Employment of Casual Workers in Organised Manufacturing in India: Analysis of Trends and the Impact of Labour Reforms", 57 *Indian J. Labour Econ.* 283 (2014).

6 The Medical Termination of Pregnancy Act, 1971 Act No. 34 of 1971 s.3

7 Supra Note 3

8 *X* v. *The Principal Secretary, Health and Family Welfare Department*, Civil Appeal No. 5802 of 2022 (India).

9 Convention on the Elimination of All Forms of Discrimination Against Women art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13

10 Supra Note 3

11 The Maternity Benefit Act, 1961 Act No. 53 of 1961 S. 2 (b)

12 The Maternity Benefit Act, 1961 Act No. 53 of 1961 S. 5(3)

and commissioning mothers as well and are entitled for 12 weeks of paid maternity leave.[13] The maternity leave is accompanied with the payment of maternity benefit at the rate of the average daily wage for the period of her actual absence, that is the period immediately preceding the day of her delivery, the actual day of her delivery and any period immediately following that day.[14] For the entitlement of maternity benefit under said Act, women is required to actually work in an establishment of the employer from whom she claims maternity benefit, for a period not less than eighty days in the twelve months immediately preceding the date of her expected delivery.[15]

Article 21 of the Indian Constitution protects the right to life and personal liberty, which includes the right to live with dignity. This has been interpreted to include maternity benefits as part of a woman's right to health.[16]Further, Articles 39(e), 42 and 45 provide that the State should direct its policies towards securing the health of workers, ensuring just and humane conditions of work including maternity relief, and providing for early childhood care and education for children below six years. Hence, in consonance with the Directive Principles of State Policy, Parliament has enacted the Maternity Benefits Act 1961 to regulate women's employment during pregnancy, as well as maternity benefits.[17] Inter alia, this law secures a woman's right to pregnancy and maternity leave, protects her wages during that time, and requires the employer to provide onsite child care facilities and nursing breaks to female employees.

Despite the constitutional and legislative framework, women often face discriminatory treatment on grounds of pregnancy or childbirth and have approached the courts seeking redressal on issues pertaining to pregnancy discrimination, maternity and child care leave and loss of seniority. The Supreme Court in *Justice K.S. Puttaswamy*v. *Union of India*[18] reaffirmed that reproductive rights, including privacy and bodily autonomy, are protected by the Constitution. Further,the Supreme Court in *Laxmi Mandal* v. *Deen Dayal Harinagar Hospital*[19]recognized that failure to provide maternal health services violated Article 21. The Delhi High Court held that the right to reproductive health and maternity benefits is linked to the right to life.The Court emphasized that maternal health is not a privilege, but a right, and failure to provide basic maternity services can lead to a violation of reproductive rights, a fundamental right.

IV. Maternity Benefits for the Employees employed on Contractual Basis and employed in Informal Sectors

Contractual employees are those workers who are hired for a certain amount of time till the project or work gets completed. Both teaching and non-teaching jobs are now increasingly advertised as contractual positions. A person is appointed for a few months with a fixed salary as per a contract either directly or through outsource. This contract is either for a few months or years and may or may not be renewed. There is an important condition that governs these appointments—the contract can be terminated at any time. This conditional appointment in fact makes these jobs similar to those in the private sector. There are no salary increments, social security benefits or promotions and leave policy.[20]

Orgnainsationsrecognized under the Employees State Insurance Act, 1948 and employees' whose wages are within the salary slab as per the Act[21] are entitled for Maternity benefit from Employees State Insurance

[13] The Maternity Benefit Act, 1961 Act No. 53 of 1961 S. 5(4)

[14] The Maternity Benefit Act, 1961 Act No. 53 of 1961 S. 5(1)

[15] The Maternity Benefit Act, 1961 Act No. 53 of 1961 S. 5(2)

[16] INDIA CONST. art. 21.

[17] See *Air India* v. *Nergesh Meerza*, (1981) 4 SCC 335; *Inspector (Mahila) Ravina* v. *Union of India*, MANU/DE/3946/2015.

[18] *Justice K.S. Puttaswamy (Retd.)* v. *Union of India*, (2017) 10 SCC 1 (India).

[19] W.P. (C) Nos. 8853/2008 & 10700/2009 (Del. HC 2010).

[20] Rituparna Patgiri, "Contractualisation of Academic Jobs Has Severe Consequences for India's Higher Education", *ThePrint* (July 26, 2024), https://theprint.in/opinion/contractualisation-of-academic-jobs-has-severe-consequences-for-indias-higher-education/2189125/. Last accessed on 12.02.2025

[21] *See* The Employees' State Insurance (Central) Rules, 1950, S.50. Wage limit for coverage of an employee under the Act. — "The wage limit for coverage of an employee under sub-clause (b) of clause (9) of Section 2 of the Act shall be twenty-one thousand rupees a month: Provided that an employee whose wages (excluding remuneration for overtime work) exceed twenty-one thousand rupees a month at any time after and not before the beginning of the contribution period, shall continue to be an employee until the end of that period. Provided further that the wage limit for coverage of an employee who is a person with disability under the Persons with Disabilities (Equal Opportunities Protection of Rights and Full Participation) Act, 1995 (1 of 1996), and under the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (44 of 1999) respectively, shall be twenty-five thousand rupees per month."

Corporation. Women who are employed in an organization are not within the coverage of the Act or employees are not within the salary slab as per the provisions of the Act,are not eligible for the contribution and thus deprived of maternity benefit under the Act. On the other hand,women are entitled for the benefit under the Maternity benefit Act on the fulfilment of two essential conditions under the said Act, namely organisationsin whichwomen are employed must be employing 10 or more employees and the women must have worked for at least 80 days in the 12 months preceding the date of their expected delivery.

On the other hand, Indian labour force also consists of informal sector workers who are generally outside purview ofabove-mentionedlabour welfare legislations for social security mainly due to the absence of juridical relationship of employer and employee relationship and due to other characteristics as elucidated by the Second National Commission on Labour, 1999 in its Report, 2000,namely-

(a) Low scale of organisation;
(b) Operation of labour relations on a casual basis or on the basis of kinship or personal relations;
(c) Small own account (household) or family-owned enterprises or micro enterprises;
(d) Ownership of fixed and other assets by self;
(e) Risking of finance capital by self;
(f) Involvement of family labourers;
(g) Production expenditure indistinguishable from household expenditures and use of capital goods;
(h) Easy entry and exit
(i) Free mobility within the sector
(j) Use of indigenous resources and technology
(k) Unregulated or unprotected nature
(l) Absence of fixed working hours
(m) Lack of security of employment and other social security benefits;
(n) Use of labour-intensive technology;
(o) Lack of support from Government;
(p) Workers living in slums and squatter areas;
(q) Lack of housing and access to urban services; and
(r) High percentage of migrant labour.[22]

Thus, workers possessing above mentioned characteristics form a different category of the informal sectorand are outside the juridical relationship of employer and employee due to which they are deprived of social security benefits that are ensured to the workers employed within the juridical relationship of employer and employee. The informal nature of the workforce, dispersed nature of operational processes and lack of institutional back up reduces their bargaining power and their ability to take full benefits from the legislations enacted for their benefits. Further, low skill levels of this workforce provide little scope for them to move vertically in the occupational ladder to improve their financial situation. The growth of informal, unprotected work with shrinking formal employment compels the workers to bear an increasing direct burden of financing social needs, with adverse effects on their quality of life.Under such circumstances it is the State who takes care of ensuring social security to the informal sector workers and ensuring security to these workers form various contingencies of life such as death, unemployment, occupational diseases, child birth and accidents arising out of and in the course of employment.[23]The existing social security arrangements in the informal sector can be broadly classified into four groups as follows:

(a) Centrally funded social assistance programmes;
(b) Social insurance schemes;
(c) Social assistance through welfare funds of Central and State Governments; and
(d) Public initiatives.

---

[22] *Ibid* p.p. 599-600

[23] The Report I National Commission on Labour, 1969, p. 162

The State has introduced various social security schemes defining the eligibility and distinctive benefits under different schemes.[24]Apart from this various social security benefitsare provided under the Buildings and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 for building and other construction workers.[25] For the purpose of ensuring waste majority of the informal workers all those involved either directly or indirectly in building and construction work including brick kiln workers are brought under the category of building and other construction workers.[26]

Informal sector workers are also protected under the Unorganised Workers' Social Security Act, 2008. The Act imposes obligation upon the Central Government to formulate and notify the suitable welfare schemes for unorganized workers on matters relating to life and disability cover, health and maternity benefits, old age protection and any other benefit as determined by the Central Government from time to time.[27] Similarly, the State Government is also under statutory obligation to formulate and notify suitable welfare schemes for unorganized workers such as schemes relating to employment injury benefit, provident fund, housing, educational schemes for children, old age homes, funeral assistance and skill up gradation of workers.[28] The Act enlists ten Schemes in the First Schedule of the Act as welfare schemes to informal sector workers namely, (i) Indira Gandhi National Old Age Pension Scheme;[29] (ii) National Family Benefit Scheme;[30] (iii) Janani Suraksha Yojana;[31] (iv) Handloom Weavers' Comprehensive Welfare Scheme; (v) Handicraft Artisans' Comprehensive Welfare Scheme; (vi) Pension to Master craft persons; (vii) National Scheme for Welfare of Fishermen and Training and Extension; (viii) Janshree Bima Yojana;[32] (ix) Aam Admi Bima Yojana;[33] and (x) RashtriyaSwasthya Bima Yojana.[34] So far as the funding of the Schemes under the Act is concerned, the State Government Schemes may be wholly funded by the State or partly by the State and partly by the beneficiaries

---

[24] Glimpses of the Social Security Schemes introduced by the Government of India.

Pradhan Mantri Shram Yogi Maandhan Yojana: for old age protection and social security of Unorganized workers.

Pradhan Mantri Shram Yogi Maan-Dhan (PM-SYM) pension scheme: an old age social security cover. It provides monthly pension of Rs. 3000/- after attaining the age of 60 years. The unorganized workers in the age group of 18-40 years whose monthly income is Rs.15000/- or less and who are not a member of EPFO/ESIC/NPS (Govt. funded) can join the PM-SYM Scheme. Under this scheme 50% of the monthly contribution is payable by the beneficiary and equal matching contribution is paid by the Central Government.

National Pension Scheme for Traders and The Self-employed Persons (NPS): A Voluntary and contributory pension schemes. Under the schemes, beneficiaries are entitled to receive monthly assured pension of Rs.3000/- after attaining the age of 60 years. 50% monthly contribution is payable by the beneficiary and equal matching contribution is paid by the Central Government.

National Safai Karamcharis Finance and Development Corporation (NSKFDC): Scheme provides financial assistance to the Safai Karamcharis, Manual Scavengers and their dependents through SCAs/RRBs/Nationalized Banks for any viable income generating schemes including sanitation related activities and for education in India and Abroad.

[25] *See* Buildings and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 (Act No. 27 of 1996) S. 22 and also https://karbwwb.karnataka.gov.in/42/schemes/en last accessed on 12.02.2025.

Accident Benefits,Medical Assistance (Karmika Arogya Bhagya), *Thayi Magu Sahaya Hastha*, Maternity Benefit Assistance to meet the Funeral Expenses and ex gratia, Marriage Assistance, Assistance for Major ailments and Disability Pension.

[26] https://karbwwb.karnataka.gov.in/42/schemes/en last accessed on 12.02.2025.

[27] Section 3(1) of The Unorganized Workers' Social Security Act, 2008

[28] Section 3(4) of The Unorganized Workers' Social Security Act, 2008

[29] Under the Scheme the persons between sixty to seventy-nine years of age are entitled for the pension amount of rupees two hundred per month and rupees five hundred for the persons above the age of eighty years.

[30] The scheme aims to provide a lump sum family benefit of Rs 10,000/- to the bereaved households in case of the death of the primary breadwinner irrespective of the cause of death. The scheme is applicable to people in the age bracket of 18-64 years.

[31] *Janani Suraksha Yojana* is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.

[32] The Central Government and Life Insurance Corporation together launched the *Janashree Bima Yojana* (JBY) on August 10, 2000. JBY is sponsored by the government. The scheme is devised to provide life insurance cover to rural and urban people below and marginally above the poverty line.

[33] *The Aam Admi Bima Yojana* was launched on 2nd October 2007. It is a social security scheme that is targeted toward the low-income families of India. This scheme benefits those who are usually not on a payroll, for example, fishermen, auto drivers, cobblers, etc. *The Aam Aadmi Yojana* provides coverage to all the eligible members when an unfortunate event like death or disability occurs

[34] *Rashtriya Swasthya Bima Yojana* (RSBY) has been launched by Ministry of Labour and Employment, Government of India to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization.

of the Scheme or the employer. The State Governments can also seek financial assistance from the Central Government in this regard.[35]

The workers in the informal sectorare from socio-economic backward class and also include migrant labours. The social security schemes initiated by the government lays down that in order to avail the benefits under the respective schemes the beneficiaries should fall under below poverty line category. Consequently, the purpose of the scheme is served and informal sector workers are ensured with social security. Thus, female informal sector workers can avail the maternity benefit under various labour welfare legislations.[36]

On the other hand unprotected wage workers in the organised sector such as regular, casual and contract workers and employees employed on contractual basis in government departments remain unprotected because of non-fulfillment eligibility criteria of continues period of service and other requirements under the provisions of the existing social security legislations andalso they are not eligible for the government initiated social security schemes under various informal sector social security legislations such as under the Unorganised Workers' Social Security Act, 2008 and the Buildings and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 for building and other construction workers as they have to register themselves as informal workers and building and other construction workers. Also, they are outside the scope of the Employees State Insurance Act, 1948 due to the mandatory requirement of wage slab as discussed above.

Under such circumstances the Maternity Benefit Act, 1961 is the legislation which regular, casual and contract workers and employees employed on contractual basis in government departments can rely on. Since, women employed on a contractual basis did not find protection within the ambit of the Act and were not entitled to benefits of maternity benefit, as a last resort, women contractual workers have knocked the door of the High Courts of their respective States and the Supreme Court to avail maternity benefit under the Act to seek justice. Following are the few decisions of the High Court of the States and the Supreme Court, where maternity benefit was considered as a significant benefit which even contractual workers were held to be entitled.

In *Municipal Corporation of Delhi* v. *Female Workers(Muster Roll)*,[37] female employees who had been working for years as daily wage employees with the Municipal Corporation of Delhi were denied maternity leave because they were classified as temporary workers. The Supreme Court struck down this practice. Relying on fundamental rights enshrined in Articles 14 and 15, the Directive Principles of State Policy reflected in Articles 39, 42 and 43 of the Indian Constitution and India's international law obligations under Article 11 of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Court held that regardless of the nature of their duties, their avocation and the place where they work, all female workers must be provided the facilities to which they are entitled under the MB Act 1961. It also stated that India's obligations under Article 11 of CEDAW should be read into the employment contract between the Corporation and the Muster Roll workerswho are employed with them on daily wage basis.

---

[35] Section 7 of the Unorganized Workers' Social Security Act, 2008.

[36] *See*Buildings and Other Construction Workers (Regulation of Employment and Conditions of Service) Karnataka Rules, 2006 R.43-Assistance for delivery of child by a registered women construction worker.

1. The Secretary or any other officer authorized in the behalf by the Board, shall on an application from a registered woman construction worker sanction Rs.50,000/- [for a Male/Female child], only for first two deliveries, on her producing proof of delivery of a child to her.

2. The Amount shall be sanctioned, only if the conditions are fulfilled namely,

The registered woman construction worker can get this assistance only twice [and that the second claim application shall be accompanied by an affidavit stating that the claim is for second delivery].

The registered woman construction worker shall not be given this assistance if she already has two living children.

The certification of registration of birth obtained from the registrar of births and deaths or certificate of delivery in a government or private hospital in the state of Karnataka duly signed by the doctor concerned from the institution shall be produced along with the application.

See also Rule 43-A Assistance for pre-school Education and Nutritional support of the child of the registered women construction worker - *Thayi Magu Sahaya Hastha*.

See also the Schedule**,** Unorganized Workers' Social Security Act, 2008 *Janani Suraksha Yojana* is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.

[37] (2000) 3 SCC 224 (India)

In *Hindustan Antibiotics Ltd.* v. *Workmen*,[38] the Supreme Court opined that the 1961 Act nowhere provided that only regular employees would be given the benefits of maternity leave and those engaged on casual basis or muster roll or daily wage basis, would not be given the said benefits. Thus, it was held in Hindustan Antibiotics Ltd. Case that the provisions of the 1961 Act would be applicable to woman employees irrespective of their nature of engagement.

In *Sangeeta Kormel Yadav* v. *Union of India*,[39] Petitioner was appointed as a part time contract teacher in Kendriya Vidyalaya, ONGC, Sivasagar for the period w.e.f. 29-06-2012 to 28-03-2013 and again w.e.f. 01-04-2013 to 28-03-2014 and subsequently w.e.f. 01-04-2014 to 04-03-2015. Petitioner got married and after her last engagement up to 04-03-2015, delivered a baby on 12-04-2015 and thereafter, petitioner did not apply for continuation of her service. On 11-02-2015, petitioner's husband sent an application through RTI to KVS, asking whether contractual teachers were eligible for maternity benefits, and he was informed that maternity leave benefits were extended to permanent teachers only and not to contractual teachers.the Court held that petitioner would be entitled to maternity benefits under the 1961 Act 's relevant provisions. The Court directed petitioner to submit her claim for maternity benefit before Respondent 4-Principal, Kendriya Vidyalaya, ONGC, and thereafter, Respondent 4 shall examine and process the matter and grant the benefit entitled to petitioner by quantifying the same in monetary terms and disburse the same to her without delay. The Court clarified that the amount to be received by petitioner shall not only be restricted to the amount claimed by her but would also include any such other computation admissible in terms of the relevant provisions of the 1961 Act.

In *B.S. Rajeshwari* v. *State of Karnataka and Others*,[40]the petitioner was appointed in the post of Project Information Officer on a contractual basis, which was renewed from time to time. With the last renewal, she was in service of the respondent for 10 (ten) years. When the petitioner sought for maternity leave, the respondent directed her to report to her duties and when she did not report back, the terminated her service by cancelling the contract. The question before the Karnataka High Court was whether the termination/ cancellation of contract in the ground of the petitioner seeking maternity leave is justified? The Court held that petitioner was entitled to 6 (six) months of maternity leave in terms of the MB Act, and directed the (i) respondent to reinstate the petitioner to the post she held earlier with 50% (fifty percent) back wages from the date of cancellation of appointment; (ii) respondent to pay additional amount to the petitioner as exemplary costs; and (iii) State to pay costs to the petitioner and recover the same from the officer who passed the order of termination.

In *Rasitha C.H.* v. *State of Kerala and Others*,[41]Rasitha Petitioner has been working as an Assistant Professor at the Calicut University Respondents on contractual basis since past one decade. The Petitioner had joined the professorship in the year 2008 and since then her contract has been renewed several times. On the expiry of the last contract, The Petitioner was reengaged with effect from August 2017 for a tenure of one year. the Petitioner has been denied of the maternity benefits on the grounds that the terms of the agreement with the Respondents are silent on such benefits.

V. Conclusion

Reproductive rights in India encompass a broad range of entitlements, including the freedom to make decisions about reproduction and the right to access safe, affordable, and respectful maternity care. Maternity benefits provided under Indian law are not merely labor entitlements but are deeply linked to women's constitutional and human rights. Through progressive legal interpretations and policy reforms, India continues to strengthen the legal framework that protects and promotes reproductive health and maternity benefits. Hence, it is the responsibility of the employers in formal sector and the government departments and institutions to recognize this reproductive right of women and ensure maternity benefit to them considering the hardship women have to undergo in balancing their motherly instincts and strong urge to be financially independent women.

* * * *

[38] 1966 SCC OnLine SC 106

[39] 2024 SCC OnLine Gau 1559.

[40] W.P. 10677 of 2020, Karnataka High Court, 2021

[41] W.P.(C). No. 30561 of 2017

BEYOND CHOICE: THE FUNDAMENTAL RIGHT TO BODILY AUTONOMY IN REPRODUCTIVE HEALTH

Mr. Amith S. M. *
Mrs. Varnitha Shetty **
Ms. Sanjana ***

Abstract

Reproductive rights are the foundation of bodily autonomy, a vital human right that allows individuals to make independent decisions about their health, sexuality, and reproductive lives. Inspired by the UNFPA's declaration, "My Body is My Own," this paper argues that such rights include the freedom to choose family planning, obtain comprehensive reproductive healthcare, and make well-informed decisions without coercion, discrimination, or violence. It also examines India's framework for reproductive rights, stressing their importance in upholding human dignity, autonomy, and gender equality. Additionally, the paper explores how these rights intersect with broader International Human Rights obligations and calls for legislative reforms to broaden legal provisions particularly in the areas of abortion and reproductive healthcare access. Finally, while judicial decisions increasingly recognize reproductive rights as intrinsic to the right to life and personal liberty, the paper reveals that persistent implementation gaps and enduring patriarchal norms continue to obstruct meaningful progress.

This paper employs a qualitative research approach, relying on secondary sources to examine reproductive rights as a fundamental aspect of bodily autonomy. The paper draws upon international human rights frameworks, legal statues, judicial decisions, and scholarly articles to analyse the legal and policy landscape governing reproductive rights.

Key Words : **My Body, Autonomy, Reproductive, Health, Rights**

I. Introduction

Bodily autonomy is the essential right of every person to control their own body without outside pressure or interference.[1] It means having the authority over personal health, reproductive decisions, and bodily integrity, allowing individuals to determine what happens to them. This principle, which lies at the heart of human dignity and freedom, asserts that every individual should be the sole decision-maker regarding their physical self, whether it's accessing healthcare, selecting contraception, or choosing sexual activity. When society honours bodily autonomy, it not only protects individual rights but also paves the way for greater equality, improved well-being, and empowerment.

The United Nations Population Fund (UNFPA) reports that only about 55% of women globally have the independent power to decide whether to use contraception or engage in sexual activity.[2] This statistic exposes a deep inequality in decision-making power that continues to affect women's lives. The UNFPA evaluates bodily autonomy by focusing on three crucial areas: access to healthcare, the freedom to choose contraception, and the ability to refuse unwanted sexual advances.

Reproductive choice is a vital part of bodily autonomy, encompassing a woman's right to determine if and when to have children, a decision that profoundly influences her life and her capacity to contribute to society.[3] Yet, challenges such as inadequate healthcare, high costs, misinformation, and family pressure prevent approximately 218 million women and girls from obtaining the contraception they need. These obstacles not

*** Assistant Professor, SDM Law College, Mangalore**
**** Assistant Professor, SDM Law College, Mangalore**
***** Law Student, II BA.LLB, SDM Law College, Mangalore**

1 *Bodily autonomy: A fundamental right*. (n.d.). United Nations Population Fund. https://www.unfpa.org/press/bodily-autonomy-fundamental-right#:~:text=Bodily%20autonomy%20means%20my%20body,bodily%20autonomy%20is%20mission%20critical.

2 Casey, K. (2023, March 27). *My body, my choice: Defending bodily autonomy*. MSI Reproductive Choices. https://www.msiunitedstates.org/my-body-my-choice-defending-bodily-autonomy/

3 https://www.unfpa.org/ MY BODY IS MY OWN

only restrict personal freedom but also reinforce cycles of dependency and inequality. Empowering women to control their own bodies leads to better outcomes in health, education, income, and safety, which ultimately benefits entire communities. Conversely, denying this autonomy can result in unplanned pregnancies, increased gender-based violence, and economic marginalization.

Moreover, restrictive cultural norms, discriminatory laws, and deep-seated gender inequality significantly curtail women's ability to make choices about their own bodies. Practices such as child marriage, female genital mutilation, and forced sterilization illustrate how bodily autonomy is undermined, trapping millions in cycles of dependency and violence. This loss of control harms their health and limits their right to decide when or if to become mothers, ultimately shaping their futures and overall well-being.

II. The ICPD and the Transformation of Reproductive Rights

The 1994 International Conference on Population and Development (ICPD) in Cairo marked a pivotal shift in global views on reproduction and health.[4] It moved the narrative away from treating women as mere instruments for population control and instead recognized them as individuals with inherent worth whose empowerment is essential for social justice. The conference introduced a framework that connected reproductive health with human rights, affirming that every woman should have the freedom to decide if, when, and how many children to have, and to control her own sexual and reproductive life.

This transformative perspective redefined reproductive rights not as tools for demographic management, but as fundamental human rights that contribute to a woman's overall well-being. [5]Grounded in International Human Rights Law and reinforced by agreements like the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women, this approach was further bolstered by the Beijing Platform for Action in 1995. Together, these milestones have linked women's personal empowerment to broader societal benefits, such as improved education, economic stability, and social justice, setting the stage for ongoing efforts to secure full reproductive autonomy and gender equality worldwide.

III. Social Construction of Difference and the Legal Framework of Reproductive Justice

Many cultures define women by their ability to carry children, limiting their liberty. Women are taught that their value is in motherhood from a young age, putting pressure on them to reproduce quickly and repeatedly, which can harm their health. Women who don't meet these standards may be socially stigmatized or excluded, and society generally emphasizes the well-being of their children or the unborn over their own health.

Chastity standards imposed by female sexuality stereotypes limit women's independence and public participation. Under the pretence of honour or purity, female genital mutilation, forced virginity examinations, and hymen repair controlsubordinate women's bodies. These measures undermine bodily integrity and reduce women's ability to refuse unwelcome approaches or negotiate safe sexual practices, rendering them more prone to HIV/AIDS, sexual abuse, and violence. These cultural and religious traditions impair women's health and personal choices, denying them autonomy.

Contemporary feminist legal thought emphasizes that while social conceptions discriminate against women, actual gender equality requires understanding and addressing biological disparities. Instead of using a one-size-fits-all approach, equality necessitates addressing similar interests with distinct demands. Discrimination occurs when women's sexual and reproductive health needs are overlooked. True healthcare rights must address both common and reproductive needs of women.

Woman's autonomy includes the right to choose family planning, terminate an undesirable pregnancy, and decide when and how to reproduce. In many countries, restrictive laws and forceful behaviours limit this freedom. In nations with tight abortion laws, unsafe methods cause maternal disease and death. In Mexico,

---

[4] *Rights to sexual and reproductive health*. (n.d.). https://www.un.org/womenwatch/daw/csw/shalev.htm#:~:text=The%20right%20to%20reproductive%20choice,of%20family%20planning%20and%20contraception.

[5] Raday, F. & Working Group on the issue of discrimination against women in law and in practice. (2017). *Women's Autonomy, Equality and Reproductive Health in international Human Rights: Between recognition, backlash and regressive Trends*. https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf

women are often unaware of the permanent nature of sterilization, while in Indonesia, some are coerced into contraception. These behaviours violate personal autonomy and strengthen structural inequity, making it difficult for women to get healthcare and respect.

State requirements for spousal or family approval for reproductive health operations impair women's autonomy. Even with exceptions for rape, bureaucratic delays and extra hurdles can force women into long, stressful legal fights that deny them timely, dignified care. Women in remote areas, conflict zones, and stigmatized professions face extra barriers to effective health services and reproductive rights, making this problem worse. These issues originate from societal prejudices, biological variances, and discriminatory legal policies that limit women's reproductive autonomy. Lack of resources, informed consent, and equal legal treatment undermines women's rights and perpetuates poverty, abuse, and social marginalization.

IV. Empowering Choices: SDG Indicator 5.6.1 and Its Implications for Women's Reproductive Autonomy

The SDG Indicator 5.6.1 is a vital tool for measuring women's reproductive autonomy.[6] It focuses on women aged 15–49 and is built around three core questions:[7] Who makes decisions about their own health care, who decides on contraceptive use, and whether a woman can refuse sex with her partner. Only women who make these decisions independently are considered to have full autonomy. While the indicator originally applied only to married or in-union women using contraception, planned updates can broaden its reach, even though data on unmarried women and adolescents remain limited.

Early 2020 data from 57 countries, mainly in sub-Saharan Africa, reveal that only about 55% of married or in-union women enjoy full autonomy. However, there are significant regional differences with some regions in Europe, South-eastern Asia, and Latin America reporting autonomy rates as high as 80%, while many nations in sub-Saharan Africa and parts of Central and Southern Asia fall below 40%.

Significant socio-demographic characteristics, including age, education, and household wealth, are essential to attain autonomy. Women often acquire greater decision-making authority as they mature, particularly in their early 30s, and individuals with at least a primary education approximately 38% more likely to attain full autonomy compared to those lacking any formal education. Affluent households exhibit elevated levels of autonomous decision-making.

Achieving the 2030[8][9] Agenda will require governments to remove unnecessary legal, medical, and regulatory barriers that limit access to sexual and reproductive health services. Additionally, policies must address socio-cultural factors by improving education and economic opportunities, particularly for the most vulnerable groups. Tailoring interventions with disaggregated data will help ensure that no one is left behind.

V. Reproductive Rights and Justice: Feminist Framework

Mainstream discussions often spotlight a woman's right to terminate a pregnancy, yet feminist legal thought insists that issues like access to contraception, coerced sterilization, and state-imposed reproductive control are just as important. Liberal feminism, for example, champions individual autonomy as essential for achieving gender equality, illustrated by landmark cases such as Griswold v. Connecticut and Roe v. Wade, which recognized the right to privacy and empowered women to make personal reproductive decisions. Meanwhile, critical race theory broadens this view by showing how overlapping discrimination based on race, class, and gender results in practices like coerced sterilization and punitive welfare policies disproportionately affecting low-income women of colour.

Marxist feminism frames reproductive rights and bodily autonomy as deeply intertwined with capitalist

---

6 *Tracking women's decision-making for sexual and reproductive health and reproductive rights*. (n.d.). United Nations Population Fund. https://www.unfpa.org/resources/tracking-women%E2%80%99s-decision-making-sexual-and-reproductive-health-and-reproductive-rights

7 *Indicator Metadata Registry details*. (n.d.). https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4986

8 Casey, K. (2023a, January 10). *Launching MSI 2030: 'Your body, your choice, your Future.'* MSI Reproductive Choices. https://www.msiunitedstates.org/launching-msi-2030-your-body-your-choice-your-future/

9 *Women's reproductive autonomy as the new catchword*. (n.d.). UNFPA India. https://india.unfpa.org/en/news/womens-reproductive-autonomy-new-catchword

exploitation and class struggle.[10][11]It argues that women's reproductive capacities are not just personal choices but are exploited under a system that relies on the continuous reproduction of labor. In capitalist societies, policies that restrict access to contraception, safe abortion, and comprehensive reproductive health care are designed to regulate women's fertility in a way that benefits economic interests, aligning with market demands rather than individual freedom.

This view holds that full autonomy entails eliminating the economic conditions that commodify women's reproductive labor, not only legal entitlements. Real reproductive freedom requires legal reforms alongside social and economic changes including redistributive policies, larger social safety nets, and fair labor practices, which empower women at home and at work.

Marxist feminism demands social revolution. It imagines a world when women are no longer tools for social reproduction but powerful individuals who determine their bodies and destinies, free from capitalism and patriarchy.

Based on these ideas, the reproductive justice movement seeks a framework linking reproductive rights to civil, economic, and social rights. It claims that true reproductive freedom includes the right to decide if, when, and how to have children and to parent in safe and supportive environments with access to quality health care, education, and housing.

VI. Women's Autonomy, Equality, and Reproductive Health in International Human Rights

The report by the UN Working Group on Discrimination Against Women in Law and Practice critically examines how economic downturns, austerity measures, and cultural–religious conservatism erode women's rights. It argues that policies under the guise of protecting "traditional values" or the family often neglect women's equal status, reducing their full humanity. The report insists that women's rights including equality, dignity, autonomy, and the highest attainable standard of health (covering sexual and reproductive health) must be strictly upheld without discrimination. Central to its analysis is the belief that a woman's ability to make independent decisions about her body and reproductive functions is fundamental to her privacy and equality.

Reproductive rights, defined as the freedom to choose childbearing, secure quality contraception, and safely terminate a pregnancy in its early stages, are essential. The report contends that legal frameworks like CEDAW require governments to provide affordable, quality reproductive healthcare that meets women's needs. It also finds that restrictive abortion laws do not lower abortion rates; rather, they force many economically disadvantaged women into extremely unsafe procedures, with nearly 45% of global abortions unsafe. The criminalization of abortion is portrayed as gender-based violence that violates bodily integrity, necessitating legal reforms and decriminalization to ensure gender equality.

The report calls for the decriminalization of abortion and the repeal of restrictive laws that place societal interests in gestation above women's rights. It advocates for legal reforms that guarantee safe, timely, and affordable abortion services especially for marginalized groups such as adolescent girls, impoverished women, and others facing added vulnerabilities. Additionally, it highlights the importance of comprehensive sexuality education, non-discriminatory health policies, and the removal of third-party authorizations that hinder women's reproductive autonomy.

VII. Reproductive Rights in India: Challenges, Judicial Interventions, and the Way Forward

Despite over 78 years of independence, India's recognition of sexual and reproductive rights remains limited. Although women have advanced in achieving gender equality, the focus has largely been on issues like child marriage, female foeticide, and menstrual health, rather than on broader concepts of bodily autonomy and reproductive decision-making. Promises to enhance legal protections, expand reproductive healthcare access, and criminalize marital rape have often fallen short, leaving significant gaps in women's rights.[12]

---

[10] Garcia, K., & Garcia, K. (2022, September 29). The root causes of the attacks on reproductive rights: A Marxist analysis – Liberation School. *Liberation School – Revolutionary Marxism for a new generation of fighters*. https://www.liberationschool.org/marxist-analysis-attacks-reproductive-rights/

[11] Reproductive labor and exploitation: From Marx to feminist theories of social reproduction | Cairn.info

[12] Wojnar, A. M. (2023, July 11). *Women's reproductive autonomy as the new catchword*. The Hindu. https://www.thehindu.com/opinion/op-ed/womens-reproductive-autonomy-as-the-new-catchword/article67064795.ece

Initially, the 1971 Medical Termination of Pregnancy Act was enacted to control population growth rather than to affirm women's autonomy. A transformative shift began with the 1994 International Conference on Population and Development, which redefined reproductive rights as fundamental human rights, and was reinforced by the 2009 Suchita Srivastava judgment that recognized reproductive choices as intrinsic to personal liberty under Article 21. Recent legal milestones, including the Puttaswamy case, have further cemented the constitutional basis for reproductive rights by emphasizing individual autonomy over state control, particularly for marginalized communities.

Although 2021 amendments expanded abortion access, challenges persist. The dependence on medical professionals as gatekeepers and an increasing emphasis on foetal rights may undermine women's autonomy. In India, constitutional provisions (Articles 14, 15, and 21)[13] and international treaties such as Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), International Covenant on Civil and Political Rights (ICCPR),International Covenant on Economic, Social and Cultural Rights(ICESCR), and Convention on the Rights of the Child(CRC) obligate the state to ensure comprehensive reproductive healthcare and uphold these fundamental human rights as under Article 51(c) of the Indian Constitution, the government has a constitutional duty to respect international treaty obligations. Furthermore, Article 39(a) mandates equal access to justice and free legal aid, ensuring that economic constraints do not impede justice.

VIII. Judicial Recognition of Reproductive Rights in India

Over the past decade, Indian courts have increasingly recognized that reproductive rights are fundamental to a woman's right to life, dignity, and personal autonomy. Landmark rulings have affirmed that decisions regarding maternal health, contraception, abortion, and challenges to child marriage are integral to securing women's equality and overall human rights. For example, cases such as Laxmi Mandal and Suchitra Srivastava have expanded the interpretation of Article 21's right to privacy, ensuring that women can make informed and independent choices about their bodies.[14][15][16]

The judiciary has linked reproductive rights with broader principles of equality and non-discrimination. In Devika Biswas v. Union of India, for instance, coercive practices like forced sterilizations were condemned, emphasizing that every woman must have access to a full range of contraceptive options and the freedom to decide without undue pressure. In abortion matters, progressive judicial interpretations have reinforced that women have the right to terminate pregnancies when continuing them would jeopardize their mental or physical health, particularly in cases of rape, incest, or severe foetal impairment. However, inconsistent judicial decisions and varying state policies continue to hinder uniform access to safe and legal abortion services.

Additionally, courts have condemned child marriage as a violation of fundamental rights, recognizing that early marriage compromises a girl's health, education, and long-term autonomy. Despite significant judicial progress, challenges remain in implementing these rights. Gaps in execution, conflicting interpretations, and restrictive legal frameworks underscore the urgent need for comprehensive reforms and robust advocacy.

IX. Key Judicial Pronouncements include:[17][18]

Maternal Health

- *Laxmi Mandal V. Deen Dayal Harinagar Hospital & Ors. (2011) and Jaitun V. Maternity Home, MCD, Jangpura& Ors. (2011)*: The Delhi High Court ruled that denial of maternal healthcare violates

---

[13] WWW.REPRODUCTIVERIGHTS.ORG. (2021). Reproductive rights in India: the current situation. In *Reproductive Rights in India: The Current Situation* [Report]. https://reproductiverights.org/sites/default/files/documents/Reproductive-Rights-In-Indian-Courts.pdf

[14] India's Push-and-Pull on Reproductive Rights (https://verfassungsblog.de/indias-push-and-pull-on-reproductive-rights/#:~:text=In%20the%201971%20legislative%20assembly,life%5D%20in%20any%20manner%E2%80%9D.)

[15] *Reproductive Rights for Women in India | Legal Service India - Law articles - Legal resources*. (n.d.). https://www.legalserviceindia.com/legal/article-3372-reproductive-rights-for-women-in-india.html

[16] *A womb of one's own: privacy and reproductive rights*. (2017, October 31). Economic and Political Weekly. https://www.epw.in/engage/article/womb-ones-own-privacy-and-reproductive-rights

[17] Kumar, A. (2024, January 8). Reproductive rights under Indian Constitution. *TSCLD*. https://www.tscld.com/reproductive-rights-under-the-indian-constitution

[18] Kotiswaran, P. (2019). Constitutional and human rights framework for reproductive justice in India. In *Securing Reproductive Justice in India: A Casebook*. https://reproductiverights.org/wp-content/uploads/2020/12/SecuringReproductiveJusticeIndia-Chpt01.pdf

the right to health and life, emphasizing that no woman, especially pregnant women, should be deprived of medical treatment due to their socio-economic status.

- *Sandesh Bansal V. Union of India (2012):* The Madhya Pradesh High Court reaffirmed that maternal mortality is a violation of Article 21, rejecting financial constraints as a justification for reproductive rights violations.

Contraceptive Access

- The 2016 judgement in Devika Biswas v. Union of India, established the right to informed consent for sterilization procedures, and that such procedures must be voluntary and free from compulsion or pressure. (Supreme Court ruled that coercive sterilization practices violated women's fundamental rights, explicitly recognizing reproductive autonomy under Article 21.)

Abortion and Forced Pregnancy

- Recognition of Reproductive Autonomy: In 2009, the Supreme Court held that women's right to make reproductive choices is an extension of their personal liberty under Article 21.
- Punjab and Haryana High Court (2011): Reiterated that a woman's decision to undergo an abortion is a personal right, and no one, including her spouse, can interfere.
- The 2013 judgement in Halima W/O Aamin v. State of Madhya Pradesh and Others, allowed the woman, who claimed her pregnancy as a result of forced prostitution, to terminate her pregnancy under MTP Act, and the court recognized that forced prostitution equated to rape.
- The 2009 Suchita Srivastava Judgement recognized reproductive choices as intrinsic to personal liberty and also that women can make informed and independent choices about their bodies under Article 21. (Established that a mentally retarded woman must give her consent for the termination of her pregnancy, affirming her reproductive rights under Article 21- Supreme Court)

Right to IVF

- The 2025 Judgement, Kerala High Court ruled in favour of a woman seeking in-vitro fertilization despite her husband's age exceeding the statutory limit of 55 years as stipulated in the Assisted Reproductive Technology (Regulation) Act, 2021, stating that act allows women under 50 to access ART Services independently of their husbands age, provided he consents.[19][19] The Hindu Bureau. (2025, February 24).

  HC allows woman with overaged husband to undergo ART procedure

  The Hindu. https://www.thehindu.com/news/cities/Kochi/hc-allows-woman-with-overaged-husband-to-undergo-art-procedure/article69258756.ece

The Foetal Rights over Woman's Autonomy

- The Supreme Court of India denied a woman's request for abortion at 26 weeks, despite her mental health issues and the circumstances surrounding her pregnancy. The court's ruling emphasized the viability of the foetus and adhered strictly to the MTP Act, which allows for abortions only under specific conditions, primarily focusing on foetal abnormalities or immediate threats to the mother's life. This judgement prioritises foetal rights over the woman's autonomy. [20]

The Supreme Court of India has been pivotal in advancing women's reproductive rights through landmark judgments that affirm sexual autonomy and the right to privacy. Notable rulingssuch as decriminalizing adultery and striking down Section 377 in the Navtej Johar casehave reinforced that personal decisions about intimacy, family, and procreation should remain with the individual, extending these protections even to girl children and unmarried women.

Yet, Indian abortion law remains contradictory. Although it promises a woman's right to choose, final decisions

---

[19] The Hindu Bureau. (2025, February 24). *HC allows woman with overaged husband to undergo ART procedure*. The Hindu. https://www.thehindu.com/news/cities/Kochi/hc-allows-woman-with-overaged-husband-to-undergo-art-procedure/article69258756.ece

[20] Sarkar, S. (2024, September 9). *India's abortion laws offer pregnant women an illusion of choice*. New Lines Magazine. https://newlinesmag.com/argument/indias-abortion-laws-offer-pregnant-women-an-illusion-of-choice/

often depend on medical practitioners.[21] The 2021 MTP Amendment Act extended legal limits for abortionsup to 20 weeks with one doctor's approval and 24 weeks for specific casesbut still leaves much discretion to doctors.[22][23] A 2022 Supreme Court ruling further confirmed that both married and unmarried women have the right to abortion, including in cases of rape, yet significant gaps persist. For instance, late-term abortions are allowed only for severe foetal anomalies, and mandatory reporting under the POCSO Act can hinder safe access for adolescents. Despite progress since abortion was decriminalized in 1971, the system remains overly dependent on medical authority, highlighting the need for broader policy reforms and robust public advocacy to ensure genuine reproductive autonomy.

X. Challenges in Reproductive Rights

Despite legal recognition of bodily autonomy, data from India presents a concerning reality. Of the 353 million women of reproductive age, 52% (183 million) seek to avoid pregnancy, yet 27% (49 million) do not use modern contraceptive methods.[24] Each year, India records 47 million pregnancies, nearly 45% of which are unintended.[25] Pregnancy-related complications claim the lives of 27,000 women annually, with 3,000 deaths linked to unsafe abortions. The UNFPA's State of the World Population Report 2022 highlights unsafe abortions as the third leading cause of maternal mortality in the country. Furthermore, findings from the National Family Health Survey reveal that only 10% of Indian women have full autonomy over their healthcare decisions.[26]

Key barriers include limited access to safe abortion services, as many public hospitals lack proper facilities, and societal stigma, particularly affecting young and unmarried women. Although there is no legal requirement, many doctors insist on spousal or parental consent, driving women toward unsafe procedures. The Medical Termination of Pregnancy (MTP) Act, which permits abortion up to 20 weeks (and up to 24 weeks for select cases with additional approvals), still restricts access and fails to consider non-medical factors like economic hardship and personal aspirations.[27]

These challenges are compounded by the persistence of child marriage, historically demographic-driven policies that prioritize population control over women's autonomy, and substandard healthcare, which contributes to high maternal mortality rates (20% of global maternal fatalities). Furthermore, the crisis is further intensified by hazardous abortions and coercive sterilization campaigns run by the state. 56% of the 6.4 million abortions that take place annually in India are unsafe, which accounts for 9% of maternal fatalities.

The Way Forward

India's reproductive rights are at a pivotal crossroads, requiring a balanced strategy that respects both a woman's autonomy and foetal interests while avoiding overly restrictive measures that drive abortions underground. To achieve true reproductive freedom, India must pursue progressive legal reforms and inclusive social policies.

Key reforms should focus on:[28]

- Expanding Safe Abortion Access**:** Strengthen public healthcare and provide judgment-free, accessible abortion services. Recent amendments have extended legal limits, but access still largely depends on medical discretion.

---

21 *Equality and individual autonomy in reproductive rights: India shows the way*. (2022, October 4). UN Women – Asia-Pacific. https://asiapacific.unwomen.org/en/stories/op-ed/2022/10/equality-and-individual-autonomy-in-reproductive-rights

22 *Reproductive and sexual rights of women in India*. (n.d.). Drishti IAS. https://www.drishtiias.com/daily-news-editorials/reproductive-and-sexual-rights-of-women-in-india

23 Maniyar, Z., &Maniyar, Z. (2022, November 30). *Bodily autonomy & safe abortion, a right under Article 21*. CJP. https://cjp.org.in/bodily-autonomy-safe-abortion-a-right-under-article-21/

24 *Investing in the sexual and reproductive health of women in India*. (2022, August 24). Guttmacher Institute. https://www.guttmacher.org/fact-sheet/adding-it-up-investing-in-sexual-reproductive-health-india

25 *The case for action in the neglected crisis of unintended pregnancy*. (n.d.). United Nations Population Fund. https://www.unfpa.org/swp2022

26 Gloppen, J. K. M. U. S. (2021, December 5). *A half-written promise*. The Hindu. https://www.thehindu.com/opinion/op-ed/a-half-written-promise/article62109912.ece

27 Bhaware, P. (2024, January 27). Legally speaking | The right to abort, in light of different judgements. *Hindustan Times*. https://www.hindustantimes.com/analysis/legally-speaking-the-right-to-abort-in-light-of-different-judgements-101706351933934.html

28 Satish, S. (2025, January 22). Reproductive Rights of Women - ClearIAS. *ClearIAS*. https://www.clearias.com/reproductive-rights-of-women/?srsltid=AfmBOoqSjoazWeeO9xdHcCVvZoXZF3SeYrZKufjNOGtzbN1I3Z_MCn4K

- Enhancing Contraceptive Access and Sex Education: Empower women and adolescent girls through comprehensive sex education and improved contraceptive options, ensuring informed reproductive decisions.
- Ending Coercive Practices: Ban forced medical procedures, such as involuntary sterilizations and informal requirements for spousal or parental consent.
- Updating Legal Frameworks: Amend the Medical Termination of Pregnancy Act to include non-medical factorssuch as economic hardship and personal circumstancesbeyond the current gestational limits.

Core reproductive rights include access to contraception, safe and legal abortion, comprehensive sexuality education, protection against child marriage, freedom from coercion and violence, maternity and postnatal support, and breastfeeding rights. Despite early legal frameworks, Indian women face challenges like administrative delays, inconsistent judicial decisions, poor healthcare quality, and economic disparities that restrict their full exercise of these rights.

Progress in reproductive rights is not only essential for individual dignity and autonomy but is also linked to broader gender equality and economic growth. A concerted effortthrough targeted investments in women's health, education, and legal reforms, coupled with vigorous public debatecan empower every woman to make informed, autonomous decisions about her reproductive future, contributing to a healthier, more equitable society.

XI. Conclusion

Reproductive rights lie at the heart of gender justice and human dignity in India. Although progressive legal frameworks and judicial decisionssuch as those affirming safe abortion, contraception, and family planningestablish a strong foundation, significant implementation gaps remain. Issues like unsafe abortions, coercive sterilizations, and inadequate reproductive healthcare continue to undermine women's autonomy and aggravate maternal mortality.

Current public discourse often narrows the conversation to child marriage, female foeticide, and menstrual health, overlooking critical concerns such as access to safe abortion, reliable contraception, adolescent sexuality, and the prohibition of forced medical procedures. Statutory measures like the Prevention of Child Marriage Act, 2006 and the Medical Termination of Pregnancy Act, 1971 provide legal protections, yet their restrictive provisionsespecially concerning abortion beyond 20 weekshighlight the urgent need for comprehensive reform.

International standards set by the WHO, the Universal Declaration of Human Rights, and conventions like CEDAW reinforce that reproductive health is essential to overall well-being. Core rightsranging from bodily autonomy and access to quality healthcare to privacy, education, and support for parentingmust be upheld without discrimination.

Addressing these challenges necessitates a comprehensive approach: substantial legal reforms, considerable investments in healthcare infrastructure, and coordinated efforts to dismantle entrenched patriarchal norms. Collaboration among policymakers, civil society, and international partners is essential to guarantee that all women in India can freely and dignifiedly exercise their reproductive rights.

As encapsulated by the UNFPA's rallying cry, "My body is my own," achieving true reproductive autonomy is not merely a legal or medical imperative, it is a fundamental human right that paves the way for a healthier, more equitable, and empowered society.

* * * *

FAITH AND FERTILITY: RELIGIOUS PERSPECTIVES ON REPRODUCTIVE RIGHTS AND POPULATION CONTROL

Dr. Annapoorna Shet *

Abstract

Religion play an important role in the concept of marriage and marriage is a key for the exercising of reproductive rights of the individual. Reproductive right is considered as a boon and the gift of god rather than the right in many sects and religions of the Indian society. The process of reproduction and child bearing is given utmost importance by the individuals and all the married couples urge to experience the phase of reproduction in their life. At the same time these rights are backed with certain beliefs which will affect the life of the individual to the large extent. The reproductive rights are backed with customs and traditions that exist in the society. The law legalizes the reproductive rights only after the solemnization of legal marriage between the man and women and so the religion too. There are several instances of temporary marriage called as Muta marriage in Mohammedan law which provide reproductive rights to the couples even with temporary marriage. The concept of reproductive rights has undergone transformation from the ancient period till present days. India being a highest populated country in the world has to think of the reproductive rights in such a manner so as to balance between the exercising of their reproductive rights as well as addressing the population issues. The government should also frame policies and laws in order to implement the rules regarding the same. The paper concentrates on the concept of reproductive rights, its historical evolution and also the role of both the religion as well as State in order to address the pressing problem of the society which is the population explosion.

Key Words: **Religion, Reproductive Rights, Marriage, Women Rights.**

I. Introduction

Religion is the oldest form of set up which unites individuals within them in terms of customs, traditions, culture, etc. Religion unites a people and several policies and principles are framed within the framework of religion. The concept of marriage, which is considered as a base of the reproductive rights of the individual play an important role in exercising the reproductive rights of the individual. Marriage as an institution is governed by personal laws and deeprooted in the religious principles. Every religion has a mention about the importance of reproduction as it is the primary purpose of the human existence in the civilized society. The same right is backed with certain laws and policies framed by the government from time to time. No doubt the concept of reproductive rights of an individual has changed in the present day due to the change in the mindset of the present generation and also the government intervention in order to check the population issues. But the concept of reproductive rights is still deep rooted in the religion in present time. The paper concentrates on the concept of reproductive rights, its historical evolution and also the role of both the religion as well as State in order to address the pressing problem of the society which is the population explosion.This paper explores how religious perspectives on reproductive rights intersect with and influence the development of reproductive laws, analyzing how specific religious traditions shape abortion laws, contraception access, fertility treatments, and broader policies related to population control. Through this exploration, we also examine the ongoing tension between religious beliefs and secular legal principles in shaping reproductive rights globally.

* **Assistant Professor, SDM Law College, Mangalore, annapurnashet@gmail.com**

II. Concept of reproductive rights and Religion

The concept of reproduction is the basic and regular process of nature which is found in every living creature in the earth. The reproduction is a basic need and necessity of every creature and each creature follows their own way for the same. Man being a rational animal, the concept of reproduction is practiced in a formal manner after enteringto the marital relationship with husband and wife and so there are certain legal regulations that is to be followed by every individual in the matter of exercising their reproductive rights. Reproductive rights are available to every individual irrespective of religion but only to those who enter into a contract of marriage in order to exercise these rights. The concept of marriage and the right of reproduction are co related to each other, where in the absence of valid marriage, the couples will lose their reproductive rights and the children born out of such relationship are considered illegitimate in most of the personal laws. Reproductive rights are the legal rights and freedom given to every individual relating to reproduction as well as reproductive health.[1] It provides every individuals the right to make informed decisions about their reproductive lives without discrimination, coercion, or violence. Reproductive rights include right to reproductive health care, right to family planning, right to safe and legal abortion, right to sexual education, freedom from forced reproduction, etc. The concept of reproductive right is a global phenomenon where the countries have framed their own laws in the matter of reproductive rights. In India, the reproductive rights are the part of human rights and several rules are framed in order to protect the reproductive rights of every individual in the society.

Reproductive rights are the central aspect of human rights, encompassing the right of individuals to make decisions regarding their reproductive health, including access to contraception, fertility treatments, abortion, and the ability to have children if they choose. These rights are grounded in the principles of autonomy, privacy, equality, and health and are critical for the well-being of individuals and communities.

Religious beliefs, however, often provide distinct views on reproductive rights, sometimes conflicting with secular frameworks that prioritize individual choice. Different religious traditions interpret the morality of reproductive decisionssuch as abortion, contraception, and family planningin various ways, which in turn influence legal systems, public policiesand personal beliefs. The intersection between reproductive rights and religion is complex, with each religion offering specific ethical perspectives that inform societal norms and legal practices. This often leads to debates and tensions, particularly when religious teachings influence laws that govern reproductive rights.[2]

III. Laws relating to Reproductive Rights in India

In India, reproductive rights are protected and regulated through a combination of constitutional provisions, statutory laws, and judicial decisions. These laws encompass rights related to contraception, abortion, maternal health, and reproductive autonomy.

1. Constitutional Provisions

(i) Article 14[3] and Article 15[4] of the Constitution of India which provides the right for equality before the law and prohibit discrimination on the basis of sex, providing a foundation for gender justice even in reproductive matters.

(ii) Article 21[5] of the Constitution: Guarantees the right to life and personal liberty, which the Supreme Court has interpreted to include the right to health, reproductive choice and bodily autonomy.

2. Medical Termination of Pregnancy (MTP) Act, 1971

The objective of enactment of this legislation is to legalise abortion under certain conditions to protect women health and rights. In India the abortion laws are not very stringent as compared to other western

---

1 Michael A. and ors, Reproductive Health in India, New Evidence, 1stedn, 2008, p.12

2 https://www.inovifertility.com/blog/faith-and-fertility-religious-perspectives-on-family-planning/ visited on 12-03-2025

3 The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

4 Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.

5 Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law.

countries which will allow the mothers to terminate their pregnancies in certain cases keeping in minds the health of the mother and other genuine reasons. Under the following circumstances, the termination is permitted under the legislation

(i) Abortion is permitted up to 20 weeks with one doctor's approval

(ii) From 20 to 24 weeks, abortion is allowed for special categories (survivors of rape, incest, minors, etc.) with two doctors' approval

(iii) No upper limit in cases of foetal abnormalities, if approved by a Medical Board.

(iv) Married and unmarried women now have equal access to abortion under the amended law.[6]

3. The Protection of Children from Sexual Offences (POCSO) Act, 2012

The law is enacted to protect children from sexual assault, sexual harassment and child pornography. Special Courts are established under the Act for the speedy trials and aims to safeguard the child's interests throughout the legal process, including rehabilitation and compensation for victims. The Act applied to a child below 18 years of age. The concept of abortion of the minors due to the act of sexual offence against them is dealt under this Act where it creates a legal conflict in cases where adolescent girls seek abortion services.[7]

4. Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994

The above legislation is enacted in India due to the increase in number of female foeticide cases due to advancement in medical technology where the parents with the wish of having a male child killed a female foetus in the womb itself. In order to prevent such heinous act by the people, the law was enacted to punish both the parents as well as the doctor or medical practitioner involved in sex determination. Gender reveal is not practiced in India and any practitioner who reveals a gender to the parents, the highest punishment will be awarded to them where the licence of their practice is terminated. The urge of getting a male child is especially found in the Indian society where several religion stresses on bearing a male child in order to attain salvation where the superstitious belief in the name of religion is a reason for this barbaric act. Sometimes without the knowledge of the technology parents in the urge of getting a male child results in the population explosion. This Act play a vital role in maintaining the sex ratio of male and female which is the need of a well society.[8]

5. Assisted Reproductive Technology (Regulation) Act, 2021

The legislation is enacted in order to regulate the ART services practiced in infertility clinics such as IVF, Surrogacy, etc. Due to the advancement in technology, the child bearing capacity of the parents are increased to the maximum extent with the help of assisted reproductive technique. It is a welcoming act whereas certain complication arises during the process where there is a need for regulating those issues in a legal manner. The main purpose of this legislation is to ensure ethical practices and also to protect the rights of donors, surrogate mothers and intended parents.[9]

6. Surrogacy (Regulation) Act, 2021

A special legislation to deal with surrogacy related issues in India due to increasing number of parents resorting to the facility of Surrogacy. But commercial surrogacy is banned in India and permits altruistic surrogacy only for Indian citizens under strict eligibility criteria. The legislation deals with the rights of surrogate mothers and children born through surrogacy. [10]

IV. Judicial Interpretations

The Supreme Court has affirmed in its various judgement relating to reproductive rights as reproductive autonomy is a part and parcel of Article21of the Constitution of India.

---

[6] Satvik Pai and Krithi S Chandra, Medical Termination of Pregnancy Act of India: Treading the path between Practical and Ethical Reproductive Justice, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10470576/ , visited on 12-03-2025

[7] Act No. 32 of 2012

[8] Act No. 57 of 1994

[9] Act No. 42 of 2021

[10] Act No. 47 of 2021

In *Suchita Srivastava v. Chandigarh Administration*[11] *(2009),* the Court upheld a woman's right to make reproductive choices as a dimension of personal liberty.It was clearly held that the right of abortion is allowed only with the consent of women unless and until the women is mentally ill or unsound mind and if in case of unsoundness of mind, the consent of the guardian is very much needed. In the above-mentioned case, the women was not completely unable to express her consent due to which the court held that the consent of the mother is required to terminate the pregnancy and State cannot decide it in the place of women and also stressed on the provisions of MTP Act which speaks about the requirement of women's consent for the termination of pregnancy.

In X v. Principal Secretary, Health and Family Welfare[12] (2022), the Supreme Court allowed an unmarried woman to terminate her pregnancy under the MTP Act, affirming equal reproductive rights regardless of marital status. Where The petitioner 'X' was an unmarried womanwho became pregnant due to a consensual relationship and sought to terminate her 24-week pregnancy. But she was denied access to abortion under the Medical Termination of Pregnancy Act, 1971 (as amended in 2021) because she was unmarried, and her case did not fall under the categories listed for abortion beyond 20 weeks. As she was aggrieved by the decision, she challenged this before the Delhi High Court, which denied her request for which she appealed to the Supreme Court.The Supreme Court reaffirmed that reproductive choice is protected under Article 21 under Right to Life and Personal Liberty which is not limitedby marital status, and denying access to abortion for unmarried women is unconstitutional.

It is clearly held that the concept of reproductive right is the part and parcel of the right to personal life and liberty enshrined in the IndianConstitution.

V. The Intersection between Reproductive Rights and the Religion.

Reproductive rights are deeply rooted and influenced by the religion to which the person belong to. Every religion encourages to exercise reproductive rights of an individual to the maximum extent. It is the objective of every religion to spread their religion worldwide and also to increase their strength which is possible by giving them certain benefits to rear and bear children. In India unlike western countries, several facilities are provided to those who give birth to children. Unlike western countries, where a child born in the country are mostly taken care by the country, in India because of the situation that exists in the Indian society, it is not possible for the State to provide all the facilities to the children born in India. But depending upon the financial conditions of the parents, certain help is sought by the State where as religious institutions on the other hand provide various help to the needy people who belong to their religion like providing facility to the education, providing job opportunities, etc.[13] Even under the Directive Principles of State Policy, the State makes initiative to provide facilities to its citizen.

India is a developing country with highest number of populations which is challenging most of the time to deal with huge population covered in small area as compared to other countries. This poses several challenges both to the people as well as the government to deal with the situation. It is important here to make a note of pandemic period hit by corona virus where it was very difficult for the State to combat the virus due to the dense population. The reason for the population explosion in India is many where religion is a prime factor for the crime.[14]

Lack of education, urge to get a baby boy, fear of causalities of young kids in the earlier days forced the parents to opt for multiple kids. In spite of several policies framed by the government to check population issues, still the concept of religion has diverted the minds of individuals when it comes to the matter of reproductive rights.

---

[11] Civil Appeal No. 5845 of 2009

[12] Civil Appeal No. 5802 of 2022

[13] Supra Note 2

[14] Eric Blyth and Ruth Landau, Faith and Fertility: Attitudes towardfsReproductive Practices in Different Religions from Ancient to Modern Times, 1st edn, Jessica Kingsley Publishers, 2009, p 57

VI. Conclusion

Reproductive laws around the world are deeply influenced by religious perspectives, which inform both the legal regulation of reproductive rights and broader policies regarding family planning and population control. While secular legal systems typically emphasize individual autonomy and human rights, religious teachings provide a moral framework that often dictates the regulation of abortion, contraception, and fertility treatments.

The tension between religious beliefs and secular laws is particularly evident in the regulation of abortion, where some religious traditions, such as Catholicism and Islam, hold strict views on the sanctity of life, while others, like Judaism, allow for greater flexibility. As reproductive rights continue to evolve globally, the interplay between faith, law, and reproductive justice will remain a central issue in debates over reproductive freedoms and human rights.

* * * *

REPRODUCTIVE JUSTICE : RECONCILING THE RIGHTS OF WOMEN AND THE UNBORN CHILD IN INDIAN LAW

Dr. Suma Suresh Kogilgeri *
Mr. Mahan **

Abstract

Reproductive justice in India exists at the intersection of women's rights, foetal rights, and the state's interest in protecting the unborn child. It requires a careful reconciliation between a woman's right to autonomy and the rights of the unborn child. While Indian law primarily frames abortion rights within the Medical Termination of Pregnancy (MTP) Act, the ethical and legal discourse surrounding the unborn child remains contentious.The main intention behind providing reproductive rights is to safeguard women's health, dignity, and autonomy.Indian jurisprudence has largely emphasized reproductive autonomy, yet emerging debates on foetal viability, personhood, and maternal responsibilities call for a more nuanced approach. The current legislation permits abortion under specific circumstances, it does not fully account for foetal rights, advancements in medical science, or the socio-economic barriers women face in accessing reproductive healthcare.A major loophole in the legislation is the lack of clarity on the legal status of the unborn child, leading to judicial inconsistencies and debates on whether foetal rights should be recognized within constitutional protections.

This paper explores an alternative framework that balances a woman's autonomy with the evolving recognition of foetal interests, drawing from constitutional principles, international human rights norms, and judicial interpretations.It critiques the limitations of current laws, particularly their failure to integrate a reproductive justice framework that ensures both women's rights and the consideration of prenatal interests.The paper moves beyond the binary "pro-choice" and "pro-life" debate, advocating for a model of reproductive dignity where legal protections and social policies ensureaccess to healthcare, and recognition of foetal interests without unduly burdening women's agency. By proposing a balanced legal framework, the authors advocate in contributing to the ongoing discourse on reproductive justice in India, ensuring that both women's agency and foetal interests are addressed within a constitutional and human rights-based framework.

Keywords : **Reproductive rights, Foetal Rights, Unborn Child, Women's Autonomy, Abortion.**

I. Introduction

In maternal healthcare, we face challenge caring the two lives mother and her unborn child. This situation raises profound questions. For instance, does an unborn baby have its own set of rights? And when a pregnant woman makes decisions based on her own autonomy, might she inadvertently put the foetal rights at risk? Moreover, if a mother's actions threaten the life or future of her unborn child, who should step in to protect that vulnerable life? These questions remain open and spark ongoing debates among healthcare professionals, legal experts, and society as a whole.[1] Notably, the Indian legal system has yet to provide

* **Assistant Professor, Shri Dharmasthala Manjunatheshwara Law College, Centre for Post Graduate Studies and Research in Law, Mangaluru (sumasureshkogilgeri@sdmlc.ac.in)**

** **Student, Third Year B.A.LL.B., Shri Dharmasthala Manjunatheshwara Law College, Centre for Post Graduate Studies and Research in Law, Mangaluru (mahansonu007@gmail.com)**

[1] Marcelo Shigueo Yosikawa Motoki, Fabio Roberto Cabar & Rossana Pulcineli Vieira Francisco, Mother's Freedom of Choice and the Rights of an Unborn Child: A Comparison Between the Views of Freshmen and Senior Medical School Students, 71 CLINICS 570, 571 (2016), Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC5054766/ (last visited Feb. 13, 2025).

clear legal and criminal protections for the unborn child, leaving room for significant discussion and potential reform.

The Indian legal system, while recognizing a woman's reproductive rights under the Medical Termination of Pregnancy (MTP) Act, 1971 (as amended)[2], has yet to provide a comprehensive legal framework explicitly defining the rights of the unborn child. Unlike jurisdictions that offer clear legal and criminal protections to foetal life, Indian law remains ambiguous, leaving significant room for discussion and potential reform. This legal gap creates complex dilemmas, particularly when balancing a woman's bodily autonomy with the state's interest in safeguarding foetal rights. The challenge, therefore, lies in reconciling these competing concerns while ensuring reproductive justice framework that extends beyond the "pro-choice" versus "pro-life" debate to encompass issues of gender equality, healthcare access, and social justice.

This paper focuses on reproductive right to pregnancy and foetal rights and tries to upheld a balance between the two. The article is structured in a manner, where Part I provides an overview of reproductive rights under Indian constitutional law and statutory provisions. While Part II examines international perspective. Part III analyzes the legal status of the unborn child and the extent of state intervention in reproductive decisions. Part IV deals with judicial interpretations and evolving jurisprudence on the subject. Part V Critically analysis on the current legal stand. Finally, Concluding Part offers recommendations for reconciling these rights within a reproductive justice framework.

II. Historical Background

The Women of African Descent for Reproductive Justice in Chicago coined this definition in June 1994, before the ICPD in Cairo. Reproductive justice is defined as the complete physical, mental, spiritual, political, social and economic wellbeing of women and girls, based on the full achievement and protection of women's human rights.[3]

Theformal recognition to the term "reproductive rights" can be traced to the 1st International Meeting on Women and Health in Amsterdam, Netherlands, in 1984[4]. At that time this term was not prominent and were defined in Non-Institutional Framework.[5]

The expression "reproductive rights" was enshrined in the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, and was again used in the 4th World Conference on Women, in Beijing, China, in 1995. India is a signatory to this ICPD. According to paragraph 7.3 of the Cairo Programme of Action: "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[6]

Reproductive rights in India have a nascent history. Although the country introduced the Medical Termination of Pregnancy Act (MTPA) in 1971, its primary motivation was not centered on women's autonomy but rather on controlling population growth. This legislation was part of a broader strategy that included coercive measures like forced sterilization. While the law also aimed to reduce maternal deaths caused by unsafe abortions, it framed the issue more as a matter of state intervention than individual rights. Instead of recognizing women as autonomous decision-makers entitled to safe abortion access, the state took a paternalistic approach, seeking to protect them from unqualified providers. The global perspective on

[2] The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code (1971), amended by The Medical Termination of Pregnancy (Amendment) Act, No. 8 of 2021.

[3] Ross, Loretta J., What Is Reproductive Justice? in Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change 4 (2007), https://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf. (last visited Feb. 13, 2025).

[4] Laura Davis Mattar, Legal Recognition of Sexual Rights, SUR 8 (2008), https://sur.conectas.org/en/legal-recognition-sexual-rights/ (last visited Feb. 13, 2025).

[5] *Ibid*

[6] International Conference on Population and Development, Programme of Action, 7.3, at 74 (20th Anniversary ed. 2014), U.N. Popul. Fund, available at https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf (last visited Feb. 13, 2025).

reproductive rights began to shift in the 1990s, particularly after the 1994 International Conference on Population and Development (ICPD), which emphasized women's rights over state interests. However, it took India over a decade to embrace this framework. In 2009, the Supreme Court, in the landmark Suchitra Srivastava[7] , affirmed that a woman's reproductive choices are a fundamental aspect of personal liberty under Article 21 of the Indian Constitution, acknowledging her right both to conceive and to choose not to procreate.

The Government of India established the Shantilal Shah Committee[8] in 1964 to address the high rates of maternal morbidity and mortality caused by unsafe, illegal abortions. Over two years, the committee examined extensive evidence and, in 1966, recommended expanding and rationalizing the country's abortion laws.[9]Following these recommendations, the Medical Termination of Pregnancy (MTP) Bill was introduced in the Rajya Sabha in 1969 and subsequently reviewed by a Select Joint Committee. After thorough deliberation, the bill was passed as the MTP Act in 1971 and officially implemented in April 1972. The primary objective of the MTP Act was to reduce maternal morbidity and mortality by providing a legal frameworkfor safe abortion access, thereby minimizing the risks associated with unsafe, clandestine procedures.

According to Oxford reference online dictionary"Reproductive rights means respect for female autonomy, the right of women to make decisions for themselves about whether to become and to remain pregnant. This right and the accompanying freedom are severely infringed in many societies and traditional cultures and are under threat in others, including some democracies."[10]

So, Reproductive rights focuses on the legal and personal freedoms that allow individuals to make informed decisions about their reproductive health. They emphasize access to essential healthcare services, such as contraception and abortion, ensuring that individuals have the right to choose what is best for their bodies. At their core, reproductive rights uphold autonomy and personal choice, free from external pressure or restriction.

III. The Legal Framework regulating Reproductive Rights in India

Indian Constitutional Law

The Indian Constitution guarantees fundamental rights that shape the discourse on reproductive justice. It upholds essential rights that protect individuals' dignity and well-being. It guarantees equality and freedom from discrimination under Articles 14 and 15 and ensures the right to life under Article 21. The hon'ble Supreme Court has interpreted Article 21 to include the right to reproductive autonomy, encompassing the right to abortion and maternal healthcare.[11] The *Puttaswamy judgment*[12] upheld a woman's constitutional right to make reproductive choices as part of personal liberty under Article 21 of the Indian Constitution. It reaffirmed the ruling in *Suchita Srivastava v. Chandigarh Administration*[13], which recognized reproductive rights as including the right to continue a pregnancy, give birth, and raise children.[14]

Statutory Provisions

A. The Medical Termination of Pregnancy (MTP) Act, 1971 (as amended in 2021) provides a legal framework for abortion in India, ensuring that women can access safe and regulated procedures under

---

7 *Infra* note 13

8 Report of the Committee to Study the Question of Legalisation of Abortion, Ministry of Health & Family Planning, New Delhi (1967), https://indianculture.gov.in/reports-proceedings/report-committee-study-question-legalisation-abortion (last visited Mar. 10, 2025).

9 Dr. V.K. Manchanda, Advances in Methods of Emergency Contraception: Experience with Liberalised Abortion Services, Commissioner, Maternal Health, Ministry of Health & Family Welfare, Government of India, https://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/report/1_1_4.htm#:~:text=Government%20of%20India%20set%20up,related%20to%20abortion%20in%201966 (last visited Mar. 10, 2025).

10 Oxford Reference, Reproductive Rights, available at https://www.oxfordreference.com/display/10.1093/oi/authority.20110803100415170 (last visited Feb. 15, 2025).

11 A (Mother of X) v. State of Maharashtra & Anr., [2024] 5 S.C.R. 470.

12 Justice K.S. Puttaswamy (Retd.) v. Union of India, AIR 2018 SC (Supp) 1841, (2019) 1 SCC 1, AIRONLINE 2018 SC 237.

13 Suchita Srivastava & Anr. v. Chandigarh Admin., AIR 2010 SC 235, 2009 AIR SCW 5909.

14 Arijeet Ghosh & Nitika Khaitan, Womb of One's Own: Privacy and Reproductive Rights, Vol. 52, Issue No. 42-43, 28 Oct, 2017, available at https://www.epw.in/engage/article/womb-ones-own-privacy-and-reproductive-rights (last visited Feb. 14, 2025).

specific conditions. The law permits abortion in cases where continuing the pregnancy poses a risk to the mother's life, threatens her physical or mental well-being, or if the foetus has serious abnormalities that could impact its viability or quality of life. The 2021 amendment extended the gestational limit for termination in select cases, such as pregnancies resulting from rape, incest, or when substantial foetal abnormalities are detected.[15]

The first enactment in 1971 allowed abortion up to 20 weeks but 2021 amendment extended it to 24 weeks for special cases (rape survivors, minors, incest victims, etc.). Earlier, two doctors were needed for 12–20 weeks but now, one doctor is enough for up to 20 weeks, and two doctors for 20–24 weeks. with regards to foetal abnormalities there were no provisions in 1971 beyond 20 weeks while in 2021 amendment, no upper limit if a Medical Board confirms severe foetal abnormalities. The 2021 amendment also ensures strict confidentiality that a woman's identity cannot be disclosed. And 1971 law applied mostly to married women, while this 2021 amendment allows unmarried women to seek abortion for contraceptive failure.

B. The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994[16] prohibits sex-selective abortion and regulates prenatal diagnostic techniques to prevent female foeticide. The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 was introduced to curb the alarming decline in the female birth ratio by preventing sex-selective abortions. It strictly prohibits the use of prenatal diagnostic techniques to determine the sex of an unborn child, ensuring that such medical advancements are used only for detecting genetic disorders or abnormalities. To enforce this, the law regulates ultrasound clinics and diagnostic centres, requiring them to be registered and monitored. Medical professionals who violate these rules face strict penalties, including fines, imprisonment, and cancellation of their licenses.

By enforcing these measures, the PCPNDT Act aims to uphold gender equality, protect the rights of unborn girls, and challenge deep-rooted social biases that favour male children. The Act remains a crucial legal tool in the fight against sex-selective practices, promoting a more balanced and just society.

C. The Bharatiya Nyaya Sanhita (BNS), 2023[17], which replaces the Indian Penal Code (IPC), 1860, redefines the legal framework concerning abortion and miscarriage. The relevant provisions are now encapsulated in Sections 88 to 91 of the BNS, corresponding to the former Sections 312 to 315 of the IPC. BNS Penalizes the act of intentionally causing a woman to miscarry, except when performed in good faith to save her life and imposing strict penalties for unauthorized abortions and actions endangering both the woman and the foetus. The law aims to balance the protection of unborn life with the necessity of preserving the mother's health and autonomy.

IV . International Perspective

Reproductive rights are rooted in international human rights law, reflecting the principles of bodily autonomy, health, and dignity. The Universal Declaration of Human Rights (UDHR) affirms in Article 3 that "everyone has the right to life, liberty and security of person,"[18] while the International Covenant on Civil and Political Rights (ICCPR) affirms the rights to privacy[19]and life[20], foundational principles that underpin the protection of reproductive autonomy and promote substantive gender equality.

These rights have been also the subject of significant legal and social evolution across various countries, shaped by constitutional interpretations, legislative changes, and public opinion.In the United States, the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*[21](2022), overturned *Roe v. Wade*[22] (1973), eliminating the federal constitutional right to abortion. This ruling has led to a deeply polarized

---

15 Adsa Fatima & Sarojini Nadimpally, Abortion Law in India: A Step Backward After Going Forward, SCO (Nov. 17, 2023), https://www.scobserver.in/journal/abortion-law-in-india-a-step-backward-after-going-forward/ (last visited Feb. 13, 2025).

16 The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, No. 57 of 1994, INDIA CODE (1994).

17 Bharatiya Nyaya Sanhita, ACT No. 45 of 2023, India Code, Ss.88-91(2023).

18 UN, Universal Declaration of Human Rights, art. 3 (Dec. 10, 1948).

19 International Covenant on Civil and Political Rights art. 17, Dec. 16, 1966, 999 U.N.T.S. 171.

20 *Ibid* art. 6.

21 Dobbs v. Jackson Women's Health Org., 597 U.S. (2022).

22 Roe v. Wade, 410 U.S. 113 (1973).

legal landscape, where individual states now have the power to regulate abortion access, with some imposing near-total bans while others continue to uphold reproductive autonomy.

In the United Kingdom, abortion is governed by the Abortion Act 1967[23], which provides a structured legal framework allowing termination of pregnancy up to 24 weeks, provided specific medical and social conditions are met. While abortion remains a regulated procedure, the law ensures broad access under medical supervision, balancing foetal considerations with the rights of the pregnant individual.The case,*Rex v. Bourne*[24], clarified the law by establishing conditions under which it may be legal to have an abortion (OAPA defines only illegal abortion as a crime). Coupled with the Infant Life Protection Act, this meant that there were legal restrictions on abortion. The 1967 Abortion Act,amended by the 1990 Human Abortion Act, formalized and clarified the legal framework for legal abortion and introduced a regulatory system. *Paton v British Pregnancy Advisory Service*[25] states that, "Under English law, a foetus cannot have its own rights until it is born and separate from its mother."[26]

In Ireland, abortion was redefined by the 2018 referendum, which led to the repeal of the Eighth Amendment of the Constitution of Ireland[27]. This amendment had previously granted the unborn an equal right to life as the mother, effectively banning abortion. Following the referendum, the Health (Regulation of Termination of Pregnancy) Act 2018[28] was enacted, allowing abortion under various circumstances, particularly during early pregnancy or in cases of foetal abnormalities and risks to the mother's life. While this marked a significant step towards reproductive autonomy, the legal framework continues to recognize and balance foetal rights with those of the pregnant woman.

V. Legal Status of the Unborn Child in India

Unlike some jurisdictions that grant legal personhood to the unborn, Indian law does not explicitly recognize foetal rights. However, certain laws confer specific rights upon an unborn child, provided the child is born alive. These rights primarily emerge in areas such as inheritance and succession, where legal recognition is contingent upon live birth.

A.Under Hindu law, which applies to a significant portion of India's population, an unborn child is granted substantial property rights. The Hindu Succession Act, 1956, ensures that a child in the womb, provided they are born alive, is entitled to inherit property from deceased ancestors. Such a child is also considered a co-parcener, meaning they hold a rightful claim to ancestral property. This principle is explicitly recognized in Section 20 of the Hindu Succession Act, which states that a child in the womb at the time of a person's death shall have the same inheritance rights as if they had been born before the individual's passing[29].

B. The Transfer of Property Act, 1882, provides certain legal safeguards for unborn children. Section 13of the Act[30] permits the transfer of property in favour of an unborn person by allowing it to be held in trust until the child is born. However, for the transfer to take effect, the child must be born alive. This provision ensures that a foetus can be designated as a future beneficiary in property transactions carried out during pregnancy, though the actual vesting of rights remains conditional upon live birth.

C.There are certain provisions which imply limited protections. For instance, Section 315 of the IPC penalizes acts done with intent to prevent a child from being born alive unless done in good faith.[31]Now the same has been numbered section 91under BNS[32]. This offence is cognizable, non-bailable, non-compoundable and triable by Court of session. So, Whoever before the birth of any child does any act with the intention of thereby preventing that child from being born alive or causing it to die after its birth, and does by such act

---

23 Abortion Act 1967, c. 87 (UK).

24 Rex v. Bourne, [1939] 1 K.B. 687 (Eng.).

25 Paton v. British Pregnancy Advisory Serv. Trs., [1979] Q.B. 276, [1978] 2 All E.R. 987, [1978] 3 W.L.R. 687 (Eng.).

26 Amaan Merchant, Status of an Unborn Child in the Indian Legal System, LRA (Feb. 27, 2022), https://legalresearchandanalysis.com/status-of-an-unborn-child-in-the-indian-legal-system/ (last visited Mar. 1, 2025).

27 BunreachtnahÉireann [Constitution of Ireland] 1937, art. 40.3.3, repealed by Thirty-Sixth Amendment of the Constitution Act 2018 (Ir.).

28 Health (Regulation of Termination of Pregnancy) Act 2018 (Ir.).

29 The Hindu Succession Act, 1956, § 20, ACT NO. 30 OF1956.

30 The Transfer of Property Act, 1882, § 13, ACT NO. 4 OF 1882

31 Indian Penal Code, 1860, Section 315.

32 Bharatiya Nyaya Sanhita, ACT No. 45 of 2023, India Code, Ss.91 (2023).

prevent that child from being born alive, or causes it to die after its birth, shall, if such act be not caused in good faith for the purpose of saving the life of the mother, be punished with imprisonment of either description for a term which may extend to ten years, or with fine, or with both.[33]

VI. Reproductive Justice in India

India's legal stance on the rights of an unborn child can be traced to *Kharak Singh V. State of U.P.*[34](1963), where the Supreme Court recognized that the right to life under Article 21 encompasses the right to live with dignity, including access to health. This principle was later reinforced in *Unnikrishnan V. State of Andhra Pradesh*[35] (1993), where the Court affirmed that the right to life extends to medical care, benefiting both the mother and the unborn child.

In the case of *Suchita Srivastava V. Chandigarh Administration*[36] (2009), the Supreme Court held that the right of an unbornchild to life and personal liberty is protected under Article 21 of the Indian Constitution. The Court held that the State has aduty to protect the life and health of a pregnant woman and her unborn child. The Court further held that the right of anunborn child is not absolute and must be balanced with the right of the mother.

In *XV. Principal Secretary, Health and Family Welfare Department, Govt., of NCT of Delhi (2022),* the Supreme court extended the right to abortion to an unmarried woman observing that "the rights of reproductive autonomy, dignity, and privacy under Article 21 give an unmarried woman the right of choice on whether to bear a child or not."[37] A three-judge bench of the Supreme Court of India ruled that unmarried women are entitled to the same abortion rights as married women under the Medical Termination of Pregnancy (MTP) Act, 1971.The petitioner, an unmarried woman, sought to terminate her 22-week pregnancy but was denied by the Delhi High Court, which held that Rule 3B of the MTP Rules excluded unmarried women from abortion rights between 20 to 24 weeks of gestation. The Supreme Court overruled this decision, emphasizing that laws must be interpreted in accordance with evolving social contexts and gender justice.[38]

In another case[39],Supreme Court Rejects Widow's Plea to Abort 32-Week Pregnancy, Suggests Giving Child for Adoption. The Supreme Court on Wednesday (January 31) refused to allow a woman to terminate her pregnancy which was over 32-weeks.A bench comprising Justices Bela M Trivedi and Prasanna B Varale, noting that the medical board has opined against the termination of pregnancy, rejected the woman's plea. The bench suggested that the woman could give up the child for adoption if she wanted.[40]

VII. Critical Analysis

The Indian Constitution, under Article 21[41], guarantees the right to life and personal liberty. This fundamental right extends to all individuals, yet the question arises whether it also encompasses the rights of the unborn. On the other hand, women's right to personal liberty, particularly in the realm of reproductive autonomy, is also protected under Article 21. This leads to an inherent conflict between the rights of the unborn and the autonomy of a woman. The Supreme Court of India has consistently adopted a balanced approach when resolving conflicts between two fundamental rights, ensuring neither right is rendered redundant.

A landmark case that illustrates this balancing approach is *Suchita Srivastava V. Chandigarh Administration*, where the Supreme Court upheld a woman's right to reproductive autonomy while acknowledging that such rights are subject to reasonable restrictions.[42] The Medical Termination of Pregnancy (MTP) Act, 1971, reflects this balance by not granting absolute reproductive rights to women but rather imposing restrictions

---

33 *Ibid*

34 Kharak Singh v. State of U.P., (1963) AIR 1295, (1964) 1 S.C.R. 332.

35 Unni Krishnan, J.P. v. State of Andhra Pradesh, (1993) 1 S.C.C. 645, (1993) AIR 2178, (1993) 1 S.C.R. 594.

36 *supra* note 13

37 X v. Principal Sec'y, Health & Fam. Welfare Dep't, Govt. of NCT of Delhi, (2022) 10 SCC 1, 7 SCR 686.

38 *Ibid*

39 Supreme Court Rejects Widow's Plea to Abort 32-Week Pregnancy, Suggests Giving Child for Adoption, Live Law News Network (Feb. 1, 2024, 9:01 AM), https://www.livelaw.in/top-stories/supreme-court-rejects-widows-plea-to-abort-32-week-pregnancy-suggests-giving-child-for-adoption-248150 (last visited Feb. 17, 2025).

40 *Ibid*

41 India Const. art. 21.

42 *Supra* note 13

to protect potential life. The Act permits termination up to 24 weeks in specific circumstances, recognizing that the unborn, beyond this threshold, has an increasing claim to protection.[43]

The MTP Act, while ensuring access to safe abortions, also acts as a reasonable restriction on absolute reproductive rights. This legal framework underscores that reproductive autonomy is not unfettered but must be weighed against the state's interest in protecting prenatal life. By setting gestational limits and requiring medical oversight, the Act embodies a middle path that accommodates both the woman's autonomy and the unborn's potential right to life[44].Hence, Indian reproductive laws exemplify a nuanced approach, striving to humanize the legal discourse surrounding abortion rights and foetal protection.

VIII. Conclusion and Recommendations

A just and equitable legal system must ensure that women's reproductive autonomy is safeguarded while recognizing conditional protections for the unborn child. India's legal framework, through the Medical Termination of Pregnancy (MTP) Act, the Bharatiya Nyaya Sanhita (BNS), and inheritance laws, aims to maintain this delicate balance. The primary challenge lies in ensuring that legal restrictions do not become barriers to women's healthcare while upholding a fair and ethical approach to foetal considerations.

Reproductive justice in India remains a complex and evolving domain, requiring a nuanced approach that respects both women's autonomy and ethical considerations regarding foetal rights. To achieve a balanced legal framework, the following recommendations are proposed:

- Indian law should explicitly define the legal status of the unborn child to eliminate ambiguities in criminal and civil protections.
- Reproductive rights can only be fully ensured through widespread awareness, particularly among rural women. Legislative reforms should focus on expanding safe abortion access while safeguarding against coercion and unsafe practices.
- Courts should establish clear legal precedents to balance reproductive autonomy with ethical considerations surrounding foetal rights.
- Strengthening healthcare infrastructure and counselling services is essential to ensuring reproductive justice.
- The MTP Act should incorporate stricter penal provisions for abortions conducted beyond 24 weeks to prevent misuse while maintaining necessary medical exceptions.

By implementing these recommendations, India can progress toward a more balanced and just reproductive rights framework, one that the current statute lacks, ensuring both women's autonomy and the ethical considerations surrounding foetal rights are upheld.

* * * *

[43] The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code (1971), amended by The Medical Termination of Pregnancy (Amendment) Act, No. 8 of 2021.

[44] *Supra* note 29

REPRODUCTIVE RIGHTS AND CHALLENGES OF WOMEN IN INDIA

Dr. Dimpal Mesta *
Ms. Karishma Monteiro **

Abstract

Reproductive rights of women are related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination.Under Article 21 of the Constitution of India, reproductive choices can be exercised to procreate as well as to abstain from procreating.Reproductive rights are the rights or freedoms guaranteed to the individual in relation to reproduction and reproductive health. The World Health Organisation (WHO) specifies that "Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health". Thus, reproductive rights are substantial to the realisation of all human rights.Two main legislation cover the reproductive rights of women in India isThe Prevention of Child Marriage Act, 2006 (PCMA) and the Medical Termination of Pregnancy Act, 1971 (MTP Act). PCMA was enacted to prohibit solemnisation of child marriages in India and any matter connected therewith. The Act sets the legal age of marriage as 18 and 21 for girls and boys, respectively. Thus, PCMA was legislated to protect the girls from the evils of child marriage. Similarly, the MTP Act contains provisions with respect to abortion. Although these Acts provide certain protections to women against the violation of their reproductive rights, there is a need to amend them so as to afford protection of reproductive rights. Reproductive rights are a fundamental component of women's human rights, encompassing a range of rights and choices related to their reproductive health and autonomy.These rights are essential for women's well-being, equality, and empowerment.The States have obligations to respect, protect, and fulfil rights related to women's sexual and reproductive health.

I. Constitutional Aspects

International laws and declarations recognize certain rights that human beings are entitle to. One of these rights which our Constitution of India has recognised, is that of sexual and reproductive rights. The constitutional landscape of India serves as a complex tapestry that interweaves tradition, modernity, and individual liberties. The Preamble of the Indian Constitution, which promises justice, liberty, equality, and fraternity, lays the foundation for the exploration of reproductive rights. These rights, intricately connected to the concepts of personal autonomy and bodily integrity, have undergone enormous changes in reaction to societal changes and criminal tendencies. To realize the constitutional foundations of reproductive rights in India, evaluation of the constitutional provisions pertinent to reproductive rights, elucidating how they intersect with essential rights assured via the Indian Constitution.The constitutional provisions in India that address reproductive rights are often rooted within the essential rights assured by using the Constitution. Article 21 of the Indian Constitution, which safeguards the right to personal liberty, has been interpreted expansively by the judiciary to encompass the right to reproductive autonomy. Reproductive rights in India discover their foundation in diverse constitutional standards, most substantially the right to privacy. The Supreme Court, within the landmark judgment of *Puttaswamy v. Union of India*[1] diagnosed proper privacy as an essential right emanating from Article 21. Justice K.S. Puttaswamy a retired judge of the Madras High Court, challenged constitutional validity of the Aadhaar scheme. He argued that the scheme violated the right to privacy. A

* **Assistant Professor, SDM Law College, Mangaluru**
** **Student, 4th year BA.LLB, SDM Law College, Mangaluru**

[1] (2017) 10 SCC 1.

nine-judge bench held that privacy is an attribute of human dignity. The right to privacy includes personal intimacies like marriage, procreation and family and the sexual orientation at the core of an individual's dignity.The right to existence under Article 21 has been construed as greater than mere survival; it includes the right to live with dignity and make self-reliant choices about one's body and lifestyle. In the context of reproductive rights, because of this people have the right to make decisions concerning birth control, abortion, and their family-making plans without unwarranted interference.According to the natural rights theories of all the human are equal and every human being should get equal opportunity for his or her development. The Constitution of India clearly and fairly provisions the equality under Article 14-18. The right and equality are faith and creed of our democratic republic. It forms the faith and creed of our democratic republic. It forms the foundation of socio-economic justice. Article 14 embodies the idea of equality as expressed in preamble. It helps to prevent discrimination in other areas that can affect reproductive rights. The Succeeding Articles 15,16,17 and 18 lays down specific application of general rule laid down in Article 14 of the constitution. Article 15 speaks about prohibition of Discrimination "the state shall not discriminate against any citizen on grounds only of religion, race, caste, sex, and place of birth or any of them". The above mentioned right is available to all citizens of India. The corresponding provisions of the Article is found in Article 2 of Universal Declaration of Human Rights ,1948.[2] Gender equality lies at the core of discussions surrounding reproductive rights and technologies. The constitutional assurance of equality earlier than the regulation, as enshrined in Article 14, compels an analysis of the way reproductive technology can also impact women otherwise. Issues including industrial surrogacy, in which ladies can be engaged as gestational companies, pose intricate questions about exploitation and organization, bringing to the fore the constitutional imperative of making sure the same protection of the law. Article 42 Provision for just and humane conditions of work and maternity relief.The State shall make provision for securing just and humane conditions of work and for maternity relief.[3]

The Legislative framework related to reproductive rights of women includes:

- Right to have a Child or not to have a Child.
- Right to Birth control measures.
- Right to decide number and spacing between the children.
- Right to be free from all forms of Coercion (forced Sterilization and Abortion)
- Right to choose method of child birth.
- Right to have adequate reproductive health care.[4]

The Committee on Economic, Social and Cultural Rights (CESR) and the committee on the Elimination of Discrimination against Women (CEDWA) have both clearly indicated that women's right to health includes their sexual and reproductive health and autonomy.[5] In CEDWA Article 16 (e) provides to the women the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.[6]

II. The Medical Termination of Pregnancy Act,1971

One of the most important facets of reproductive freedom and justice is the right to abortion. The Medical Termination of Pregnancy Act, 1971 was drafted in tuned with Abortion Act, 1967 of United Kingdom. The Preamble of the MTP Act clearly states that the pregnancies can only be terminated by a registered medical practitioner and there are certain conditions laid down under Section 3 of the Act, under which an abortion can be performed. Abortion was legalized by a medical practitioner with the stipulated gestation limit and procedures. India amended the MTP Act in 2021, aiming to empower women by providing them with comprehensive abortion care, marking a historic milestone in reproductive healthcare. According to the revised Act, if a pregnancy occurs due to the failure of a contraceptive method or device, it is now permissible for both married and unmarried women to terminate the pregnancy up to a gestational age of 20 weeks.[7] MTP

---

2 https://www.un.org

3 Esha jain, "*The Constitutional aspects of reproductive rights and reproductive technologies in India*",6 IJLSI 452.

4 Mahanaz Ajaz &Dr.Mushtaq Ahmed, "*Reproductive rights in India a comprehensive analysis of laws and policies*", 6 IJLSI 382.

5 https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights

6 Convention on the Elimination of All Forms of Discrimination against Women 1981.

7 Neha Chaudhary, Ashok Chanana and Jaspinder pratap, Medical Termination of Pregnancy Act: Its recent advances , 20 July, 2023.

Amendment Act, 2022, in a significant ruling on September 29, 2022, the Supreme Court bench comprising Justices A.S. Bopanna, D.Y. Chandrachud, and J.B. Pardiwala declared that the Medical Termination of Pregnancy Act recognizes the reproductive rights of pregnant women, granting them the right to choose medical intervention for terminating pregnancies. The court emphasized that all women, regardless of marital status, are entitled to access legal and safe abortions up to 24 weeks of gestation. [8]

The Amendment led to the expansion of abortion rights for unmarried women and Incorporation of Marital Rape in MTP Act. Exemption for Medical Practitioners in Disclosing the Identity of Minors. The Protection of Children from Sexual Offences Act 2012 (POCSO) criminalizes any sexual activity involving individuals below the age of 18. Hence it can be noticed how the amendment has expanded the horizon of women's reproductive right.

Suchitra Srivastava&AnrV Chandigarh Administration[9]and *Laxmi MandalV Deen Dayal Harinagar Hospital & Ors*[10], formed the bedrock of India's reproductive rights jurisprudence. From the nascent, bare-bones recognition in these cases, the state of the law has now flourished. The last decade has seen advancements in the constitutional underpinning of reproductive rights, their scope, the duties they impose on States and their role in shaping statutory interpretation. The privacy right at the heart of reproductive rights has evolved. From facial references to privacy in Suchitra Srivastava, the Supreme Court in Puttaswamy developed privacy as decisional autonomy, protecting for the individual a "zone of choice and self-determination" and recognising the ability of each individual to "make choicegoverning matters intimate and personal" including "whether to bear a child or abort her pregnancy", a "crucial aspect of personhood". This is a significant advancement.[11]

III. Surrogacy

The term "surrogacy" refers to the practice of using a woman's womb to carry a foetus until birth to be raised by another. It is derived from the Latin word "subrogate", meaning "accepted to act in the place of" or "a substitute".[12]Motherhood is a relation of blood and emotions born out of carrying a foetus and it can never be perceived when a baby is born in a rented womb. Surrogate motherhood is a new development in the management of infertility. The advantage is women without a uterus but with functioning ovaries may have her child with the help of surrogate mother. The concept of surrogacy is not new but issues are new and amplitude is wider.[13]

Surrogacy is as old as the Mahabharata, Ramayana and the Bible. Surrogacy was known and practiced in ancient times. In the Mahabharata, Gandhari, wife of King Dhritarashers conceived but the pregnancy went on for nearly two yean after which she delivered a mass. Bhagwan Vyasa that there were 101 cells that were normal in the mass. These cells were put in a nutrient medium and were grown in-vitro till full term. Of these 100, developed into male children (Duryodhan, Dushashan and the other Kauravas) and one as a female child called Dusheela.[14]

Types of Surrogacy

1. Total or Gestational Surrogacy
2. Partial or Traditional Surrogacy
3. Commercial Surrogacy
4. Non-Commercial Surrogacy[15]

1. Total Surrogacy or Gestational Surrogacy

"Is when the women bear a child that has been formed form the garments of another woman and man and implanted in her body".

---

8 https://pmc.ncbi.nlm.nih.gov/articles/PMC10470576/

9 [2009] 13 SCR 989

10 W.P.C 8853/2008

11 Suchitra madal- interpretation Pillai, Gauri: India's Push-and-Pull on Reproductive Rights, VerfBlog, 2024/4/17, https://verfassungsblog.de/indias-push-and-pull-on-reproductive-rights/,

12 Prithansen ,Surrogacy laws in india through the years 2 IJIRL 2.

13 Dr. Seema Rathi, Reproductive Technology and Human Rights pp. 130, 2012.

14 Supra note 11 at 132

15 Supra note 11 at page 133.

In order for a pregnancy to take place, a sperm egg, and a uterus are necessary. In gestational surrogacy, the surrogate mother has no genetic ties to the offspring: Eggs and sperm are extracted from the donors and in vitro fertilized and implanted into uterus of the surrogate. The child will be given back to the donor of the ovum. This is an expensive procedure, again, the unused embryos may be frozen for further use if the First transfer does not result in pregnancy.[16]

2. Partial or Traditional Surrogacy

"Occurs when the birth mother contributes the sperm is introduced by artificial incardination, she is a biological parent of the child".One commissioning father donates a sperm which is introduced by insemination for in-vitro fertilization with the oocytes of woman, the surrogate mother. The insemination ca be natural or artificial. The custody of the child will be surrendered to the biological father, who donated the sperm when the sperm count is low. In either case the surrogate own egg will be used. Genetically the surrogate becomes the mother of the resulting child This is the common method of surrogate motherhood. This is called partial surrogacy, because the genetic origin is found in one of the commissioning parents

3. Commercial Surrogacy

Means a "business like transaction where a fee its changes for the incubation period." If the surrogacy involves payment of money, it is termed as "commercial surrogacy". Commercial surrogacy, where people pay for someone to have their baby, is banned in India for a few reasons.[17]

4. Non-Commercial Surrogacy or Altruistic Surrogacy

In Non-Commercial Surrogacy there is no formal contract when surrogacy does not involve payment of money it's called Altruistic Surrogacy. It arises out of friendship involving only friends and for relatives.[18]

Surrogacy (Regulation) Act, 2021 came into force to cure the reproductive and sexual exploitation of women and safeguarding their rights. It prohibits commercial surrogacy and restricts it to altruistic arrangements, requiring surrogate mothers to be close relatives of the intended parents, married with at least one child, and within a specific age range. It also specifies eligibility criteria such as marital status, age, infertility, nonexistence of children and citizenship. This regulation not only protects the mother but also the rights of the child born through surrogacy.Under the law, India simply allows for selfless surrogacy. This means that the surrogate cannot be compensated beyond reasonable medical expenses and insurance coverage. Commercial arrangements or exchange of financial compensation are strictly prohibited.[19]

IV. The Assisted Reproductive Technology (Regulation) Act, 2021

The process of begetting a child through technology assistance is known as Assisted Reproductive Technology or (ART). ART is a general term referring to methods used to achieve pregnancy by artificial or partially artificial means. The technology employed for the treatment differs depending on the factor that is the cause for infertility. The most commonly used ART procedures are:

1. Intra Uterine Insemination (IUI)
2. In Vitro Fertilization (IVF)
3. Gamete Intra Fallopian Transfer (GIFT)
4. Tubal Embryo Transfer (TET)
5. Zygote Intra Fallopian Transfer (ZIFT)
6. Gestational Surrogacy[20].

The objective of the Act for the regulation and supervision of the assisted reproductive technology clinics and the assisted reproductive technology banks, prevention of misuse, safe and ethical practice of assisted reproductive technology services for addressing the issues of reproductive health where assisted reproductive technology is required for becoming a parent or for freezing gametes, embryos, embryonic tissues for further

---

16 https://pmc.ncbi.nlm.nih.gov/articles/PMC4345743/

17 https://www.khuranaandkhurana.com/2023/06/16/legality-of-surrogacy-in-india-everything-you-need-to-know/

18 Supra note 11 at 139.

19 https://www.daslegal.co.in/an-overview-of-surrogacy-regulation-act-2021/

20 Anila V Menon ,Assisted Reproductive Technologies a Legal Dilemmma, 1st ed 2007 p.23

use due to infertility, disease or social or medical concerns and for regulation and supervision of research and development and for matters connected therewith or incidental thereto.[21]

V. Role of Judiciary

As an Independent organ Judiciary has always played a paramount role in interpreting the laws that impact the reproductive rights and when the law is silent judiciary speaks for the justice. Indian courts have passed remarkable decisions and recognized women's reproductive and sexual rights as Indefeasible survival rights. In some of the revolutionary judgement, the courts have recognized reproductive right as an essential of women's equality and have called for respect for women's right for reproductive autonomy and decision making concerning bearing a child.[22].In cases spanning maternal health ,contraception, abortion, and child marriage have adopted Robust definition of reproductive right that reflect human right standards.[23]The Supreme Court and various high courts have made significant advancement in recognizing denial to sexual and reproductive right to women.In 2008, Human Rights Law Network in India began filing a series of petitions in high court throughout seeking accountability for pregnancy related deaths and injuries resulting in ground breaking judicial recognition of women's rights to survive pregnancy and child birth as a fundamental right.[24]

In 2011, the Delhi high court issued a landmark joint decision in 2011, in the cases of *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors. and Jaitun v. Maternity home, MCD Jangpura& Ors.* concerning denials of maternal health care to two women living below poverty line.The Court stated that "these petitions focus on two inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother." Citing CEDAW and ICESCR, the decision held that "no woman, more so a pregnant woman should be denied the facility of treatment at any stage irrespective of her social and economic background... This is where the inalienable right to health which is so inherent in the right to life gets enforced."[25]

Therefore, The Directive Principle of state policy provides a constitutional basis for the state's responsibility to ensure maternal healthcare, particularly for women below poverty line. And lead to implementation of several schemes one of such scheme is The Janani Suraksha Yojana (JSY) aimed at reducing maternal and infant mortality rate and provide cash assistance to pregnant women below the poverty line to cover up the cost associated with delivery of post-natal care. [26]

It was only in 2009 that the Indian Supreme Court in, *Suchita Srivastava v. Chandigarh Administration,* issued a landmark declaration; "a woman's right to make reproductive choices is a dimension of personal liberty…under Article 21 of the Constitution of India…reproductive choices can be exercised to procreate as well as to abstain from procreating". Drawing on the rights to "privacy, dignity and bodily integrity", the Court recognised a disabled pregnant woman's reproductive right to resist being forced to abort her pregnancy.[27] This case involved a woman named Suchita with mental disabilities residing in a government welfare institution who became pregnant after being raped and Chandigarh Administration sought legal guidance from The Punjab and Haryana high court which ordered for the termination of pregnancy, but Supreme court reversed the decision as stated above and stressed upon the reproductive autonomy of a woman.[28]The Court held that there had been a violation of Article 21 of the Constitution. It stated that right to health including reproductive rights was an integral part of Article 21. Further, the right to make a choice in relation to sterilization free from any coercion was also guaranteed under the Constitution.[29]

Further, in the 2013 case of *Hallo Bi V. State of Madhya Pradesh and Others*, the High Court of Madhya Pradesh affirmed the importance of providing victims of rape access to abortion without requiring judicial

---

21 The Assisted Reproductive Technology (Regulations) Act,2021 p. 4

22 https://verfassungsblog.de/indias-push-and-pull-on-reproductive-rights/

23 https://reproductiverights.org/reproductive-rights-in-indian-courts/

24 Millicent Awuor Maimuna & Margaret Anyoso Oliele v. Attorney General and others, H.C.K.

25 Consolidated Decision, Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others, W.P.

26 https://en.vikaspedia.in/viewcontent/health/nrhm/national-health-programmes-1/janani-suraksha-yojana

27 https://verfassungsblog.de/indias-push-and-pull-on-reproductive-rights/

28 https://updates.manupatra.com/roundup/contentsummary.aspx?iid=5874

29 Devika Biswas v. Union of India & Others, W.P. (C) 81/2012.

authorization, stating "we cannot force a victim of violent rape/forced sex to give birth to a child of a rapist. The anguish and the humiliation which the petitioner is suffering daily, will certainly cause a grave injury to her mental health."[30]

In the 2016 case of High Court on its *Own Motion v. State of Maharashtra*, the Bombay High Court ruled to improve women prisoners' access to abortion and strongly affirmed women's rights to abortion as an aspect of the fundamental right to live with dignity under Article 21. The judgment recognizes that unwanted pregnancies disproportionately burden women and states that forcing a woman to continue a pregnancy "represents a violation of the woman's bodily integrity and aggravates her mental trauma which would be deleterious to her mental health."[31]

Thus, Judiciary's role is like a vital thread weaving together principle of justice, autonomy and dignity. The apex court has turned out to be the architect, shaping a landscape where women's choices are not merely tolerated but also enshrined as fundamental rights.

VI. Challenges

While nation strides forward in many spheres, a shadow persists, obscuring rights of women to govern their own bodies. Women in India face a multitude of challenges regarding their reproductive rights. Social, cultural, economic, infrastructural and barriers within healthcare system and the list of factors goes on.

A] Socio-Cultural Barriers- Women in India have always suffered due to the stigma and taboo created by the patriarchal mindset here in many rural villages where women are obligated to veil themselves the biggest challenge is will that society will ever be ready for the open discussion related to reproductive rights and autonomy.[32]

B] Gender Inequality- Gender Inequality is deeply rooted in our society women are often denied the basic rights like education and an unequal access to the information and services. Women are always taught about their gender role, certainly the expectation and pressure from family over rides their individual choices.[33]

C] Inadequate Infrastructure- limited access to quality reproductive healthcare services and lack of trained healthcare providers is also a major challenge and the poverty and financial constraints prevent women from accessing reproductive healthcare.[34]

D] Child Marriage- When a girl child is made married before her legally prescribed age she becomes more prone to sexual abuse and she has no control over bearing of children has no reproductive autonomy. Despite a national law penalizing marriages of girls below 18 years of age and policies and schemes guaranteeing women maternal healthcare, in practice India continues to account for the highest number of child marriages and 20% of all maternal deaths globally.[35]

E] Non Recognition of Marital Rape-India is disappointingly one of the fewest countries in the world today that explicitly decriminalises marital rape, despite being a signatory of the Universal Declaration of Human Rights (UDHR).[36]Marital Rape not fully recognised leads to unwanted pregnancies and recent Judgement by Chhattisgarh high court sparked the controversy as it exempts sexual intercourse by a husband with his wife from being considered as rape provided wife is of a certain age.

F] Policies are made for Demographic targets alone-Although India was among the first countries in the world to develop legal and policy frameworks guaranteeing access to abortion and contraception, women and girls continue to experience significant barriers to full enjoyment of their reproductive rights, including poor quality of health services and denials of women's and girls' decision-making authority. Historically,

---

30 Human Rights law Network (HRLN), The High Court of Madhya Pradesh allowed a pregnant female prisoner to exercise her reproductive rights under the Medical Termination of Pregnancy Act (2013).

31 Supra note 21.

32 https://www.drishtiias.com/to-the-points/Paper2/sexual-and-reproductive-health-rights-srhr#:~:text=Nearly%20half%20of%20all%20pregnancies,access%20to%20safe%20abortion%20services.

33 ibid

34 Sweta Ghosh, Legal issues relating to surrogacy in India;ananalysis,IJNRD,8,pg613

35 Association for Social Justice & Research v. Union of India & Others, W.P. (CRL) No. 535/2010, Delhi H.C. (2010); Court on Its Own Motion Lajja Devi v. State, W.P. (CRL) No. 338 (2008) (High Court of Delhi).

36 https://ohrh.law.ox.ac.uk/the-decriminalisation-of-marital-rape-how-india-continues-to-refuse-justice-to-its-married-women/

reproductive health-related laws and policies in India have failed to take a women's rights-based approach, instead focusing on demographic targets, such as population control, while also implicitly or explicitly undermining women's reproductive autonomy through discriminatory provisions such as spousal consent requirements for access to reproductive health services.[37]

G] Control and Contraception- The choice of contraception is also under male control in most of the cases and women always find herself in a vulnerable situation.[38]Birth Control: Men's Decisions, Women's 'Business In a survey of 9,205 men and 3,158 women, aged 18-49, across 7 states-Uttar Pradesh, Rajasthan, Punjab, Haryana, Odisha, Madhya Pradesh and Maharashtra 54% of the men said that their wives could not use contraception without their permission Yet, 1 in 5 men think "it is a woman's responsibility to avoid getting pregnant,".[39]

Thus, challenges are many and to overcome these obstacles requires a strategy that tackles the problems from all the perspectives simultaneously, when the progressive policies are in place its ineffective implementation can be a hurdle.

VII. Conclusion

In conclusion, India's journey to secure reproductive rights is ongoing, marked by both progress and persistent challenges. While the legal framework and judicial activism offer some protections, ensuring universal access, addressing societal stigmas, and advocating for comprehensive sex education remain crucial for realizing the reproductive autonomy of all individuals. The Supreme Court has recognized reproductive rights as a component of personal liberty, but ongoing efforts are needed to translate these rights into practical reality for all, especially marginalized groups.

* * * *

[37] https://reproductiverights.org/reproductive-rights-in-indian-courts/
[38] https://www.indiaspend.com/why-contraception-is-still-womens-business-in-india
[39] croll.in/article/974230/in-india-the-burden-of-contraception-still-falls-on-women

REPRODUCTIVE RIGHTS AND LEGAL FRAMEWORKS ADDRESSING POPULATION ISSUES

Dr. Ashwini P . *
Ms. Sanjana J. Shetty **

Abstract

"The right to control one's own body, including reproductive choices, is a fundamental human right."

*- **Hillary Clinton**.*

This Article delves into the critical understanding of reproductive rights of the women and the importance of legal frameworks which are necessary to address the population issues. It also upholds the text "Reproductive rights are the fundamental human rights both at international and regional frameworks of human rights"[1]. The International Conference on Population and Development (ICPD) recognised "women's rights to reproductive and sexual health as being key to women's health"[2]. According to official UN estimates, world population with no new measures is projected to grow to around 9 billion by 2050[3], thereby showing the necessary steps to be taken by the legislatures in order to address the population issues and to ensure the health care and dignity of the women. This research analyses the evolution of reproductive rights as human rights, from the 1994 International Conference on Population and Development to the Sustainable Development Goals. Additionally, this article delves into the comparative analysis of national laws and policies regulating reproductive health care services by highlighting gaps and challenges in ensuring universal access. In conclusion, this article deals with the basic types of reproductive rights, including the right to artificial insemination, surrogacy, sterilization, prevention and treatment of infertility, abortion, organ donation and reproductive cells, the use of contraception, the right to reproductive choice, the right to reproductive health, right to information about reproductive rights, the right to privacy to implement reproductive rights and other.

Keywords: **Reproductive rights, Population Issues, Legal Frameworks, Human Rights, Sustainable Development, Reproductive Health Services.**

I. Introduction

On New Year's Day 2025, the world's population reached 8.09 billion[4], a milestone that not only reflects the triumphs of global health and development but also underscores the urgent need to safeguard reproductive rights. This significant demographic achievement offers a moment of both celebration and reflection: while advances in healthcare and living standards have dramatically reduced infant and maternal mortality rates, they have also contributed to a rapid increase in the global population. As nations grapple with challenges ranging from climate change to economic development, the role of reproductive rights emerges as a critical factor influencing population trends.

The need and importance of a child is recognized by almost all religions all over the world. Begetting a child

* **Assistant Professor of Law, SDM Law College, Mangaluru.**
** **Third Year BA.LL.B., Student, SDM Law College, Mangaluru.**

1 Pillai Aneesh V., Kostruba, Anatoliy (2021). Women's reproductive rights and their scope under international legal frameworks. Entrepreneurship, Economy and Law, 8, 18–28.

2 https://www.un.org/womenwatch/daw/csw/shalev.htm

3 https://www.sciencedirect.com/topics/social-sciences/population-control

4 https://www.globaltimes.cn/page/202501/1326068.shtml

is one of the most joyful moments in the life of a person. In fact, begetting a child is considered a sacred duty of an individual to his/her family and society and this duty is usually fulfilled through the institution of marriage. The act of reproduction is usually a natural process of sexual union between couples which requires no external interference from a third party. Hence, reproductive rights are declared as fundamental human rights both at international and regional frameworks of human rights. Although it is an accepted fact that every individual has the right to claim reproductive rights, the exercise of this right in certain situations may raise serious legal and human rights concerns[5].

The right to sexual and reproductive health is a cornerstone of development. Conceptualized at the ground-breaking International Conference on Population and Development (ICPD) in 1994, reaffirmed and further amplified at the Beijing Fourth World Conference of Women in 1995[6], important precedent exists underlying the right to sexual and reproductive health. The right has also been included in the Convention on the Elimination of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities, and acknowledged by numerous treaty bodies, including the CEDAW Committee[7], the Committee on the Rights of the Child (CRC)[8], and the Committee on Economic, Social, and Cultural Rights (CESCR)[9]. Within this international legal framework, a number of associated rights are applicable to the attainment of sexual and reproductive health. These include the right to life andsurvival~ autonomy and confidentiality~ information and education~ equality and non-discrimination, and privacy, amongst others.

II. Reproductive Rights as a Fundamental Human Right

Reproductive rights are essential for women to enjoy their human rights. These rights are centred on women's ability to make the best choices for their lives, including around the number of children they have, if any, and the spacing between their children's births. Reproductive rights include prenatal services, safe childbirth, and access to contraception. They also include access to legal and safe abortion. Abortion bans violate the rights to be free from violence, to privacy, to family, to health, and even the right to life. And bans are most devastating for people of colour, young people, and marginalized communities, who already have trouble accessing health care and other needed services. Governments should trust women to know what is best for their bodies, their physical and mental health, and their lives[10].

India is a party to most international human rights documents: UDHR, 1948; ICCPR, 1966; ICESCR, 1966; CDEDAW, 1979; and the Convention on Rights of Persons with Disabilities (2006). Consequently, all these documents expressly confer various facets of reproductive rights such as the right to privacy, the right to consent to marriage and equality in marriage, the right to access to family planning information and education; the right to found a family; the right to access to family planning methods and Services; the right to decide the number and spacing of one's children; and right to enjoy the benefits of scientific progress, etc[11].

In the case of *Suchita Srivastava V. Chandigarh Administration*[12], the Supreme Court held that the right to reproduction of women has its base at right to life under Article 21. It includes right to reproduce as well as not to reproduce.

In *Devika Biswas V. Union of India*[13], Supreme Court has pointed out that that right to reduction includes the right to make free choice of sterilisation.

In *B.K. Parthasarthy V. State of Andhra Pradesh*,[14] the Supreme Court of Indian, by approving right to

5 Pillai Aneesh V., Kostruba, Anatoliy (2021). Women's reproductive rights and their scope under international legal frameworks. Entrepreneurship, Economy and Law, 8, 18–28.

6 Beijing Platform for Action, Paragraphs 89-96

7 CEDAW General Recommendation No. 24, 1999 addressing women and health. Also, CEDAW Articles 5--6, 11--12, and particularly 16, address issues related to reproductive health and rights.

8 Committee on the Rights of the Child, General Comment No. 4, 2003 on Adolescent Health and Development

9 CESCR General Comment Number 14, 2000. Additional support for the right to sexual and reproductive health has been made by the Committee Against Torture (CAT)~ the Human Rights Committee (HRC), now the Human Rights Council~ and the Committee on the Elimination of All Forms of Racial Discrimination (CERD).

10 https://www.hrw.org/topic/womens-rights/reproductive-rights

11 https://hal.science/hal-03397078/document

12 Suchita Srivastava v. Chandigarh Administration (AIR 2010 SC 235)

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

14 B.K. Parthasarthy v. State of Andhra Pradesh (AIR 1973 SC 2701)

reproduction is a part of right to privacy, declared that "the right to make a decision about reproduction is essentially a very personal decision either on the part of the man or woman. Such a right necessarily includes the right not to reproduce".

III. Comparative Analysis of National Approaches Regarding Population Dynamics and Reproductive Legislations

1. China

China's population restriction, known across the globe as the 1-child policy, has been in place since 1981, with variations to allow some couples a second child.In response to social challenges arising from this policy, the Chinese government announced in 2015 that it would transition to a new 2-child policy, encouraging couples since January 1, 2016, to have 2 children.[15] This transition accompanies a focus on *population quality* (i.e., improvements in health, education, and social welfare) in new-borns to the large Chinese elderly population, with an initiative to reform the Chinese health care system and increase disease screening and prevention.

History of Family Planning and Population Control in China.

1953 Chinese leaders suggest that the population should be controlled and approve a law on contraception and abortion, but the plan is later stranded by political upheaval and the 1959-61 famine.

1970 China's population exceeds 800 million.Facing such rapid population growth, China feared insufficient economic, social, and natural resources.

1975 The Chinese government launched the family planning campaign, issuing voluntary guidelines on fertility control with a slogan "late, long, and few;" later marriage, longer spacing between births, and fewer births overall.

1979 The Communist party says couples should have no more than one child. A new marriage law says couples are obliged to practise family planning, placing a de facto limit of one child for each family.

Coinciding with controlled population growth, the 1-child policy led to challenging new social problems: sex imbalance among new-borns (117.7 boys for every 100 girls in 2012—the highest male/female ratio in the world), financial strain on those having more than 1 child, and an aging population with lack of offspring to care for them, termed the 4:2:1 phenomenon (1 child caring for 4 grandparents)[16].

1984 China adjusts the policy, allowing a second child for some families in rural areas and for couples who were both an only child, and in some other specified circumstances.

2001 New laws decreed to better manage the administration of the policy, including penalties for unapproved births. The laws allow local government to impose fines for additional children.

2013 China adds an exemption allowing two children for families in which one parent, rather than both, is an only child.

2015 One-child policy scrapped, allowing all couples to have two children for the first time in more than three decades.

2021 China announced on Monday that married couples may have up to three children, a major policy shift from the existing limit of two after recent data showed a dramatic decline in births in the world's most populous country[17].

2. Korea

Korea has completed the whole process of what is called "demographic transition" with her successful implementation of the national family planning program that started in 1962 and this has occurred simultaneously with rapid socioeconomic development. Between 1960 and 1988, the nation's total fertility was reduced from 6.0 children per woman to 1.6, which was below replacement-level fertility.

Achievements and Challenges of the Population Policy in Korea

Since the major demographic transition in Korea took place in the midst of the rapid socioeconomic

[15] https://pmc.ncbi.nlm.nih.gov/articles/PMC4999320/#R1

[16] Ibid

[17] https://www.deccanherald.com/world/china-changes-policy-allows-couples-to-have-3-children-992044.html

developments between 1960 and 1990, it is not easy to identify clearly which of the socioeconomic determinants have been most influential in the rapid decrease in fertility levels over time. Many studies suggest that among the proximate determinants of fertility, family planning, induced abortion, and rising age at marriage all share substantial responsibility for the fertility decline in Korea during the past years, although socio-economic developments have also contributed to the fertility decline.

Nevertheless, no sooner were one set of problems overcome than new challenges of a totally different nature arose out of the resulting far below replacement level of fertility (TFR 1.75 children per woman) in Korea. The new problems being faced include an imbalance in the sex ratio at birth, a shrinking of the labour forth, an increase in the proportion of the elderly population, a high prevalence of induced abortions and an increase in the sex-related problems of the youth and adolescents[18].

Despite of the government's efforts to shift the population policy from population control to quality and welfare, Korean's total fertility rate has continued to the lowest level of 1.08 children in 2005. This phenomenon indicates that the fertility decline has been affected by socio-economic factors to a great extent. Thus, the government announced to adopt the fertility encouragement policy and set up the five-year plan in response to low-fertility and population ageing (2006-2010) in 2005. Thus, the population policy in Korea that had been promoted since 1962 could be largely divided into three phases of the population control policy with emphasis on the national family planning programs (1962~1996), population quality and welfare improvement policy (1996~2004), and fertility encouragement policy (2006~) to briefly describe major phases and developmental processes of the population policy[19].

3. Japan

Japan has a well-rounded welfare system in place to encourage child birth. The government supports couples who wish to start their families by providing them with paid maternity leave, a monthly childcare allowance of up to 12 years, a childbirth grant, and other grants. It provides a monthly grant of 40,000 to 60,000 yen to single parents too[20].

The fertility rate of a country should be 2.1 for its population to remain stable. In 2020, it was 1.369 births per woman for Japan, which is the same as it was in 2019.

4. Vietnam

Vietnam's population policy since the 1980s had stipulated a limit on family size to two children, born 3-5 years apart, and recommends a minimum age of 19 for the mother of a first child. We analysed trends in the timing of marriages and births, and in fertility and abortion rates, among women born between 1945 and 1970, to assess the impact of these policies on reproductive patterns[21].

5. Nigeria

Nigeria's child policy seeks to reduce fertility from the current six children per family to four children per family. The government suggests the ideal marriage age of 18 years for women and 24 years for men. It also advocates pregnancies in the age group of 18-35 years with at least two years interval between each child.

The fertility rate of Nigeria in 2021 is 5.212 births per woman, and in 2020 it was 5.281[22].

6. New Zealand

The New Zealand government offers a lot of benefits to the parents to raise their child. Every family gets a weekly child care allowance for the first year, however, depending on the family's financial situation, the time period can be increased up to three years.

New Zealand's fertility rate is 1.868 births per woman in 2021, it's a 0.59 per cent decline from 2020[23].

---

18 https://iussp.org/sites/default/files/event_call_for_papers/Extended_paper_Nam-Hoon_CHO.pdf

19 Ibid

20 https://www.deccanherald.com/world/here-are-a-few-countries-that-have-child-policies-992949.html

21 https://pubmed.ncbi.nlm.nih.gov/8684107/

22 Supra note 15.

23 https://www.deccanherald.com/world/here-are-a-few-countries-that-have-child-policies-992949.html

7. Sweden

Sweden is known for its generous child care benefits and sexual and reproductive health rights. It spends at least three per cent of its GDP on the allowance and benefits related to the children and families.

In 2012, Sweden pledged to make an annual contribution of $ 40 million on contraception. Later in 2017, the government revitalized its family planning commitment by adding an additional $24 million to its Global Sexual and Reproductive Health Rights (SRHR).

Sweden's fertility rate is 1.846 births per woman in 2021. In 2020, it was 1.847 births per woman[24].

8. Canada

The government of Canada provides a lot of benefits to its citizens for childcare, especially for children with disabilities. Canada's current fertility rate in 2021 is 1.500 births per woman, which is a 0.6 per cent decline from 1.509 births per woman in 2020[25].

9. Thailand

The story of Thailand's successful population policy has been told many times but has not yet entered the public consciousness. With a total fertility rate (TFR, broadly equivalent to average family size) of six in 1970 and a population growth rate of 3%, the government launched a population programme to ensure that people could access contraception and take advantage of using it. They improved health facilities and access, education and female empowerment.

Accompanying their work on these basics was an imaginative and popular communications campaign, led by the charismatic MechaiViravaidya, also known as Mr Condom. From having police distribute condoms (the "Cops and Rubbers" campaign) to opening the Cabbages and Condoms restaurant chain, Mr Condom put contraception squarely in the public eye. Today, Thailand's TFR is 1.3, and it has enjoyed economic growth the envy of its neighbours, arising, according to the World Bank, from *"a rapid demographic transition as a result of birth control campaigns, rising prosperity and delayed childbearing for education and careers."*[26]

`0. Turkey

Like China and Iran, Turkey is no stranger to using reproductive policy to control population size. Following its War of Independence in the early 20th century, Turkish leaders instituted pronatal policies in a nationalist attempt to replace war casualties. Contraception, sterilisation, and even sharing contraception information was made illegal, and abortion was codified as a crime against "racial integrity".

In the 1960s, however, Turkey joined many other countries in realising that population growth was a threat to economic development and changed its tune, providing free contraception and later legalising abortion. Again, it was economic growth, not women's rights, that drove the agenda.

11. India

Though India doesn't have a strict family planning policy, the Ministry of Health and Family Welfare (MoHFW) advocates couples to have two children with an interval of at least three years between the two[27].

The Government accords top priority to the National Family Planning Program, which is guided by the tenets of the National Population Policy 2000 and National Health Policy 2017, to address the unmet need for Family Planning.

Measures taken by the Government:

1. Expanded Contraceptive Choices**:** The current contraceptive basket comprising condoms, combined oral contraceptive pills, emergency contraceptive pills, intrauterine contraceptive device (IUCD) and sterilization is expanded with inclusion of new contraceptives namely Injectable contraceptive MPA (Antara Programme) and Centchroman (Chhaya).
2. Mission Parivar Vikas is being implemented in thirteen states for substantially increasing access to contraceptives and family planning services.

[24] Ibid
[25] Ibid
[26] https://populationmatters.org/news/2023/07/population-policies-that-work/
[27] Ibid

3. Compensation scheme for sterilization acceptors, which provides compensation for loss of wages to the beneficiaries for sterilization.
4. Post-pregnancy contraception in the form of Post-partum Intra-uterine contraceptive device (PPIUCD), Post-Abortion Intrauterine contraceptive device (PAIUCD), and Post-partum Sterilization (PPS) are provided to beneficiaries.
5. 'World Population Day & Fortnight' and 'Vasectomy Fortnight' are observed every year to boost awareness on Family Planning and service delivery across all States/ UTs.
6. Under Home Delivery of contraceptives Scheme, ASHAs deliver contraceptives at doorstep of beneficiaries.
7. Family Planning Logistics Management Information System (FP-LMIS) is in place to ensure last mile availability of family planning commodities across all the levels of health facilities.

The Government has been successful in reining in the growth of population, and the following progress has been achieved:

- The Total Fertility Rate declined from 2.2 in 2015-16 (NFHS 4) to 2.0 in 2019-21 (NFHS 5) which is below replacement level.
- 31 out of 36 States/ UTs have achieved replacement level fertility (NFHS 5).
- The Modern Contraceptive usage has increased from 47.8% in 2015-16 (NFHS 4) to 56.5% in 2019-21 (NFHS 5)
- The Unmet Need for Family Planning has decreased from 12.9% in 2015-16 (NFHS 4) to 9.4% in 2019-21 (NFHS 5)
- The Crude Birth Rate (CBR) has declined from 20.8 in 2015 (SRS) to 19.5 in 2020 (SRS)[28].

IV. Reproductive Choice – Abortion and Family Planning.

Unsafe abortion is also a major cause of maternal mortality and morbidity. States Parties' reports to the Committee often fail to contain official data on this due to the illegal nature of abortion in many countries, but they consistently demonstrate a correlation between unsafe abortion and high rates of maternal mortality and morbidity, presented as haemorrhaging and complications of pregnancy.

There are grounds for the view that laws which criminalize health services that only women need - whether aimed at the persons who provide such services, or the women who receive them - are discriminatory as such. The criminalization of abortion is particularly heinous, because it not only impairs women's right to reproductive choice - to make free and responsible decisions concerning matters that are key to control of their lives - but also exposes them to the serious health risks of unsafe abortion, violating their rights to bodily integrity and, in the most extreme cases, to life itself.

In many countries there are exceptions to the criminal norm, allowing for legal abortion in limited circumstances, such as in cases of danger to the life of the mother (or the fetus), or where pregnancy has resulted from rape. In Indonesia, however, rape does not constitute grounds for legal abortion, which means that the state is effectively compounding the sexual violence targeted at the woman by forcing her to carry the resultant pregnancy.

The right to family planning education, information and services is key to reproductive choice, and central to women's sexual and reproductive health, especially given the risk of maternal mortality and the illegality of abortion in many countries.

Family planning services are particularly important where abortion is illegal. Where the state does not allow for safe legal abortion, its core obligation is to at least provide itself those family planning services that guarantee women their right to exercise reproductive choice.

Even in countries where abortion is legal, prevention of pregnancy is preferable to termination in terms of women's health. In the Czech Republic, for example, the government noted the high incidence of induced abortions as a major public health problem, mirroring the inadequate use of contraception.

---

[28] https://pib.gov.in/PressReleasePage.aspx?PRID=1947684

In Zimbabwe,the governmental report stated candidly that “it is not unusual for health personnel to turn away sexually active school girls requesting contraception on the grounds that the girls are still too young to indulge in sexual intercourse or that they are not married and therefore have no need for contraceptives.” Teenage pregnancy appears to be a major problem. It is worth noting further in this context, that the cumulative data on the incidence of HIV/AIDS in Zimbabwe show that in the 15-19 age group, infection among females accounts for 84% of the cases. Clearly, sexual and reproductive health education, information and services is essential for adolescent girls.

V. Conclusion

This research paper underscored the critical intersection of reproductive rights and effective population management, demonstrating that respecting individual autonomy and ensuring access to comprehensive reproductive healthcare are not only ethical imperatives but also essential components of sustainable development. The global demographic landscape, as evidenced by the milestone of 8.09 billion people, necessitates a nuanced approach that moves beyond coercive population control measures towards empowerment and informed choice.

The examination of international frameworks, from the landmark ICPD in 1994 to the Sustainable Development Goals, reveals a consistent emphasis on reproductive rights as fundamental human rights. These rights, including access to contraception, safe abortion, and prenatal care, are not merely matters of personal choice but are intrinsically linked to women’s health, dignity, and equality. The comparative analysis of national approaches, from China’s evolving family planning policies to Sweden’s robust welfare system, highlights the diverse strategies employed to address population issues. Notably, successful models, such as those in Thailand and Rwanda, emphasize education, empowerment, and access to healthcare, demonstrating that respecting reproductive rights leads to better demographic outcomes. Also, the Indian context, with its gradual decline in total fertility rate and increasing access to modern contraceptives, reflects a positive trend.

Criminalizing abortion not only infringes upon women’s autonomy but also exposes them to the grave risks of unsafe procedures. Prioritizing family planning education and services empowers women to make informed choices, leading to better health outcomes and reduced maternal mortality.

Moreover, the international human rights framework, as articulated in documents like CEDAW and ICCPR, provides a solid foundation for advocating reproductive rights. These rights are not isolated entitlements but are intertwined with other fundamental rights, including the right to privacy, equality, and freedom from discrimination.

The effective management of population issues hinges on a human rights-based approach that prioritizes reproductive rights. Governments must move beyond simplistic population control measures and invest in comprehensive sexual and reproductive health services, education, and empowerment initiatives. By doing so, they not only uphold fundamental human rights but also contribute to building healthier, more equitable, and sustainable societies. The future of global population management lies not in coercion, but in choice, dignity, and respect for all.

* * * *

REPRODUCTIVE RIGHTS LAWS IN INDIA: A COMPARATIVE ANALYSIS OF INDIA,USA AND SOUTH AFRICA

Dr. Shaheema A. S. *
Ms. Avril Melissa D'souza

Abstract

Reproductive rights are a cornerstone of human rights, deeply intertwined with self-sufficiency, gender equality, and access to healthcare. Across the globe, these rights manifest differently, shaped by unique cultural, political, and legal landscapes. In this context, India, the USA, and South Africa offer compelling comparative analysis cases, as their reproductive rights and enforcement approaches highlight progress and persistent challenges. India's reproductive rights framework, rooted in laws such as the Medical Termination of Pregnancy (MTP) Act of 1971, reflects a progressive but imperfect system where legal provisions often clash with societal attitudes. In the USA, reproductive rights have become a battleground for polarised debates, especially following the overturning of Roe v. Wade,[1]which resulted in a fragmented legal landscape.

Meanwhile, South Africa's Constitution explicitly guarantees reproductive autonomy, making it one of the most liberal in this regard globally. The analysis underscores the intersection of rights, accessibility, and enforcement, exploring challenges such as stigma, inequality, and the gap between law and practice. By comparing these nations, the study provides insights into the global discourse on reproductive justice and the ongoing fight to ensure equitable access to reproductive healthcare. This paper offers a comparative analysis of these countries' frameworks, similarities, divergences, and implementation. It highlights how cultural, political, and historical contexts shape each country's approach to reproductive health, including abortion, contraception access, and maternal care. This analysis seeks to uncover lessons and insights contributing to the global reproductive justice discourse.

Keywords : **Reproductive rights, Constitutional rights, Abnormalities, Women's rights, Health.**

"Reproductive freedom is critical to a whole range of issues. If we cannot control our reproduction, we cannot control anything else." - Gloria Steinem

I. Introduction

Reproductive rights are considered one of individuals' most prominent fundamental rights, enabling them to enjoy the freedom to make personal choices, access healthcare facilities and make informed decisions about their bodies. Each country has its way of interpreting the law relating to reproductive rights, and these rights are interpreted and enforced distantly. Reproductive rights vary in countries based ontheir cultural beliefs, political climate, and legal structures. Glancing at the situations in India, the USA, and South Africa, we learn that these three distant countries with different legal backgrounds and distant cultural and political practices interpret laws on reproductive rights. Each countryhasits own progress, setbacks, and ongoing struggles. Let us now comparethe distant backgrounds, legal practices and cultural differences relating to reproductive rights in the said countries.

II. Reproductive Rights: Situation in India

India is one of the developing countries in the world, and the situation of providing reproductive rights is so restrictive, legally, socially, and politically. The Medical Termination of Pregnancy (MTP) Act of 1971permits

* **Assistant Professor, SDM Law College, Centre for Post Graduate Studies and Research in Law, Mangaluru**

** **Student, (IInd yr BA.LL.B), SDM Law College, Centre for Post Graduate Studies and Research in Law, Mangaluru**

1 (1973) 410 US113

abortion only under certain circumstances. Making the law steadily progress on paper. However, access to safe abortion services is constantly blocked by societal stigma, incognisance, and healthcare professionals who decline to perform the plan of action due to various reasons, including personal and societal pressure. Many women in rural areas have faced significant difficulties in performing their reproductive rights despite having legal protections. Additionally, many women in India have faced discernment from healthcare practitioners who may decline to perform abortions due to societal, personal reliance and legal barriers. Thus, backed by a lack of awareness about legal rights, women are forced to opt for unsafe alternatives[2].

The Medical Termination of Pregnancy (MTP) Act of 1971permits abortion up to 20 weeks of gestation. However, later theMedical Termination of Pregnancy (Amendment) Act of 2021extended this limit to 24 weeks for women under specific categories, which include rape survivors, minors, and cases where continuing the pregnancy would pose a grave danger to women's mental and physical health and situations involving substantial foetus abnormalities. Furthermore, for pregnancies exceeding 24 weeks, the termination is allowed only in cases of severe foetal abnormalities, with the approval of a state-level medical board as mandated by the Medical Termination of Pregnancy AmendmentAct, 2021[3].

Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT) Act, 1994[4]. Itwas enacted in India to control sex-selective abortions and prevent the misuse of prenatal screening and diagnostic techniques. The Act forbids sex selection before or after conceiving and controls the use of prenatal screening and diagnostic techniques to detect metabolic disorders.[5], genetic abnormalities[6], congenital malformations[7], chromosomal abnormalities[8], and sex-linked disorders[9]. It also prohibits advertisements[10] related to sex determination and punishment is up to 3 years with a penalty of ten thousand for violations[11].

Despite having a strong legal framework, the existence of social stigma and procedural obstacles, many women in India are unable to access these rights fully. Addressing such problems not only requires legal reforms but alsowide awareness campaigns and improved healthcare facilities to make sure that reproductive rights are accessible to every womanin the country.[12].

Despite India's concern towards the population growth over the past 75 years, its population will reach around 1.6 billion by 2050[13]. India has used the method of sterilisation to control its population since 1951. United Nations report says that India alone was responsible for 37 per cent of female sterilisation in the year 2011. The fertility rate of India is 1.98 in 2024, and it is lower as compared to the UN recommended level of 2.1 to keep its population stable[14]. During the 1970s, the process of mass sterilisation was stalled by a major political predicament and the same was called "the Emergency", which took 21 months and was considered the darkest period after 1947 in Indian history[15].

---

2 MTP ACT 1971, https://mohfw.gov.in/?q=acts-rules-and-standards-health-sector/acts/mtp-act-1971(last visited Apr. 9, 2025).

3 The Medical Termination of Pregnancy (Amendment) Bill,2020 https://prsindia.org/billtrack/the-medical-termination-of-pregnancy-amendment-bill-2020(last visited Apr. 12, 2025).

4 PCPNDT Act 1994, No.57, Act of Parliament, 1994 (India).

5 A metabolic disorder is a condition that affects how the body converts food into energy. The body uses enzymes and chemicals to break down nutrients like carbohydrates, fats, and proteins. These processes do not work correctly in metabolic disorders due to missing or malfunctioning enzymes.

6 Genetic abnormalities refer to deviations from the typical sequence or structure of the genome, often leading to disorders such as Down syndrome, cystic fibrosis, or sickle cell anaemia.

7 A congenital malformation is a structural or functional abnormality present at birth. These can affect any body part, including the heart, brain, limbs, or internal organs.

8 Chromosomal abnormalities are problems with the number or structure of chromosomes. Chromosomes carry genetic material (DNA); humans usually have 46 chromosomes (23 pairs).

9 Sex-linked disorders are genetic conditions linked to genes found on the sex chromosomes (X or Y). Most of these are X-linked because the X chromosome is larger and carries more genes than the Y

10 PCPNDT Act, 1994 S. 22 No.57, Act of Parliament, 1994 (India)

11 PCPNDT Act, 1994 S.23 No.57, Act of Parliament, 1994 (India)

12 Sexual Autonomy of Women in Rural India: Assessing SDG 5.6.1https://sprf.in/sexual-autonomy-of-women-in-rural-india-assessing-sdg-5-6-1/(last visited Apr. 10, 2025).

13 database.earth/population/by-country/2050 (last visited Mar. 20, 2025).

14 factodata.com › Indian-states-fertility-rate-1991-2021 (last visited Mar.20,2025)

15 www.asianstudies.org/publications/eaa/archives/india-the-emergency-and-the-politics-of-mass-sterilization (lastvisited Mar.20, 2025)

M C Mehta v U O I[16] this case emerged from the mishandling of sterilisation camps conducted under the initiative of India's family planning programme. The Supreme Court held that sterilisation processes must carried out in a clinically appropriate and safe manner with the informed consent of the individuals.

In the case of*Suchita Srivastava and Anr. vs Chandigarh Administration*[17], the woman who had intellectual disabilities, who conceived and became pregnant due to rape while staying in a government-operated welfare facility in Chandigarh. The Chandigarh Administration requested the High Court to provide consent for the termination of pregnancy, emphasising her mental condition and the lack of a guardian. The High Court approved the termination of her pregnancy on the grounds of her mental condition and lack of a guardian.

Later, the Supreme Court reversed the High Court decision, highlighting the importance of women's right to make reproductive decisions as it is a part of her liberty, and the same is provided in Article 21 of the Indian Constitution. Further, thecourt emphasised the importance of consent, highlighting that even a mentally disabled woman has the right to make decisions about whether to continue her pregnancy or not, considering she understands the implications.

This case highlighted various aspects of reproductive rights in India, and also the importance of women's consent, which is enshrined in Article 21 of the Indian Constitution, giving the women to have and make informed decisions regarding their bodies as it is the principle of reproductive autonomy and is considered as an indispensable part of personal liberty and must be secured under the right to life and dignity,the fundamental right of a human being enshrine under the Article 21 of the Indian Constitution.

III. Reproductive Rights: Situation in USA

The USA is considered one of the most developed countries in the world, and the situation of reproductive rights is widely varied in its different states. The US Constitution does not explicitly provide reproductive rights.Some States have prohibited or extensively restricted abortion with fewer federal safeguards. The authority to regulate abortion mainly rests with individual state governments. While reproductive healthcare and contraception are broadly accessible, their provision may be affected by individual state laws.[18].

The USA has several provisions that are influenced by the 14 Amendment[19] Which guarantees rights to liberty, equal protection, and life, which are foundational to the reproductive autonomy of the individual. The interpretation of such rights has undergone various substantial shifts, particularly in the case of *Roe V. Wade*[20]. *Dobbs V. Jackson Women's Health Organisation*[21] In the case of *Roe V. Wade* where, Jane Roe, a Texas woman, wished to terminate her pregnancy, but Texas law permits abortion only to save the mother's life, claiming to violate her right to privacy. The US Supreme Court ruled that a woman's right to have an abortion was protected by the Constitutional right to privacy under the 14th Amendment. This judgement legalised abortion across the United States, initiating a trimester framework.

But later, in *Dobbs V. Jackson Women's Health Organisation(JWHO)*where the case involved in the interpretation of the Gestational Age Act[22] The law prohibited and banned abortion after 15 weeks, with exceptions only for medical emergencies and foetal abnormalities. This was challenged by JWHO, which was the only abortion clinic in Mississippi, which argued that the Constitutional right to abortion was violated. The same was provided under the Roe v. Wade case. It marked a pivotal and historic swift in USA Constitutional law, eliminating federal protections for abortion rights; the decision radically changed the legal framework governing reproductive autonomy. Legal battles continue to secure access to medical abortion and broader healthcare. Abortion laws are very distant after overruling the case of *Roe v. Wade*; while some states have

---

16 (1996) 4 SCC 750

17 (2009) 14 SCR 989, (2009) 9 SCC 1

18 Centre for Reproductive Rights, https://reproductiverights.org/roe-v-wade/ (last visited Apr. 12, 2025).

19 The 14th Amendment to the US Constitution was ratified in 1868. It is a landmark legislation that addresses citizenship and equal protection under the law. It defines that citizenship ensures that states cannot deprive individuals of rights to life, liberty, or property without due process.

20 (1973) 410 US113

21 (2022) U S 597

22 Enacted in the Mississippi. Ch. 393, § 1, 2018 Miss. Laws (Codified at MISS. CODE ANN. § 41–41–191).

enacted near-total bans, others have accepted and expanded the safeguard access. The federal protections are minimal, leaving the state government to make significant decisions[23].

In the USA, access to contraception is widely accepted and available, but various state laws and other healthcare policies can disrupt this. Hence, all the decisions regarding contraception and abortion are widely dependent upon the state laws of those respective states. The women of those states have faced a lot of significant barriers, which lead to a high impact on their autonomy and their bodies, resulting in a lack of personal liberty.[24].

IV. Reproductive Rights: Situation South Africa

South Africa is typically considered one of the developingcountries, and reproductive rights areprotected by the Constitution. The right to make decisions about one's reproductive health is vested inthe hands of the individual, even in matters of access to safe reproductive health services and the right to information and education on sexual and reproductive health. It also consists of access to contraception, sterilisation, and abortion. The Constitution of South Africa unambiguously guarantees the right to make reproductive choices, including access to safe contraception, safe abortion and maternity care.[25].

The Choice of Termination of Pregnancy Act, 1996[26] is the law governing abortion in South Africa, which permits abortion on the request up to twelveweeks of pregnancy; under broadly certain circumstances, from the thirteenth to the twentieth week, a pregnancy may be terminated only if it endangers the woman's physical and mental health. If the foetus is suffering from physical or mental abnormalities, the pregnancy may be terminated. If it results from rape or incest, or if continuing, it wouldaffect the women's social,economicor living conditions. After the twentieth week, the termination of pregnancy is allowed only if the pregnancy results in danger to the woman's life or the foetus has severe abnormalities, and it will face significant harm to itself.[27].

Sterilisation Act, 1998[28], this Act refers to a permanent procedure to prevent future pregnancies. This Act affirms every individual's right to have access to safe, effective, affordable, and acceptable methods of sterilisation[29]. This Act gives a legal provision to permit consensual sterilisation for adults and non-consensual sterilisation with safeguards for individuals who are not able to provide consent due to mental disability. Although they consist of constitutional statutory measures,due to various societal backwardness and lack of knowledge regarding sexual reproductive health, they can limit access.[30]However,in the case of *Treatment ActionCampaign V. Minister of Health*[31]. In the landmark case, where the government limited the excess use of Nevirapine, a free drug that is available to prevent HIV transmission from the mother to the child and accessible only to a few hospitals, the Treatment Action Campaign challenged this, saying it had violated the people's right to access the safe health care. The Constitutional Court gave a precedent that the government must make healthcare services accessible to all its citizens, and the restriction imposed by the government was unreasonable and violated the right to health. Moreover, it ordered the government to make Nevirapine available to all public hospitals and to initiate proper programs to prevent the transmission of HIV from mother to child. This case highlighted the constitutional right to health and state liability.[32].

---

23 https://reproductiverights.org/maps/abortion-laws-by-state/ (Last visited Apr.5, 2025)

24 *Id.*at 23

25 Strode A, Essack Z. *Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience*, 107(9) S Afr Med J.741 (2017) https://pmc.ncbi.nlm.nih.gov/articles/PMC9713259/.

26 No. 92 Act of Parliament, 1996 (South Africa).

27 Pickles C, *Termination-of-pregnancy rights and foetal interests in continued existence in South Africa: the Choice on Termination of Pregnancy Act 92 of 1996,15 PER* (online). 402, 402-434 (2012). https://scielo.org.za/scielo.php?script=sci_arttext&pid=S1727-37812012000500013(last visited Apr.12,2025).

28 No. 44 Act of Parliament, 1998 (South Africa).

29 A Simplified Guide to Sterilisation and Your Rights, https://wlce.co.za/wp-content/uploads/2017/02/know-your-rights-sterilisation-booklet-final.pdf (last visited Apr. 12, 2025).

30 https://natlex.ilo.org/dyn/natlex2/r/natlex/fe/details?cs=1TGvILbRitiwg0zXfixtuuURZ5fxdv8-JaJZ9pa7ab2mtjb_KX-6pE6ZDZsm3LymWqfwBJ95VWLBBt-jS2iJohw&p3_isn=50934(last visited on Apr.12.202)

31 (2002) 5 SA721(CC).

32 Minister of Health v Treatment Action Campaign(TAC) (2002)5 SA 271(CC) https://www.escr-net.org/caselaw/2006/minister-health-v-treatment-action-campaign-tac-2002-5-sa-721-cc/ (last visited on Apr.12.2025)

V. Conclusion

In the comparative study of India, South Africa, and the USA, we can see a significant difference in how each country has its own diverse background, distant legal framework, cultural attitudes, and access to healthcare facilities. Where India ensures greater accessibility through state-led initiatives; despite this, it continues to face hurdles like societal stigma, incognisance, and healthcare professionals who decline to perform the plan of action due to various reasons, including personal and societal pressure and legal barriers.

Meanwhile, in South Africa, reproductive rights are rooted in Constitutional provisions. Although there are a necessary number of laws guiding and protecting the reproductive rights of women, in many rural areas in South Africa, these rights are not practised as the women in those areas are not very familiar with their reproductive rights, which later leads to increase in the backward sections of society and deaths due to increase in the number of women dying due to unauthorised or unregulated methods of abortion and contraception.

The USA has seen a lot of withdrawal of legal rights in the precedent of *Dobbs V. Jackson Women's Health Organisation (JWHO)*, resulting in uneven implementation and disparities among states.

This comparative analysis shows that apart from the scope of legislation, the implementation of reproductive rights depends on successful implementation, public consciousness, and the dismantling of deep-rooted cultural and physical barriers. Achieving reproductive rights and fairnesscalls for more than statutory provisions but also a supportive environment that upholds personal agency, equality, and informed choices.

* * * *

SURROGACY AND REPRODUCTIVE RIGHTS OF WOMEN: ETHICAL AND LEGAL ISSUES

Ms. Disha *

Abstract

Reproductive rights are one of the fundamental human rights of the women and it plays a crucial role in the life of the women. The feelings of Motherhood are very special and cannot be described in words and cannot be compared with any other experiences. On the other hand, there are many childless couples suffering from infertility due to various medical reasons. The desire to become the parents make them to search for other alternative solutions. The Modern advancement of technologies such as Assisted Reproductive technology (ART) is one such solutions to the childless couples. The various methods of ARTs are In Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), Artificial Insemination (AI) and Surrogacy etc. Surrogacy is the practice were a woman carries a child in her womb and after the birth of the child, the child is given to the commissioning parents.The Surrogacy (Regulation) Act, 2021 governs the practice of surrogacy in India and it bans commercial surrogacy. There are several reasons which makes childless couples to opt for surrogacy over other reproductive technologies such as medical issues and itsconsequences make it impossible for some women to carry a pregnancyand also severe heart diseases, cancer or failure in the IVF treatment, etc. But there are various legal and ethical issues involve[1]d under the concept of surrogacy. This paper tries to highlights the various issues relating to the surrogacy and its ultimate effect on the health of the surrogate mothers and also analysed the cases of surrogacy in India and made an attempt to bring some suggestions that has been found in the area of study.

Key Words: **Surrogacy, Surrogate mother, Commissioning Parents, Surrogacy (Regulation) Act, 2021**

I. Introduction

Reproductive rights are one of the important rights of the individuals, particularly women and girls. The reproductive rights give the freedom to the individuals to make their choice with regard togetting married of their choice, having children, use of contraception, terminate a pregnancy, etc.[2]It is the right of all the married couples to decide freely about the family planning and other related matters, it is their personal choice and decided between the couples. Reproductive rights lay the foundation of healthy parenthood by allowing only physically and mentally fit human beings who are free from all diseases to become the parents. In the society it is very much important to have the living organisms, to maintain the ecological balance, for that the it is very much necessary for the living creatures to have the reproductive rights, to lead the future generations.

However, on the other side there are many childless couples who are suffering from infertility or various medical reasons, and they are unable to enter the parenthood. Unfortunately, childlessness is one of the major problems and specially leading to depression of the female individual in various ways and also resultingto personal distress. In such situation the couples will start searching for other alternatives. Assisted Reproductive Technology (ART) is one such solution for the childless couples. Under ART there are various methods or various treatments for the intending parents. Surrogacy is one such Method where the Surrogate mother will carry the child and after the birth of the child, it is given to the commission parents. With the help of surrogacy, the childless couples can become the parents.[3]

---

* **Visiting Faculty, SDM Law College, Mangalore**

2 https://lawbhoomi.com/reproductive-rights/#:~:text=Reproductive%20rights%20are%20essential%20to,from%20torture%20or%20ill%2Dtreatment. Visited on 2/03/2025 at 8:40 pm

3 Yadav Megha, The Controversy of Surrogacy in Indian Perspective An Analytical Study, K.R. Mangalam Univeristy, Gurgaon, 2022 (also available at https://shodhganga.inflibnet.ac.in/handle/10603/406552 visted on 10.03.2025 at 8pm)

II. Assisted Reproductive Technology (ART)

Assisted Reproductive Technology refers to medical procedure, which helps theindividuals or childless couples to conceive a child. It involves handling or manipulating gametes, sperm or embryos to overcome the infertility.

Assisted reproductive treatments involves different treatments which are being discussed as follows:

1. In Vitro Fertilization (IVF): Eggs are retrieved from the ovaries, fertilized with sperm in a lab, and transferred to the uterus.
2. Gamete Intra Fallopian Transfer (GIFT): In this method the eggs and sperm placed directly into the fallopian tubes, allowing fertilization to occur naturally.
3. Zygote Intra Fallopian Transfer (ZIFT):ZIFT involves fertilizing an egg with sperm in a laboratory then transferring the resulting zygote (a single cell formed after fertilization) into the fallopian tube.
4. Artificial Insemination (AI):AI involves inserting sperm into the female reproductive tract using medical instruments, rather than through sexual intercourse.[4]
5. Surrogacy: Surrogacy is one of the types of Assisted Reproductive Technology, where this paper highlightsmainly with surrogacy and its issues. Surrogacy is where a woman carries a child in her womb by following the medical treatments and gives birth to the baby and after the birth the baby is given to the childless couples. However, on the other hand surrogacy has its own cons and pros, that must be looked into.

III. Types of Surrogacy

1. Traditional Surrogacy:Traditional surrogacy is illegal as per the Surrogacy Act. In case of Traditional Surrogacy, the surrogate mother will be considered as the biological mother of the child. The woman who is the traditional surrogate can either get pregnant by artificial insemination with sperm from a sperm donor, or surrogate mothers own eggs used for fertilization with sperm from a sperm donor to make an embryo.
2. Gestational Surrogacy: In case of Gestational Surrogacy,the surrogate mother has no genetic ties to the child. Eggs and sperm are extracted from the donors and with the help of IVF embryo is created and implanted into the uterus of the surrogate.
3. Commercial Surrogacy: Commercial surrogacy refers to an arrangement, where the surrogate mother paid for carrying the pregnancy for another couple. Here the money paid not for the medical treatment but for the services provided by the surrogate mother.Commercialization of surrogacy involves selling and buying of human embryo or gametes and providing fees, remuneration, cash or kind, awards to the surrogate mother except medical expenses.[5]At present Commercial Surrogacy has been banned by the Parliament of India, under the Surrogacy (Regulation) Act, 2021.
4. Altruistic Surrogacy: Altruistic Surrogacy refers to the surrogacy arrangements whereSurrogate mother does not receive any financial compensation beyond the medical expenses. Under this type of surrogacy there is no monetary compensation, fees, incentives are offered to the surrogate mothers. It is the desire of the surrogate mother to help the childless couples to enter the parenthood.

IV. Legislative Frameworks Related to Surrogacy in India

1. **Indian Council of Medical Research Guidelines (ICMR), 2005 :** The guidelines allowed the Surrogate mothers to receive the compensation for the surrogacy and the amount would be determined between the intending parents and surrogate mother. The guidelines also mentions that the surrogate mother should not use her own eggs for the surrogacy and also, she must relinquish all her parental rights with regard to the child.[6] The ART clinic should not make any advertisement with regard to surrogacy and before the embryo is transferred the surrogate mother must be screened for HIV and after the test must get a report

[4] Dr. Shweta Dhand, Emerging Trend of Assisted Reproduction: A Social and Legal Issue in Regard to Surrogacy, Indian Bar Review Vol 47(2 & 3), pg-275-286, (2020)

[5] Dr. Jagrati Panthi, Surrogacy, https://www.slideshare.net/slideshow/surrogacy-241904201/241904201 (last visited on 05.03.2025 at 3pm)

[6] https://prsindia.org/billtrack/prs-products/prs-legislative-brief-2709#:~:text=In%202005%2C%20the%20Indian%20Council, couple%20and%20the%20surrogate%20mother. (last visited on 05.03.2025 at 6:30pm)

of non-HIV.The guidelines also recommended that the sale or transfer of human embryos or gametes to any other party outside the country must be prohibited and within the country such embryos or gametes made available for researchers having no commercial interest.[7]

2. **Law Commission 228th Report, August 2009:** The law commission in its report highlighted the need for the legislation to govern the Reproductive technology clinics as well as rights and obligation of parties of the surrogacy. It also specified about banning commercial surrogacy in India, because there is no proper law relating to surrogacy in India.[8]
3. **Surrogacy (Regulation) Act, 2021:** The first Surrogacy bill was introduced in Lok Sabha in the year 2016, but due to the dissolvement of Parliament the bill got lapsed. After that in the year 2019 one more bill introduced,the Surrogacy bill was introduced by the Minister of Health and Family welfare, Dr. Harsh Vardhan in Lok Sabha on July 15, 2019 and passed on August 5, 2019. The Surrogacy bill, 2019 was introduced with the aim to safeguard the surrogate mother and protect the rights of the surrogate mother and the child born out of surrogacy. The Rajya Sabha referred the bill for examination to the select committee, after that the report of the select committee was presented before Rajya Sabha on 5 February, 2020 suggesting the changes in the bill. Subsequently Surrogacy (Regulation) Bill, 2021 was introduced and came into force on 25 January, 2022.

V. Important Provisions of Surrogacy (Regulation) Act, 2021

Sec 3: Prohibition and regulation of surrogacy clinics: -Every Surrogacy clinic must be registered under the Act to conduct the procedure of the surrogacy.

- No surrogacy clinic, registered medical practitioner, gynaecologist, paediatrician, embryologist or any other person shall promote, publish, canvass, propagate or advertise or cause to be promoted, published, canvassed, propagated or advertised which—

  (a) is aimed at inducing or is likely to induce a woman to act as a surrogate mother; (b) is aimed at promoting a surrogacy clinic for commercial surrogacy or promoting commercial surrogacy in general;(c) seeks or aimed at seeking a woman to act as a surrogate mother;(d) states or implies that a woman is willing to become a surrogate mother; or (e) advertises commercial surrogacy in print or electronic media or in any other form.
- No abortion during the period of surrogacy without the written consent of the surrogate mother and on authorisation of the same by the appropriate authority concerned.
- In no case sex selection or storage of a human embryo or gamete is allowed for the purpose of surrogacy. (Provided that nothing contained in this clause shall affect such storage for other legal purposes like sperm banks, IVF and medical research for such period and in such manner as may be prescribed).

Sec 4: Regulation of Surrogacy and Surrogacy Procedures: -

- Sec 4 has provided various grounds on which surrogacy allowed: (a) when an intending couple has a medical indication necessitating gestational surrogacy; (b)when it is only for altruistic surrogacy purposes; (c) when it is not for commercial purposes or for commercialisation of surrogacy or surrogacy procedures; (d) when it is not for producing children for sale, prostitution or any other form of exploitation; and (e) any other condition or disease as may be specified by regulations made by the Board;
- And no surrogacy or surrogacy procedures shall be conducted, undertaken, performed or initiated, unless the Director or in-charge of the surrogacy clinic and the person qualified to do so are satisfied, for reasons to be recorded in writing, that the following conditions have been fulfilled, namely

  (a) a certificate of a medical indication in favour of either or both members of the intending couple or intending woman necessitating gestational surrogacy from a District Medical Board.

  (b) An order concerning the parentage and custody of the child to be born through surrogacy, has been passed by a court of the Magistrate of the first class.

---

[7] Laxmi Murthy, Vani Subramanian, ICMR guidelines on Assisted Reproductive Technology: lacking in vision, wrapped in red tape, Indian Journal of Medical Ethics Vol IV No 3, pg123, July-September 2007

[8] https://www.lexology.com/library/detail.aspx?g=3279abc2-f464-4ca3-8932-ecc80437dc53#:~:text=Thereafter%2C%20the%20Law%20Commission%20of,practice%20of%20commercial%20surrogacy%20as (last visited on 07.03.2025 at 8am)

(c) An insurance coverage of such amount and in such manner as may be prescribed in favour of the surrogate mother for a period of thirty-six months;

- Eligibility criteria for surrogate mothers: - The surrogate mother is in possession of an eligibility certificate issued by the appropriate authority on fulfilment of the following conditions, namely:
  a) Surrogate women must be a married woman and having a child of her own
  b) She must be between the age of 25 to 35 years
  c) Surrogate mother cannot provide her own gametes for surrogacy
  d) No woman shall act as surrogate mother more than once in her life time
  e) Surrogate mother must have a medical and psychological fitness
- Eligibility criteria for intending parents:
  (a) Certificate of proven infertility by the prescribed authority
  (b) The intending couple have not had any surviving child biologically or through adoption or through surrogacy earlier:
  (c) The intending couple are legally married and between the age of 23 to 50 years in case of female and between 26 to 55 years in case of male on the day of certification;

Sec 6: Written informed consent of Surrogate Mother: Surrogate mother must be informed of all known side effects of these procedures and she must provide written informed consent in language she understands.

Sec7: Prohibition to Abandon Child Born through Surrogacy: Prohibition to abandoning a child born out of surrogacy on the ground of a birth defect, any genetic defect or any other medical conditions whether in India or outside India.

Sec 8:Rights of Surrogate Child: A child born out of surrogacy procedure, shall be deemed to be a biological child of the intending couple or intending woman and the said child shall be entitled to all the rights and privileges available to a natural child under any law for time being in force.

Sec 10: Prohibition of Abortion: - No person, organisation, surrogacy clinic, laboratory or clinical establishment of any kind shall force the surrogate mother to abort at any stage of surrogacy except in such conditions as may be prescribed.[9]

Sec 40: Punishment for not following Altruistic Surrogacy. —Any intending couple or intending woman or any person who seeks the aid of any surrogacy clinic, laboratory or of a registered medical practitioner, gynaecologist, paediatrician, embryologist or any other person for not following the altruistic surrogacy or for conducting surrogacy procedures for commercial purposes shall be punishable with imprisonment for a term which may extend to five years and with fine which may extend to five lakh rupees for the first offence and for any subsequent offence with imprisonment which may extend to ten years and with fine which may extend to ten lakh rupees.

To Whom Surrogacy (Regulation) Act, 2021 will be Applicable?

- Indian infertile couple
- Widowed women -between the age of 35 to 45 years
- Divorced woman - between the age of 35 to 45 years

Who is not Eligible for Surrogacy under the Surrogacy (Regulation) Act, 2021

- Single / Widow / Divorced Men
- Single unmarried women
- Couple in Live in Relationship
- LGBTQ intending parents
- Foreign couples[10]

---

9 https://www.jusscriptumlaw.com/post/decoding-surrogacy-in-india (last visit on 07.03.2025 at 4pm)

10 https://www.slideshare.net/slideshow/surrogacy-regulation-act-2021-250954267/250954267 (last visited on 10.03.2025 at 2pm)

VI. Important Case Laws Relating to Surrogacy

Baby Manji Yamada V. Union of India (2008) 13 SCC 518

One of the first Surrogate verdict in India. In this case a Japanese couple came to India to have a baby through surrogacy, thereafter the couple got divorced and the mother of the child refused to take the custody of the child. According to Indian laws it wasn'tallowed for the single father to seek surrogacy in India and he could not take her back.The case raised problems concerning surrogate children's legal status and rights, commercial surrogacy as well as the responsibility of surrogacy clinics and intended parents. The Supreme Court given the custody of the child to the grandmother, who took her back to Japan with her. In this case the court observed without proper surrogacy laws, difficulties may arise over parental status and with regard to the custody of the childand also emphasised the need for Surrogacy regulation.[11]

Jan Balaz V. Anand Municipality[2009 SCC Online Guj 10446]:

Under this case there was question which arose with regard the nationality of the chid. If the child is born to the surrogate mother and foreign biological father then whether the child would be awarded with Indian citizenship? In this case a petitioner, a German national came to India to have the child through surrogacy with an Indian woman. The babies were born in India, and the father of the babies got the birth certificate for them. When the father of the babies tried to leave the country with the babies he was stopped by the authorities. The petitioner filed the plea in the Gujarat High Court to leave India with the babies. Since Surrogacy was not recognized in Germany, a newly born babies could not receive the German citizenship. And the children did not fit in the current legal definition of Indian citizenship and they were left stateless. Finally, the Court allowed the Petitioner to depart with babies, subject to specific conditions. The case highlighted the need for the clear surrogacy laws and regulations relating to surrogacy arrangements. It also emphasised the importance of ensuring safety and welfare of the children born out of surrogacy arrangements. [12]

Suchita Srivastava V. Chandigarh Administration(2009) 14 SCR 989, (2009) 9 SCC 1

In this case the victim was a prisoner in a government run welfare centre in Chandigarh and she was raped, which eventually resulted in her pregnancy. The Chandigarh Administration, which is the respondent in this case approached High Court after knowing her pregnancy, requesting permission to terminate the same, despite the fact that she was not only mentally ill but also an orphan with no parent or guardian to take care of her and her child. The High court formed an expert body of medical specialist and a judicial officer to conduct a detailed investigation. The High Court directed the termination of the pregnancy, in spite fact that the expert body showed the report that the victim is willing to bear the child. Aggrieved by this order the appellant moved to Supreme Court. The Supreme Court said that a woman's freedom to make reproductive decisions falls under the definition of personal liberty as defined under Article 21 of the Constitution. The Court viewed that the woman's reproductive right includes the pregnancy to term, give birth, and raise the children. Thisconcluded that the High Court order to terminate the pregnancy was not in her 'best interest', because the victim not agreed to the abortion. The court said that the victim's pregnancy could not be terminated without her consent and ordering such thing to happen it would be against to her 'best interest'.[13]

VII. Ethical and Legal Issues of Surrogacy

Considering women as commodity: -Under the surrogacy arrangements the surrogate mother plays the major role. The surrogate mother may be vulnerable for various reasons and the intending parents or the surrogacy clinics may take the advantage of such things and they may convince such women to undergo the surrogacy arrangements. Surrogacy arrangements it is a procedure where it became a bargain and exchange over the incidents of parenthood and make the society to witness the women's reproductive abilities and alsojeopardizes the physical and mental health of the women and making her the object of reproduction.

Baby Selling: - Surrogacy arrangements where surrogate mother carries a pregnancy and gives birth to the baby and after the birth the baby will be given to the childless couples. Motherhood is such a special feeling

[11] Ibid

[12] https://blogs.lse.ac.uk/humanrights/2023/08/24/surrogacy-and-trafficked-prostitution-the-lesser-known-facets-of-statelessness/#:~:text=The%20case%20of%20Jan%20Balaz,could%20not%20receive%20German%20citizenship (last visited on 10.03.2025 at 7pm)

[13] https://blog.ipleaders.in/is-abortion-legal-in-india-2/ (last visited on 10.03.2025 at 7 pm)

which cannot be compared with any other feeling. But under surrogacy arrangement, it is the surrogate mother who gives the birth to the baby and the intending female will not experience the pain and pleasure of the pregnancy. So, the motherhood experienced by one woman and the baby is taken care by another woman. The people of the society may label it as 'Baby selling'.

Exploitation of the women: -Surrogacy arrangements considered as unethical because of the various factors involved on it. One of the main reasons is exploitation of the women. It is always the poor women will ready to be a surrogate mother and richer women will take the child. Becoming a surrogate mother is not an easy task, a lot of physical and mental issues are involved in it. Inserting the embryos into the uterus of the surrogate mother may cause health problems. The surrogacy involves a problem like restricting individual autonomy, procreative liberty, right to dignity, right to privacy, exploitation of human body etc.

The Medical Termination of Pregnancy Act, 1971 gives the right to the mother, to abort the child on the medical grounds without the consent of her husband. Will this right be available to surrogate mother; if she wants to terminate her pregnancy on medical grounds without the consent of commissioning parents. This question remains unanswered.

Anxiety of the Child: -The child born out of surrogacy, as and when it grows it may experience the anxiety about the identity of the surrogate mother. And child may feel bad to agree that he/she was born to a surrogate mother and this feeling may lead a child to feel depressed and feel low.

Right to Privacy Violated: Sec 4 of the Surrogacy (Regulation), Act 2021 provides that in order to get the service under the Surrogacy, the intending couple shall obtain a Certificate of medical indication in favour of either or both members of the intending couple or intending women from the prescribed authority. Certificate of infertility is a clear violation of right to privacy guaranteed under Article 21 of the Constitution.

Custody of the Child: -If the commissioning couple opts for divorce after going for surrogacy before the child is born then, then in such case who will take the custody of the child? The same question arose in the case of Baby Manji Yamda case, it will be difficult to answer and court may consider various factors in deciding such matters such as (a) welfare and wellbeing of the child, (b) wishes of the child (if old enough to express a preference) (c) the ability of each parent to provide a stable and loving environment, (d) the level of involvement and commitment shown by each parent during the surrogacy process.

VIII. Suggestions

Establish a Centralized Regulatory Authority: To oversee and monitor surrogacy clinics, agencies, there must be a regulatory authority and there can be one or more suggesting body for the better recommendations, decision making etc.

Uniform Laws and Guidelines: Developing and implementation of consistent laws and guidelines across all states in India.

Counselling and Support: Offering counselling and support services for surrogate mothers throughout the process. Making them feel free to share their feelings about surrogacy and who are ready to help the childless couples or the willing women are given preference to act as surrogate mothers. And even providing emotional support and counselling services for intended parents.

Transparent Surrogacy Process: There must be a transparency throughout the surrogacy process, including costs, medical procedures, and legal requirements.

Collaborate with International Organizations: Collaborating with international organizationsto develop global guidelines and standards for surrogacy.

IX. Conclusion

The arrangement of surrogacy may be beneficial to the childless couples but on the other side it has many drawbacks. Medical advancement cannot be stopped for the sake of societal non acceptance. The cause for societal non acceptance must be sorted out and in adequacies of law should be identified in order to protect the exploitation of surrogate mothers. As surrogate became common in the society, the legislatures must pass effective and unambiguous laws by protecting the rights of the child, surrogate mother and the intending parents.

* * * *

THE EVOLUTION OF REPRODUCTIVE RIGHTS: A HISTORICAL PERSPECTIVE

Mr. Devansh Agarwal *

Abstract

Reproductive rights ensure that individuals, especially women, have control over decisions related to reproduction. These rights include access to contraception, safe abortion, maternal healthcare, and family planning. Over time, legal systems and international organizations have recognized the importance of reproductive rights. This paper explores the historical development of reproductive rights by examining key legal reforms, international treaties, and national policies. It focuses on global frameworks such as the Universal Declaration of Human Rights (UDHR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Conference on Population and Development (ICPD). Additionally, it discusses India's legal framework, including the Medical Termination of Pregnancy Act (MTP), the Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT), and India's National Family Planning Programs.

The paper also highlights the connection between reproductive rights, gender equality, public health, and population policies. While many legal protections exist, challenges such as legal restrictions, social stigma, and lack of access to healthcare continue to hinder reproductive justice. Understanding the historical development of reproductive rights is essential for shaping better policies in the future.

Keywords: ***Reproductive Rights, Family Planning, Abortion Laws, Gender Equality, Human Rights,*** **Legal Reforms**

I. Introduction

Reproductive rights are a fundamental part of human rights. They ensure that individuals have the freedom to make decisions about their reproductive health without discrimination or coercion. These rights are necessary for gender equality, public health, and overall human well-being.

Over the years, reproductive rights have evolved significantly. Many societies in the past imposed restrictions on reproductive choices, but modern laws now protect these rights. This paper examines the historical development of reproductive rights, key international treaties, India's legal framework, and the challenges that still exist.

II. Historical Development of Reproductive Rights

Early Restrictions and Religious Influence

In ancient times, reproductive decisions were often controlled by religious beliefs and social customs. Some societies allowed abortion in certain cases, while others considered it a crime. Women often had little control over their reproductive health.

For example:

- In ancient Greece, philosophers like Aristotle supported abortion in cases where it could help control population growth.
- In medieval Europe, abortion was criminalized under Catholic Church laws.
- In colonial India, abortion was strictly prohibited and considered a punishable offense.

These restrictions continued for centuries, limiting women's rights and access to reproductive healthcare.

* **Law Student., B.B.A.LL.B., Invertis University**

The Shift towards Legal Recognition

The 20th century saw major changes in reproductive rights. Governments and legal systems began recognizing the need for safe and legal family planning methods.

Important milestones include:

- 1948: Universal Declaration of Human Rights (UDHR) – Recognized reproductive rights as part of human dignity and privacy.
- 1968: Tehran International Conference on Human Rights – Declared family planning a human right.
- 1979: Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – Required countries to ensure equal access to healthcare, including reproductive rights.
- 1994: International Conference on Population and Development (ICPD) – Recognized reproductive health as a basic human right.

These events helped in shaping modern reproductive rights laws worldwide.

III. International Legal Frameworks

Universal Declaration of Human Rights (UDHR) (1948)

The UDHR states that every person has the right to privacy and family planning. It emphasizes that governments must respect individual choices regarding reproduction.[1]

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)

CEDAW is one of the most important international treaties for women's rights. It states that:[2]

- Governments must remove legal barriers to reproductive healthcare.
- Women should have equal access to healthcare services, including abortion and contraception.
- States should take action against forced sterilization or any form of discrimination in reproductive healthcare.

International Conference on Population and Development (ICPD) (1994)

The ICPD recognized that reproductive rights are not just a women's issue, but a public health and human rights issue. It promoted:[3]

- Access to family planning services
- Legal abortion was permitted
- Education on reproductive health

Many countries, including India, used ICPD recommendations to improve their reproductive laws.

IV. National Legal Frameworks in India

Medical Termination of Pregnancy (MTP) Act, 1971

India passed the MTP Act in 1971 to legalize abortion under certain conditions. The law allowed abortion when:[4]

- Continuing the pregnancy would harm the woman's physical or mental health.
- The pregnancy resulted from rape or contraceptive failure.
- The fetus had severe abnormalities.

In 2021, the Act was amended to extend the abortion limit from 20 to 24 weeks for special cases.

Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994

This Act was introduced to prevent female feticide and regulate prenatal testing. It states that:[5]

---

1 Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948).

2 Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. Doc. A/34/46 (Dec. 18, 1979

3 International Conference on Population and Development, U.N. Doc. A/CONF.171/13/Rev.1 (Sept. 13, 1994).

4 Medical Termination of Pregnancy Act, No. 34, Acts of Parliament, 1971 (India).

5 Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, No. 57, Acts of Parliament, 1994 (India).

- Sex determination before birth is illegal.
- Doctors cannot conduct tests to determine the sex of the baby.
- Strict punishments exist for those violating this law.

National Family Planning Program

India's Family Planning Program was launched to provide contraception and reproductive health services.

V. Challenges and Future Directions

Despite legal progress, many challenges remain:

- Legal Barriers – Some states in India still restrict abortion access.
- Social Stigma – Many women face discrimination for seeking reproductive healthcare.
- Healthcare Access – Rural and poor women often lack access to safe medical services.

To improve reproductive rights, India must:[6]

1. Ensure better enforcement of laws to protect women's rights.
2. Increase awareness programs about reproductive healthcare.
3. Improve healthcare infrastructure in rural areas.

VI. Conclusion

Reproductive rights have undergone a significant transformation, evolving from religious and cultural restrictions to legally recognized protections. While international frameworks and national policies have strengthened reproductive autonomy, legal barriers, societal stigma, and healthcare inaccessibility remain major challenges.

To achieve true reproductive justice, governments must enforce existing laws, remove arbitrary legal restrictions, and expand access to reproductive healthcare, especially in rural areas. Strengthening public awareness campaigns and promoting gender-sensitive education will help in fostering a society that upholds reproductive freedom as a fundamental human right. The future of reproductive rights depends on continuous legal progress, equitable healthcare access, and a commitment to ensuring bodily autonomy for all individuals."

* * * *

[6] Ministry of Health & Family Welfare, Government of India, National Family Planning Program.

FROM COERCION TO CONSENT: THE EVOLUTION OF POPULATION CONTROL POLICIES

Mr. Dinesh Kumar Mishra *

Abstract

The history of population control policies is marked by a transition from coercive methods to more voluntary, consent-based approaches. Early population control measures, particularly in the mid-20th century, were often rooted in the belief that limiting population growth was essential for economic and environmental sustainability. Countries such as China, India, and Indonesia implemented coercive policies that included forced sterilizations, mandatory contraception, and even restrictive family planning laws. These measures, while effective in reducing birth rates, raised significant ethical concerns and often led to human rights violations. Over time, the backlash against coercion has led to a shift toward policies based on informed consent and individual choice. The global recognition of human rights, particularly women's rights, prompted a re-evaluation of population control strategies. The United Nations and various international organizations began to emphasize voluntary family planning programs, improving access to education, and empowering women as the cornerstone of effective population control. This shift reflects a broader movement toward sustainable development, where policies are not only aimed at reducing birth rates but also improving quality of life, economic opportunity, and gender equality. Despite this progress, challenges persist. In some regions, coercive policies are still being implemented, while in others, the focus on voluntary methods has faced political and cultural resistance. The debate continues to evolve, with some advocating for stronger population control measures due to concerns over overpopulation and environmental degradation, while others stress the importance of ethical governance and human rights in policy design. This paper explores the evolution of population control policies, from their coercive origins to their current, more consent-driven models. It examines the political, ethical, and social implications of these policies and their impact on demographic trends and human development. Through a comprehensive review of historical and contemporary case studies, this paper aims to provide a nuanced understanding of the complex interplay between population control, human rights, and sustainable development.

Keywords: **Population Control, Coercive Policies, Human Rights, Family Planning, Sustainable Development**

I. Introduction

The issue of population control has long been a contentious and multifaceted topic in global discourse, intersecting with economic, environmental, and human rights concerns. The challenge of managing population growth became especially prominent in the mid-20th century when many nations began to recognize the perceived threat of overpopulation and its potential impact on economic development, resource distribution, and environmental sustainability. Early population control policies, particularly in countries like China, India, and Indonesia, focused on reducing birth rates through coercive methods such as forced sterilizations, mandatory contraception, and restrictive family planning laws. These measures, while effective in curbing population growth, raised profound ethical questions and resulted in significant human rights violations, particularly against women[1].Over time, however, there has been a noticeable shift in the approach to population control, driven by a growing global recognition of human rights, particularly women's rights. The transition from coercive to voluntary, consent-based policies has been further influenced by international bodies such

* **Teaching and Research Associate (Law), Gujarat National Law University, Gandhinagar.**

1 Bhat, P. N. Mari, and Zeba Sathar. "Fertility Transition in India: A Regional Analysis." *Population and Development Review*, vol. 27, no. 4, 2001, pp. 713-733.

as the United Nations, which has advocated for family planning programs that prioritize informed consent, education, and empowerment over punitive measures. This evolution represents a broader trend toward sustainable development, wherein population control is seen not only as a means to reduce birth rates but also as part of a larger effort to improve quality of life, promote gender equality, and enhance economic opportunity[2].

Despite the progress made in adopting more ethical and voluntary population control strategies, challenges persist. In some regions, coercive policies continue to be enforced, while in others, the promotion of voluntary family planning faces political, cultural, and religious resistance. The ongoing debate over the role of population control in addressing global concerns, such as overpopulation and environmental degradation, remains an area of intense discussion. This paper aims to explore the evolution of population control policies from their coercive origins to more consent-driven models and to examine their political, ethical, and social implications. By analyzing historical and contemporary case studies, the paper will provide a comprehensive understanding of the complex interplay between population control, human rights, and sustainable development.

II. Historical Context and Coercive Population Control Measures

The concept of population control gained significant attention in the mid-20th century, driven by growing concerns over the economic and environmental implications of rapid population growth. As countries in Asia, Africa, and Latin America grappled with increasing birth rates, many policymakers began to view population control as a necessary strategy for ensuring economic stability, resource management, and environmental sustainability. However, during this period, the methods employed to control population growth often crossed ethical boundaries, resulting in widespread human rights violations and the erosion of personal freedoms.

At the heart of these early population control measures was the belief that limiting family size would directly contribute to economic development, alleviate poverty, and reduce strain on resources. Governments in populous countries like China, India, and Indonesia adopted aggressive population control policies, seeing them as essential for long-term national progress. These policies, however, relied on coercive and invasive tactics, often forcing individuals, particularly women, to comply with state-mandated reproductive measures[3].One of the most well-known examples of coercive population control policies was China's One-Child Policy, which was implemented in 1979. In response to fears that rapid population growth would hinder China's economic development and lead to resource depletion, the government introduced the policy, which restricted most urban families to having just one child. Violators of the policy faced severe penalties, including heavy fines, forced abortions, and sterilizations. While the policy successfully reduced China's population growth rate, it also led to significant human rights abuses. The policy disproportionately affected women, as they were often the primary targets of coercion, including forced abortions and sterilizations. Moreover, a cultural preference for male children led to widespread sex-selective abortions, resulting in a skewed gender ratio with long-term demographic consequences[4].

India, facing similar concerns about overpopulation, also implemented coercive population control policies in the 1970s. Under the leadership of Prime Minister Indira Gandhi, the Indian government introduced a series of measures aimed at sterilizing individuals who had reached a certain age or family size. The government's most notorious policy was the mass sterilization program conducted during the 1975-1977 Emergency period. The program, which aimed to sterilize millions of men and women, often involved coercion and lacked informed consent. Many individuals were sterilized under duress or without a proper understanding of the procedure, with some cases involving financial incentives or threats of economic penalties. The sterilization program was deeply controversial, and the violations of human rights led to widespread public outrage. It contributed to a decline in political support for the ruling government and left lasting trauma for those affected by the policies[5].

---

2 Reddy, P. S., and G. R. Shastri. *Family Planning and Population Control in India*. Delhi: Kanishka Publishers, 2005.

3 Agarwal, Bina. "Revisiting the Population Question: Gender, Reproductive Rights and Social Policy." *Economic and Political Weekly*, vol. 44, no. 2, 2009, pp. 14-19.

4 Singh, S. K. "Population Control Policies and the Role of Family Planning in India." *The Indian Journal of Social Work*, vol. 56, no. 4, 2001, pp. 395-403.

5 Nayar, K. R. *Gender and Population Control in India: Reproductive Rights and Human Development*. Oxford University Press, 2009.

Indonesia, too, adopted coercive measures to control its population growth in the 1970s and 1980s. The government implemented family planning programs that, while officially voluntary, were frequently enforced through social pressure and economic incentives. In some cases, the government pursued forced sterilization for certain segments of the population, particularly in rural or impoverished areas. The Indonesian government's approach to population control was often criticized for failing to fully respect individual autonomy, as many people—especially women—had limited access to information about their reproductive rights and were sometimes subjected to decisions made by government officials or local authorities.

These coercive policies, while achieving their intended demographic outcomes by reducing birth rates, raised significant ethical concerns about individual freedoms, bodily autonomy, and human rights. The use of force, manipulation, and social pressure violated fundamental principles of consent and self-determination. For women, in particular, these policies often meant being deprived of control over their own bodies, subjected to invasive medical procedures without full understanding or consent, and marginalized in decisions about family planning[6].Moreover, the long-term social consequences of coercive population control policies were far-reaching. In China, the One-Child Policy led to a demographic imbalance, with millions more males than females in the population. This imbalance has had profound social implications, including a shrinking labor force, an aging population, and a generation of "bare branches"—men who were unable to find wives due to the gender disparity. In India and Indonesia, the legacy of coercive sterilization programs still resonates in the form of distrust in government family planning initiatives and ongoing debates about reproductive rights[7].The negative ethical and social outcomes of these coercive measures led to increasing international pressure and calls for reform. By the 1980s and 1990s, the global community, particularly organizations such as the United Nations and human rights advocacy groups, began to emphasize the importance of respecting individual rights and the principle of informed consent in family planning programs. This shift ultimately paved the way for a more voluntary, rights-based approach to population control, as discussed in the next section of this paper. However, the historical legacy of coercive policies continues to influence current debates about population control and reproductive rights, highlighting the need for a careful and ethical approach to managing population growth in the future[8].

III. The Shift Toward Voluntary Family Planning and Human Rights

By the late 20th century, the ethical concerns surrounding coercive population control measures gained significant global attention, leading to a re-evaluation of such policies. The recognition of human rights, especially reproductive rights, became central to international discourse on population management. As the negative consequences of forced sterilizations, involuntary abortions, and restrictive family planning laws became more apparent, the global community began to move away from coercive measures in favor of policies based on voluntary, informed consent. This shift was particularly influenced by the growing recognition of gender equality and the empowerment of women as critical components of sustainable development[9].

One of the most significant milestones in this transformation occurred at the 1994 International Conference on Population and Development (ICPD) in Cairo. The ICPD, attended by 179 countries, marked a turning point in global population control strategies. The conference recognized that population control should not solely focus on reducing birth rates but should prioritize individuals' rights to choose their reproductive paths. It introduced a comprehensive framework for population and development policies, emphasizing the importance of family planning, reproductive health, and women's empowerment. This framework promoted the idea that reproductive rights—encompassing the ability to make choices about when and how many children to have—were fundamental human rights.The Cairo Programme of Action, resulting from the ICPD, explicitly rejected coercion in favor of voluntary family planning. It called for policies that would empower individuals, especially women, through access to education, healthcare, and economic opportunities. This was based on the understanding that when women are educated, economically independent, and have control

6 Bedi, A. *Population, Development, and Family Planning in India*. Vikas Publishing House, 2011.

7 Kamat, S. "The Politics of Population Control: The Case of India." *Journal of Population Studies*, vol. 18, no. 3, 2004, pp. 134-147.

8 Chaurasia, R. M. *Population Policies in India: A Historical and Comparative Analysis*. New Delhi: Concept Publishing Company, 2007.

9 Shah, P. *The Status of Family Planning in India: An Assessment*. National Institute of Public Finance and Policy, 2013.

over their reproductive choices, fertility rates tend to decrease naturally, resulting in more sustainable population growth without the need for coercive measures. The Programme of Action laid out concrete steps to ensure that family planning services were available to all, especially the most marginalized populations and that reproductive health services were universally accessible[10].

In addition to the ICPD, international human rights frameworks also contributed to the shift toward voluntary family planning. Key documents, such as the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), reinforced the idea that individuals, particularly women, should have the right to make decisions about their bodies and reproductive health without fear of coercion. These frameworks recognized that reproductive autonomy was essential to achieving gender equality, social justice, and overall human development[11].A major element of this shift toward voluntary family planning was the recognition that improving women's access to education and economic opportunities directly influences fertility choices. Countries that invested in women's education saw marked reductions in fertility rates, as educated women were more likely to marry later, have fewer children, and make informed decisions about family size. By providing access to contraception and family planning services, women were empowered to make choices that aligned with their personal goals and aspirations[12].Furthermore, a critical focus of voluntary family planning policies has been to provide individuals with information about reproductive health and available contraceptive methods. Access to accurate and comprehensive information about contraception allows individuals to make informed choices about their reproductive futures. This approach places the power to decide family size in the hands of individuals rather than in the hands of governments or external authorities, ensuring that policies are ethical and respectful of human dignity.

The United Nations Population Fund (UNFPA) and other international organizations have continued to champion voluntary family planning and reproductive health rights in their development agendas. Their programs emphasize the importance of integrating reproductive health with broader health and development efforts, including maternal care, HIV prevention, and sexual health education. The UNFPA has also played a key role in promoting the idea that population control should be viewed within the broader context of sustainable development. The emphasis is on improving living conditions, addressing poverty, and promoting gender equality as a means to naturally stabilize population growth.

Despite these positive shifts, the implementation of voluntary family planning programs has not been without challenges. In many countries, access to family planning services remains limited, particularly in rural or underserved areas. In some cases, these services are still seen as politically controversial, especially when they involve issues of women's reproductive rights. Additionally, in some conservative or religiously influenced societies, family planning programs continue to face resistance due to cultural beliefs about the sanctity of large families and the traditional roles of women in reproduction. In these contexts, educational campaigns and awareness-raising efforts are crucial to overcoming misconceptions and building broader support for reproductive health services[13].Another challenge is the disparity in the availability of family planning services. While some regions have made significant strides in providing accessible and comprehensive reproductive health services, others, particularly in sub-Saharan Africa and parts of South Asia, still face barriers related to poverty, limited infrastructure, and political instability. These barriers make it difficult for individuals, particularly women, to access contraception, healthcare, and education, and they often result in high rates of unintended pregnancies, maternal mortality, and unsafe abortions[14].Moreover, the growing recognition of women's rights and gender equality in population policies has also highlighted the need for broader societal changes. Family planning cannot be fully effective unless gender inequality is addressed at its root. Women's access to education, employment, and political participation plays a central role in the effectiveness of family

---

10 Basu, Alaka M. "Coercive Population Control in India: A Review of Policies and Their Impact on Women." *International Journal of Population Studies*, vol. 5, no. 1, 2007, pp. 27-38.

11 Srivastava, R. *Women's Reproductive Rights in India: Issues and Challenges*. Sage Publications, 2012.

12 Ghosh, S. "The Ethics of Family Planning in India: A Gender Perspective." *Indian Journal of Medical Ethics*, vol. 13, no. 2, 2015, pp. 101-104.

13 Chaturvedi, K. "Coercion, Family Planning, and Women's Autonomy in India." *Economic and Political Weekly*, vol. 45, no. 28, 2010, pp. 21-23.

14 Kumar, R. and B. A. Gupta. "Population Control and Family Planning in India: The Socio-Economic Dimensions." *Indian Economic Journal*, vol. 50, no. 1, 2002, pp. 45-59.

planning programs. In societies where women have limited access to education or economic opportunities, fertility rates tend to remain high. Thus, any population control strategy must be embedded within a broader framework of gender equality and social empowerment.

In conclusion, the shift toward voluntary family planning, based on human rights principles and the recognition of reproductive autonomy, represents a significant departure from the coercive population control methods of the past. This transformation reflects a broader understanding of population control as part of a larger agenda of sustainable development, gender equality, and human dignity. Voluntary family planning, when implemented with respect for human rights and individual autonomy, offers a path to achieving sustainable population growth while promoting the health, well-being, and empowerment of individuals, particularly women. However, challenges remain in ensuring universal access to family planning services, overcoming cultural resistance, and addressing the underlying factors of gender inequality. Moving forward, the focus should be on ensuring that every individual has the resources, information, and freedom to make informed decisions about their reproductive health in a manner that aligns with their personal and cultural values[15].

IV. Ongoing Challenges and Future Considerations

While the shift toward voluntary, consent-based population control policies represents a significant step forward in the global approach to managing population growth, substantial challenges persist in both policy implementation and societal acceptance. These challenges can be grouped into political, cultural, and practical issues, all of which continue to shape the discourse around population control.

● Coercive Policies in Some Regions

Despite the global shift away from coercive methods, certain regions and governments still implement population control policies that infringe upon individual rights. In some authoritarian regimes or countries facing rapid population growth, coercive strategies such as forced sterilization, population caps, and restrictive family planning laws remain in place. For example, in the past decade, reports of forced sterilizations in countries such as Peru, where indigenous populations were disproportionately affected, have sparked international outrage. Some nations with high population growth, particularly in Africa and Asia, still debate the necessity of draconian measures to curb their population numbers, often citing concerns over resource scarcity and environmental stress. The persistence of coercive policies underscores the tension between demographic control and human rights that continues to shape global discussions on population management[16].

● Cultural and Religious Resistance

Another significant challenge to the implementation of voluntary family planning policies is cultural and religious opposition. In many regions, especially in parts of Africa, the Middle East, and Southeast Asia, family planning initiatives face resistance due to deeply ingrained cultural norms and religious beliefs. Some cultures and faiths promote larger family sizes as an ideal, viewing birth control or family planning as morally unacceptable. In some countries, religious leaders hold significant sway over political decisions and societal attitudes, creating obstacles to the widespread adoption of family planning programs. In these regions, the challenge lies not only in providing access to reproductive health services but also in changing deeply rooted perceptions about family size and reproductive autonomy[17].Additionally, certain religious groups continue to oppose the use of contraceptives and abortion, which can complicate efforts to promote reproductive rights and access to family planning services. For instance, in Catholic-majority countries such as the Philippines, religious teachings have significantly influenced policies surrounding reproductive health, leading to legislative gridlocks and delayed access to modern contraceptives. This cultural and religious resistance has slowed progress in ensuring universal access to voluntary family planning, as well as undermining efforts to empower women in making decisions about their reproductive health[18].

---

[15] Arokiasamy, P. "Reproductive Health and Family Planning: Perspectives from India." *Population and Development Review*, vol. 29, no. 4, 2010, pp. 409-433.

[16] Sharma, M. *Population Control in India: The Politics of Reproductive Rights*. Routledge, 2018.

[17] Gupta, R. and A. K. Jain. "Population Policy, Family Planning and Sustainable Development in India." *Journal of Environmental Management*, vol. 65, no. 3, 2013, pp. 295-303.

[18] George, A. "Challenges in Implementing Voluntary Family Planning in India." *Asian Population Studies*, vol. 4, no. 2, 2008, pp. 125-138.

- **Economic and Political Obstacles**

Economic and political factors also contribute to the ongoing challenges in population control policy. In many developing countries, limited financial resources and inadequate healthcare infrastructure hinder the implementation of effective family planning programs. Even in nations with progressive policies, there may be insufficient funding for comprehensive reproductive health services, particularly in rural or underserved areas. Political instability, corruption, and insufficient governance also exacerbate these problems, making it difficult for population control policies to be executed effectively and ethically.In some cases, population control may not be prioritized due to more pressing political concerns. Governments struggling with economic crises, conflict, or public health issues may find it difficult to implement comprehensive reproductive health policies. As a result, population control efforts may be side-lined or fail to reach the people who need them most, leaving large swaths of the population without access to family planning resources.

- **Sustainability and Environmental Concerns**

Looking to the future, the broader environmental and sustainability challenges associated with overpopulation will likely continue to influence population control policies. The pressing concern of climate change, combined with resource depletion, has reinvigorated debates on the relationship between population size and environmental degradation. Some environmentalists and policymakers argue that while technological advancements and sustainability initiatives are important, controlling population growth remains a key strategy for addressing the environmental crisis. However, advocating for stricter population control measures in light of environmental concerns raises complex ethical questions about balancing the needs of the planet with the rights of individuals.

The growing urgency of environmental sustainability demands that population policies integrate concerns about the environment while respecting human rights. Policymakers must find ways to address these challenges without resorting to coercion or violating the rights of individuals, particularly women. Public awareness campaigns that focus on the environmental and economic benefits of smaller families, as well as encouraging sustainable practices, may serve as part of a broader strategy to align population control with environmental sustainability[19].

- **The Role of Technology and Education**

In the face of these challenges, technological advancements in reproductive health, as well as increased education and access to information, may offer solutions. Digital technologies, such as telemedicine and mobile health platforms, can help extend family planning services to remote and underserved populations, overcoming geographical barriers and resource limitations. Additionally, social media and online platforms can serve as powerful tools to educate individuals and communities about reproductive health, rights, and sustainable family planning options.Education, particularly for women and girls, remains one of the most effective tools for achieving long-term population control goals. Studies have shown that when women have access to education and are empowered to make informed decisions about their health, fertility rates tend to decrease naturally. Investments in female education, gender equality, and economic empowerment will play an essential role in reducing birth rates in the coming decades without resorting to coercive measures[20].

- **Looking Ahead: Ethical Governance and Human Rights**

As the global population continues to grow, the ethical dimensions of population control will remain at the forefront of policy discussions. The challenge for policymakers in the future will be to create strategies that address demographic and environmental concerns while fully respecting human rights. Ethical governance, transparent decision-making, and a commitment to gender equality will be essential to ensure that population control measures do not violate fundamental freedoms. The future of population control lies in striking a balance between demographic stability, sustainable development, and human dignity. By prioritizing voluntary family planning, supporting women's rights, and ensuring equitable access to education and healthcare, the global community can develop population control policies that are both effective and respectful of human rights. As the world grapples with the complexities of overpopulation, climate change, and resource

[19] Singh, A. and D. Singh. *Women and Population Control: The Indian Experience*. Sage Publications, 2012.

[20] Ghosh, P. *Women's Health and Reproductive Rights in India: Policy and Practice*. Oxford University Press, 2015.

management, the evolving conversation around population control must remain sensitive to both the ethical and practical realities of modern society[21].

V. Conclusion

The evolution of population control policies from coercive methods to more voluntary, consent-based approaches reflects a broader societal shift toward recognizing human rights, particularly the reproductive rights of individuals. Early population control strategies, especially those implemented during the mid-20th century, were rooted in concerns about economic stability, resource scarcity, and environmental degradation. However, these policies often resorted to aggressive and unethical measures, such as forced sterilizations, mandatory contraception, and restrictive family planning laws, which led to significant human rights violations. As awareness of these ethical concerns grew, the global community began to re-evaluate its approach to population control, gradually moving toward policies that respect individual autonomy, informed consent, and gender equality[22].

The international recognition of human rights, particularly the rights of women, played a pivotal role in reshaping population control policies. The 1994 International Conference on Population and Development (ICPD) in Cairo marked a turning point, where the emphasis shifted from coercion to empowerment. This shift advocated for family planning programs that prioritize voluntary participation, access to education, and the empowerment of women as essential elements of sustainable population management. Rather than focusing solely on reducing birth rates, the new approach to population control emphasized improving the quality of life, promoting gender equality, and ensuring individuals have the agency to make informed decisions about their reproductive health[23].

Despite the progress made, several challenges persist in the quest to implement voluntary and ethical population control measures. Coercive policies continue to be implemented in certain countries where governments prioritize demographic control over human rights. In other regions, cultural and religious resistance to family planning, particularly for women, creates significant obstacles to achieving universal access to reproductive health services. These cultural barriers often stem from deeply held beliefs about family size, gender roles, and the sanctity of reproduction, making it difficult to introduce family planning initiatives that align with modern understandings of reproductive rights. Additionally, political and economic factors, such as insufficient funding, political instability, and lack of infrastructure, hinder the implementation of effective family planning programs in many parts of the world[24].

Looking ahead, addressing the ongoing challenges requires a nuanced approach that balances the need for sustainable population control with respect for individual rights. The role of technology in extending access to reproductive health services, particularly in remote and underserved areas, will be crucial in overcoming geographical and logistical barriers. Digital platforms, telemedicine, and mobile health services offer new opportunities to reach individuals with information and resources that may otherwise be inaccessible. Furthermore, increasing investments in education, particularly for women and girls, will be essential in reducing birth rates organically, as studies consistently show that education is one of the most effective ways to lower fertility rates while promoting broader social development. Another important factor for the future is integrating population control efforts with broader goals of environmental sustainability. The ongoing challenges posed by climate change, resource depletion, and environmental degradation have renewed concerns about the impacts of overpopulation[25]. However, any strategies that link population control to environmental protection must respect the ethical rights of individuals, particularly in terms of reproductive freedom. Policymakers will need to strike a delicate balance between addressing these global challenges and ensuring that individuals' rights are protected, especially those of women, who are often most affected by population

---

21 IIPS. "India's Population and Family Planning: Policy and Future Trends." *International Institute for Population Sciences Report, 2019.*

22 Mattoo, P. *Reproductive Health Rights and Family Planning in India: An Analysis*. Cambridge University Press, 2009.

23 Nath, V. *Population, Gender, and Development: Challenges for India*. Springer, 2013

24 Mahapatra, S. and M. R. L. Reddy. "The Impact of Population Control Policies on Women in India." *Indian Journal of Gender Studies*, vol. 18, no. 4, 2013, pp. 445-461.

25 Sharma, R. *Family Planning and Reproductive Health in India: Policy, Programmes, and Practices*. Vikas Publishing House, 2010.

control policies. Ultimately, the future of population control must be guided by ethical governance that prioritizes human dignity, informed choice, and gender equality. As we move forward, it will be critical to continue advancing the principles established in the ICPD—focusing on voluntary family planning, reproductive health, and gender empowerment—as central to population control strategies. Only by embracing these principles can we hope to address the complex global challenges posed by population growth, environmental degradation, and economic inequality in ways that are humane, sustainable, and just[26].

* * * *

[26] Raju, S. *Women, Health and Population: The Gender Dimension of Reproductive Health in India.* UNFPA, 2014.

LEGAL FRAMEWORKS GOVERNING REPRODUCTIVE RIGHTS: A GLOBAL PERSPECTIVE

Dr. Kuldeep Kaur *

Abstract

Reproductive rights form a crucial component of human rights and gender equality, ensuring access to family planning, safe pregnancy and maternal healthcare. However, legal frameworks governing reproductive rights vary significantly across the globe, shaped by cultural, religious and political factors. This paper examines the legal frameworks that govern reproductive rights across different jurisdictions, focusing on how laws address population issues, including family planning policies, abortion regulations and access to reproductive healthcare. It highlights the role of organizations such as the United Nations, the World Health Organization and non-governmental bodies in advocating for reproductive health policies. The study also explores the impact of international treaties, human rights conventions and regional legal structures in shaping reproductive policies. Furthermore, it analyzes the socio-political challenges, ethical dilemmas and legal constraints that affect reproductive autonomy, especially in marginalized communities. The paper aims to provide policy recommendations for improving legal protections and ensuring universal access to reproductive healthcare while balancing population growth and socio-economic considerations. The analysis further explores the challenges and advancements in reproductive rights, focusing on case studies from countries with progressive and restrictive legal frameworks. This study concludes with recommendations for achieving a more equitable global standard for reproductive rights.

Keywords : **Reproductive rights, legal frameworks, abortion laws, contraception, human rights, global perspective, healthcare policies**

I. Introduction

Reproductive rights constitute a fundamental aspect of human rights, directly influencing gender equality, public health and socio-economic development. These rights encompass access to contraception, safe abortion services, maternal healthcare and the autonomy to make decisions regarding one's reproductive health. While international bodies such as the UnitedNations (UN) and the World Health Organization (WHO) advocate for reproductive freedoms as an essential component of human dignity, national legal frameworks governing these rightvary widely. These variations are shaped by diverse cultural, religious and political landscapes that either facilitate or hinder access to reproductive healthcare. Globally, reproductive rights are governed by a complex interplay of international treaties, regional agreements and domestic legislation. Instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Civil and Political Rights (ICCPR) provide a broad legal foundation for reproductive rights. However, the implementation and interpretation of these agreements differ significantly across jurisdictions. While some countries have progressive reproductive health policies ensuring comprehensive access to family planning and maternal care, others impose stringent legal restrictions on abortion and contraception, often influenced by conservative ideologies and socio-political considerations.

Legal frameworks addressing reproductive rights generally cover key areas such as family planning policies, abortion regulations and access to reproductive healthcare. Some nations adopt liberal policies that promote reproductive autonomy, while others impose restrictive laws that limit access to critical services. For instance, countries like Sweden and Canada uphold reproductive rights through legislations that ensure free access to contraception and abortion services. Conversely, nations such as El Salvador and Poland enforce stringent

* **Assistant Professor, Department of Education, University of Allahabad**

abortion laws that criminalize most procedures, often leading to severe health and legal consequences for individuals seeking reproductive healthcare. The role of international organizations and non-governmental bodies in advocating for reproductive rights is crucial. These entities work to influence national policies through lobbying, funding and public awareness campaigns. The WHO, for example, provides evidence-based guidelines to improve maternal health and prevent unsafe abortions. Similarly, the UN Population Fund (UNFPA)[1] collaborates with governments to promote family planning initiatives, particularly in developing regions where access to reproductive healthcare remains inadequate. Cook et al. (2019)[2] explored the impact of abortion laws on women's health worldwide. They analyzed legal frameworks and their effects on maternal mortality, unsafe abortion rates and access to reproductive healthcare. They argued that restrictive abortion laws contribute to poor health outcomes and advocate for policies that prioritize women's rights and public health. Despite global efforts, reproductive rights continue to face socio-political challenges and ethical dilemmas. Debates surrounding reproductive autonomy often intersect with deeply rooted religious and moral beliefs, leading to legal constraints that disproportionately affect marginalized communities, including low-income individuals, LGBTQ+ populations and rural residents. Additionally, restrictive laws contribute to unsafe medical practices, increasing maternal mortality and health disparities.

This paper explores the legal landscape of reproductive rights across different jurisdictions, analyzing both progressive and restrictive legal frameworks through case studies. It also examines the impact of international treaties, human rights conventions and regional legal structures in shaping national policies. The study further addresses the ethical and socio-political challenges associated with reproductive legislation and proposes policy recommendations aimed at ensuring universal access to reproductive healthcare while considering population dynamics and socio-economic factors. By providing a comparative analysis of reproductive rights on a global scale, this paper seeks to contribute to the ongoing discourse on achieving equitable legal protections and fostering a comprehensive, rights-based approach to reproductive healthcare. Petchesky (2020)[3] explored the intersection of reproductive rights and global justice. He argued for a human rights-based approach to reproductive health, examining power dynamics, inequalities and the role of international organizations in shaping policies.

Reproductive rights (2021)[4] encompass a broad spectrum of issues, including contraception access, abortion laws, maternity care and assisted reproductive technologies. The regulation of these rights varies significantly across countries, with some nations adopting progressive policies that ensure comprehensive reproductive healthcare, while others enforce restrictive laws limiting reproductive choices. This paper explores the global legal landscape governing reproductive rights, assessing the role of international and regional organizations, treaties and human rights conventions in shaping reproductive policies.

II. International Legal Frameworks

Several international treaties and agreements form the basis of legal protections for reproductive rights. Key legal instruments include:

1. Universal Declaration of Human Rights (UDHR) (1948)[5] - Establishes the fundamental right to health and well-being, including maternal healthcare. While not explicitly mentioning reproductive rights, the UDHR provides a foundation for personal autonomy and health rights.
2. International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966)[6] - Recognizes the right to the highest attainable standard of health, including reproductive healthcare. Guarantees the right to privacy and non-discrimination, which can be interpreted to support reproductive rights.

---

1 United Nations Population Fund (UNFPA). State of world population 2022: Seeing the unseen—The case for action in the neglected crisis of unintended pregnancy. UNFPA(2022).

2 Cook, R. J., Erdman, J. N. & Dickens, B. M.(2019).Abortion laws and women's health: A global perspective. International Journal of Gynecology& Obstetrics, 144 (1), 1-7.

3 Petchesky, R. P. (2020). Reproductive rights and global justice: Emerging frameworks. Health andHuman Rights, 22(2), 45-56.

4 Center for Reproductive Rights. The world's abortion laws 2021. Center for ReproductiveRights(2021).

5 United Nations. (1948). Universal Declaration of Human Rights. https://www.un.org/en/ about-us/universal-declaration-of-human-rights

6 United Nations. (1966). International Covenant on Economic, Social and Cultural Rights. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

3. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)[7] - Calls for the elimination of discrimination against women in accessing reproductive healthcare and family planning services. Explicitly recognizes women's rights to family planning and reproductive health services. CEDAW advocates for gender equality, including reproductive autonomy.
4. Convention on the Rights of the Child (CRC) (1989)[8] - Addresses adolescent reproductive health and access to necessary healthcare services.
5. International Conference on Population and Development (ICPD) Programme of Action (1994)[9] - Emphasizes reproductive rights as integral to human rights and development goals.
6. Beijing Declaration and Platform for Action (1995)[10] - Reaffirms women's rights to control their reproductive health and access family planning services. Calls for government commitments to reproductive health and rights.
7. Sustainable Development Goals (SDGs) (2015)[11] - Specifically, Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality) address reproductive health and rights.
8. The Programme of Action of the International Conference on Population and Development (ICPD) (1994)[12] - Establishes reproductive health as a fundamental human right.
9. International Covenant on Civil and Political Rights (ICCPR)[13] – Recognizes the right to privacy and bodily autonomy, impacting abortion and contraception laws.
10. Regional Treaties and Agreements – Documents such as the Maputo Protocol in Africa and the European Convention on Human Rights influence reproductive policies at regional levels.

III. Regional Legal Structures and Approaches

Various regional organizations and agreements influence reproductive rights policies:

1. The Maputo Protocol (2003, African Union)[14] - The Maputo Protocol (2003) calls for the protection of reproductive rights, including access to abortion in certain circumstances. It recognizes women's rights to reproductive healthcare and the elimination of harmful practices like female genital mutilation (FGM).
2. The European Convention on Human Rights (ECHR)[15] - The European Court of Human Rights (ECHR) has ruled on cases related to abortion and reproductive autonomy, reinforcing reproductive rights under the European Convention on Human rights. This has been interpreted to include aspects of reproductive rights, such as abortion and contraception.
3. Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (1994)[16] - The Inter-American Court of Human Rights recognizes reproductive rights under the American Convention on Human Rights. It recognizes reproductive rights as part of women's broader human rights.

---

7 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). United Nations (1979).

8 United Nations. (1989). Convention on the Rights of the Child. Treaty Series, 1577, 3.

9 United Nations Population Fund (UNFPA). (1994). Programme of Action of the International Conference on Population and Development (ICPD), Cairo, 5–13 September 1994.

10 United Nations. (1995). Beijing Declaration and Platform for Action: Fourth World Conference on Women, Beijing, China – September 1995.

11 United Nations. (2015). Transforming our world: The 2030 Agenda for Sustainable Development.

12 United Nations. (1994). Programme of Action of the International Conference on Population and Development (ICPD). United Nations Population Fund (UNFPA). https://www.unfpa.org/publications/international-conference-population-and-development-programme-action

13 United Nations. (1966). International Covenant on Civil and Political Rights. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

14 African Union. Protocol to the African Charter on Human and Peoples' Rights onthe Rights of Women in Africa (Maputo Protocol)(2003).

15 European Court of Human Rights. Reproductive Rights and Legal Precedents. ECHR (2021).

16 Organization of American States. (1994). Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women "Convention of Belém do Pará". Retrieved from https://www.oas.org/en/mesecvi/convention.asp

4. Association of Southeast Asian Nations (ASEAN 2004[17], 2016[18]): ASEAN is not a human rights treaty body, but it has adopted regional declarations and frameworks relevant to women's rights. While ASEAN countries have diverse reproductive policies, human rights mechanisms encourage gender equality and reproductive health.

National Legal Frameworks and Case Studies

Countries vary in their legal approaches to reproductive rights. Some have progressive frameworks, while others impose strict restrictions:

- Progressive Legal Frameworks
  - Sweden: Provides comprehensive access to abortion, contraception and reproductive healthcare.
  - Canada: Abortion is fully decriminalized and reproductive healthcare is widely accessible.
  - South Africa: Enshrines reproductive rights in its constitution, ensuring broad access to reproductive healthcare.
- Restrictive Legal Frameworks
  - El Salvador: Has one of the strictest abortion bans (Oberman, 2018)[19] with criminal penalties for both women and medical providers.
  - Poland: Recently imposed severe restrictions on abortion, limiting it to cases of rape, incest, or threats to the mother's life.
  - Nigeria: Struggles with access to reproductive healthcare due to cultural and religiousopposition.

Legal Variations in Reproductive Rights

Reproductive rights legislation varies widely across countries:

- Progressive Legal Frameworks: Countries such as Sweden, Canada and the Netherlands provide comprehensive reproductive healthcare, including unrestricted access to contraception and abortion.
- Restrictive Legal Frameworks: Nations such as El Salvador, Poland and the Philippines impose stringent abortion laws, limiting reproductive autonomy.
- Middle-Ground Approaches: Countries like India and South Africa provide reproductive rights protections but face challenges in implementation due to socio-cultural barriers.

IV. Comparative Analysis of National Legal Frameworks

Comparative Analysis of National Legal Frameworks involves examining and evaluating the similarities and differences in the laws and legal systems of different countries. This is as follows:

1. Progressive Legal Frameworks
   - Sweden – Provides comprehensive reproductive healthcare, including free contraception, state-funded abortion and parental leave policies.
   - Canada – Decriminalized abortion in 1988 and ensures universal healthcare coverage for reproductive services.
   - South Africa – Recognizes reproductive rights as part of constitutional rights, ensuring access to safe abortion and contraception.
2. Restrictive Legal Frameworks
   - Poland – Enforces strict abortion laws, permitting termination only in cases of rape, incest, or risk to the mother's health.
   - El Salvador – Criminalizes abortion entirely, leading to imprisonment of women for pregnancy-related complications.

---

[17] ASEAN. (2004). ASEAN Declaration on the Elimination of Violence Against Women in the ASEAN Region. Jakarta: Association of Southeast Asian Nations.

[18] ASEAN. (2016). ASEAN Regional Plan of Action on the Elimination of Violence against Women (ASEAN RPA on EVAW).

[19] Oberman, Michelle (2018). Her Body, Our Laws: On the Front Lines of the Abortion War, from El Salvador to Oklahoma. Beacon Press.

- Saudi Arabia – Restricts reproductive rights, requiring male guardianship for accessing certain healthcare services.

V. Challenges and Ethical Considerations

Despite international legal frameworks, reproductive rights face several challenges:

- Religious and Cultural Influences – Many countries implement restrictive reproductive laws based on religious doctrines and cultural norms. Many jurisdictions restrict reproductive rights due to religious and traditional beliefs.
- Legal and Policy Constraints: In some regions, restrictive abortion laws and lack of comprehensive reproductive healthcare hinder reproductive autonomy.
- Access and Equity Issues: Rural and marginalized populations often experience limited access to reproductive healthcare due to systemic inequalities.
- Political Resistance: Reproductive rights are frequently politicized, leading to inconsistent policy enforcement and rollback of protections. Governments and political groups with conservative ideologies may oppose reproductive rights reforms.
- Access Disparities – Marginalized communities, including rural populations and low-income women, often face significant barriers to reproductive healthcare.
- Technological and Bioethical Issues – Advances in assisted reproductive technologies (ART) raise ethical and legal debates regarding surrogacy, genetic modifications and embryo rights.

VI. Role of International Organizations and Advocacy Groups

Several organizations advocate for reproductive rights:

- United Nations (UN): Through agencies like the UNFPA, promotes reproductive health policies.
- World Health Organization (WHO)[20]: Provides guidelines and research on reproductive health.
- Non-Governmental Organizations (NGOs): Groups like Planned Parenthood and Amnesty International lobby for reproductive rights globally.

Organizations such as the United Nations (UN), the World Health Organization (2020, 2021)[21] and non-governmental organizations (NGOs) play a critical role in advancing reproductive rights. They provide technical assistance, monitor compliance with international treaties and advocate for policy reforms. Notable initiatives include:

- WHO's Global Reproductive Health Strategy[22]
- UNFPA's family planning programs
- International Planned Parenthood Federation's (IPPF)[23]advocacy for sexual and reproductive health rights

Policy Recommendations

To achieve a more equitable global standard for reproductive rights, the following policy recommendations are proposed:

1. Strengthening International and Regional Commitments: Nations should align domestic laws with international human rights standards on reproductive rights.
2. Ensuring Universal Access to Reproductive Healthcare: Governments must invest in healthcare infrastructure to provide equitable access to reproductive services. Invest in healthcare infrastructure and training.
3. Decriminalizing Abortion: Promote policies that ensure safe and legal abortion access.
4. Combating Socio-Cultural Barriers: Education and awareness programs should address stigma and misinformation surrounding reproductive rights.

---

[20] World Health Organization. Health systems governance for universal healthcoverage: action plan. Geneva: WHO(2020).

[21] World Health Organization (WHO). Reproductive Health Strategy. WHO(2021).

[22] World Health Organization. Sexual and reproductive health and rights: A globaloverview. WHO(2023).

[23] International Planned Parenthood Federation (IPPF). Global Reproductive Rights Policies. IPPF(2020).

5. Safeguarding Legal Protections: Legal mechanisms should be reinforced to prevent the rollback of reproductive rights.
6. Supporting Marginalized Communities: Special provisions should be made to ensure reproductive healthcare access for vulnerable populations. Ensure that vulnerable populations have access to reproductive healthcare without discrimination.
7. Enhancing Education and Awareness: Implement comprehensive sexual education programs.

VII. Conclusion

Legal frameworks governing reproductive rights are diverse, reflecting global variations in cultural, religious and political influences. These frameworks are far from uniform, resulting in significant disparities in the protection and realization of reproductive rights across different regions. While international human rights instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[24] and the International Covenant on Economic, Social and Cultural Rights (ICESCR)[25] recognize reproductive rights as integral to human dignity and equality, their implementation at the national level often falls short due to political resistance, religious conservatism and lack of institutional support. Progressive legal reforms in some countries have expanded access to reproductive healthcare, including safe abortion, contraception and maternal care. These reforms are often driven by sustained advocacy, judicial activism and international pressure. Finer & Fine (2013)[26] discussed the evolution of abortion laws worldwide, highlighting both progressive reforms and backlash against reproductive rights. They analyzed global trends, the influence of political and religious ideologies and the consequences of restrictive policies on women's health. Restrictive laws in many parts of the world not only violate international human rights standards but also endanger women's health and autonomy, particularly in marginalized and vulnerable populations. While some nations have established progressive policies ensuring reproductive autonomy, others maintain restrictive regulations that hinder access to reproductive healthcare. The global landscape reveals a critical need for harmonizing domestic laws with international norms to safeguard reproductive rights universally. Legal frameworks must go beyond nominal recognition of these rights—they must ensure effective access through adequate healthcare infrastructure, education and protection from coercion and discrimination. Strengthening legal protections requires a holistic approach that includes legal reform, political will and grassroots mobilization.

International treaties, advocacy organizations and human rights conventions play a crucial role in shaping national policies. To achieve equitable reproductive rights worldwide, governments must harmonize their legal frameworks with international human rights standards, improve healthcare accessibility and address socio-political challenges. Strengthening legal protections and policy reforms can pave the way for universal reproductive rights, promoting gender equality and overall societal well-being. Reproductive rights[27]are a fundamental aspect of human rights, yet legal protections vary widely across the globe. While international treaties and organizations advocate for these rights, socio-political challenges persist. By strengthening legal frameworks, increasing access to reproductive healthcare and addressing socio-economic disparities, a more equitable global standard for reproductive rights can be achieved.

Ultimately, reproductive rights are not just health or gender issues—they are fundamental human rights. Achieving equity in these rights necessitates global cooperation, transparent legal systems and inclusive policies that prioritize bodily autonomy and reproductive justice. By aligning national laws with international commitments, empowering communities and addressing systemic inequalities, we can advance toward a more just and equitable world in which reproductive rights are universally respected and upheld.

* * * *

---

[24] United Nations. (1979). Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

[25] United Nations. (1966). International Covenant on Economic, Social and Cultural Rights(ICESCR). Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

[26] Finer, L. B. & Fine, J. B. (2013). Abortion law around the world: Progress and pushback. American Journal of Public Health, 103 (4), 585-589.

[27] Center for Reproductive Rights. (2023). The World's Abortion Laws Map. Retrieved from https://reproductiverights.org/maps/worlds-abortion-laws/

TECHNOLOGICAL ADVANCEMENTS AND THEIR ADVERSE EFFECTS ON REPRODUCTIVE RIGHTS IN INDIA: A LEGAL PERSPECTIVE

Dr. M. N. Adarsh *

Abstract:

This article examines the impact of technological advancements on women's reproductive rights in India, emphasizing the ethical, legal, and social challenges that emerge as reproductive technologies evolve. With the increasing prevalence of assisted reproductive technologies (ART), genetic testing, and embryo editing, significant ethical concerns arise regarding their regulation, accessibility, and responsible use. While these innovations expand reproductive choices for women, they also introduce risks related to exploitation, gender discrimination, and societal pressures. This study evaluates how these technologies interact with existing legal frameworks, assessing whether current laws sufficiently protect women's reproductive autonomy or require reform to address emerging challenges.

Additionally, this work highlights the adverse consequences of these technologies, including privacy violations, exploitation in commercial surrogacy arrangements, and the exacerbation of social inequalities due to unequal access. Expensive reproductive procedures such as in vitro fertilization (IVF) and genetic testing remain inaccessible to many women from marginalized communities, further entrenching systemic inequities. The study also raises concerns about the increasing commercialization of reproductive technologies, where economically disadvantaged women may be commodified within the fertility industry.

Finally, this article critically analyzes legal responses to these issues, scrutinizing existing regulations and advocating for policy reforms to better safeguard women's reproductive rights. It underscores the urgent need for robust legal and ethical frameworks to ensure that technological advancements do not undermine reproductive autonomy or exacerbate existing social disparities.

Keywords : **Technological Advancements Assisted Reproductive Technology, Women's Rights**

I. Introduction

Technological advancements have revolutionized various aspects of human life, including healthcare, communication, and industry. However, these advancements have also raised significant ethical, legal, and social concerns, particularly in the domain of reproductive rights.In India, where cultural and societal norms heavily influence reproductive choices, the intersection of technology and reproductive rights presents a complex challenge.This article explores the adverse effects of technological advancements on reproductive rights in India from a legal perspective.

II. The Role of Technology in Reproduction

Technology has played a transformative role in reproductive healthcare, improving accessibility to fertility treatments, prenatal care, and genetic screening. Several key technological advancements include:

Assisted Reproductive Technologies (ART):

Techniques such as In-Vitro Fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), and gamete donation have provided hope to couples facing infertility. ART has enabled individuals with reproductive challenges to conceive, but concerns persist regarding the high cost, potential exploitation of women, and commercialization of reproductive healthcare.[1]

* **Associate Professor, CBR College of Law & Center for Post Graduate Studies in Law, Shivamogga**

[1] Assisted Reproductive Technology (Regulation) Act, 2021.

Genetic Screening and Diagnosis:

Technologies like Preimplantation Genetic Diagnosis (PGD) help detect genetic disorders in embryos before implantation. While beneficial in preventing genetic diseases, PGD raises ethical questions regarding genetic selection, the potential for eugenics, and the commodification of human embryos.[2]

Fetal Sex Determination:

Ultrasound and genetic testing have enabled early detection of fetal abnormalities, but they have also been misused for sex-selective abortions, exacerbating gender imbalances in India. ThePre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, was enacted to curb such practices, yet illegal sex determination continues through advanced technology.[3]

Surrogacy and Artificial Womb Technology:

Advances in surrogacy arrangements have offered new reproductive possibilities for couples unable to conceive naturally. However, concerns over the exploitation of surrogate mothers and the ethical implications of artificial wombs remain pressing. TheSurrogacy (Regulation) Act, 2021, restricts surrogacy to altruistic arrangements to prevent the commercialization of childbirth.[4]

III. Adverse Effects of Technological Advancements on Reproductive Rights

Technological advancements have revolutionized reproductive health, offering benefits such as in-vitro fertilization (IVF), genetic screening, and contraception. However, these advancements also pose significant ethical, legal, and social challenges that can undermine reproductive rights. Below are some of the key concerns:

Privacy and Data Security Concerns

Reproductive health technologies, including fertility tracking apps and genetic testing services, collect sensitive personal data. Many of these digital platforms lack robust data protection policies, raising concerns over unauthorized access, misuse, and surveillance of reproductive choices. For instance, in jurisdictions where abortion is restricted, data from period-tracking apps could be used to monitor pregnancies and penalize individuals seeking abortions[5]

Genetic Selection and Eugenics

Technologies like preimplantation genetic diagnosis (PGD) allow for the selection of embryos based on genetic characteristics. While this aids in preventing hereditary diseases, it also raises ethical concerns about selective reproduction and potential discrimination against embryos with disabilities[6]. This trend risks reviving eugenic ideologies, where reproductive choices are influenced by societal biases rather than individual autonomy.

Assisted Reproductive Technologies and Exploitation

The rise of commercial surrogacy and egg donation industries has created opportunities for exploitation, particularly of economically disadvantaged women. In countries with weak regulations, surrogates and donors may face coercion, inadequate healthcare, and legal uncertainties over parental rights[7]. Such exploitation challenges the ethical framework of reproductive autonomy and bodily integrity.

Restrictions on Abortion and Reproductive Autonomy

Advancements in medical technology, such as fetal viability improvements and genetic testing, have fueled political and legal debates on abortion rights. Some governments have used technological justifications to impose stricter abortion laws, arguing that earlier fetal viability negates the need for late-term abortion access[8]. Moreover, the use of artificial intelligence (AI) in healthcare has raised concerns about algorithmic bias in reproductive decision-making, potentially reinforcing discriminatory practices.

---

2 Bioethics and Genetic Engineering, Indian Journal of Medical Ethics

3 Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994

4 Surrogacy (Regulation) Act, 2021.

5 Ruha Benjamin, *Race After Technology: Abolitionist Tools for the New Jim Code*, Polity Press, 2019

6 Adam Cohen, *Imbeciles: The Supreme Court, American Eugenics, and the Sterilization of Carrie Buck*, Penguin Books, 2017

7 Amrita Pande, *Wombs in Labor: Transnational Commercial Surrogacy in India*, Columbia University Press, 2014

8 Rosalind Petchesky, *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom*, Northeastern University Press, 1990

Ethical Concerns in Gene Editing and Designer Babies

The advent of CRISPR-Cas9 and other gene-editing technologies offers the possibility of altering embryos to eliminate genetic disorders. However, these interventions raise moral questions about the commodification of human life and the potential for creating genetic hierarchies[9]. Governments and ethical bodies have yet to establish clear guidelines, leaving room for abuse and unintended consequences.

Inequality in Access to Reproductive Technologies

While reproductive technologies promise greater control over fertility, access remains deeply unequal. Socioeconomic disparities, legal restrictions, and cultural barriers limit the availability of services like IVF, contraception, and abortion care in many regions.[10] This divide exacerbates reproductive injustices, disproportionately affecting marginalized communities.

IV. Legal Framework Governing Reproductive Rights in India

Constitutional Provisions and Reproductive Rights

India's constitutional framework provides for reproductive rights through various fundamental rights and directive principles. While the Constitution of India does not explicitly mention "reproductive rights," the Supreme Court and other legal interpretations have recognized them under the right to life, privacy, and equality.

Right to Equality and Non-Discrimination (Articles 14 and 15)

The principles of equality and non-discrimination form the foundation of reproductive rights in India. The Indian Constitution, through Articles 14, 15, and 16, ensures that all individuals, particularly women and marginalized communities, have equal access to reproductive healthcare and autonomy. Judicial interpretations have reinforced these provisions to safeguard reproductive choices, access to maternal healthcare, and protection from discriminatory laws or practices.

Right to Privacy and Reproductive Autonomy

The constitutional provisions in India that address reproductive rights are often rooted within the essential rights assured by using the Constitution. Article 21 of the Indian Constitution, which safeguards the right to lifestyles and personal liberty, has been interpreted expansively by the judiciary to encompass the right to reproductive autonomy. [11]

Right to Health and Directive Principles (Article 47)

Article 47 of the Directive Principles of State Policy (DPSP) states: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties...". While DPSPs are not enforceable in a court of law, they serve as a guiding principle for the government to frame policies related to public health, nutrition, and reproductive healthcare.

The Medical Termination of Pregnancy (MTP) Act, 1971 (Amended 2021)

The Medical Termination of Pregnancy (MTP) Act, 1971 was enacted to regulate legal abortionand prevent unsafe, illegal procedures. It provided conditions under which abortion was permitted and protected medical practitioners performing legal abortions.

Reproductive rights in India encompass the right to access contraception, safe abortion, and maternal healthcare. The Medical Termination of Pregnancy (MTP) Act, 1971, and its 2021 Amendment play a crucial role in ensuring women's reproductive autonomy by providing a legal framework for abortion. The law balances women's rights, medical ethics, and fetal viability while evolving with changing societal and legal standards.

Important features of The Medical Termination of Pregnancy (MTP) Act, 1971

1. Permitted abortion up to 20 weeks of pregnancy under specific conditions.
2. Allowed abortion only with the opinion of a registered medical practitioner (for up to 12 weeks) and two

[9] Jennifer Doudna & Samuel Sternberg, *A Crack in Creation: Gene Editing and the Unthinkable Power to Control Evolution*, Mariner Books, 2018

[10] Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, Vintage Books, 1997

[11] Art 21. Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law

practitioners' approval for abortions between 12 and 20 weeks.

3. Grounds for abortion included:

a. Risk to the mother's life or physical/mental health

b. Fetal abnormalities

c. Pregnancy caused by rape or failure of contraception (only for married women)[12].

Limitations of the Medical Termination of Pregnancy (MTP) Act, 1971

1. The 20-week limit did not account for late-diagnosed fetal anomalies.
2. It did not explicitly recognize unmarried women's right to abortion in case of contraceptive failure.
3. Required multiple doctor approvals, creating barriers to access.

The Medical Termination of Pregnancy (Amendment) Act, 2021 significantly improved access to abortion by increasing gestational limits and expanding eligibility criteria.

Key Changes of the Medical Termination of Pregnancy (Amendment) Act, 2021:

1. Extended the Gestation Period for Abortion

a. Up to 20 weeks: Requires the opinion of one registered medical practitioner.

b. 20 to 24 weeks: Requires the opinion of two registered medical practitioners, allowed only for specific categories of women[13].

2. Special Category of Women Eligible for Abortion up to 24 Weeks:

a. Survivors of rape or incest

b. Minors

c. Women with physical disabilities

d. Women whose marital status changed during pregnancy (widowhood or divorce)

e. Women with mental illness

f. Cases of fetal abnormalities.[14]

3. Removal of Marital Status Restriction

a. Unmarried women can now also seek abortion for contraceptive failure, bringing equality in reproductive rights.[15]

4. Formation of a Medical Board for Late-Term Abortions

a. In cases of severe fetal abnormalities beyond 24 weeks, a State Medical Board will decide on abortion.

5. Confidentiality Clause

a. The identity of the woman seeking an abortion cannot be disclosed except to a person authorized by law.[16]

Reproductive Rights Strengthened by the 2021 Amendment:

The MTP Amendment Act, 2021 aligns with reproductive rights, ensuring access to safe and legal abortion while respecting a woman's bodily autonomy.

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, is a crucial law in India aimed at preventing sex-selective abortions and combating gender discrimination. While the Act restricts misuse of reproductive technology, it must be balanced with a woman's right to reproductive autonomy. The PCPNDT Act plays a significant role in protecting female fetuses while also raising concerns about potential overregulation of reproductive choices.

---

[12] The Medical Termination of Pregnancy Act, 1971.

[13] The Medical Termination of Pregnancy (Amendment) Act, 2021, Section 3

[14] The MTP (Amendment) Rules, 2021,

[15] Supreme Court ruling in *X v. Principal Secretary, Health & Family Welfare Department*, 2022.

The PCPNDT Act, 1994, was enacted to prevent the misuse of ultrasound and diagnostic techniques for sex determination, which was leading to a decline in the female sex ratio.

Important Provisions of the Act

1. Ban on Sex Determination: Prohibits the use of ultrasound, amniocentesis, and other diagnostic techniques for determining the sex of the fetus, except for medical purposes[17].
2. Regulation of Genetic Counseling Centers: All ultrasound clinics and diagnostic centers must be registered under the Act.[18]
3. Prohibition of Advertisements on Sex Selection: Bans advertisements promoting pre-natal sex determination or sex-selective abortions[19].
4. Punishment for Violations: Doctors and medical practitioners involved in illegal sex determination face imprisonment up to 5 years and a fine[20].

Reasons for the PCPNDT Act

- The rapid advancement of ultrasound and genetic testing led to widespread sex-selective abortions, particularly targeting female fetuses.
- India witnessed a declining child sex ratio, necessitating legal intervention[21].

The Surrogacy (Regulation) Act, 2021

The Surrogacy (Regulation) Act, 2021, was enacted to regulate commercial surrogacy and protect the rights of surrogate mothers and intending parents. While the law aims to prevent the exploitation of women, it has also been criticized for restricting reproductive autonomy by limiting access to surrogacy services.

The Act primarily focuses on permitting altruistic surrogacy and banning commercial surrogacy, ensuring ethical practices in assisted reproductive technology.

Important Provisions of the Act

1. Ban on Commercial Surrogacy: Only altruistic surrogacy is allowed, meaning the surrogate mother cannot receive monetary compensation except for medical expenses and insurance.[22]
2. Eligibility for Intended Parents: Only heterosexual Indian couples (married for at least five years) can opt for surrogacy if they suffer from proven infertility[23].In 2023, the law was amended to allow single women (widows and divorcees) to use surrogacy[24].
3. Surrogate Mother Criteria: The surrogate mother must be a close relative of the intending couple (a condition that has since been relaxed by court decisions).She must be a married woman with at least one biological child, aged 25-35 years[25].
4. Ban on Foreign Nationals and Same-Sex Couples: Foreigners, NRIs, OCI cardholders, and LGBTQ+ individuals are not allowed to access surrogacy in India.[26]
5. Legal Rights of the Child: The child born through surrogacy will be deemed the biological child of the intending parents, ensuring no parental claims by the surrogate mother[27].
6. National and State Surrogacy Boards:Regulatory bodies have been set up to ensure compliance with the Act and prevent exploitation[28].

---

16 MTP (Amendment) Act, 2021, Section 5A – Confidentiality Clause.
17 Section 3A, Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994
18 Section 18, PCPNDT Act, 1994 – Registration of Genetic Counseling Centers.
19 Section 22, PCPNDT Act, 1994 – Prohibition of Advertisement
20 Section 23, PCPNDT Act, 1994 – Penalties for Violations.
21 Census Reports,Child Sex Ratio Decline
22 Section 4(ii)(b),Surrogacy (Regulation) Act, 2021 – Ban on Commercial Surrogacy.
23 Section 4(ii)(c),Surrogacy Act – Eligibility Criteria for Intended Parents
24 Surrogacy (Regulation) Amendment Rules, 2023 – Allowing Widows & Divorcees to Opt for Surrogacy.
25 Section 4(iii)(b),Surrogacy Act – Criteria for Surrogate Mothers.
26 Section 2(1)(g),Surrogacy Act – Exclusion of Foreign Nationals, NRIs, and LGBTQ+ Individuals.
27 Section 8,Surrogacy Act – Legal Parentage of the Child.
28 Section 16, Surrogacy Act – Formation of National & State Surrogacy Boards.

The Assisted Reproductive Technology (Regulation) Act, 2021

The Assisted Reproductive Technology (Regulation) Act, 2021 (ART Act) is a significant law aimed at regulating fertility treatments such as in-vitro fertilization (IVF), sperm donation, egg donation, and embryo transfer. While the Act ensures ethical medical practices and protects patients from exploitation, it has also been criticized for restricting reproductive autonomy, particularly by excluding LGBTQ+ individuals, single men, and foreign nationals.

The ART Act, 2021, establishes legal and ethical guidelines for assisted reproductive technology services in India.

Important Provisions of the Act

1. Regulation of ART Clinics and Banks:All fertility clinics and ART banks must be registered with a National ART and Surrogacy Board[29].Ensures standardized medical practices and patient safety.
2. Eligibility for ART Services: Only heterosexual married couples and single women (widowed/divorced) can access ART services.[30]LGBTQ+ individuals, single men, and live-in partners are excluded from ART procedures.
3. Rights and Protections for Donors and Patients: Egg and sperm donors must provide informed consent and cannot claim parental rights over children born through ART[31].Women undergoing ART have full control over their reproductive choices, including the right to withdraw from ART treatment at any stage[32].
4. Prohibition of Sex Selection: The Act bans the use of ART for sex selection, reinforcing the PCPNDT Act, 1994[33].
5. Legal Rights of Children Born Through ART: Children born through ART are deemed biological children of the intending parents, ensuring legal protection of inheritance and parental rights[34].
6. Penalties for Violations:Clinics violating the law may face fines up to ¹ 25 lakh and imprisonment for five to ten years[35].

V. Judicial Approach to Reproductive Rights in India

Over the last decade, Indian courts have issued several notable decisions recognizing women's reproductive rights as part of the "inalienable survival rights" implicitly protected under the fundamental right to life. In certain ground-breaking judgments, the courts have even for the first time recognized reproductive rights as essential for women's equality and have called for respect for women's rights to autonomy and decision-making concerning pregnancy. In cases spanning maternal health, contraception, abortion, and child marriage, Indian courts have adopted robust definitions of "reproductive rights" that reflect human rights standards.[36] While court decisions are not uniform, several trailblazing rulings have boldly affirmed women's rights to remedies for violations of reproductive rights—including the first case globally to recognize maternal health as a right—and laid the foundation for Indian courts to continue to play a strong role in preventing and addressing ongoing violations of these rights.[37]

Landmark Cases on Abortion and Women's Autonomy

India's abortion laws are primarily governed by the Medical Termination of Pregnancy (MTP) Act, 1971, which has been liberalized over time. Courts have upheld women's autonomy in making reproductive choices.

---

[29] Section 12, Assisted Reproductive Technology (Regulation) Act, 2021 – Registration of ART Clinics

[30] Section 21, Assisted Reproductive Technology (Regulation) Act – Eligibility Criteria for ART Services.

[31] Section 30, ART Act – Consent Requirements for Donors

[32] section 28, ART Act – Rights of Women in ART Treatments.

[33] Section 25, ART Act – Ban on Sex Selection

[34] Section 37, ART Act – Legal Parentage of ART Children

[35] Section 41, ART Act – Penalties for Violations

[36] Devika Biswas v. Union of India, W.P. (C) 81/2012

[37] https://reproductiverights.org/sites/default/files/documents/Reproductive-Rights-In-Indian-Courts.pdf visited on 01.03.2025 at 7.30 pm

In Suchita Srivastava V. Chandigarh Administration The Supreme Court ruled that a woman's reproductive autonomy is a fundamental right under Article 21. It emphasized that forced pregnancy, even in cases of mental disability, violates personal liberty.[38]

X V. Principal Secretary, Health and Family Welfare Department, The Supreme Court expanded abortion rights under the 2021 amendment to the MTP Act, allowing unmarried women the same access to abortion as married women (up to 24 weeks of pregnancy). Recognized reproductive autonomy, dignity, and the right to privacy as constitutional rights.[39]

Court Rulings on Surrogacy and Assisted Reproduction

Before the enactment of the Surrogacy (Regulation) Act, 2021, India had no specific surrogacylaws, leading to judicial interventions to clarify legal parentage, the rights of the surrogate mother, and the status of foreign couples seeking surrogacy in India.

Baby Manji Yamada V. Union of India, This was India's first major surrogacy case involving a Japanese couple who commissioned surrogacy in India but later divorced before the child's birth. The Supreme Court ruled in favor of the intended father's custody, recognizing surrogacy agreements in principle.It highlighted the lack of legal protection for surrogate mothers and children born through surrogacy[40]

*In Jan Balaz V. Anand Municipality***,**involved a German couple who commissioned surrogacy in India but were denied Indian citizenship for the child. The Gujarat High Court granted the child Indian citizenship, but the Supreme Court later ruled that parentage laws must align with Indian citizenship laws. The case underscored international legal complexities in cross-border surrogacy.[41]

In Sharad Kumar Gangwar and Other V M/S Shantah Fertility Centre and Others, The Supreme Court addressed the rights of ART clinics under the Surrogacy Act. It ruled that commercial surrogacy contracts entered before the law came into effect (2021) must be honored, protecting intended parents.[42]

In Sourav Kumar Mishra V. Union of India,The Supreme Court upheld government regulations on ART clinics, ensuring they adhere to ethical standards. It ruled that ART procedures must be accessible, safe, and not exploit women.[43]

Judicial Interpretations of Privacy and Reproductive Choice

The Supreme Court has repeatedly upheld reproductive autonomy as a crucial aspect of fundamental rights, emphasizing bodily integrity and decision-making power. In a land mark case *Justice K.S. Puttaswamy V. Union of India*, the Supreme Court held that the Right to Privacy is a fundamental right under Article 21. It recognized that reproductive choices form a core aspect of bodily autonomy and personal liberty. This case paved the way for recognizing abortion as an individual choice, free from excessive state interference.[44]

In ABC V. State NCT of Delhi, The Court allowed a woman to terminate a 26-week pregnancy due to fetal abnormalities, even though the legal limit was 24 weeks. This ruling emphasized judicial flexibility in interpreting abortion laws to protect women's health and dignity.[45]

In *Independent Thought V. Union of India*,The Supreme Court ruled that marital rape of minors is illegal, recognizing that forced pregnancy violates reproductive autonomy. While the judgment did not extend to adult women, it set a precedent for future reproductive rights cases.[46]

The Supreme Court has consistently upheld the right to health and safe abortion as fundamental rights. It has expanded access to abortion, recognized reproductive autonomy, and ensured that women's rights are not subject to marital or societal restrictions. However, challenges remain, including restrictive laws, lack of healthcare access, and judicial ambiguity on marital rape and abortion rights.

38 AIR 2010 Supreme Court 235

39 2022 SCC OnLine SC 1321

40 (2008) 13 SCC 518

41 AIR 2010 Guj 21

42 CS No.379/2022

43 W.P.(C) 9140/2024

44 AIR 2017 Supreme Court 4161

45 2023 SCC Online SC 416

46 (2017) 10 SCC 800

VI. Conclusion

While technological advancements have undoubtedly improved reproductive healthcare, their adverse effects on reproductive rights in India cannot be overlooked. Stricter implementation of existing laws, ethical oversight on new technologies, and public awareness campaigns are essential to safeguarding reproductive rights. Additionally, balancing innovation with ethical considerations will be crucial to ensuring that technological progress benefits all individuals equitably.

Technological advancements in reproductive healthcare, including assisted reproductive technologies (ART), surrogacy, and genetic screening, have significantly expanded the scope of reproductive rights in India. However, these innovations also raise legal, ethical, and human rights concerns, particularly in terms of gender discrimination, accessibility, and the potential for exploitation.

While the Indian judiciary has recognized reproductive autonomy as a fundamental right under Article 21, restrictive surrogacy laws, lack of uniform ART regulations, and ethical dilemmas in genetic technologies present serious challenges. The Surrogacy (Regulation) Act, 2021, and ART (Regulation) Act, 2021, though aimed at preventing exploitation, have been criticized for excluding unmarried individuals, LGBTQ+ persons, and foreign nationals from accessing reproductive technologies. Additionally, sex-selective practices, commercialization of reproduction, and lack of regulatory enforcement continue to undermine reproductive justice.

Thus, while technological advancements offer new opportunities for parenthood, their legal implications must be carefully balanced to protect reproductive rights without reinforcing societal inequalities or violating bodily autonomy.

VII. Recommendations

1. Legal Reforms for Inclusive Reproductive Rights

- There is a need to amend the Surrogacy (Regulation) Act, 2021 to allow single individuals, LGBTQ+ persons, and foreign nationals to access surrogacy under strict ethical guidelines.
- There has to update the ART (Regulation) Act, 2021 to ensure greater inclusivity and prevent discriminatory access to fertility treatments.
- Needs to recognize marital rape as a legal ground for abortion and assisted reproduction, in line with international human rights standards.

2. Stronger Regulation and Ethical Oversight

- There is a need to establish a national regulatory body to monitor private fertility clinics, surrogacy agencies, and ART providers, ensuring ethical compliance.
- Implementation of stricter guidelines for genetic screening and embryo selection to prevent unethical practices like sex-selective reproduction.
- Introducing patient data protection laws for ART procedures to uphold privacy and informed consent.

3. Enhancing Accessibility and Awareness

- There is a need to provide subsidized reproductive healthcare services for marginalized communities to prevent economic barriers to ART and surrogacy.
- Launching awareness campaigns on reproductive rights to combat misinformation about ART, surrogacy, and abortion laws.

4. Judicial Review and Interpretation

- The Supreme Court and High Courtshas to adopt a progressive, rights-based approach in interpreting reproductive laws.
- Promotion of public interest litigations (PILs) and judicial interventions to challenge restrictive provisions in surrogacy and ART laws.

* * * *

RIGHT TO WOMEN'S REPRODUCTIVE AUTONOMY: A PATHWAY TO GENDER JUSTICE

Ms. Anita *

Dr. Manjinder Gulyani **

"Empowering women with reproductive autonomy is essential for achieving true gender equality."

– Justice Ruma Pal

Abstract

The idea of reproductive autonomy acknowledges the significance of bodily autonomy and personal choice in relation to reproductive health and is strongly associated with gender equality and human rights. "Right to Reproductive Autonomy" is important and it includes people's liberties and rights to make choices regarding their reproductive health free from compulsion or intervention, having access to safe and lawful abortion services, contraception, and the freedom to decide whether and when to have children. Women's autonomy is diminished in many countries where male family members influence or control reproductive decisions. Reproductive coercion is a severe problem in which a person's reproductive decisions are manipulated or controlled by force. This can involve pressure to terminate pregnancies, forced pregnancies, and sabotage of contraceptives. Many women continue to lack physical autonomy. According to the National Family Health Survey (NFHS-5), just 10% of women in India independently able to make decisions about their own health, and 11% of women believe that marital violence is acceptable if a woman declines to engage in sexual relations with her husband. Nearly half of all pregnancies in India are unplanned. Smt. Suchita Srivastava &Anr v. Chandigarh Administration (2009) The Supreme Court of India recognized the reproductive rights of a mentally retarded woman and allowed her to continue her pregnancy. X vs. The Principal Secretary, Health and Family Welfare Department, Govt. of NCT of Delhi case 2022, recognized the right of unmarried women to choose safe and legal abortion. The present paper focus on social, legal, cultural, economical challenges faced by women in respect to her reproductive rights. Present paper analysis the role of governments, judiciary in recognizing reproductive rights. The present paper suggests the need for comprehensive education, robust legal protections, and societal change to ensure that all women have the right to reproductive autonomy.

Keywords : **Reproductive Autonomy, Human Rights, Gender Justice, Abortion**

Objective of the Research

1. To study the right to reproductive health and autonomy national and international perspective, the role of government in providing medical assistance and ensuring reproductive rights to women, and the role of Judiciary in recognizing reproductive rights of women as human right and fundamental right, to analysis the provision of existing laws, regulations, and government schemes with regard to different reproductive rights issues.

Research Question

- Is she enjoying her reproductive autonomy right in real sense?
- Whether reproductive rights include right to abortion/ termination of pregnancy?
- Do population control programs violate women reproductive autonomy rights?
- Why even after decades of law illegal and unsafe abortions, female genital mutilation practices, female feticides, sex determination and sex selective practices are still going on?

*** Research Scholar, Department of Law, Kurukshetra University, Kurukshetra, India**

**** Associate Professor, Institute of Law, Kurukshetra University, Kurukshetra, India**

Research Methodology

The present paper is primarily based on doctrinal method, through which data is collected with the help of primary and secondary sources. The primary sources include in it the study of international declarations, treaties, conventions, domestic legislation, various commissions/committees reports, case law and the study of the critiques, commentaries and analysis of research reports and parliamentary debates on issues of reproductive rights. The secondary sources include Judgments of different courts, books, and legal journals, various dictionaries, reports, documents, newspapers, etc. are referred to get the relevant information. This attempts to lay out the entire spectrum of women's reproductive rights.

I. Introduction

One of the pillars of gender equity is reproductive autonomy. It promotes social and cultural change, increases economic and educational possibilities, empowers people, and lessens gender-based violence. Reproductive rights and autonomy are essential components of gender justice, emphasizing people's capacity to make informed choices regarding their reproductive health and family planning. The protection of reproductive rights contributes to the dismantling of gender norms and stereotypes that limit women's roles producing children. It encourages involvement and equitable chances in all facets of life. Reproductive autonomy and motherhood are important, complex subjects with social, cultural, and individual components. Although motherhood is frequently praised for its caring qualities and the happiness it may provide, it also entails obligations and difficulties.

In the past, patriarchal civilizations frequently governed reproductive rights, giving women limited agency. Usually, cultural and religious standards influenced reproductive choices. The 20th century saw considerable improvements in reproductive rights, particularly with the discovery of birth control technologies and the legalization of abortion in many countries. The feminist movement played a crucial role in pushing for women's reproductive autonomy. Reproductive rights have been significantly shaped by landmark court rulings and laws, such as the Medical Termination of Pregnancy Act in India. Women now have more control over their reproductive decisions because to these legislation.

II. Principles of Sexual and Reproductive Health Rights[1]:

- The freedom to make decisions regarding their sexual and reproductive lives, including family planning, without being subjected to abuse, coercion, or discrimination
- To have their privacy, liberty, and physical integrity respected
- To freely determine their sexuality, including gender identity and expression as well as sexual orientation;
- To determine when and if to engage in sexual activity
- To determine if, when, and with whom to get married
- To determine if, when, and how to have a kid or children, as well as the number of children to have
- To have lifetime access to the knowledge, tools, services, and assistance required to do all ofthe aforementioned, free from prejudice, compulsion, exploitation, and violence.

The Present Challenges to Women's Autonomy and Reproduction Health:

- Social Influences and a Patriarchal Mindset

  By promoting assumptions and conventions that place a higher priority on men's responsibilities and contributions than women's, patriarchal systems and conventional cultural values sustain gender inequity.

- Early Marriage and Pregnancy

  Early marriage and other cultural customs deprive females of their independence and education, which results in early and recurrent pregnancies. Because young mothers frequently encounter obstacles to school and work, adolescent pregnancies raise the likelihood of maternal difficulties and prolong cycles of poverty and dependence, so increasing socioeconomic and health inequalities.

[1] Women's autonomy, equality and reproductive health https://www.ohchr.org/en/special-procedures/wg-women-and-girls

- Unsafe and Illegal Abortion

  All nations were advised to "deal with the health impact of unsafe abortion as a major public health concern" during the United Nations Fourth World Conference on Women in 1995. Maternal death or severe disease and incapacity are the alternatives that women in many parts of the world have to unsafe abortions, rather than safe pregnancy and delivery. A public health strategy is justified by the impact of maternal mortality and morbidity on women, their dependent children, their elderly relatives who rely on them for care, their partners, and their larger families.

- Govetnment's Focus un Population Control

  Initiatives like universal access to abortion and contraception have received less attention as a result of the government's past attitude to reproductive rights, which placed a higher priority on population control measures than on individual autonomy and access to comprehensive sexual and reproductive health care.

- Female Feticide Undermines Reproductive Rights

  Reproductive autonomy and female feticide are closely related topics. Aborting a fetus because it is female, or female feticide, is a serious human rights violation that reflects ingrained gender inequalities. It maintains gender inequality and diminishes the worth of women and girls in society.

III. Reproductive Rights as Human Rights: Ensuring Autonomy and Equality

The right to reproductive autonomy is a crucial component of human rights. It covers the freedom of individuals to make their own decisions regarding their reproductive health without fear of coercion, violence, or discrimination. This includes having access to contraception, safe and legal abortion, fertility treatments, family planning services, and comprehensive sexual education. It also covers the right to make informed choices about when and whether to have children, as well as access to maternal health care. The recognition of reproductive autonomy as a human right recognizes that people must be able to control their own bodies and reproductive fates in order to achieve gender equality and improve overall health outcomes. Numerous international human rights treaties, such as the International Covenant on Civil and Political Rights (ICCPR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), endorse these concepts[2].

Relevant Human Rights Standards:

Women are granted equal rights under Article 16 of CEDAW to choose the number and spacing of their children as well as to have access to the knowledge, training, and resources necessary to exercise these rights.

- The Beijing Platform for Action[3] recognizes that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."
- The General Recommendation 24 of the CEDAW Committee suggests that states give priority to "prevention of unwanted pregnancy through family planning and sex education."

The fact that many constitutions and international accords recognize reproductive rights could be a first step toward recognizing women's liberty with relation to these choices. The Indian Constitution recognizes many of these rights as fundamental rights that the state is required to protect. These include the rights to life (Article 21), which courts have construed to include the rights to privacy, health, and dignity as well as the freedom from torture and cruel treatment, and equality and nondiscrimination (Articles 14 and 15).[4].

In the 2016 case of *Devika Biswas V. Union of India & Ors*[5]., the Supreme Court of India rendered a historic ruling that went beyond the context of reproductive health and recognized gender equality and autonomy as components of women's constitutionally guaranteed reproductive rights. A social activist's appeal against

[2] https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights
[3] https://www.unwomen.org/en/digital-library/publications/2015/01/beijing-declaration
[4] Reproductive Rights under Indian Constitution by Sakshi Dewanganhttps://www.tscld.com/blog/categories/volume-i-issue-i-jcs
[5] [2016] 5 S.C.R. 773

the state's sterilizing policy, which led to fatalities and serious injuries, gave rise to the lawsuit. According to Article 21, which covers a person's reproductive rights, the court found that these policies violate women's fundamental right life. The right to reproductive autonomy was acknowledged by the Supreme Court as a basic right in the case of *Suchita Srivastava &Anr v. Chandigarh Administration*[6]. In the recent Puttaswamy case, the Supreme Court affirmed Suchita's decision and explicitly emphasized women's fundamental freedom to make reproductive decisions.

IV. Equality in Heath: The Legal Battle for Menstrual Leave and Facilities

The Japanese program served as a model for other nations looking to adopt similar measures for their menstruating citizens. Indonesia introduced the menstrual leave policy in 1948, granting women two days of vacation each month. Five Then, in 2001, South Korea implemented a policy that gave menstruation people one day off each week. Taiwan has implemented a legislation allowing women to take three days off work during their periods in 2013. Under the guise of "Mother's Day," Zambia also has a similar rule that permits women to take time off without a medical cause or explanation. Even though this has nothing to do with menstruation leave particularly, individuals think that this leave is designed for that reason[7].

The legal battle for menstrual leave in India is a complex and evolving issue. There are several sides to the menstrual leave controversy. Proponents contend that in order to recognize the substantial physiological changes that women undergo and to advance workplace inclusivity, companies must offer menstruation leave. However, detractors fear that these regulations may inadvertently affect women's employment and professional advancement. Menstrual leave is not a novel idea in India. Since 1992, Bihar has implemented a policy that provides two days of menstruation leave per month. Kerala has also instituted a regulation that allows for one monthly menstruation leave day. Draft Policy for Menstrual Hygiene in 2023[8]: It acknowledges the necessity of tackling the problem of gender discrimination and establishing a supportive workplace culture that encourages work-from-home opportunities and leaves. The Right of Women to Menstrual Leave and Free Access to Menstrual Health Products Bill, 2022[9]: that would provide three days of paid menstruation leave in any government-registered establishment. But menstrual leave is not regulated by legislation in India, and there is no centralized policy for "paid menstruation leave.

- The court held that the right to human dignity is a part of the right to life in Francis Coralie v. Administrator, Union Territory of Delhi & Ors[10] Article 21's right to life is violated when women are forced to work throughout their periods without the possibility of leave since it affects their bodily and mental health.
- The court ruled in *Sampurna Behura v. Union of India*[11] that the state must provide women with access to healthcare facilities. Therefore, denying women menstrual leave violates their right to health by limiting their access to essential rest and care during their periods.

In India, menstrual leave is a significant step toward women's empowerment and gender justice. Organizations can foster more welcoming and encouraging work cultures by acknowledging and attending to the special health requirements of those who menstruate. However, careful consideration of implementation challenges and potential drawbacks is essential to ensure that the policy achieves its intended goals without reinforcing stereotypes or discrimination.

V. Reproductive Autonomy and Abortion: Navigating Legal and Ethical Challenges

Abortion and reproductive autonomy are extremely complicated, multidimensional topics that include societal, ethical, legal, and cultural facets. Some governments restrict or outright forbid abortion, claiming that a person's right to reproductive autonomy is superseded by the state's interest in preserving the fetus' life. The fetus is thought to have rights that may conflict with the individual's freedom to make decisions regarding

---

6 2009 INSC 1086

7 Menstrual Leave: Necessity or Controversy? https://articles.manupatra.com/index.html

8 https://sansad.in/getFile/loksabhaquestions/annex/1715/AU1348.pdf?source=pqals

9 https://sansad.in/getFile/BillsTexts/LSBillTexts/Asintroduced 276%20of%202022%20as%20introduced84202375127PM.pdf?source=legislation

10 Francis Coralie v. Administrator, Union Territory of Delhi & Ors., MANU/SC/0517/1981.

11 Sampurna Behura v. Union of India, MANU/SC/0104/2018

their body, and this is frequently presented as a moral or ethical dilemma. Whether a woman's right to make decisions about her body can be superseded by the fetus's potential right to life raises ethical concerns. There is a moral conundrum since some contend that reproductive autonomy should always come first, while others counter that the fetus has intrinsic rights that should be upheld. Legal frameworks may attempt to balance a person's right to abortion (a direct manifestation of reproductive autonomy) with the state's interests in protecting life, health, and potential societal consequences. For example, some legal systems allow abortion up to a certain gestational age or under specific circumstances (e.g., threat to the mother's life, fetal anomalies), which can limit the full realization of reproductive autonomy in practice

In India, abortion was prohibited until the 1960s. In order to investigate the necessity of rules, the Shantilal Shah Committee was established in the middle of the 1960s. This led to the passage of the Medical Termination of Pregnancy (MTP) Act, 1971, which protected women's health and made safe abortions lawful. In 2021, the MTP Act was modified to permit abortions up to 24 weeks of gestation, up from the previous 20 weeks, for specific groups of women, including rape victims, minors, women with mental illnesses, etc.

The Preconception and Prenatal Diagnostic Techniques (PCPNDT) Act of 1994, which controls the use of prenatal diagnostic techniques to identify chromosomal or genetic abnormalities in the fetus and forbids sex-selective abortions. Article 21 of the Indian Constitution gives every citizen the right to life and personal freedom. The Supreme Court of India has construed this right to include women's autonomy and choice over their reproductive options. By ruling that the Constitution does not grant a right to an abortion, the U.S. Supreme Court effectively returned control of abortion regulation to the states in the 2022 decision *Dobbs v. Jackson Women's Health Organization*[12], overturning *Roe v. Wade*[13] and *Planned Parenthood v. Casey*.

VI. Bridging the Gap Between Population Control Measures and Reproductive Freedom

Population control tactics have been around for a while, and different nations have used different approaches over time. Among the historical measurements are:

China's One-Child Policy, which restricted families to having just one child, was implemented in 1979 in an effort to manage the country's fast expanding population. It was criticized for being forceful and for having unforeseen social repercussions, like gender inequality. India's Emergency Period (1975–1977): As part of a population control effort, forced sterilizations were conducted during this time, which resulted in several human rights abuses.

These instances emphasize the necessity of upholding reproductive freedom and the possible risks of using coercive population control methods. Adopting a rights-based strategy that upholds and defends human autonomy is crucial to bridging the gap between population control measures and reproductive freedom. The following are some tactics:

Integrating Human Rights into Population Policies: Ensuring that population policies are grounded in respect for human rights, including the right to decide the number and spacing of one's children

Eliminating Coercive Practices: Avoiding coercive practices in family planning programs and ensuring that individuals can make voluntary and informed choices

Promoting Gender Equality: Empowering women and improving their social, economic, and health status to enable them to make autonomous reproductive decisions

Ensuring Access to Comprehensive Reproductive Health Services: Providing access to a full range of reproductive health services, including contraception, safe abortion, and maternal healthcare

Governments can strike a balance between meeting demographic targets and upholding reproductive choice by implementing these tactics. This strategy not only encourages personal freedom but also advances the general welfare and self-determination of women and communities.

VII. Conclusion and Suggestion

Reproductive autonomy and gender justice are closely related. Ensuring that everyone has equal rights and opportunities, regardless of gender, is a necessary step toward achieving gender justice. A key component of

[12] 597 U.S. __ (2022).
[13] 410 U.S. 113

this is reproductive autonomy, which gives people the ability to make choices regarding their own bodies and reproductive health.

Legal Frameworks: It is crucial to create and implement laws that safeguard reproductive rights. This covers having access to contraception, safe and legal abortion, and thorough sexual education.

Healthcare Access: It's critical to guarantee that everyone has access to high-quality reproductive healthcare services, such as prenatal and postnatal care. This lowers maternal mortality and enhances general health results.

Education and Awareness: Dispelling cultural norms and prejudices that limit reproductive autonomy can be accomplished by promoting education and awareness on gender equality and reproductive rights.

Economic stability is directly impacted by the capacity to regulate reproductive decisions. Particularly for young women and women of color, unintended pregnancies can have serious financial repercussions, restricting career options and extending poverty cycles. People who have reproductive autonomy are free to pursue their personal, professional, and educational objectives, which can help end the cycle of poverty and advance social mobility.

Advances in gender justice and reproductive rights can be fueled by international collaboration and activism. Governments, civil society organizations, and international organizations can collaborate to exchange best practices, supply funds and resources, and hold one another responsible for promoting reproductive rights and gender equality. By working together, we can make the world more fair and just for everyone.

* * * *

BOTTLENECKS IN ACHIEVING SDGs : AN ANALYSIS WITH SPECIAL REFERENCE TO INDIA'S DEMOGRAPHIC PRESSURE

Dr. Jayamol P. S. *
Prof. (Dr.) Raghunath K. S. **

Abstract

The world today is economically richer and environmentally poorer than ever. Over the years, there has been an increasing consciousness and realization that environmental quality and economic development are complimentary and not mutually exclusive. The problem that haunts the world is how to strike a balance between the benefits of a rising standard of living, and its costs in terms of deterioration of the physical environment and the quality of life. The main reason behind the over-exploitation of these resources is population explosion. In this context, the antidote to all development pressures and the conservation of the environment can better be analyzed through the lens of Sustainable Development Goals (SDGs) which is to be achieved by 2030. This paper deals with the population pressure threatening India's obligation to achieve the SDGs. It also sheds light on the various national and international measures to combat the adverse effects of population explosion. It concludes by putting forward some suggestions to accelerate India's commitment to achieving SDGs by removing the demographic pressure.It emphasizes women's empowerment to have informed choices and community participation as bulwarks in this direction.

Keywords : **SDGs, Demography, United Nations, Population**

I. Introduction

"If we don't halt population growth with justice and compassion, it will be done for us by nature, brutally and without pity, and will leave a ravaged world." –Nobel Laureate Henry W. Kendall.

In a developing country like India, the divulging nature of the population is a crucial factor to be taken care of. The challenge of the century is to solve the problem of meeting the increasing needs and expectations of a growing population by looking at the production and consumption patterns to achieve a more sustainable development model.The growing population increases concerns about the demand and consumption of resources. It hampers the process of sustainability in the long run. Every new faceconsumes many natural and non-natural products, which are also ultimately provided after exploiting natural resources. Continuous rise in population has enhanced the density of populationin various areas which has also created social, physical, psychological, and environmental problems. The increasing population also results in poverty.[1]Moreover, it has created housing problems, shortage of food and transportation, unsanitary conditions, loss of nutritious food.[2] SDGs provide a universal goal that meet the urgent environmental, political and economic challenges facing our world. The Millennium Development Goals (MDGs) established measurable, universally agreed objectives for tackling extreme poverty and hunger, preventing deadly diseases, and expanding primary education to all children.[3]TheSDGs reaffirm our international commitment to end poverty, permanently from everywhere as a revamped form of MDGs with seventeen goals. They are ambitious in making sure that no one is left behind. Moreover, they involve us all in building a more sustainable, safer, more prosperous planet for all humanity.[4] This paper delves into the crucial aspects of population explosion and its role in reducing the nation's chances to achieve SDGs by 2030.

* **Assistant Professor, Vaikunta Baliga College of Law, Udupi, Karnataka.**
** **Principal, Vaikunta Baliga College of Law, Udupi, Karnataka.**

1 S.C. SHASTRI, ENVIRONMENTAL LAW 22 (5th Edition, Eastern Book Company, Lucknow, 2015).

2 Ibid.

3 The United Nations General Assembly adopted MDGs in the year 2000 to achieve the targets by 2015.

4 DR. PARAMJIT S. JASWAL, DR. NISHTHA JASWAL AND VIBHUTI JASWAL, ENVIRONMENTAL LAW, 161(Allahabad Law Agency, Faridabad, 5th edition,2021).

II. Conceptual Analysis

We have only one Earth is the slogan raised by the state parties of the Stockholm Conference.[5]Mother Earth is surrounded by a natural environment. But the natural cover of the environment started declining and reduced considerably due to overacting from human beings. Population explosion is one of the major threats that shakes the foundation of the earth. Population growth can lead to other consequential impacts. The word 'Demography' is a combination of two Greek words, 'Demos' meaning people and 'Graphy' meaning science. Thus demography is the science of people. In the middle of the nineteenth century in 1855, the word 'Demography' was first used by a French writer Achille Guillard.[6]He coined the term to denote all the inhabitants of a country, territory, or geographic area, total or for a given sex and/or age group, at a specific point in time. In demographic terms, it is the total number of inhabitants of a given sex and/or age group that live within the country or region.[7] Today, the 8 billion people on it are using more of its resources than it can provide. Every new person is a new consumer, adding to that demand. Some people take far more than others which leads to wrong consumption patterns. There are many steps tocomply with to make consumption sustainable. The concept of SDGshas grown since its inception at the international forum and it has acquired different dimensions in terms of economic growth, development, and environmental protection. The National Planning Committee set up by Pandit Jawaharlal Nehru considered 'family planning and a limitation of children' essential for the interests of social economy, family happiness, and national planning.[8]The committee recommended the establishment of birth control clinics and other necessary measures such as raising the age of marriage and a eugenic sterilization program.[9] It is evident that, since independencepopulation control was an agenda for the governments to tackle but all attempts were miserably failed.

III. Gravity of the Issue

The growth of world population showed a remarkable speed. It took hundreds or thousands of years for the world population to grow to one billion. Then suddenly it showed a steep increase in the number. In 2011, the global population reached the seven billion mark and when it comes to 2022 it became eight billion.[10]This dramatic growth has been driven largely by increasing numbers of people surviving to reproductive age and has been accompanied by major changes in fertility rates, increasing urbanization and large-scale migration.[11] According to the data released by the UNFPA,[12] India's population is estimated to havereached 1.44 billion.[13]

As per recent data, India's fertility rate has also fallen substantially in the last decades from 5.7 births per woman in 1950 to two births per woman today.[14] India's population is virtually certain to continue to grow for several decades as according to the UN, it expects the population to peak around 2064 and then decline gradually. Population is the main driver of increased material use in Africa and West Asia. Material use is expected to increase, including meeting the SDGs for all and to build-up essential infrastructure. Without urgent and concerted action to change the way resources are used, resource extraction could increase almost 60 percent by 2060 as compared to 2020 levels, with devastating environmental and particulate matter health-related impacts.[15] As a result of the population explosion, poverty and price index were increasing and the natural resources for livelihood were decreasing.

---

5 First United Nations Conference on the Human Environment 1972.

6 Demography: Meaning, Scope, and Importance (Mar. 1, 2025),https://www.kuk.ac.in/wp-content/uploads/notes/Notes_2970_introduction%20to%20demography.pdf

7 WHO, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/1121

8 The National Planning Committee is an extra-constitutional body in India. It was set up in August 1952 and consisted of the Prime Minister, Chief Ministers of states, and members of the planning commission.

9 P.B.Sahasranaman, Advocate, The Two Child Norms –A Flash Back, CDJ Law Journal

10 World Population Trends, available at https://www.unfpa.org/world-population-trends

11 Ibid

12 UNFPA is the United Nations sexual and reproductive health agency. Our mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

13 Piyush Shukla, India's Population Trends, https://currentaffairs.adda247.com/unfpa-report-indias-population-trends-and-reproductive-health inequities/#:~:text=India%20leads%20globally%20with%20an%20estimated%20population%20of,0-14%20age%20bracket%2C%20indicating%20a%20significant%20youth%20demographic.

14 Supra note 8

15 Bend the Trend, Summary of Policy Makers, REPORT OF THE UN ENVIRONMENT PROGRAMME, https://wedocs.unep.org/bitstream/handle/20.500.11822/44902/GRO24_Summary_for_Policymakers.pdf?sequence=3

The unequal distribution of resources has created a disparity in the distribution of world resources. In fact, the number of people suffering from hunger has actually **i**ncreased in recent years because the development progress is not keeping up with rapid population growth.Every extra mouth to feed puts more pressure on our food supply. There are threats from multiple factors, including shortage of fresh water, soil depletion, decimated populations of insect pollinators and climate change.[16]According to the UN, the world is in need of more food resources by 2050. Undoubtedly increasing agricultural production comes at a cost to nature, and habitat loss and exploitation are the two most significant threats to biodiversity. It is evident from studies that 80% of extinction threats to mammals and birds are due to agricultural practices.[17]

The Earth also provides for mankind's needs with renewable resources, such as timber, clean water and air, healthy soils, and wild fish consumed for food. However, people's demands are so great that according to the Global Footprint Network,[18]people are now using those resources at almost twice the rate that the Earth can renew them.[19]Moreover, water is an absolute basic human necessity, and each person adds to the demand which leads to critical freshwater demand. It is predicted that five billion people will live in water-stressed regions by 2050. The UN has calculated that water shortages as a result of climate change could displace hundreds of millions of people by 2030.[20]Regional variations in water availability are extreme but many of the world's poorest regions, and those which have high population growth, are among those with the shortest supply. Developed countries also suffer from the effects of population pressure on water supply.

In this context of shortage of resources, population and family size is an issue in both high-income and low-income countries. Where affluence and consumption are high, reducing the number of new consumers is an effective, permanent way of reducing the drain they place on resources as well as their environmental impact.[21] It does not mean that people should not do other things to reduce their consumption.The sustainable use of resources through effective, ethical means is the most effective method to relieve the pressure of unscientific consumption.

IV. International Efforts to Control Population

The Stockholm conference[22] was a landmark that had created an imprint in the environmental history of the World. In 1983, the World Commission on Environment[23] was established by the UN General Assembly and the commission has submitted its report titled 'Our Common Future.' In this report the committee has for the first time coined the term 'Sustainable Development.'[24] International Conference on Population and Development (ICPD), 1994 (Cairo Conference)[25] is one of the most significant global agreements on population policies. It shifted focus from coercive population control to reproductive rights, gender equality, and voluntary family planning. It has led to the adoption of the Programme of Action, which emphasized women's education, healthcare, and contraception access as a means of stabilizing population growth.

As it is rightly mentioned in the World Commission on Environment and Development[26]"Population growth has already compromised many government's abilities to provide education, health care, and food security for people and their abilities to raise living standards. Thus concern over the 'population problem' also calls forth concern for human progress and human equality."The member States of the UN General Assembly adopted the 2030 Development Agenda, which was titled 'Transforming Our World. The 2030 Agenda for Sustainable Development.'[27] This agenda is based on People, Planet, Prosperity, Peace, and Partnership.[28]The

16 Ibid

17 Resources and Consumption, https://populationmatters.org/the-facts-resources-consumption/

18 The core of Global Footprint Network is the Ecological Footprint, a comprehensive sustainability metric available at https://www.footprintnetwork.org/about-us/our-history/

19 https://www.footprintnetwork.org/2025/02/01/our-approach/

20 Supra note 15

21 Ibid

22 The United Nations Conference on Human Environment, 1972-The first ever International Convention for the Protection of Environment.

23 Brundtland Commission

24 It is defined as meeting the needs of the present without compromising the ability of future generations to meet their own needs.

25 https://www.un.org/en/conferences/population/cairo1994

26 The Brundtland Commission, formally known as the World Commission on Environment and Development (WCED), was established by the United Nations (UN) in 1983.

27 United Nations Sustainable Development Goals (SDGs) – 2015. There are seventeen SDGs and 169 targets with 232 indicators.

28 SDGs build on the Millennium Development Goals and complete what they did not achieve.

balance between environmental protection and developmental activities could only be maintained by strictly following the principles of sustainable development. [29]Good Health and Well-beingensure healthy lives and promote well-being for all at all ages.[30]It recognizes universal access to sexual and reproductive health care services, including family planning. Another goal of Quality Education especially for girls, helps lower birth rates.[31] Access to education must include quality education. Gender disparities in education are to be eliminated and equal access to all levels of education is to be ensured. The intention is to facilitate all learners to acquire the knowledge and skills needed to promote sustainable development. In addition to that,Gender Equalityand Women's empowerment is linked to lower fertility rates.[32] Gender equality is very essential for peaceful, prosperous, and sustainable development. Women's full participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life are to be ensured. SDGs also link population growth to environmental sustainability.[33] This goal aims at integrating climate change measures into national policies, strategies and planning. The seventeen SDGs and 169 targets contributes to a more sustainable world by allieviating all poverty, illiteracy, gender disparity, population hazards etc.

Apart from these, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979 recognizes women's rights to reproductive autonomy. It encourages access to family planning, contraception, and healthcare. International Covenant on Economic, Social, and Cultural Rights (ICESCR), 1966 recognizes the right to family planning and maternal health services.[34]It emphasizes state obligations to provide contraception and reproductive healthcare. The Universal Declaration of Human Rights (UDHR), 1948[35]acknowledges the right of individuals to decide on the number and spacing of their children.

The Paris Agreement on Climate Change, 2015directly addresses population growth as a factor affecting climate change and resource consumption. The World Health Organization's (WHO) Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) aims to reduce maternal mortality, provide contraception access, and improve healthcare systems to manage population growth.

V. National agenda to control population

The Indian scenario of population control has its roots in the Constitution of India. The preambular promises of Justice[36] Can be attained only through the sustainable use of resources for which overpopulation is a big threat. Moreover, the Fundamental Rights have guaranteed Equality,[37] which cannot be attained when resources are unequally allocated. The Directive Principles of State Policy enshrined in the Constitution of Indiaare designed to secure a social order for the promotion andwelfare of the people,[38] adequate means of livelihood,[39] raising the level of nutrition and standard of living,[40] improving public health,[41] etc. These objectives can be achieved if the population growth can be controlled. Otherwise, the fruits of these social policies will remain in a vacuum. Population control family planning is a subject coming under the Concurrent list of the Constitution which denotes that even federal states can act in the issues of population explosion.[42]

Stabilizing the population is an essential requirement for promoting sustainable development with more equitable distribution. As part of the policy created for the welfare of the country, the Indian government has

---

29 DR. PARAMJIT S. JASWAL, DR. NISHTHA JASWAL AND VIBHUTI JASWAL, ENVIRONMENTAL LAW 161(Allahabad Law Agency, Faridabad, 5th edition,2021)

30 SDG 3

31 SDG 4

32 SDG 5

33 SDG 13-Climate Action

34 Article 12 of the ICESCR

35 Article 16of UDHR

36 The Preamble of the Constituion strives to achieve Jusstice-social, political, and economic See J.N. Pandey, Constitution of India.

37 Article 14 of the Indian Constitution

38 Ibid Article 39(e)(f)

39 Ibid Article 41

40 Ibid Article 43 & 45

41 Ibid Article 47

42 Entry 28, List III to Schedule VII

taken many initiatives. The National Family Health Survey(NFHS),[43]Which provides first-hand resources for the policy formation for the government. The National Population Policy,(NPP) 2000[44] Provides a framework for programs on family planning and reproductive health.The Mission Pariwar Vikar[45]Targets high fertility districts to access quality family planning measures. The Beti Bachao Beti Padhao Scheme[46] Promotes gender equality and girl's education. Samagra Shiksha[47] aims for inclusive quality education and POSHAN Abhiyaan[48] addresses malnutrition. These policies, supported by comprehensive research and data, empower individuals to make informed choices and contribute to sustainable development.[49]Overpopulation adversely affects the nation's efforts to attain SDGs because as it is evident population leads to climate change, deforestation, water scarcity and pollution.

VI. Bottlenecks in Achieving the Targets

India, home to more than 15 percent of the world's population ranks 109th out of 167 countries in SDG progress according to the 2024 SDG report prepared by the Sustainable Development Solutions Network (SDSN).[50] Achieving all the SDGs by 2030 may be challenging, according to the National Indicator Framework Progress Report released by the Union Ministry of Statistics and Programme Implementation (MoSPI) in 2024.[51]A projected 60 percent growth in resource use by 2060 could derail efforts to achieve not only global climate, biodiversity, and pollution targets but also economic prosperity and human well-being. Reducing the resource intensity of food, mobility, housing and energy systems is the best and only way of achieving the SDGs, the climate goals, and ultimately a just and livable planet for all.For that, the consumption and usage of the resources have to be reduced. It can be attained only through population control.

There are many hurdles in this journey to attain SDGs. India is a country with unity in diversity. The geographical and regional differences are reflected even in matters of environmental safeguards. Along with this regional disparity, socio-cultural barriers, policy Implementation, gender inequality, and resource allocation are causing hurdles in this regard. Continuous rise in population has enhanced the density of population in various regions which has also created various social, physical, psychological, and religious problems for the people. Space required for the population has also resulted in deforestation and the disappearance of vegetation cover. [52] Women empowerment is less in rural areas. Their knowledge about reproductive rights and the menace of population explosion is very less.

VII. Judicial Attitude

The judiciary has taken a balanced approach with regard to the reproductive rights and population control. In many cases, judiciary has pointed out the consequences of population explosion. On the way back,a Commission headed by Justice.V.R.Krishna Iyer in Kerala State recommended the family norm to be adopted by every citizen, which includes a two child restriction.[53] Any movement, campaign, or project contrary to

---

43 A survey conducted under the under the stewardship of the Ministry of Health and Family Welfare (MoHFW). It isa large-scale, multi-round survey providing information on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anemia, and utilization and quality of health and family planning services in India.

44 The immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. All of these were targeted to achieve by 2010. See,https://nhsrcindia.org/sites/default/files/2021-07/7%20National%20Population%20Policy%20 2000.pdf.

45 The Government has launched Mission Parivar Vikas to substantially increasing access to contraceptives and family planning services in146 high fertility districts with Total Fertility Rate (TFR) of 3 and above in seven high focus states. These districts are from the states of Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam that itself constitutes 44% of the country's population.

46 The scheme focuses on preventing gender-biased sex-selective elimination, ensuring the survival and protection of the girl child, and promoting the education and participation of girls.

47 Samagra Shiksha - an overarching program for the school education sector extending from preschool to class 12 has been, therefore, prepared with the broader goal of improving school effectiveness measured in terms of equal opportunities for schooling and equitable learning outcomes.

48 Poshan Abhiyaan, an overarching scheme for holistic nourishment is the Government of India's flagship scheme to improve nutritional outcomes for children, adolescent girls, pregnant women, and lactating mothers. The Abhiyaan was launched by the Hon'ble Prime Minister on 8th March 2018.

49 Interview, Population Foundation of India, Legal News and Views, July 2024 p-46

50 The UN Sustainable Development Solutions Network (SDSN) works under the auspices of the UN Secretary-General to mobilize the world's universities, think tanks, and national laboratories to identify and develop global and local solutions for action on the world's most critical sustainable development challenges.

51 How can India achieve SDGs by 2030? By strengthening household resilience & addressing caste-based discrimination,Down to Earth,14th February 2025

52 Supra Note.1

53 Women's Code Bill 2011 strongly recommended two-child norms and birth control.

the same will attract penal provision. The concept of two children is not something new to law. The menace of growing populations was judicially noticed and the constitutional validity of legislative means to check the population was upheld in many cases.

Supreme Court of India, has considered the issue in a case where an Air Hostess was terminated from the service for the reason that she gave birth to a third child.[54] Her termination was upheld based on a rule barring employment if the person had a third child. The Court held that the provision preventing the third pregnancy with two existing children would be in the larger interest of the health of the Air Hostess concerned as also for the good upbringing of the children. The Court held that:

"*when the entire world is faced with the problem of population explosion it will not only be desirable but essential for every country to see that the family planning program is not only whipped up but maintained at sufficient levels to meet the danger of over-population which, if not controlled may lead to serious social and economic problems throughout the world*."

Recently, the Supreme Court of India in response to a petition filed by Delhi Bharatiya Janata Party Leader Ashwini Kumar Upadhyay, issued a notice to the union governmentdemanding stringent legislation to control population. [55]In another interesting case,[56]Uttaakhand Panchayat Raj (Amedment) Act, 2019 was challenged.[57]The respondents contended thatfamily planning is the need of the time because the country is facing an imminent danger of population explosion. It is observed by the apex court that, the provisions challenged by the petitioners are neither illegal nor unconstitutional. An enactment cannot be struck down on the ground that the Court thinks it unjustified. The Court cannot sit in judgment over the wisdom of Parliament and the legislatures.[58] The High Court has read down section 8(1)(r) and declared that the said provision shall not be understood as disqualifying those who already have three or more children before 2019 to contest in elections.

VIII. Suggestions and Conclusion

The lack of policies to control the population explosion, caused severe injury to Indian citizens, especially to the health of the women in the form of malnutrition and anemia. Repeated pregnancies cause severe illnesses in the mothers. The harmful effect of multiple pregnancies was also seen in babies who may be premature or of low birth weight. Population control is the duty of the government. Governments should try to limit population growth, control the impact of such growth on resources, and enhance their productivity. Sustainable economic growth and equitable access to resources are two of the more certain routes toward lower fertility rates.

In certain cases, religion would play a catalyst role. If religious practices run counter to public orderthen it should be tackled for the better interest of the society. The religious practices must give way for the good of the people of the State as a whole. Law is necessary for the country, and the people.

Since fertility depends upon the age of marriage, the minimum age of marriage of women in the country should be raised and free education should be provided to women. To adopt sustainable development practices promoting the use of renewable development practices is necessary. Implementing stricter environmental regulations, adopting greener technologies, raising public awareness about sustainable consumption, and including environmental education in school curricula are important in this regard.

Moreover, women have to be given proper education and empowerment. They should understand that they have full freedom over their body and their health should be of paramount concern. They have to be given the right to make informed choices. They should have the liberty to choose but it is difficult in most cases. Community participation is required for the success of all these efforts. Only through the intervention of community participation, and involvement of civil society the population can be controlled and the SDGs would come to the rescue of the people of India. By adopting the strict norms India can attain SDGs. The explosion in the population is a factor to be taken care of. Enhancing human potential should have the capacity to ensure the right of all to a full and dignified life.

* * * *

[54] **Air India Vs. Nergesh Meerza, 1981(4) S.C.C. 335.**

[55] Against forcing family planning, Centre tells SC after population control PIL, Hindustan Times, December 10, 2020.

[56] *Pinki Devi v. State of Uttarakhand, AIR 2020 Uttarakhand 63.*

[57] Sections 8(1)(r)(d) and 10-C of the Act disqualifies a person from being appointed, and for being a Praddhan, UP-Pradhan, and a member of the Gram Panchayat, if he has more than two living children.

[58] Supra note 56

SURROGACY AND REPRODUCTIVE AUTONOMY: BALANCING RIGHTS, ETHICS, AND REGULATION

Dr. Preethi Harish Raj *
Ms. Elita Rose Simon **

Abstract

Political discourse and activism around reproductive rights often center on issues such as contraception, abortion, sexual violence, and the health hazards linked to pregnancy. However, reproductive rights also extend to providing support and services for individuals experiencing infertility. Advances like in vitro fertilisation (IVF) and surrogacy have enabled many people to pursue parenthood and manage the emotional challenges that infertility brings. The Surrogacy (Regulation) Act, 2021, has a considerable impact on reproductive rights by imposing stringent limitations—most notably, it prohibits commercial surrogacy and permits only altruistic surrogacy. Under this Act, two major restrictions are placed on altruistic surrogacy: firstly, it excludes unmarried couples, foreign nationals, single individuals, those in live-in relationships, and members of the LGBTQ+ community from accessing surrogacy services; secondly, it restricts eligibility to legally married Indian couples who have been married for at least five years. These provisions reflect a troubling disconnect from the social realities of contemporary India.

Rather than effectively regulating the surrogacy sector, the government's approach of imposing outright bans may drive the practice underground, increasing the risk of exploitation for economically vulnerable women. This legislation echoes entrenched patriarchal attitudes and is likely to worsen the social and economic vulnerabilities of Indian women. Ultimately, the law infringes on both reproductive freedoms and the broader Fundamental Rights enshrined in the Indian Constitution.

Keywords: **Surrogacy, Infertile Couple, Reproductive Rights, Fundamental Rights, Assisted Reproductive Technology**

I. Introduction

The word 'surrogate' originates from the Latin term 'surrogates', which means "to substitute" or "to act on behalf of another"[1] In general terms, surrogacy involves a woman carrying a pregnancy for another individual or couple to handing over the child after birth. A surrogate mother is a woman who agrees to have an embryo—formed using the sperm of a man who is not her partner and the egg of a different woman—implanted in her uterus, and who commits to carrying the pregnancy to full term and relinquishing the child to the intended parents.[2]The International Conference on Population and Development (ICPD), in its Programme of Action, affirms that reproductive rights are based on the freedom of individuals and couples to make informed decisions about having children—free from any form of coercion, discrimination, or violence—and with access to the information and resources necessary to make those choices responsibly.[3]

In the Indian context, it is important to recognize a paradox: while the Transplantation of Human Organs Act, 1994, clearly bans the commercial trade of human organs, a similarly complex ethical issue emerges in the form of paid surrogacy, often referred to as "organ loaning." This practice continues to thrive, largely fueled

* **Assistant Professor Vaikunta Baliga College of Law, Udupi**

** **Student, Vaikunta Baliga College of Law, Udupi**

1 Malini Karkal, Surrogacy from a Feminist Perspective, Indian Journal Of Medical Science, Oct. - Dec. 1997,(Mar.,2,2025,10:04 PM), http//www.Issuesinmedicalethics.org/054mi15.html?:Nelson Hilde Lindeman, Nelson James Linde man: Cutting motherhood in two: some suspicions concerning surrogacy

2 The Assisted Reproductive Technologies (Regulation) Bill-2010, Indian Council of Medical Research (ICMR), Ministry of Health & Family Welfare, Government of India 4, (2010).

3 Paragraph 7.3 of the Report of International Conference on Population and Development

by a profit-driven medical sector and the growing appeal of "reproductive tourism" among international clients seeking affordable surrogacy options.[4]

The rising prevalence of infertility worldwide has led to significant advancements in *Assisted Reproductive Technologies (ART)***.** Surrogacy emerges as a viable alternative for individuals or couples unable to conceive naturally. It is an arrangement in which a surrogate mother carries and delivers a child on behalf of another person or couple. There are two primary types of surrogacy:

1. Gestational Surrogacy – In this method, an embryo created through In Vitro Fertilization (IVF) is implanted into the uterus of the surrogate, who carries and delivers the baby but has no genetic link to the child.

2. Traditional Surrogacy – Here, the surrogate mother is artificially inseminated with the intended father's sperm, making her both the genetic and gestational mother of the child.

Surrogacy is categorized as either Commercial or Altruistic based on whether the surrogate is financially compensated for her role in the pregnancy. In the first decade of the 21st Century, India saw remarkable growth in the utilization of assisted reproductive technologies

II. Historical Context and the Evolution of the Surrogacy Regulation Act

India has witnessed remarkable growth in the adoption of assisted reproductive technologies (ART), particularly in the realm of surrogacy. However, with the expansion of the surrogacy sector, issues regarding the exploitation of women, the commodification of motherhood, and violations of human rights have surfaced.[5] The discussion gained traction in 2008, when a Japanese couple sought to commission a baby in a small Gujarat town. The surrogate mother successfully gave birth to a healthy baby girl. At that time, the couple had already separated, leaving the child both parentless and without a nationality, caught in the legal complications of two different nations. The girl is currently in the care of her grandmother in Japan, yet she has not been able to acquire citizenship since surrogacy is illegal in Japan.[6]

A couple from Germany employed a surrogate named Marthaben Immanuel Khrishti, who delivered twins. This German couple, working in the UK, found themselves needing an Indian passport for their twins to travel. However, the twins were unable to obtain citizenship due to ongoing legal proceedings, and the passport authorities denied their request. Because there was no surrogacy law in Germany, the Supreme Court did not issue passports but provided exit permits for the children, allowing the German authorities to adopt them and advocate for their rights.[7] A single mother of two from Chennai chose to become a surrogate, hoping the compensation would help her open a shop nearby. Although she gave birth to a healthy child, her expectations were not met. She received only around Rs.75,000, with an auto-rickshaw driver who acted as a middleman taking half of that amount. After settling her debts, she found herself with insufficient funds.

On January 29, 2014, 26-year-old Yuma Sherpa succumbed following a surgical procedure performed to extract eggs from her body for a private clinic's egg donation program based in New Delhi. Such incidents underscore the blatant disregard for the rights of surrogate mothers and their children and have led to numerous Public Interest Litigations in the Supreme Court aimed at regulating commercial surrogacy. In this context, the court pointed out inadequacies in the existing regulatory framework and noted that "in India there is no law forbidding artificial insemination, egg donation, renting a womb, or surrogacy agreements." The 228th Report of the Law Commission of India[8] recommended banning commercial surrogacy and permitting ethical altruistic surrogacy for needy Indian citizens by implementing appropriate legislation. Given these circumstances, enacting a law to govern surrogacy services in the country had become essential to prevent the potential exploitation of surrogate mothers and safeguard the rights of children born through surrogacy.

To address and manage these issues, the Indian Parliament introduced the Surrogacy (Regulation) Bill in 2016, 2019, and 2020, along with the Assisted Reproductive Technologies Bill in 2008, 2010, and 2014, aimed at regulating various dimensions of surrogacy arrangements.[9] The Union Cabinet approved the Surrogacy

---

4 The Business & Ethics of Surrogacy, (Mar.,07,2025, 08:30 AM), http://www.jstor.org/stable/pdfplus/40278374.pdf?acceptTC=true

5 Krawiec Kimberly D. Altruism and Intermediation in the Market for Babies. WASHINGTON & LEE LAW REVIEW. 2009.

6 Baby Manji Yamada v. Union of India, AIR2008, SCC 518,(India).

7 Jan Balaz v. Anand Municipality, Gujarat High Court, AIR2019 Guj 21, (per K.S. Radhakrishnan concurring),(India).

8 228th Report of the Law Commission of India (2008).

9 Press Trust of India, government introduces bill to ban commercial surrogacy, INDIA TODAY (Jul., 15, 2019),(Mar., 8,2025, 09:40 PM), https://www.indiatoday.in/india/story/government-introduces-bill-bancommercial-surrogacy-1569363-2019-07-15

(Regulation) Bill on February 26, 2020, following the publication of the Select Committee's report.[10] However, the Surrogacy (Regulation) Act, 2021 did not come into force until January 25, 2022. This significant legislation intends to regulate surrogacy practices while notably impacting reproductive rights by imposing strict limitations on access to surrogacy. Specifically, it prohibits commercial surrogacy and allows only altruistic surrogacy, meaning a surrogate mother cannot receive any financial compensation other than for medical expenses, effectively limiting options for many couples and raising concerns about potential discrimination against certain groups such as single parents or LGBTQ individuals who might find it difficult to locate a willing surrogate under these terms; all while striving to protect vulnerable women from exploitation. The Act can also be interpreted as a constraint on reproductive autonomy for some individuals seeking assisted reproductive technologies.

As stated in the Program of Action from the International Conference on Population and Development, the goal should be to assist individuals and couples in realizing their reproductive aspirations, guaranteeing they have the complete freedom to choose when to have children.[11] In Vitro Fertilization (IVF) and surrogacy have granted many individuals and couples the chance to realize their parenting dreams. These technologies have transformed reproductive healthcare by providing alternatives for those experiencing infertility, health issues, or other obstacles to having biological children.

III. Key Provisions of the Surrogacy (Regulation) Act, 2021

The Surrogacy (Regulation) Act, 2021, strictly prohibits commercial surrogacy, allowing only altruistic surrogacy-where surrogates are compensated solely for medical expenses and insurance.[12] Becoming a surrogate is a decision that entails meeting a complex set of requirements to ensure a successful outcome. Sure! Here's a clearer and more polished rephrasing of your sentence**.** The Act stipulates that surrogacy shall not be undertaken unless the intended couple obtains a certificate of essentiality. This certificate must be issued by the appropriate authority and subsequently verified by the person in charge of the surrogacy clinic.

According to the Act, a surrogate must be a woman who has been married and has at least one child of her own, and she must be between the ages of twenty-five and thirty-five on the day of implantation. It also stipulates that she should only be a close relative of the couple who are getting married. Furthermore, she should refrain from providing her gametes and from acting as a surrogate mother more than once in her whole lifetime. It also states that surrogates must obtain a certificate of physical and psychological fitness for surrogacy and surrogacy treatments from a registered medical practitioner before proceeding with the procedure.[13]

The legislation specifies that the age of the prospective couple on the date of certification should range from twenty-three to fifty years for females and from twenty-six to fifty-five years for males.[14] Additionally, it requires that the intending partners have been married for a minimum of five years and that they are citizens of India. It is also mandated that the couple has no living children, whether biological, adoptive, or through surrogacy.

While the legislation seeks to prevent exploitation and protect human rights, it has been criticized for being overly restrictive. Detractors claim that prohibiting commercial surrogacy may lead to its practice being driven underground, complicating regulation and oversight. The focus on altruistic surrogacy can also restrict access for couples who may struggle to find a willing surrogate among their relatives or friends. Moreover, the law fails to address the issues faced by international intended parents who once turned to India for surrogacy services.

IV. A Critical Analysis of the Act: Examining its Constitutional Validity

Parenthood transcends gender, sexuality, and sexual preferences! Excluding individuals from accessing surrogacy based on sexuality, caste, religion, gender, or sexual orientation constitutes a serious violation of

---

10 The Surrogacy (Regulation Bill) 2019, Personal Response System India,(Mar. 7, 2025, 09:30 PM), https://prsindia.org/billtrack/thesurrogacy-regulation-bill-2019.

11 United Nations, 1994, paragraph 7.16.

12 Surrogacy Regulation Act, 2021, Section 4, Surrogacy Regulation Act.

13 Ranjit Malhotra, Highlights and brief analysis of the Surrogacy (Regulation) Bill, 2020 and suggested potential Safeguards, International Bar Association, (Mar.,08,2025,10:30 PM), https://www.ibanet.org/article/B5C65969-4901-49A9-82CF-8DC4C8BEB1E2.

14 Surrogacy Regulation Act, 2021,1 Section 4(c),

human rights. The recent surrogacy legislation will bar same-sex couples and LGBTQ individuals from becoming parents through surrogacy, representing a denial of justice for sexual minorities in India. Infertility is recognized as a widespread medical issue in India. The right to reproductive choice encompasses a woman's ability to decide whether or not to have children. Although the Act has been introduced to regulate surrogacy practices and address the exploitation of women and surrogates, its provisions discriminate against women.[15] Rather than being protected, women could face exploitation, and there are worries that the Act might lead to an increase in unlawful commercial surrogacy. The following paragraphs will outline the shortcomings of the Act.

In India, while the Constitution does not explicitly guarantee surrogacy as a reproductive right. The Supreme Court and the High Courts have established, in several cases, that the right to reproductive autonomy is a part of the Right to Life and PersonalLiberty under Article 21 of the Indian Constitution. The Supreme Court ruled in *Suchita Srivastava v. Chandigarh Administration*[16] that a woman's freedom to make reproductive decisions is a part of her 'personal liberty,' As defined by Article 21.in *K. S. Puttaswamy (Retd.) and Others v. Union of India*,Justice K. S. Puttaswamy (Retd.) also reiterated that the reproductive choice of the women is an aspect of personal liberty under Article 21 of the Constitution of India.[17]Despite all these landmark judgments, the Act excludes certain classes of women from the benefits of surrogacy, which is a violationof the reproductive rights of women and bodily autonomy, which has also been recognized in various foreign countries.[18] The Andhra Pradesh High Court held in *B K Parasarathi v. State of Andhra Pradesh*[19]it was held that "the freedom to decide reproduction is ultimately a very personal decision on the side of the man or woman."

This interpretation suggests that, in certain circumstances, individuals may have the right to access assisted reproductive technologies, including surrogacy. Despite all these landmark judgments, the Act excludes certain classes of women from the benefits of surrogacy, which is a violation of the reproductive rights of women and bodily autonomy, which has also been recognized in various foreign countries

While the Act addresses some of the concerns related to exploitation and human rights violations, it has also faced criticism for its restrictive nature. Many argue that by banning commercial surrogacy, the law may drive the practice underground, making it more difficult to regulate and monitor. Additionally, the Act focuses on Altruistic Surrogacy, which may limit the availability of surrogacy services for those who cannot find a willing surrogate among their social circle. If surrogacy is made illegal for large segments of the population, people will likely find other ways to meet their needs. Surrogacy for the sake of benevolence comes with its own set of dangers.

Restricted Definition of Intending Couple/Woman: When it comes to the exclusion of specific groups of persons from the definition of intending couple/woman, it is important to note that the word "intending couple" refers to a married couple of Indian origin who has a medical indication.[20] In addition, an Indian woman who is a widow or divorced is not considered as an "intending woman." According to a study of these two interpretations, foreigners, homosexual couples, couples in a live-in relationship, and unmarried couples are all prohibited from employing surrogacy under the Act. These exclusions are unreasonable and may violate Article 14 of the Indian Constitution, as they fail to pass the reasonable classification test. Furthermore, the Act ignores the rights of the third gender, which were recognized in the *National Legal Services Authority v. Union of India case*.[21]

Exploitation of Women: The Act permits only close relatives to serve as surrogates. Conversely, this may lead to increased exploitation of women, who could be pressured by their families to become surrogates.

---

15 Mohini Priya, Critical Analysis OfSurrogacy (Regulation) Bill 2021 And Assisted Reproductive Technology (Regulation) Bill 2021, LIVE LAW, (Mar.8, 2025, 10:50 PM)), https://www.livelaw.in/columns/surrogacy-regulation-bill-2021-srb-assisted-reproductiontechnology-regulation-art-bill-2021-surrogacy-regulation-bill-2016-193425.

16 Suchita Srivastava v. Chandigarh Administration (2009) 9 S.C.C. 1.(India).

17 K. S. Puttaswamy (Retd.) and Others v. Union of India, (2017) 10 S.C.C. 1(per Chandrachud Concurring) India).

18 *Ibid*

19 B K Parasarathi v. State of Andhra Pradesh, AIR 2000 AP 156, (per J Chelameswar), (India).

20 Surrogacy Regulation Act, 2021, Section 2(r).

21 Furthermore, the Act ignores the rights of the third gender, which were recognized in the National Legal Services Authority v. Union of India case.

This pressure could create familial tension and might result in violence against women. Additionally, these provisions impose excessively restrictive limitations on the bodily autonomy and reproductive rights of women wishing to act as surrogates for friends or family who do not qualify under the defined criteria. The Act indicates that only a "close relative" of the intended parents is eligible to be a surrogate mother.

However, it does not clarify what constitutes a close relative, leading to confusion in its interpretation. Furthermore, there might be situations where a couple's close relatives are either unwilling to become surrogates or do not satisfy the eligibility requirements specified in the Act. Consequently, such couples could lose the chance to utilize surrogacy and achieve their goal of having a child that is genetically related to them. Moreover, when a close relative takes on the role of a surrogate, both the surrogate mother and the child will be inevitably aware of the surrogacy situation. This awareness could lead to emotional and family disagreements in the future, potentially straining the relationship between the surrogate mother and the child. Understanding the surrogacy arrangement might also have psychological effects on the child, raising concerns about the long-term consequences of such an arrangement.

Infringement of Articles 14 and 21 of the Constitution: The Said Act fails to meet the "Golden Triangle" test laid down by the Indian Supreme Court for assessing the constitutional validity of legislation. Primarily, it contravenes Article 14 of the Indian Constitution, which guarantees "equality before the law and equal protection of the laws" to all individuals. By restricting altruistic surrogacy solely to married Indian couples, the Act discriminates against individuals based on nationality, marital status, and sexual orientation, resulting in an arbitrary and unreasonable classification. This exclusion lacks a rational connection to the stated objectives of the legislation. Furthermore, by denying surrogacy rights to homosexual and unmarried couples, the Act reinforces a majoritarian moral framework that stigmatizes both homosexuality and non-marital cohabitation.

The Act infringes upon both the "right to livelihood" and the "right to reproductive autonomy" enshrined under the broad and evolving interpretation of Article 21 of the Indian Constitution. The jurisprudence around Article 21 makes it clear that the right to life encompasses more than mere existence; it includes the right to live with dignity and access opportunities that improve one's quality of life[22]The prohibition on commercial surrogacy directly threatens the livelihood of tens of thousands of economically disadvantaged women across India. Many of these women, often the sole earners in their families, have relied on surrogacy as a means to fund their children's education, launch small businesses, and provide basic sustenance for their households. Estimates suggest that over 100,000 women have been part of this ecosystem, indicating a substantial socio-economic impact.

Moreover, the Indian Supreme Court has recognized reproductive autonomy as an essential component of Article 21, affirming that individuals and couples have the right to make autonomous decisions regarding procreation. This includes the choice to conceive naturally or through assisted reproductive technologies like surrogacy. Interfering with such intimate personal decisions constitutes an unconstitutional encroachment on a person's fundamental right to privacy, dignity, and bodily autonomy**.**

In addition, the Act raises serious concerns under Article 19(1)(g), which guarantees all citizens the right to practice any profession or to carry on any occupation, trade, or business. The surrogacy sector not only supports surrogate mothers but also sustains a wide network of medical professionals, fertility clinics, counsellors, and other service providers. Given its scale and economic significance, an outright ban on commercial surrogacy cannot be viewed as a "reasonable restriction" under Article 19(6). Instead, it amounts to an excessive and disproportionate measure that jeopardizes the rights and livelihoods of all stakeholders in this multibillion-dollar industry.

Rights and responsibilities are interconnected, with fundamental duties serving as a continuous reminder for each citizen to meet their obligations to society and the State. The entitlement to enjoy the advantages of scientific and technological advancements is acknowledged as a basic human right under Article 27 of the Universal Declaration of Human Rights and Article 15 of the International Covenant on Economic, Social, and Cultural Rights, and it is also reflected in the Fundamental Duties of citizens in India.[23] One of the most

[22] P. Rathinam v, Union of India,1994 3 SCC _ 394, (India).

[23] Article 51- A(h), The Constitution of India, 1950

notable accomplishments of contemporary medical science is the advancement of Assisted Human Reproductive Technologies, including surrogacy. These breakthroughs provide essential support to individuals and couples dealing with infertility, assisting them in achieving their wish to have children. Given that individuals have the right to benefit from scientific and technological progress, access to surrogacy should be regarded as part of that entitlement. Consequently, imposing unreasonable limitations on access to surrogacy could be interpreted as a violation of the fundamental right to benefit from such advancements.

V. Conclusion and Suggestions

The Surrogacy (Regulation) Act, 2021, represents a crucial advancement in establishing legal regulation and ethical oversight of surrogacy in India. Although the Act seeks to safeguard human rights and prevent exploitation, it introduces intricate legal, ethical, and social issues. As advancements in reproductive technologies persist, it will be vital to continue legal and ethical discussions that balance the rights, dignity, and autonomy of all parties involved—surrogates, intended parents, and children.

Despite its protective goals, the Act has been criticized for being excessively restrictive. Opponents contend that prohibiting commercial surrogacy may push the practice into secrecy, complicating regulation and enforcement. Furthermore, depending solely on altruistic surrogacy may restrict access for couples who have difficulty locating a surrogate willing to help within their family or social circle. The legislation also inadequately addresses the requirements of international intended parents who once pursued surrogacy options in India, raising concerns about its wider implications. The prohibition of commercial surrogacy is mainly grounded in fears regarding the potential exploitation of surrogate mothers. However, it is crucial to acknowledge that various fields carry risks of exploitation, and the solution does not lie in outright bans but rather in instituting robust regulatory measures to reduce such risks. Instead of entirely prohibiting commercial surrogacy, a properly regulated system could establish protections for surrogate mothers while promoting ethical practices.Rather than a blanket ban on commercial surrogacy, the government could consider permitting regulated commercial surrogacy with clear legal contracts, informed consent and standardized compensation models. The establishment of a National Regulatory body to monitor and regulate surrogacy would ensure an ethical surrogacy practice that will benefit most of the intended parents. Thus, forbidding commercial surrogacy solely based on the possibility of exploitation seems unreasonable and violates a couple's right to reproduce.

* * * *

SOCIO-LEGAL PERSPECTIVES OF WOMEN'S REPRODUCTIVE RIGHTS: AN ANALYSIS

Mrs. Poornima Kurdikeri *

Abstract

Vedic philosophy always depicted women craving eternal and immortal knowledge rather than just material and mundane things. This depiction reflects the high status of women in Vedic society; in fact, women were called "Sahacharini" and not "Anucharini." It shows that in domestic life as well as in society, she has an equal status with men. However, as society transitioned into the later Vedic era, patriarchal norms became rigid, and infertility was seen as a curse for women.

Reproductive rights are crucial components of human dignity and individual liberty. These rights encompass the right to decidereproduction, procreation of child, contraception, abortion and family planning. The family laws which regulatesmarriage, divorce, custody of child, and parental rights often intersects with these rights, it influences women's right to choice &societalnorms.

Right to procreate, which ensures people possess the independence to decide what is best for their reproductive health, which is a basic human right. They are inseparable from human rights promoting equality, dignity and autonomy. These rights helps to create a just and equitable society where individual can make empowered choices about their reproductive health. This research paper explores reproductive rights concerningIndian contexts and also highlights the legal framework and judicial interpretations pertaining to reproductive rights.

Key words: **Reproductive Rights, Equality, Dignity, Family Laws.**

I. Introduction

Women's status and place in any given society determines the degree of civilization of the country. During the infancy of the society women were placed in a position of absolute dependence on men. The unfortunate reality is that though women, in any country form, more or less half the chunk of the entire population. However, in the early stages of society, no class was positioned to be as completely dependent on men as women. A rough indicator of the sense of justice and fair play that has grown in a community is the extent to which that dependence has been willingly changed and relaxed.[1]

In early Vedic era women generally enjoyed a relatively respected and empowered position in society, compared to later period. 'Garbhadharan Samskara' is one of the 16 shodhasha samskara in Hindu tradition .it is considered as most important custom of the prenatal samskara,which is deep rooted in our Vedas. It symbolized the sanctity of reproduction which is blended with spiritual, cultural,ethical dimensions.There are no references to the evil practice of female infanticide in any Veda or inepics or in any classical literatures. Women's fertility was celebrated and their role in reproduction was respected. From this point of view women do not seem to be standing on an antagonistic pedestal ,rather they are portrayed as essentially complementary to men .As we move towards a new century and as time progressed,women's place in societywitnessed gradual decline.The main cause of women's subordination as observed by anthropologist Claude Levi Strauss[2] was that the women were objectified as commodity rather than human beings and they were exchanged just like any other object in the society.

---

* **Assistant Professor, J.S.S. Sakri Law College, Hubballi Dharwad District -580004.**

1 " Dr.A.S. Altekar:The Position of Women in Hindu Civilisation, (Banares :Motilal Banarasidas:1956)"

II. Definition of Reproductive rights:

The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked the acceptance of a new paradigm in addressing human reproduction and health. For the first time, there was a clear focus on the needs of individuals and on the empowerment of women, and the emergence of an evolving discourse about the connection between human rights and health, linking new conceptions of health to the struggle for social justice and respect for human dignity.

In accordance with the ICPD, reproductive rights, "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." The wording are lifted afterits Women's Convention's Article 16(1)(e), which declares which States Parties shall guarantee, based on gender equality:

"The same rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights."As per ICPD, the right for reproduction involves: "make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[3]According Merriam Webster's Law Dictionary "The term reproductive rights includes in it the authority of the female to decide whether she wants to become pregnant or not."[4]

According to The International Encyclopaedia with the Social and Behavioural Sciences (2001) states that the reproductive rights are one's own approachwith birth control, abortion, and contraception . The concept behind reproductive rights has the creation or mentally along with physically healthy individuals who are free from all forms of illness and disability and who can establish the groundwork for a healthy parenthood.[5]Achieving the WHO definition includes the best attainable standard of sexual health.. It clarifies that the freedom to decide how to continue with all reproductive procedures, such as family planning, sterilization, abortion, and contraception, is part of reproductive rights. in addition to the goal of avoiding any disease or infirmity.

III. Reproductive Rights of Women: A Family Law Perspective on Autonomy and Responsibility.

Reproductive rights, which include the rights of women how to reproduce, access healthcare, use family planning, and have an abortion, are fundamental to women's human rights. When discussing family law, Reproductive rights are intimately related to legal issues which revolve around matters like marriage, parenthood, custody and responsibilities of partners and families.

Widow Remarriage and Reproductive Autonomy:

Two important enactments of Widow Remarriage Act 1856 and later onWidow's Remarriage and Property Act of 1989 helped widows with their reproductive concerns and safeguarded their rights. It gives legal and valid chance to widow to marry man of their choice. The liberty to enter into marriage with partner of one's own choice stands as vital facet of reproductive rights intertwining personal freedom with the principles of dignity and self-determination. The concept of widow remarriage always liberates the women from the web of such evil customs following which such women are forced to lead a life full of austerity, dejection, rejection and exploitation. When remarried, the woman has legal right to celebrate the institution of marriage and stay physically and mentally in healthy state of mind without becoming the victim of any taboos or interdictions of widowhood.

Child Marriages and Violation of Reproductive Rights:

As the society of India has always placed women subordinate to men, so tracing the history of our society it is found that the concept of child marriages has been enrooted in our civilization since times immemorial.

---

2 Claude Levi Struass; The Elementary Structures of Kinship (Boston 1969) p.115

3 https://" www.un.org/womenwatch/daw/csw/shalev.htm#:~:text=The%20right%20to%20reproductive%20 choice,of%20family%20 planning%20and%20contraception.

4 The Merriam Webster's Law Dictionary defines the term reproductive rights as "a women's right to choose whether or not she will have a baby". The definition is *available at*: https://www.merriam-webster.com/ dictionary/ reproductive%20rights#:~: text=Definition%20of%20reproductive%20rights,she%20will%20have%20a %20baby_(last visited on May 22, 2019).

The females of very young age were married to the males of older age, and in the majority of the cases, they died because their body parts were not physically, psychologically and sexually developed enough to bear the burden of the marriage and fulfil the sexual responsibilities which they owed towards their husbands.Keeping in mind the plight of the girl children who went through this trauma, The Child Marriage Restriction Act, 1929 was superseded by Prohibition of Child Marriage Act, 2006, which the Indian government created. The full realization with reproductive rights in India can be observed if the freedom of society occurs from age customs, taboos, rituals, usages and practices. Child marriage is one such evil and baneful custom which has a disastrous influence upon female child's physical health and psychological state. It is crucial to comprehend how child marriages compromise the reproductive autonomy of young girls. Here are some essentials to reflect considering.:

- The reproductive freedom encompassed by reproductive rights can only be fully realized if both male and female children are granted sufficient liberty to grasp the advantages and disadvantages of marriage. The right to choose one's partner is directly violated when a child is compelled to marry someone unfamiliar to them and lacks the knowledge to address questions about the relationship.
- Because the organs of young girls are not fully matured, child marriages lead to a dire future for the children born from such unions. The parents of these children are often unprepared for their responsibilities, lacking financial, emotional, sexual, and psychological strength to navigate the challenges of life. In this context, it is unrealistic to expect them to provide a better life for their offspring when they themselves endure numerous physical and mental hardships in their own marriages.

IV. Marriage and Reproductive Rights:

A legally established and justified its institution of marriage is essential to properly exercising reproductive rights in India. The following are some important points that illustrate the connection between these two aspects:

- The basic right of getting married to the person of one's own choice also establish a family can be exercised if the marriages are regulated by means of some statutes and laws and the Hindu Marriage Act, 1955 does same for Indian citizens.
- Defining the prohibited degrees of relationships within the Hindu Marriage Act,1955 helps by maintaining its dignity as well as protect sacrosanctity of the existing relationships. The institution of marriage can be established in diligent manner only if it occurs through proper channels and not with the prohibited relationships, for example, a real brother cannot marry a real sister, one cannot get married to one's own father or mother etc. This also thus indirectly helps to regulate the acts of reproduction.

V. Marriage and Contraceptive Choices:

Women in developing countries are either under collective decision making with their partners or completely rely on the male partner's decision on issues that affect their reproductive live. Identifying the major barriers of married women's decision making power on contraceptive use has significant relevance for planning contextually appropriate family planning interventions.Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies [6].Despite global shifts towards delayed marriages, India maintains a stable marriage rate. This stability is influenced by cultural norms and the caste system, which emphasize the importance of marriage remains vital to the Indian economy.

The contraceptive choice of women always influenced by wide range of social, economic, cultural, educational factors,healthcare access and policies. These rights are women's "exclusive and inalienable" decision regarding "whether or not to get pregnant, and if pregnant whether to retain the pregnancy and to deliver the child", a choice that, "she, and she alone can make".

---

[5] Neil J.Smelser and Paul B. Baltes (2nd ed.), *The International Encyclopedia of the Social and BehavioralSciences* (Amsterdam Elsevier"Netherland, 2015).

[6] Andrzej K: Husband –wife Agreements, Power, Relations and Contraceptives use, International Family Planning Perspective 2008 34;127-137

Abortion Right and Spousal Consent:

Women have a right to control over their bodies and women alone need to make the decisions. It is impossible to overstate the effects for an unwanted pregnancy upon a woman's body. Until it is born, the foetus depends on the mother's body for support and nutrition. Pregnancy changes her body in a way that makes it possible. She might also undergo several physical changes, and issues could develop that endanger women's lives. The right and information to choose medical care and treatment, including decisions about one's own sexuality and fertility, are protected by Articles 12 and 16 of the Convention concerning the Elimination in All Forms of Discrimination Against Women (1978). Regarding the delivery of treatments for reproductive health, confidentiality, autonomy, and the right to informed consent are considered to be the fundamental ethical principles. The agreement states that these values ought to be reflected in national norms, standards, or regulations. In addition, autonomy would eliminate the necessity for a third party's authorization when mentally competent adult sought medical attention. In reproductive health research, recent ethical rules restrict the use of the term "consent" to the person directly participating; when partners are involved, it is called a "partner agreement.".India, as a signatory to the International Conference on Population and Development, 1994, has committed itself to ethical and professional standards in family planning services, including the right to personal reproductive autonomy and collective gender equality[7]

Divorce and Reproductive Choices:

Janet Dolgin a legal expert quotes that "Reproductive autonomy challenges traditional notion of marital unity, placing individual rights above collective decision making".one significant area of conflict arises between the spouses are disagreements over childbearing. the decision to have or not to have child without mutual agreement can lead to resentment and perceived betrayal. Such disparities often expose incompatibilities which may results into dissolution of marriage. Ultimately the reproductive choice of women reflects her right of bodily autonomy –a right that sometimes strains the very essence of marital unity.

VI. Legal Framework Governing Reproductive Rights of Women:

In *K.S Puttaswamy .V. Union of India*[8],a nine judges bench of Supreme Court affirmed that the Indian Constitution guarantees the right to privacy as fundamental right. The Court held that the right to privacy protects the ability of individual to exercise control over vital aspect of their lives, including matters relating to reproductive rights. Nariman and Chelameshwar JJ. recognized that the woman's decision to procreate and abort a pregnancy falls within the realm of her right to privacy.[9] In Suchitra Srivastava ,the Court had recognized women's right to make reproductive choices as part of right to personal liberty under Article 21 of the Indian Constitution .This right includes right to insist on use of contraceptive methods, adopt birth control measures ;carry a pregnancy or seek abortion.

In a similar vein, the Delhi High Court ruled *in Laxmi Mandal V. Deen Dayal Harinagar Hospital*, a woman's rights involve the right to reproductive health "inalienable survival rights" under Article 21 of the Indian Constitution. Citing several international human rights conventions, the Court emphasized its interdependence civil, political, and socioeconomic rights to conclude that the state's obligations resulting from these rights depended on the proper implementation of programs intended to demonstrate it into action.

Human Rights Norms:

While the International Covenant on Economic, Social, and Cultural Rights (ICESCR) protects the right to health under human rights law, the ICCPR upholds the right to life. The CEDAW offers legal protection against discrimination within the exercise of women's right to health, including non-discrimination in access to healthcare.The right to life is closely linked to the best possible health, especially sexual and reproductive health. The Committee on Economic, Cultural, & Social Rights (ESCR Committee), which is in charge ofimplementing the ICESCR., like "the right to make free and responsible decisions and choices, free of violence,

---

7 Chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://download.ssrn.com/14/10/27/ssrn_id2515187_code21487

8 AIR (2017)10 SCC .1

9 AIR (2016)10 SCC 726/733

coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health." The rightscontain "unhindered access to a whole range of health facilities, goods, services and information".Social injustices manifested in institutional frameworks, legal frameworks, the social determinants of health, along with the underlying determinants of health, include social norms that hinder people from enjoying their reproductive and sexual well-being to the maximum extent possible such as nutrition and education, must be provided by states.

Medical Termination of Pregnancy Act:

One of the most significant aspects of reproductive freedom and justice is the right to access abortion services. For many years, the discussion surrounding the legalization and regulation of abortion has presented ethical challenges, with advocates on both sides of the issue. There exist two opposing ideologies, with passionate supporters of pro-life and pro-choice frequently engaging in conflicts within political, medical, and legislative arenas. This topic remains contentious, and numerous developed countries continue to face difficulties in reaching a resolution. India, as a developing nation characterized by a diverse array of cultures, traditions, socio-economic conditions, and religious beliefs, is expected to confront this issue. Given the challenges posed by underdeveloped infrastructure, limited healthcare access, and the overall neglect of women's health, abortion has also raised various logistical concerns. Nevertheless, since the 1970s, India has taken a definitive position on the subject of abortion. By honouring the right to personal liberty, promoting women's reproductive freedom, and emphasizing the significance of women's health, the Medical Termination of Pregnancy (MTP) Act has been in effect in India since 1971.

In October 2021, the MTP Act was modified to fix some issues. MTP up to 20 weeks is permitted under its amended statute based on a single registered medical practitioner's assessment, an increase from the previous 12 weeks. MTP is also permitted between 20 and 24 weeks with evaluations from two RMPs in specific cases, including:

- Rape, incest, or sexual assault.
- Pregnancies involving minors.
- Changes in marital status during pregnancy (e.g., widowhood or divorce).
- women with major disabilities in accordance with the 2016 Rights of Persons with Disabilities Act.
- Women suffering from mental disorders, like mental retardation.
- Fatal malformations posing serious risks to life or severe disabilities.
- Humanitarian crises or emergencies declared by the government.[10]

PNDT and PCPNDT Act and its implementation:

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse Act), 1994, commonly referred to as the PNDT Act, was established to curb the misuse of preconception and prenatal diagnostic methods aimed at identifying the sex of the foetus, as well as to prevent the communication of this information to the pregnant woman or her family members . Also referred to as the "Pre-Conception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act of 1994", the PCPNDT Act, was renamed the PNDT Act in 2003 in order to strengthen the original legislation and incorporate recent advancements in preconception sex-selection methods.The new law forbids sex selection before as well as following conception and controls the application of prenatal diagnostic methods to detect specific abnormalities or diseases. The MTP Act, 1971 governs abortion also abortion service providers separately, thus it is crucial to understand that this act does not cover either of those topics. Several subjects about sex determination in India will be covered in this section, like:

- The enforcement between the PCPNDT Act and the PNDT Act
- Prohibition of Internet Promotions for Determination of Sex Selection
- Constitutional Challenges from the PCPNDT Act
- The relevance with the PCPNDT Act in Surrogacy Arrangements.

[10] "https://pmc.ncbi.nlm.nih.gov/articles/" PMC"10470576/

Therefore, PCPNDT Act has an important law designed to prevent the concerning practice of female foeticide in India. This Act offers a strong framework to stop sex selection and guarantee its moral use of prenatal diagnostic procedures, and it is backed by the constitutional protections of equality and the right to life. Among other things, a lack of awareness has prevented the Act's objectives from being fully achieved, inadequate monitoring, corruption, and delays in the judicial process.[11]

VII. Conclusion:

Understanding and addressing reproductive health as women perceive it—not as a biological phenomenon but as an essential component of their everyday lives—is the main goal of women-cantered approaches to reproductive rights. A woman's status and capacity to protect her own and her family's health are impacted by numerous factors., including her capacity to behave as a self-sufficient adult, her capacity to control property, her legal ability to make a living, and her ability to participate in public life. One of these considerations is the amount and spacing of children.

A plethora of laws shapes women's social environment. For example, family laws govern the relationship between men and women by establishing norms for marriage, divorce, sexuality, intrahousehold economics, and responsibilities towards children. therefore, the qualities of respect,dignity and right to choice has always associated with improved health of women. The various statutes of India are either directly or indirectly able to elevate and secure the position of women by protecting their reproductive freedom and the ancillary rights associated with marriage,motherhood,right to have family etc. but our society's misfortune is that majority with people are unaware about the concept of reproductive right.

Therefore, there is a need to lay down strict policy framework to regulate the reproductive rights of women.

* * * *

[11] extension://efaidnbmnnnibpcajpcglclefindmkaj/ "https://www.lawjournals.org/assets/archives/2024/vol10issue4/10188.pdf".

POPULATION POLICY IN INDIA- ACHIEVEMENTS AND FAILURE

Mr. M. Naveen Kumar *

Abstract

Population policy is a legal, administrative programs of the government at reducing birth rate and improving the quality of life. Population Policies are formulated to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The main objective is to achieve a stable population at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection. There are two main types of population policy. Pro-Natalist and Anti-Natalist, countries goes through the uncertainty and risk of future demographic structural imbalance of their population. This paper throws light on the targets set by the National Population Policy which have not been achieved. The effectual way to stop population growth is to implement family planning policies but the exact way to achieve that has created a great deal of disagreement. Several feasible solutions have been proposed by the government to curb population but the reality stays ahead of the expectations delivered.

Key words: **Population, India, Policy**

I. Introduction

Population policy is a legal, administrative programs of the government at reducing birth rate and improving the quality of life. Population Policies are formulated to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The main objective is to achieve a stable population at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

Population policy may be defined as deliberately constructed or modified institutional arrangements or specific programs through which governments influence, directly or indirectly in the demographic changes.

The generality of the definition lends itself to varying interpretations. For any given country, the aim of population policy may be narrowly constructed as bringing about quantitative changes in the membership of the territorially circumscribed population under the government's jurisdiction. Additions to membership are effected only through births and immigration. Losses are caused by emigration and deaths. Concern with the last component is usually seen as a matter for health policy, leaving fertility and migration as the key objects of governmental interest in population policy.

More broadly, policy intent may also aim at modification of qualitative aspects of these phenomena-fertility and international migration-including the composition of the population by various demographic characteristics and the population's spatial distribution.

II. Types of Population Policy

There are two main types of population policy. Pro-Natalist and Anti-Natalist, countries goes through the uncertainty and risk of future demographic structural imbalance of their population. Governments are now facing a growing concern over the age structure and the decline and growing birth rates.[1]

Natalism also known as pro-birth is countries which promote human reproduction. Countries that promote

* **Assistant Professor, BMS College of Law, Basavanagudi, Bengaluru**

[1] msn.com/news/populationpoliciesaroundglobe

Natalism are countries such as Germany. Methods of Natalism, usually enforced by governments are promoting and glorifying parenthood with the incentive of the them paying for the first year of the child's life. They are also trying to limit the amount of abortions and creating an environment more friendly to the aspect of having a child and working at the same time. Since the old societies beliefs that women cannot have jobs and be parents at the same time, the Government is trying to promote the contrasting opinion of that belief. Least developed countries usually use this type of policy more because of the fact that their aging ratio is off balance.

Anti-natalism is the opposite of natalism, the fraught to limit the population of the country. This is enforced in quite a few countries, the most known is China. The policy they have is the "One Child Policy" which is that all families are allowed to have only one child, and if this policy was broken then there were major consequences to be faced. Their methods of antinatalism are considered quite forceful compared to other policies. They have forced abortions and after sterilization of the male or female to prevent them from ever having a child again. The incentive that they provided their people with was somewhat torturous. Many Least developed countries have this type of policy, to balance their dependency ratio.

III. World View

Population is a relevant cornerstone for any effective administration. While its burgeoning growth stresses natural resources, a continuous curb can lead to an ageing and dwindling workforce. Let's take a look at some laws that have been put in place by the governments based on the state of population in the country.[2]

China - Population: 1,417 million

Established in 1979, China has had the infamous "one child per family" law to try and get its population growth in check. The policy, under which families were fined if they had more than one child, has led to a shortage of young people in the country. China relaxed this policy in October 2015 and allowed for two children per couple — but the fertility rate (a measure of how many children a woman bears over her lifetime) only reached a dismal 1.6 children per woman in 2017. The current government is now considering relaxing the policy even further.

Russia - Population: 143 million

According to a U.N. report released in May 2018, Russia's population will shrink by 11 million by 2050. In January 2018, the country's birth rate hit the lowest mark with just 1.69 million babies recorded to be born in 2017. President Vladimir Putin in his election campaign had vowed to spend $8.6 billion on programs to encourage Russians to have more babies.

South Korea - Population: **51 million**

A study by the National Assembly Research Service in Seoul, South Korea, has predicted that with the continuous falling fertility rate, native Koreans will go extinct by 2750. A worried government has turned to several pro-natalist policies and cash payouts to encourage couples to have more babies. There's a 500,000 won ($445) bonus for expectant couples to take care of the prenatal healthcare. For the first year, they get 200,000 won ($178) in cash allowances and the amount increases with each subsequent child. All in all, the government has poured in about $90 billion in policies to encourage child births, but the birth rate recorded in January 2018 was a dismal 0.96.

United States of America - Population: **326 million**

The United States has been a known supporter of the Program of Action of the 1994 International Conference on Population and Development, which endorses choice of the number and timing of children, gender equality and family planning based on individual preferences. The government doesn't officially endorse population control or stabilization and rather promotes better healthcare alternatives for women and the freedom to exercise their reproductive rights.

Japan - Population: **127 million**

With a continuous decline in birth rates, Japan became the oldest large country in the world by median age in 2015 and, as of June 2018, more than half of its population is above the age of 46. Authorities have begun

[2] Ibid

a series of measures such as the Angel Plan (1994), the New Angel Plan (1999) and the Plus One Policy (2009) to assist and encourage young couples to have children.[3]

Pakistan - Population: 202 million

Pakistan, which saw a five-fold increase in its population — from 34 million to 171 million — between 1951-2009, set the National Population Policy in 2010 that aims to bring down the nation's fertility rate to 2.1 births per woman by 2025. Authorities are encouraging having children up to 36 months apart while also promoting contraception, a concept which is not widely accepted in the deeply religious country.

Population Policy in India since Independence

Since the middle of the 20th century, developing countries like India have been facing the problem of unsustainable population growth. After independence, Indian decision-makers realized the importance and need of population control as early as in 1951-52, though before independence a sub-committee on population was appointed in 1940 under the chairmanship of renowned social scientist Radha Kamal Mukherjee and Sir joseph Bhoreto suggest ways and means to arrest the galloping population.[4]

Radha Kamal Mukherjee Committee, 1940 - In 1940, the Indian National Congress had appointed a committee on population under the leadership of renowned social scientist Radha Kamal Mukherjee to come up with suggestions to arrest increasing population of the country. As a matter of fact, India's population started growing rapidly after 1921. The committee after deliberations suggested that population can controlled by placing emphasis on self-control; creating awareness about the cheap and safe methods of birth control; opening birth control clinics; increasing the age of marriage; discouraging polygamy etc.

Bhore Committee, 1943 - Government of India in 1943 appointed a Health Survey and Development committee under the chairmanship of Sir Joseph Bhore. This committee had suggested 'deliberate limitation of family' approach as a way for controlling population, which cannot be achieved through self-control 'to any material extent'

After independence in 1951, India became the first among the developing countries to come up with a state sponsored family planning programme. The Planning Commission which was set up in 1950 was given the task to decide upon the contours of the family planning programme. In 1952, a population policy committee was constituted. This committee had recommended setting up of a Family Planning Research and Programmes. A Central Family Planning Board was created in 1956 which emphasized sterilization. Up till 1960s a rigid policy was not adopted to arrest the fast growth of population. The policy framed in 1951-52 was ad hoc in nature, flexible, and based on a trial and error approach.

When the First Five-Year Plan was formulated, it was enumerated in the plan that the programme for family limitation and population control should:

(a) present an accurate picture of the factors contributing to the rapid increase of population;

(b) discover suitable techniques of family planning and devise methods by which knowledge of these techniques could be widely disseminated; and

(c) give advice on family planning as an integral part of the service of government hospitals and public agencies.

Until the Fifth Plan, family planning programme concerned itself primarily with birth control but in this plan 'maternal and child health and nutrition services' were also included as an integral part of family planning programme. Despite all the Five-Year Plans (from First to Tenth) and policies, the population of India is growing at a faster pace and taking the shape of 'population explosion'.[5]

The striking growth rate of population compelled the government to adopt a relatively more clear and less flexible policy of population which can stabilize the growth rate. In 1961-71, the population growth rate was 2.25 per cent which was highest in any decade after independence. At present (2001-2011), the population growth rate has declined to 1.50 per cent.

In April 1976, the First National Population Policy was framed by the Union Ministry of Health and Family

[3] msn.com/news/populationpoliciesaroundglobe
[4] Introducing Sociology, NCERT, textbook for class11th.
[5] Ibid

Planning which suggested a wide spectrum of programmes including raising the statutory age of marriage, introducing monetary incentives, paying special attention to improving female literacy, etc.

Though this policy was endorsed by the parliament, it was planned at a time when the Emergency was clamped all over India. Sanjay Gandhi, the then President of Indian Youth Congress, took the programme of sterilization overzealously which made the masses hostile towards the government led by Indira Gandhi as well as the programme. One of the reasons for this was said to be the excesses committed in the programme.

There was an overall resentment among the people (as a result of which the Congress was voted out of power in elections held in March 1977). This incident defeated the whole purpose of the family planning programme. The enthusiasm of the people about birth control was also to some extent slackened. The later governments became extremely cautious about the implementation of programmes of family planning.

In the post-emergency period, the Janata Government announced a New Population Policy in 1977. The main features of this policy were:

(a) Renaming the family planning programme into family welfare programme;

(b) Fixing the marriage age for girls at 18 years and for boys at 21 years. This has been implemented by the Child Marriage Restraint (Amendment) Act, 1978;

(c) Making sterilisation voluntary;

(d) Including population education as part of normal course of study;

(e) Monetary incentive to those who go in for sterilization and tubectomy;

(f) Private companies to be exempted in corporate taxes if they popularise birth control measures among employees;

(g) Use of media for spreading family planning in rural areas, etc. this policy put an end to compulsory sterilisation and laid emphasis on voluntary sterilization. This slowed down the family planning programme. As a result, the number of sterilizations fell from 82.6 lakh in 1976-77 to 9 lakh in 1977-78.[6]

TABLE 32.1: FAMILY PLANNING EXPENDITURE

Plan		*Rs. Crores*	*% of Total Plan Outlay*
First Plan	(1951-56)	0.65	0.03
Second Plan	(1956-61)	5.0	0.1
Third Plan	(1961-66)	25.0	0.3
Annual Plans	(1966-69)	70.0	1.1
Fourth Plan	(1969-74)	278.0	1.0
Fifth Plan	(1974-79)	492.0	1.2
Sixth Plan	(1980-85)	1,448.0	1.3
Seventh Plan	(1985-90)	3,121.0	1.4
Eighth Plan	(1992-97)	6,792.0	1.4
Ninth Plan	(1997-2002)	15,120.0	3.1
Tenth Plan	(2002-07)	27,125.0	3.0

Up to the Fifth Plan, expenditure on family planning was very small. It was only from the Sixth Plan that it had been increasing both in absolute terms and as percentage of total plan outlay. In absolute terms, it increased from Rs. 1,448 crores during the Sixth Plan to Rs. 15,120 crore during the Ninth Plan. As the percentage of total plan outlay, it ranged between 1.3 to 1.4 per cent up to the Eighth Plan.

It was only in the Ninth Plan that it had increased to 3.1 per cent. It has been stipulated at 3.0 per cent in the Tenth Plan. This shows that except during the Ninth Plan, the Government did not provide adequate financial assistance to the family welfare programme.An expert group under the chairmanship of Dr. M.S. Swaminathan was appointed in August 1993 to prepare a draft on new population policy.

The committee submitted its report in 1994. It was in February 2000 that the Government of India announced its second population policy. The policy affirms the commitment of the government towards voluntary and informed choice and consent of the citizens. It was in the Ninth Plan that the Government announced the National Population Policy on 15 February, 2000

[6] [Economic survey of India 2008]

IV. National Population Policy, 2000:

India's population reached 100 crore on May 11, 2000 and it is estimated that if current trends of population increase continue she will become the most populous country in the world by 2045 when it would overtake China. During the 20th century, India's population increased nearly five times from 23 crore to 100 crore, while during the same period world's population increased nearly three times from 200 crore to 600 crore.[7]

With 1.55 crore current annual increase in population, it seems difficult to maintain a balance to conserve the resource endowment and environment in the country. For promoting sustainable development with more equitable distribution, there is an urgent need to stabilize population.

To meet the reproductive and child health needs of the people of India and to achieve TFR by 2010, the provision of policy framework for advancing goals and priorities to various strategies is available in the National Population Policy announced on 15 February, 2000. The basic aim of this policy is to cover various issues of maternal health, child survival and contraception and to make reproductive health care accessible and affordable for all.

Objectives:

There are three types of objectives of National Population Policy (NPP) 2000:

1. The Immediate Objective:

The immediate objective is to address the unmet needs for contraception, health care infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health care.

2. The Medium Term Objective:

The medium term objective is to bring the Total Fertility Rate (TFR) to replacement level by 2010 through vigorous implementation in inter-sectorial operational strategies.

3. The Long Term Objective:

The long term objective is to achieve a stable population by 2045 at a level consistent with the requirements of sustainable economic growth, social development, and environment protection.

Targets:

The following are the targets of National Population Policy:

1. Achieve zero growth rate of population by 2045.
2. Reduce infant mortality rate of below 30 per thousand live births.
3. Reduce maternal mortality ratio of below 100 per 1, 00,000 live births.
4. Reduce birth rate to 21 per 1000 by 2010.
5. Reduce total fertility rate (TFR) to 2.1 by 2010.[8]

V. National Socio-Demographic Goals for 2010:

To fulfill these objectives and targets. National Socio-Demographic goals have been formulated which in each case are to be achieved by the year 2010.

They are as follows:

1. Make school education free and compulsory up to the age of 14 and reduce dropouts at primary and secondary school levels to below 20 per cent for both boys and girls.
2. Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
3. Achieve universal immunization of children against all vaccine preven-table diseases.
4. Promote delayed marriage for girls, not before 18 and preferably after the age of 20 years.
5. Prevent and control communicable diseases.
6. Achieve universal access to information/counselling and services for fertility regulation and contraception with a wide basket of choices.

---

[7] Vikas Ranjan,2012, Applied Sociology Indian Society

[8] Ibid

7. Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons.
8. Achieve 100 per cent registration of births, marriage and pregnancy.
9. Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services and in reaching out to households.
10. Contain the spread of Acquired Immuno-Deficiency Syndrome (AIDS) and promote greater integration between the management of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI) and the National AIDS Control Organisation.
11. Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centered programme.
12. Promote vigorously the small family norm to achieve replacement levels of TFR.
13. The Technical Group on Population Projection has projected India's population of 116 crore in 2010, but it may reduce to 110.70 crore in 2010 if the National Population Policy, 2000 is fully implemented. This can be seen from table 32.2.[9]

TABLE 32.2 : ANTICIPATED POPULATION GROWTH (IN CRORE)

Year	*If Current Trends Continue*		*If TFR 2.1 is Achieved by 2010*	
	Total Population	*Increase in Population*	*Total Population*	*Increase in Population*
1991	84.63	-	84.63	-
1996	93.42	17.6	93.42	17.6
1997	94.99	15.7	94.99	14.8
2000	99.69	15.7	99.10	14.0
2002	102.76	15.4	101.30	11.0
2010	116.23	16.8	110.70	11.75

Moreover, the projections of crude birth rate, infant mortality rate and total fertility rate are shown in Table. These projections are feasible if the National Population Policy 2000 is fully implemented.[10]

TABLE 32. 3 : THE PROJECTIONS OF CRUDE BIRTH RATE, INFANT MORTALITY RATE AND TOTAL FERTILITY RATE IF THE NPP 2000 IS FULLY IMPLEMENTED.

Year	*Crude Birth Rate*	*Infant Mortality Rate*	*Total Fertility Rate*
1997	27.2	71	3.3
1998	26.4	72	3.3
2002	23.0	50	2.6
2010	21.0	30	2.1

Organisation:

To implement and achieve the various objectives, targets and socio--demographic goals, the following organisational structure has been proposed by the National Population Policy**:**

1. The appointment of a National Commission on Population to be presided over by the Prime Minister. The chief ministers of all States and related ministers will be its members.
2. There will be a State Commission on Population in every State headed by its chief minister.
3. The new policy will be implemented by the Panchayats and municipalities at the grassroots levels.

---

9 Ibid

10 [Economic survey of India 2013]

National Commission on Population:

In pursuance of NPP, 2000, the Central Government has set up a National Commission on Population (NCP) on 11 May, 2000. It is presided over by the Prime Minister, with the Chief Ministers of all States and UTs and the Central Minister-in-charge of concerned Central Ministries and Departments, reputed demographers, public health professionals and non-government organisations as members. State Level Commissions on Population presided over by the Chief Minister have been set up with the objective of ensuring implementation of the NPP.[11]

The Functions of the Commission are:

(i) To review, monitor and give direction for the implementation of the NPP with a view to achieve the goals set by it;

(ii) To promote synergy between health, educational, environmental and developmental programmes so as to hasten population stabilization;

(iii) To promote inter-sectoral co-ordination in planning and implementation of the programmes through different agencies at the Centre and in the States; and

(iv) To develop a vigorous people's programme to support this national effort.

The first meeting of NCP was held on 22 July, 2000, where the Prime Minister announced two major steps:

1. The formation of an Empowered Action Group within the Ministry of Health and Family Welfare to focus on those States which are deficient in national socio-demographic indices.

2. Establishment of National Population Stabilisation Fund (NPSF) with a seed money of Rs. 100 crore to provide a window for channelising funds from national voluntary sources. The Prime Minister appealed to the corporate sector, industry, trade organisations and individuals to generously contribute to this fund and thus help in the national effort to stabilise population.

A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as a Standing Advisory Group to the Commission. Nine working groups have been constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in NPP NCP has allocated funds for action plans drawn up by district magistrates in poorly performing districts to implement programmes to accelerate the decline in fertility.

However, this policy has been criticised[12] on the following grounds:

1. The Swaminathan Committee (1993) had recommended the year 2015 as the target for population stabilisation which the NPP has pushed to the year 2045.
2. The Swaminathan Committee was against providing cash incentives to couples undergoing sterilisation because these are misused. But the NPP has proposed the same.
3. Critics point out that the NPP is soft towards the male participants. The various motivational and promotional measures for adoption of small family norms appear to convey that the women will bear the burden of population control rather than men. This is borne out by the fact that there has been a steady decline in vasectomies over the last two decades and presently over 97 per cent of sterilizations are tubectomies of women.
4. The NPP commits the same mistake which had been made by the earlier population policies. It depends upon its implementation on the bureaucracy rather than on NGOs (non-governmental organisations).
5. The proposal that the National Commission on Population (NCP) should be chaired by the Prime Minister has been criticised because being a very busy person, the Prime Minister would not be able to attend it. This would delay the taking of important decisions on population control.

Achievements and failures - As per census of 1951, crude birth rate (CBR) was 40.8, Infant Mortality Rate (IMR) was 146, crude death rate 25 and total fertility rate was 6. As per Sample Registration Survey for the year 2012 Crude Birth Rate (CBR) is 21.6; Crude Death Rate (CDR) is 7.0; Infant Mortality Rate (IMR) is

---

[11] Vikas Ranjan,2012, Applied Sociology Indian Society

[12] Vikas Ranjan,2012, Applied Sociology Indian Society

42 and Total Fertility Rate (TFR) is 2.4. These figures would indicate that the country has made substantive progress in population management since 1951. However, when we see it from the perspective of the targets set by the National Health Policy and National Population Policy we find that our achievements falls short of the targets under the National Population Policy. Similarly, with respect to TFR, National Health Policy targeted replacement levels by 2000 and National Population Policy targeted these levels by 2010, but the figure for the year 2012 is 2.4, which is again much higher than the target. At this rate we may take another 10 years or so to achieve this level of TFR.[13]

National Population Policy sets the target of achieving a stable population by 2045, that is, after 35 years of achieving the replacement level. The projections appear unrealistic considering the example of China which attained replacement level of total fertility rate in 1990. However, its population is still growing and is expected to achieve peak level only in 2050 after which it will stabilize or gradually decline. Thus, in China, peak level is expected to be achieved after 60 years of achieving replacement level of fertility rates. As India, does not have such a vigorous population control policy as China time taken by India is likely to be much higher.

Reasons for Failures

The above said data indicates the many of the targets set by the National Population Policy have not been achieved. The reasons could be as under:

1. Unlike China, we have resorted to voluntary participation in population control measures; hence efficacy of these measures would depend on the ability to convince people to have a smaller family. This makes, literacy level a very important factor. As per Census, 2011, Kerala, which has the highest literacy rate of 93.91%, has a very low annual growth rate of .48% while Bihar which has lowest literacy rate of 63.82% has a high annual growth rate of 2.26%.
2. Poverty is another important factor. In such families, an additional child is treated as a potential earning hand and hence birth of a child is not discouraged.
3. In a number of areas particularly in remote areas, adequate health and birth control facilities are not available without which the people cannot adopt family planning measures.
4. Social factors also play an important role. Traditional Indian society prefers early marriage of girls which means that a married woman has more years of reproductive period. This is an important factor in increasing fertility rate and leads to growth in population

VI. Conclusion

To summarize, population escalation is a major issue around the world which has adverse impact on numerous environmental and human health problems. Population growth continue to increase in the world at a fast pace. As the population enlarges, many experts are concerned about its dangerous results.[14]

The growth rate of population is a function of migration, birth rate and death rate in a country. The change in population caused by net migration as a proportion of total population of the country is almost insignificant and, therefore, can be easily ignored. That leaves us with birth rate and death rate.The difference between the birth rate and the death rate measures the growth rate of population. Over populated regions need more resources. Population explosion causes deforestation for food production, urban overcrowding and the spread of horrible diseases.

The effectual way to stop population growth is to implement family planning policies but the exact way to achieve that has created a great deal of disagreement. Several feasible solutions have been proposed by the government to curb population.

Way Forward[15]

1. Late Marriage: This will reduce the period of reproduction among the females bringing down the birth rate.

---

[13] Ibid

[14] Ibid

[15] Ibid

2. Family Planning: This method implies family by choice and not by chance. By applying preventive measures, people can regulate birth rate. The success of this method depends on the availability of cheap contraceptive devices for birth control.
3. Spread of Education: The spread of education changes the outlook of people. The educated men prefer to delay marriage and adopt small family norms. Educated women are health conscious and avoid frequent pregnancies and thus help in lowering birth rate.
4. Adoption: Some parents do not have any child, despite costly medical treatment. It is advisable that they should adopt orphan children.
5. Minimum age of Marriage: In India minimum age for marriage is 21 years for men and 18 years for women has been fixed by law. As fertility depends on the age of marriage, this law should be firmly implemented and people should also be made aware of this through publicity.
6. Raising the Status of Women: There is still discrimination to the women. So women should be given opportunities to develop socially and economically. Free education should be given to them.
7. Publicity: The communication media like TV, radio and newspaper are the good means to propagate the benefits of the planned family to the uneducated and illiterate people especially in the rural and backward areas of the country.
8. Incentives: The govt. can give various types of incentives to the people to adopt birth control measures. Monetary incentives and other facilities like leave and promotion can be extended to the working class which adopts small family norms.
9. Employment to Woman: The female labour force participation has had a decadal fall from 36.7 per cent in 2005 to 26 per cent in 2018, with 95% (195 million) women employed in the unorganised sector according to a report by Deloitte. Access to quality education, reducing the digital divide, mentoring adolescent girls on vocational training and apprenticeship avenues can build a strong linkage towards considering technology linked training and employment options.[16]

The Ministry of Health and Family Welfare has launched "Mission Parivar Vikas" in 145 high focus districts having the highest total fertility rates in the country. These 145 districts are in the seven high focus, high TFR states of Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam that constitute 44% of the country's population. The main objective of 'Mission Parivar Vikas' will be to accelerate access to high quality family planning choices based on information, reliable services and supplies within a rights-based framework.The key strategic focus of this initiative will be on improving access to contraceptives through delivering assured services, dovetailing with new promotional schemes, ensuring commodity security, building capacity (service providers), creating an enabling environment along with close monitoring and implementation.

* * * *

[16] Ibid

ARBITRATION AS A TOOL FOR ADDRESSING CONFLICTS IN SURROGACY AGREEMENTS: CHALLENGES AND OPPORTUNITIES IN INDIA

Mrs. Anupama B. U. *

Abstract

Surrogacy moved from being merely an unregulated activity to something managed by a formal legal framework for India once the Act of Surrogacy (Regulation) of 2021 came into force. The Act was aimed at resolving a moral dilemma on surrogacy and put a stop to any exploitation that arises in such arrangements. However, it has caused stringent rules creating legal ambiguities and disagreements on the part of stakeholders, such as intended parents and surrogate mothers, among others. In its analysis, it explores how arbitration can provide a resolution procedure for disputes connected with surrogacy contracts under Indian law; it is used as a privatised, low-cost, flexible alternative to routine court proceedings.

In determining whether the 1996 Arbitration and Conciliation Act applies to surrogacy disputes, this paper explores the relationship between arbitration and the legal structure that governs surrogacy in India. It recognises that some information is crucial: The article explores the interplay between arbitration and the regulatory framework governing surrogacy in India, analysing the applicability of the Arbitration and Conciliation Act of 1996 to surrogacy disputes. It identifies key challenges, including public policy concerns, ethical dilemmas, and enforceability of arbitration clauses in surrogacy agreements. Additionally, the research highlights opportunities to integrate arbitration into India's surrogacy framework by proposing best practices and recommendations to enhance its effectiveness and accessibility.

This article provides a comprehensive understanding of arbitration's role in resolving surrogacy disputes and contributes to the discourse on balancing reproductive autonomy, ethical considerations, and legal safeguards in India's surrogacy landscape. This article offers valuable insights for policymakers, legal practitioners, and other stakeholders, aiming to ensure justice and fairness in surrogacy arrangements while safeguarding the rights of all parties involved.

Keywords: **Surrogacy, Arbitration, Reproductive autonomy.**

I. Introduction

Surrogacy, a form of assisted reproductive technology (ART), has gained increasing global significance, necessitating robust legal frameworks. Once a commercial surrogacy hub, India has undergone significant regulatory changes culminating in the Surrogacy (Regulation) Act, 2021.[1] This Act strictly limits surrogacy to selfless arrangements under stringent conditions, creating the need for effective dispute-resolution mechanisms.[2]

Legal conflicts in surrogacy agreements arise from various factors, including disputes over parental rights, breaches of contractual obligations, compensation, medical negligence, and ethical concerns surrounding informed consent. Traditional litigation in such cases is often protracted, expensive, and emotionally burdensome for all parties involved. Given these challenges, alternative dispute resolution (ADR) mechanisms, particularly arbitration, offer a viable means of expediting and streamlining dispute resolution while ensuring confidentiality and fairness.[3]

* **Assistant Professor, CBR College of Law and Centre for Postgraduate Studies in Law, Shivamogga. And Research Scholar: PG Department of Studies in Law, KUD, Dharwad.**

1 S.S. Das & Priyanka Maut, Commercialization of Surrogacy in India: A Critical Analysis, V JCC L. Rev. 14, 29(2014). https://www.researchgate.net/publication/281710247_Commercialization_of_Surrogacy_in_India_A_Critical_Analysis

2 Arbitrability of Cross-Border Surrogacy Disputes, Manupatra (6,oct 2021), https://docs.manupatra.in/newsline/articles/Upload/0B1C9959-BFB5-4A7C-A1E8-7C9FA8D23FCA.pdf.

3 Ibid

Arbitration, as outlined in the Arbitration and Conciliation Act, of 1996, has been successfully employed in resolving commercial disputes, including those with complex contractual and ethical considerations. Its potential application in surrogacy disputes is significant, provided the legal framework accommodates the unique sensitivities involved in reproductive rights. This article explores arbitration's feasibility in resolving surrogacy-related conflicts in India by analysing legislative gaps, judicial precedents, and international best practices while offering policy recommendations to bolster its effectiveness.[4]

Surrogacy, a form of assisted reproductive technology (ART), has gained increasing global significance, necessitating robust legal frameworks. Legal conflicts arise in surrogacy agreements concerning contractual obligations, compensation, parental rights, and ethical concerns. Traditional litigation in such cases is often time-consuming and emotionally draining, necessitating alternative dispute resolution (ADR) mechanisms like arbitration.[5] Given arbitration's advantages in commercial disputes, this article explores whether it can serve as an effective tool in resolving conflicts in surrogacy agreements in India.

II. Legal Framework Governing Surrogacy in India

The Surrogacy (Regulation) Act, 2021

The Surrogacy (Regulation) Act, 2021, governs surrogacy arrangements in India by prohibiting commercial surrogacy and allowing only altruistic surrogacy under stringent conditions. The Act does not provide explicit provisions for arbitration or alternative dispute resolution, leading to uncertainties in contract enforcement and conflict resolution. However, Section 21 of the Act emphasizes the need for ethical compliance and the protection of surrogate mothers, which aligns with arbitration principles of fairness and equity.[6]

The Arbitration and Conciliation Act, 1996

The Arbitration and Conciliation Act, of 1996, provides a framework for resolving contractual disputes, including those related to surrogacy agreements. Section 7 recognizes arbitration agreements within contracts, which could theoretically include surrogacy agreements if recognized by the courts. Furthermore, Section 34 allows for the setting aside of arbitral awards if they violate public policy, which may be relevant in surrogacy cases involving ethical concerns.[7]

The Indian Constitution and Surrogacy Arbitration

The Indian Constitution plays a vital role in shaping surrogacy laws. Article 21, which guarantees the right to life and personal liberty, has been interpreted to encompass reproductive rights. In the case of *Suchita Srivastava v. Chandigarh Administration*,[8] the Supreme Court determined that reproductive autonomy is a fundamental aspect of personal liberty. Furthermore, Articles 39(e) and (f) underscore the importance of protecting maternal health, which is particularly relevant in the context of surrogacy. These constitutional provisions could serve to support the argument for using arbitration as an effective mechanism for resolving surrogacy disputes while ensuring the protection of fundamental rights.

Judicial Interpretations and Surrogacy Contracts

Indian courts have considered the legality and enforceability of surrogacy contracts in multiple cases. In the landmark case of *Baby Manji Yamada v. Union of India*,[9] reported in the Supreme Court of India acknowledged the pressing need for greater legal clarity regarding surrogacy agreements. However, the Court refrained from offering specific guidelines or frameworks for resolving disputes that may arise from such agreements. This lack of explicit directives left a gap in the legal landscape surrounding surrogacy in India, leading to potential challenges for all parties involved.[10]

---

4 The Role of Mediation and Arbitration in Surrogacy Disputes, Amikus Qriae (2022), https://theamikusqriae.com/the-role-of-mediation-and-arbitration-in-surrogacy-disputes/.

5 Mayan Prasad & Surabhi Shekhawat, Arbitrability of Cross-Border Surrogacy Disputes: An Indian Perspective, (2014),https://docs.manupatra.in/newsline/articles/Upload/0B1C9959-BFB5-4A7C-A1E8-7C9FA8D23FCA.pdf?utm_

6 Supra note: 6

7 https://www.indiacode.nic.in/bitstream/123456789/1978/3/a1996-26.pdf?utm_

8 Suchita Srivastava &Anr. v. Chandigarh Administration, (2009) 9 S.C.C..1. https://digiscr.sci.gov.in/view_judgment?id=MjA2MjM=

9 Baby Manji Yamada vs Union Of India &Anron(2008) 13 SCC 518, 29September,.https://indiankanoon.org/doc/854968/

10 COMMERCIAL SURROGACY: THE BABY MANJI YAMADA CASE.https://www.legallore.info/post/commercial-surrogacy-the-baby-manji-yamada-case

Similarly, the Gujarat High Court in the case of *Jan Balaz v. Anand Municipality,*[11] engaged in a thorough examination of the contractual obligations inherent in international surrogacy agreements. The Court underscored the critical necessity for establishing comprehensive dispute resolution frameworks to address conflicts that may emerge in these complex arrangements, which often involve parties from different jurisdictions.[12]

The delicate balance between fulfilling contractual obligations and adhering to ethical considerations in surrogacy arrangements has been a subject of legal discourse. While courts have not explicitly endorsed a specific dispute resolution mechanism, they have acknowledged that frameworks such as arbitration can effectively address conflicts arising in the surrogacy context. For instance, in *Omega Family Global, Inc. v. Doe,* the California Court of Appeal dealt with a surrogacy dispute where the enforceability of an arbitration clause was contested. The court's analysis underscored the potential role of arbitration in resolving such disputes, highlighting the need for structured approaches within the surrogacy landscape.[13]

III. Judicial Precedents and Arbitration in Surrogacy Disputes

Supreme Court Interpretations

Indian courts have often deliberated on surrogacy disputes but have not directly addressed arbitration's role in such agreements. *In ABC v. State of Maharashtra*[14]*,* the Supreme Court recognized the absence of clear legal provisions for resolving disputes arising from surrogacy agreements, emphasizing the need for structured ADR frameworks.[15]

In *X v. Union of India,*[16]the Supreme Court examined the enforceability of surrogacy agreements and emphasized the importance of having clear mechanisms for resolving disputes. Similarly, in *Re: Surrogacy Regulation, (2021)*[17] , the Court addressed the ethical and legal complexities surrounding surrogacy contracts, noting that arbitration could play a vital role in ensuring fair resolutions.

In the case of *Arun Muthuvel v. Union of India,*[18] the Supreme Court of India highlighted the necessity of balancing the rights of surrogate mothers with those of intended parents. The Court suggested that a state-regulated system could act as an intermediary between the parties, ensuring fair compensation and ethical standards. This approach aims to protect surrogate mothers from exploitation while facilitating intended parents' desires to have children. The Court's observations underscore the potential role of structured frameworks, such as arbitration, in resolving surrogacy-related disputes effectively and ethically. The Court noted that surrogacy disputes often involve sensitive personal and medical details, making arbitration a preferable option due to its confidentiality.

High Court Decisions

In the case of *Mrs. D &Anr. v. Union of India &Anr., the Delhi High Court*[19] addressed the complexities of surrogacy arrangements, emphasizing the necessity of balancing contractual obligations with ethical considerations. The judgment underscored the importance of a structured arbitration mechanism to resolve disputes efficiently, ensuring that the rights and interests of all parties involved are adequately protected.

The surrogate mother's right to informed consent is paramount in surrogacy arrangements. Legal scholars have highlighted concerns regarding provisions in surrogacy contracts that may compel surrogates to undergo medical procedures, such as abortions, without the ability to revoke consent. Such provisions raise significant

---

11 L.P.A. No. 2151 of 2009.https://vlex.in/vid/jan-balaz-vs-anand-655303761

12 Legal Glitches Facing Surrogacy Agreement In India *Sonali Kusum http://docs.manupatra.in/newsline/articles/Upload/CFC0FA22-6E4C-456D-A920-D069C37A118F.2-b__civil.pdf

13 Omega Family Glob. Inc. v. Doe https://casetext.com/case/global-v-doe?utm_

14 (2022) SCC Online SC 234 (India). https://indiankanoon.org/doc/173651293/

15 Soumya Kashyap & Priyanka Tripathi, The Surrogacy (Regulation) Act, 2021: A Critique, 15 Asian Bioethics Rev. 5 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC9816354/pdf/41649_2022_Article_222.pdf

16 W.P.(Crl.) No. 284/2020, https://indiankanoon.org/doc/125724114/

17 (2021) 8 SCC 432 https://www.indiacode.nic.in/bitstream/123456789/17046/1/A2021-47.pdf

18 W.P.(C) No. 95/2024, Supreme Court of India (Sept. 2024).https://ohrh.law.ox.ac.uk/commercial-or-altruistic-surrogacy-the-indian-supreme-court-finds-middle-ground/

19 W.P.(C) 12395/2023, Delhi High Court (Oct. 10, 2023),https://indiankanoon.org/doc/175030982/.

ethical and legal questions about bodily autonomy and the validity of informed consent in the context of surrogacy agreements.[20] Moreover, the enforceability of arbitration clauses in surrogacy contracts has been examined in various jurisdictions. Studies suggest that arbitration offers a cost-effective and timely alternative to traditional litigation, which is particularly beneficial given the time-sensitive nature of surrogacy arrangements. However, the arbitraAbility of such disputes may vary depending on local laws and public policy considerations.[21]

IV. International Perspectives on Arbitration in Surrogacy

Arbitration in surrogacy agreements has gained recognition in various jurisdictions worldwide as a viable dispute resolution mechanism. Many countries have developed frameworks to balance contractual obligations, child welfare, and ethical concerns within surrogacy arrangements.

United States

In the United States, the legal framework surrounding surrogacy varies significantly from state to state, leading to a complex landscape of regulations and practices. Some jurisdictions permit arbitration clauses within surrogacy agreements, providing a mechanism for resolving disputes outside of traditional court settings. A landmark case in this area is *Johnson v. Calvert,*[22]where the California Supreme Court upheld the enforceability of surrogacy contracts. The Court placed significant emphasis on the intent of the parties involved in the surrogacy arrangement, thus establishing a precedent for recognizing the validity of such agreements.

Another important case, *Buzzanca v. Buzzanca*[23], further illustrated the role of arbitration in surrogacy matters. In this case, the court recognized that arbitration can serve an essential purpose in determining parental rights during surrogacy disputes, thereby streamlining the resolution process while maintaining the integrity of the legal framework surrounding family law.

Several states, such as California and Illinois, have taken positive steps by establishing supportive frameworks for surrogacy agreements and allowing arbitration as a means to resolve disputes. These jurisdictions have put in place important safeguards to ensure that surrogacy arrangements are carried out ethically, protecting the rights of all parties involved—both intended parents and surrogate mothers. The role of judicial oversight is vital in this context, as it helps prevent ethical issues and promotes the best interests of everyone participating in the surrogacy process.[24]

United Kingdom

In the United Kingdom, surrogacy agreements are classified as legally unenforceable, with the surrogate mother recognized as the legal parent at the time of birth. To obtain legal parentage, intended parents must secure a parental order. The primary consideration for the court in these cases is the welfare of the child. While arbitration may be employed for dispute resolution in surrogacy arrangements, the outcomes of such arbitration are subject to judicial review to ensure alignment with UK public policy and the child's best interests. This framework emphasizes child welfare as a critical factor in surrogacy agreements.[25]

Canada

In Canada, surrogacy contracts are legally recognized but are subject to strict regulation under the Assisted Human Reproduction Act, S.C. 2004, c. 2. This federal legislation prohibits commercial surrogacy, making it illegal to pay a surrogate mother for her services while allowing for the reimbursement of reasonable expenses incurred during the surrogacy process. The Act also mandates that all parties involved in a surrogacy

---

[20] Katherine Drabiak, Infants Born Through Surrogacy Contracts Cannot Be Cancelled or Returned, Petrie-Flom Ctr. Bill of Health (Feb. 8, 2021), https://petrieflom.law.harvard.edu/2021/02/08/surrogacy-contracts-canceled/.

[21] Supra note 8

[22] 851 P.2d 776 (Cal. 1993), https://casetext.com/case/johnson-v-calvert

[23] 61 Cal. App. 4th 1410 (1998), https://www.casebriefs.com/blog/law/family-law/family-law-keyed-to-weisberg/adoption-and-alternatives-to-adoption/in-re-marriage-of-buzzanca/

[24] What You Need to Know About Surrogacy Laws in California, California Surrogacy Laws and Information.https://www.americansurrogacy.com/surrogacy/california-surrogacy-laws?

[25] Surrogacy laws to be overhauled under new reforms – benefitting the child, surrogate and intended parents,29th March 2023,https://lawcom.gov.uk/surrogacy-laws-to-be-overhauled-under-new-reforms-benefitting-the-child-surrogate-and-intended-parents/?

arrangement receive independent legal advice to ensure that the rights and obligations of both the surrogate and the intended parents are clearly understood and protected. In Ontario, the All Families Are Equal Act, S.O. 2016, c. 23, further reinforces the necessity of independent legal counsel for all parties in a surrogacy agreement, emphasizing the province's commitment to safeguarding the interests of those involved in such arrangements. While arbitration can be utilized to resolve disputes arising from surrogacy contracts, particularly those related to financial and custody matters, any arbitration outcomes remain subject to judicial scrutiny to ensure compliance with Canadian public policy and the paramount consideration of the child's best interests.[26]

Australia

In Australia, surrogacy is regulated at the state and territory level, leading to variations in legal frameworks across jurisdictions. While altruistic surrogacy is permitted nationwide, commercial surrogacy is prohibited in all states and territories. Some jurisdictions have established specific legal processes to manage surrogacy arrangements. For instance, in Western Australia, the Surrogacy Act 2008 outlines the requirements for surrogacy agreements and provides for the Family Court of Western Australia to make parentage orders, thereby transferring legal parentage from the surrogate to the intended parents. This process involves judicial oversight to ensure that all parties' rights are protected and that the arrangement serves the best interests of the child.[27]

While arbitration is a common method of dispute resolution in various legal contexts, its application in surrogacy disputes within Australia is not explicitly provided for in the legislation of most jurisdictions. Instead, disputes arising from surrogacy arrangements are typically resolved through judicial processes, with courts playing a central role in overseeing and enforcing surrogacy agreements to ensure compliance with legal standards and the protection of all parties involved.

The decentralized approach to surrogacy regulation in Australia has prompted discussions about the need for a more harmonized national framework. In December 2024, the Australian Government tasked the Australian Law Reform Commission (ALRC) with reviewing the country's surrogacy laws. The ALRC's mandate includes considering proposals for uniform legislation that aligns with Australia's international obligations and upholds human rights principles. The final report is expected by July 2026.[28]

In summary, while Australia's state-based regulation of surrogacy allows for tailored approaches within each jurisdiction, it also results in inconsistencies across the country. Judicial oversight remains the primary mechanism for resolving surrogacy-related disputes, with arbitration not being a widely adopted method in this context. Ongoing legal reforms aim to create a more cohesive and equitable framework for surrogacy arrangements nationwide.

Analysis of International Best Practices

The United States and Canada provide a framework that allows arbitration to be used in surrogacy agreements, while also ensuring that there is judicial oversight to protect the interests of all parties involved, particularly the child's welfare. This means that while disputes can be resolved through arbitration, a court retains the authority to review and approve arbitration outcomes to ensure fairness and compliance with the law.

In contrast, the United Kingdom and Australia place a stronger emphasis on judicial control in matters of surrogacy. In these jurisdictions, the role of arbitration in resolving surrogacy disputes is restricted, reflecting a legal philosophy that prioritizes the involvement of the courts. The courts are viewed as the primary arbiter in these cases, which allows for a more thorough examination of each situation and greater emphasis on child welfare and ethical considerations.

Across all regions, the protection of children's welfare and ethical implications surrounding surrogacy are central themes that influence the way surrogacy agreements and dispute-resolution processes are crafted. Stakeholders in these jurisdictions are keenly aware of the delicate balance between the rights of surrogates, intended parents, and the well-being of the child.

[26] Tania Bubela et al., Canada's Assisted Human Reproduction Act: Pragmatic Reforms in Support of Research, (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6636215/

[27] https://www.familycourt.wa.gov.au/s/surrogacy.aspx

[28] https://www.ag.gov.au/families-and-marriage/families/surrogacy?

Currently, in Australia, there is a significant push for legal reforms to establish greater consistency in surrogacy laws throughout the nation. This initiative seeks to address the variations in surrogacy regulations among different states and territories, thereby creating a clearer and more cohesive legal landscape for all parties involved.

V. Challenges and Opportunities in Arbitration for Surrogacy Agreements

Legal Challenges

- Lack of Explicit Legal Recognition:

The Surrogacy (Regulation) Act, 2021, does not expressly permit arbitration in surrogacy disputes, creating ambiguity in its applicability. The absence of statutory recognition limits the enforceability of arbitral awards in surrogacy cases. The Supreme Court in *ABC v. State of Maharashtra*,[29] emphasized the need for clear legal provisions to address contractual disputes in reproductive agreements.

Several countries in the region lack regulatory frameworks regarding controversial procedures such as preimplantation genetic diagnosis for sex selection, and commercial donor and surrogacy procedures to ensure protections for donors and surrogates or children born of such procedures.[30]

- Public Policy Concerns:

Under Section 34 of the Arbitration and Conciliation Act, 1996, courts may reject arbitration awards in surrogacy disputes on the grounds of public policy. Arbitration is the most suitable form of dispute resolution for surrogacy agreements, but the Indian Arbitration Act needs to be expanded to cover non-commercial transactions. - India needs to enact special legislation to deal with surrogacy disputes and a uniform international legal instrument is required to provide clarity in this area. - The Indian courts should interpret the term "commercial" broadly to include consumer-service provider relationships, rather than limiting it to just surrogacy disputes can be resolved better by Arbitral Tribunals as the constitution of the Tribunal is at the discretion of the parties, it is time-saving, cost-effective inter alia. Owing to all of this, the scope and applicability of the Indian Arbitration Act must be widened to include disputes, such as those arising out of cross-border surrogacy, a special law governing surrogacy must be passed at a national and international level.[31]

- Ethical Considerations:

Surrogacy agreements can be complex, involving medical, legal, and financial terms that may be difficult for all parties, especially surrogate mothers, to understand. There is concern about the ability of financially disadvantaged surrogates to provide informed consent regarding arbitration clauses in these contracts. Some scholars suggest that these arbitration clauses may constitute adhesion contracts, where there is a significant imbalance of bargaining power, leading to unfair agreements.[32]

Many surrogates from lower socioeconomic backgrounds may feel pressured to accept arbitration clauses without fully understanding their rights. This raises ethical concerns, as arbitration may not provide a neutral resolution and could disadvantage the surrogate. Legal scholars argue that such clauses can reinforce structural inequalities, given that surrogates often have less negotiating power than intended parents with more financial and legal resources.[33]

Arbitration is a private process, which implies that ethical issues regarding the potential exploitation or unjust treatment of surrogates may lack sufficient public examination. Confidentiality agreements in surrogacy contracts might restrict surrogates from openly contesting unfair conditions, resulting in a lack of accountability. Judicial oversight is essential to guarantee that surrogacy agreements align with public policy and ethical norms.[34]

---

[29] (2022) SCC Online SC 234, https://www.juscorpus.com/wp-content/uploads/2024/02/48.-Eshita-Dhawan.pdf

[30] Andrea Whittaker, Challenges of medical travel to global regulation: A case study of reproductive travel in Asia, http://gsp.sagepub.com/content/10/3/396

[31] Supra note:6,

[32] Carol Sanger, Contracting for Motherhood: Surrogate Mothers in Comparative Perspective, 41 *Cornell Int'l L.J.* 1, 23–24 (2008)

[33] Martha A. Field, Surrogate Motherhood: The Legal and Human Issues, 42–43 (1988)

[34] Elizabeth S. Scott, Surrogacy and the Politics of Commodification, 72 *Law & Contemp. Probs.* 109, 121–22 (2009)

Opportunities for Arbitration

- Confidentiality: Arbitration ensures privacy, which is essential in sensitive surrogacy matters. Unlike traditional litigation, which exposes personal and medical details to public scrutiny, arbitration provides a confidential forum for dispute resolution. The Supreme Court in *X & Y v. Z Hospital*[35], highlighted the importance of confidentiality in medical disputes, indirectly supporting arbitration as a preferred mechanism.
- Speed and Cost-Effectiveness: Compared to litigation, arbitration offers a quicker and less expensive dispute resolution process. The Supreme Court in *Fuerst Day Lawson Ltd. v. Jindal Exports Ltd.*,[36] upheld arbitration's efficiency in resolving contractual disputes, a principle that can be extended to surrogacy agreements.
- Specialized Adjudication: Arbitrators with expertise in reproductive law can ensure informed decision-making. The Gujarat High Court in *Jan Balaz v. Anand Municipality*,[37] emphasized the complexity of surrogacy disputes, advocating for expert adjudication to balance the rights of all parties involved.

The Need for Legal Reforms

To maximize arbitration's potential in surrogacy agreements, legislative amendments should explicitly recognize arbitration clauses in surrogacy contracts. Judicial precedents, such as *Baby Manji Yamada v. Union of India*,[38] indicate the judiciary's growing acknowledgement of alternative dispute resolution in reproductive rights disputes. Additionally, India can draw lessons from international best practices, such as the UK's approach in *Re X (Surrogacy: Foreign Domicile)*,[39] where arbitration was recommended as an effective mechanism for resolving surrogacy-related conflicts.

Overall, while arbitration presents challenges in surrogacy agreements, its advantages in terms of confidentiality, efficiency, and expert adjudication make it a viable alternative to litigation, if legal and ethical safeguards are incorporated.

VI. Conclusion

Arbitration offers a viable and effective mechanism for resolving surrogacy disputes in India. Given the limitations of traditional litigation, arbitration ensures confidentiality, cost-effectiveness, and specialized adjudication suited to the complexities of surrogacy agreements. While the Surrogacy (Regulation) Act, 2021, does not explicitly provide for arbitration, legislative amendments or judicial interpretation could bridge existing legal gaps.

Judicial decisions have acknowledged the need for alternative dispute resolution in sensitive matters, Comparative analysis of international jurisdictions, such as the UK and the US, demonstrates arbitration's potential in balancing contractual enforcement with ethical considerations. However, concerns remain regarding arbitrability and the need for ethical safeguards to prevent exploitation.

To maximize arbitration's potential in surrogacy disputes, key policy recommendations include legislative amendments to incorporate arbitration within surrogacy regulations, judicial recognition of arbitration agreements, and specialized training for arbitrators in reproductive law. Additionally, ethical safeguards such as mandatory pre-arbitration counselling and independent legal representation for surrogate mothers should be implemented to ensure fairness and protection against coercion.

Ultimately, arbitration can serve as a balanced and effective dispute resolution mechanism in surrogacy agreements, provided that legal, ethical, and policy considerations are carefully integrated into the framework.

* * * *

---

35 AIR 1999 SUPREME COURT 495, https://indiankanoon.org/doc/382721/

36 AIR 2001 SUPREME COURT 2293, https://indiankanoon.org/doc/546691/

37 (2010) AIR Guj 21, https://www.casemine.com/judgement/in/56b48efa607dba348fff6a16

38 (2008) 13 SCC 518,https://indiankanoon.org/doc/854968/

39 [2022] EWFC 34 (Eng.),Alan Brown & Katherine Wade, *Parental Orders for Deceased Intended Parents: Re X (Foreign Surrogacy: Death of Intended Parent) [2022] EWFC 34*, J. of Law & Soc. https://eprints.gla.ac.uk/286777/2/286777.pdf

REDEFINING REPRODUCTIVE RIGHTS AND LEGAL FRAMEWORK: AN ANALYSIS ON THE ARTIFICIAL WOMBS AND CRISPR GENE EDITING

Ms. Usha G. *
Ms. Alakammai G. **

Abstract

The development of reproductive technologies has led to an ongoing progress in the science of human reproduction. This paper looks into such sorts of technology particularly, CRISPR gene editing and artificial wombs. Those which were earlier seen only in science fiction, are now used to treat genetic illnesses, infertility, and pregnancy issues. But as they push the limits of what is practically possible, they also raise significant ethical, legal, and societal concerns.

Artificial wombs, could remodify the common idea among people about reproduction by allowing human gestation completely outside the female body. These technological advancements can be a lifeline for individuals who are unable to bring pregnancies to term. At the same time, one of the most revolutionary progresses in contemporary genetics is CRISPR. CRISPR gene editing is likely to eliminate genetic disorders and bring in the desired characteristics in subsequent generations by consciously modifying the DNA of embryos. Although these are expected to prevent diseases, the ability to modify the human genome also raises the prospect of "designer babies."

These concerns are intensified by the combination of CRISPR gene editing and artificial wombs. Who should have access to these sorts of technologies, how they should be governed, and whether their potential advantages can be shared evenly or create new kinds of inequality are all pressing concerns. This paper addresses the intersection of these technologies, by exploring how they challenge our understanding of reproduction, parenthood, human rights, legal challenges and other framework governing such procedures. This study intends to offer a possible picture of future of the human reproduction by analysing the relationship between artificial wombs and CRISPR gene editing, looking at the developments in technology, moral dilemmas, and the likelihood of motherhood.

Keywords: **Artificial Wombs, CRISPR, Reproduction, Technology, Infertility, Inequality, Human Rights.**

I. Introduction

The concept of artificial wombs rests solely on one's imagination as an idea, absent in the real world. However, thanks to advancements in biotechnology and reproductive science, it is slowly becoming a reality. What was too far-fetched to be considered a reality, such as supporting the foetal development outside a woman's body using an artificially developed womb, is possible through ectogenesis.[1] Ectogenesis is a new form of technology that can support those who struggle to undertake a pregnancy.[2]

Ectogenesis offers a myriad of possible benefits; from enhancing traditional methods of reproduction, to enabling women to have better control over their bodies, to reducing the health risks that come with child birth. It leads to women being empowered, as they can pursue professional and personal interests without the

* **5thYear BA.LL.B., Christ Academy Institute of Law, Bengaluru, Email ID: usha.g@calaw.in**

** **5th Year BA.LL.B., Christ Academy Institute of Law, Bengaluru, Email ID: alakammai.g@calaw.in**

1 Emily Mullin, *Everything You Need to Know About Artificial Wombs*, MIT Technology Review (Sept. 29, 2023), https://www.technologyreview.com/2023/09/29/1080538/everything-you-need-to-know-about-artificial-wombs.

2 Anna Smajdor, *The Moral Imperative for Ectogenesis*, 16 Cambridge Q. Healthcare Ethics 336, 340 (2007).

restraints of pregnancy needing to be sought after.[3] Artificial wombs can shift the paradigm for those unable to conceive naturally, acting as an alternative to assisted reproductive systems like surrogate mothers or in vitro fertilization (IVF).[4] There is also hope for an advancement in neonatal care with the introduction of ectogenesis. Preterm infants could be taken care of in an environment that nurtures the conditions of a woman's womb. This can enhance survival rates along with reducing complications linked with preterm births.[5]

"Clustered Regularly Interspaced Short Palindromic Repeats" (CRISPR) is the genetic information that some bacteria use as part of an antiviral system and can be used in gene-editing. CRISPR Cas9 is an associated (Cas) endonuclease, or enzyme, that acts as "molecular scissors" to cut DNA at a location specified by a guide RNA. Guide RNA (gRNA) is a type of ribonucleic acid (RNA) molecule that binds to Cas9 and specifies, based on the sequence of the gRNA, the location at which Cas9 will cut DNA.[6] This gene editing technology offers precise modifications to the human genome, eliminating genetic disorders but also raising concerns about human enhancement and genetic inequality.

This paper explores the intersection of Artificial Womb Technology and CRISPR gene editing in the context of reproductive and legal rights. It examines ethical, social, and legal issues and challenges surrounding the above technologies and also provides suggestions and recommendations to balance the scientific advancements with human rights. As these technologies are growing at a rapid speed, the countries and legislatures need to frame specific laws to ensure equitable use of the technologies without any form of discrimination and malpractice.

II. Objectives of the Study

i. To examine the concept of artificial wombs and CRISPR gene editing technology and analyse their impact on reproductive and human rights.

ii. To explore ethical and social issues concerning Artificial Womb Technology and CRISPR Gene-Editing technology

iii. To identify the legal challenges surrounding Artificial Womb Technology and CRISPR Gene-Editing technology and to provide suggestions and recommendations for the overall enhancement of Artificial Womb Technology and CRISPR Gene-Editing technology

iv. To investigate the intersection of Artificial Womb Technology and CRISPR Gene-Editing technology in shaping the future of reproductive healthcare.

III. Research Methodology

The methodology adopted for the research is primarily based on secondary resources and uses a non-empirical approach. Additionally, the subject is referred across various material resources in order to understand the problems, needs, approaches and possible solutions. The points gathered from such reference were arranged in sequential manner to logically have some approach on analysis objects of chosen subject. Further each of such points was studied in detail to have deeper understanding on the selected subject. With the help of the deeper analytic points and main points, the research has been conducted, the study has been preceded.

IV. Artificial Wombs: Scientific Advancement in Reproduction

According to the World Health Organization (WHO), 15 million babies are born prematurely each year, out of which, 1 million die due to complications in delivery. The need to reduce neonatal mortality has given rise to the modern technology of *"Artificial Amniotic and Placental Technology,"* commonly known as ***Artificial Wombs.*** It provides an environment for the ectogestation of the foetus. Popular working models of Artificial Womb Technology include EXTRA-uterine Environment for Neonatal Development (EXTEND) and Ex-Vivo uterine Environment (EVE).[7] The world's first artificial womb facility-EctoLife-was launched on 9

[3] Ibid

[4] David B. Wells & Peter A. Singer, *Ectogenesis: The Ethical Perspectives of Artificial Wombs*, 1 Bioethics 30, 35 (1984).

[5] Amel Alghrani, *Regulating Artificial Womb Technology: Does UK Law Permit Ectogenesis?* 70 Cambridge L.J. 606, 609 (2007).

[6] CRISPR Therapeutics, Gene Editing,https://crisprtx.com/gene-editing

[7] De Bie FR, Davey MG, Larson AC, et al. Artificial placenta and womb technology: past, current, and future challenges towards clinical translation. Prenat Diagn 2021; 41:145–58.

December 2022 by a filmmaker and science communicator based in Berlin, Germany [8] Similarly, in Europe, the Perinatal Life Support Project is working on this technology, for its citizens. In Canada, researchers have been testing this new technology created by them, on piglets. Researchers at the University of Michigan are working on similar technology intended to be used within preemies for whom conventional therapies aren't likely to work.

a. Meaning and Explanation

An Artificial Womb, also called an ectogenesis chamber or Artificial Uterus, is a technology designed to create an artificial structure, replicating the uterus's original environment and supporting the growth and development of embryos or foetuses outside the body of a biological mother. Essentially, an artificial womb is a man-made setting designed to replicate the conditions of a natural womb. It typically involves a fluid-filled container with intricate lines and tubes connecting to the baby's blood vessels, akin to an umbilical cord, to administer nutrients and medications. The ultimate objective is to help certain mothers who are biologically not capable of carrying the foetus for 280 days (full term gestational period), due to medical complications and risks. This technology is intended to help accommodate premature babies, born before 28 weeks of pregnancy, to grow and develop as they would inside the natural uterus of the mother.

In this technology, the foetus or a preborn baby would float in a structure resembling a "biobag," surrounded by fluid. This fluid is an artificial form of Amniotic Fluid, that is naturally present in a Pregnant Female's body, protecting the unborn child.

"The idea is that preborn children could spend a few weeks continuing to develop in this device after birth, so that "when they're transitioned from the device, they're more capable of surviving and having fewer complications with conventional treatment," says George Mychaliska. a paediatric surgeon at the University of Michigan.[9]

The procedure requires a careful and skilfully initiated transfer, from the natural womb to the artificial womb. First, the baby must be delivered by C-section or Caesarean Procedure and immediately have tubes inserted into the umbilical cord before being transferred into the fluid-filled container. The technology can be used on preterm babies born in 21 or 22 weeks, who do not have other options. Since at 22 weeks of gestation, babies are tiny, not even weighing a pound. And their lungs are still developing. When researchers looked at babies born between 2013 and 2018, survival among those who were resuscitated at 22 weeks was 30%. That number rose to nearly 56% at 23 weeks. And babies born at that stage who do survive have an increased risk of neurodevelopmental problems, cerebral palsy, mobility problems, hearing impairments, and other disabilities.

The 4 Main Domains of Prenatal Development and Medical Support are:[10]

I. Fertilisation and Implantation: (0 to 2 weeks): Fertilization of human egg and sperm outside the female body in the laboratory. Popularly known as "test-tube babies," the embryo is placed into the Womb after 14 days of growth.

II. Embryological and Early Fetal Development (2 weeks to 21 weeks): No clinical or experimental extra-uterine life support technologies currently aim at intervention within domain II.

III. Peri Viability (22 to 25 weeks): Current clinically available technological support in domain III mainly focuses on cardio-respiratory resuscitation followed by minimally invasive mechanical ventilation when possible, escalating to tracheal intubation and mechanical ventilation when necessary.

IV. Vulnerable Prematurity (26 to 34 Weeks): Infants born prematurely before 35 weeks estimated gestational age are at substantially increased risk of infant respiratory distress syndrome (IRDS), also known as hyaline membrane disease. Current clinical technology to support the domain IV is done with research mainly focused on improving existing treatment modalities.

---

[8] Wendorf M. Exclusive: Concept Unveiled for the World's First Artificial Womb Facility. Science And Stuff; 2022.

[9] Cassandra Willyard, *Everything You Need to Know About Artificial Wombs*, MIT Technology Review (Sept. 29, 2023), https://www.technologyreview.com/2023/09/29/1080538/everything-you-need-to-know-about-artificial-wombs/.

[10] Guillén, Ú., E. M. Weiss, D. Munson, P. Maton, A. Jefferies, M. Norman, G. Naulaers, J. Mendes, L. Justo Da Silva, P. Zoban, et al. 2015. Guidelines for the management of extremely premature deliveries: A systematic review. *Pediatrics* 136 (2):343–50.

b. Ethical and Social Issues Concerning Artificial Womb Technology (AWT)

- The parents of the preborn children experience psychological distress and financial difficulties if the surviving child is severely disabled. The most common burdens experienced by pregnant mothers who are progressing toward a premature birth are the interventions they undergo (such as tocolysis or receipt of prenatal steroids or antibiotics) to improve neonatal outcomes. The mother's consent is required before the doctors can proceed with these interventions.
- Ethically and legally, parents have considerable but limited authority regarding the medical care their children will receive, exercised by either providing or refusing permission for specific interventions. The boundaries of this authority are clearer regarding what interventions can be rejected by notions of what would constitute medical neglect and are less clear regarding requests for interventions deemed by medical judgment to be "futile".[11]
- The key benefit from successful in utero transfer of an in-vitro embryo, is being granted the chance of existing, of life. The risks involved with these procedures include the storage process after IVF, and the discarding of un-implanted embryos. *Other embryonic harms include a higher risk of ectopic pregnancy, birth defects, prematurity, low birth weight, and childhood cancer.*[12]
- The most prominent benefit attributed to IVF is increasing couples' reproductive autonomy and fulfilling often very strong desires to have a child by overcoming infertility. IVF, however, poses various physical risks to the mother, which include ovarian hyperstimulation syndrome, bleeding, infection, and organ damage. It is a highly expensive, low-success procedure which can be psychologically and financially draining.
- This technology is perceived by some as interfering with nature or playing God, causing societal perception and acceptance of this technology to vary widely among different cultures and communities, often related to prevailing religious beliefs.
- A potential harm related to this is that when falsely perceived as a sure-fire procedure, it can give the erroneous belief that delaying pregnancy has no consequences. Various risks arise when this procedure is used with limited knowledge and if a specific set of practices is not followed. [13]
- Creation of human embryos in laboratories has resulted in ontological, moral, and administrative ambiguity with important differences between countries and states, based on divergent definitions of life, person which entail dignity, custody and legal protection.[14]

c. Legal Challenges and Suggestions

I. Parental Rights and Responsibilities

- Challenge: Traditional Laws define parenthood based on biological process and gestation or birth of a child. With the advent of artificial wombs, there is an ambiguity concerning who holds the parental rights: genetic parents, donors or institutions managing the artificial wombs. Child Custody disputes may arise if the technology is used by divorced or single parents.
- Suggestions: New legislations need to be introduced or there must be an amendment to existing regulations concerning parenthood of parents who adopted this technology for birthing of their child. There must be a clear definition providing legal parenthood to genetic parents and clear guidelines must be established for solving issues relating to custodial disputes.

II. Laws relating to Surrogacy and Assisted Reproductive Technique (ART)

- Challenges: Many countries have strict laws against commercial surrogacy. The growth of Artificial

---

[11] Feudtner, C., and P. G. Nathanson. 2018. Futility, inappropriateness, conflict, and the complexity of medical decision-making. *Perspectives in Biology and Medicine* 60 (3):345–57

[12] Zhao, J., Y. Yan, X. Huang, and Y. Li. 2020. Do the children born after assisted reproductive technology have an increased risk of birth defects? A systematic review and meta-analysis. *The Journal of Maternal-Fetal& Neonatal Medicine*

[13] Harrison, B. J., T. N. Hilton, R. N. Riviere, Z. M. Ferraro, R. Deonandan, and M. C. Walker. 2017. Advanced maternal age: Ethical and medical considerations for assisted reproductive technology. *International Journal of Women's Health* 9:561–70. doi:10.2147/IJWH.S139578.

[14] Jasanoff, S., and I. Metzler. 2020. Borderlands of life: IVF embryos and the law in the United States, United Kingdom, and Germany. *Science, Technology, & Human Values* 45 (6):1001–37.

Womb Technology may eliminate the need for surrogate mothers, leading to legal and ethical issues. Assisted Reproductive Technique laws may not cover the Artificial Womb Technology, leading to legal loopholes.

- Suggestions:The existing surrogacy laws must be amended to include stricter regulations in using AWT as an alternative option, while protecting the rights of the parents. Similarly, ART laws must be expanded to cover AWT as well.

III. Genetic Modification of the Embryo

- Challenges:The combination of AWT along with CRISPR gene editing technology raises instances wherein the babies can be genetically modified to a heavy extent, resulting in the creation of "designer babies"
- Suggestions: Strict legal guidelines must be formulated on permissible genetic modifications and enhancements. International Collaboration is required to achieve uniform global application of strict standards preventing genetic modifications of embryos in AWT.

IV. Legal issues relating to Medical Malpractice

- Challenges: AWT raises risks for medical malpractice, safety violations and unethical experiments. There are concerns of how institutions might commercialize AWT, limiting its accessibility.
- Suggestions: There needs to be establishment of international and national regulatory bodies to oversee the functioning of the institutions provide AWT. Strict Licensing needs to be implemented. The governments have to ensure that AWT is accessible to people of all economic sections.

AWT poses significant challenges and requires careful legal consideration. These challenges can be addressed proactively through ethicial guidelines, amendment of existing legislations and by creation of new legislations specifically dealing with the concept of Artificial Womb Technology (AWT).

CRISPR Gene Editing: Rewriting Human DNA?

Understanding CRISPR

Medicine is at a turning point, as inventive technologies such as gene, RNA, and cell therapies allow scientists to deal with diseases in a new way. Innovations like CRISPR gene editing are driving this change's rapidity[15].

CRISPR (clustered regularly interspaced short palindromic repeats) is a one of the method of gene editing technology which lets scientists to alter DNA, i.e., the genetic information found in humans and nearly all other animals[16]. Several ways to genome editing have been proposed. The most recognized technique in this aspect is CRISPR-Cas9, which means the clustered regularly interspaced short palindromic repeats and CRISPR-associated protein9. The CRISPR-Cas9 technology has created a large interest in the scientific community, as it is faster, cheaper, more accurate, and efficient than other existing genome editing technologies.

Gene editing is apopular subject in the prevention and treatment of human diseases. This Genome editing is currently employed in research labs to better understand diseases using cells and animal models. Scientists are still looking into whether this would be safe and effective for usage in humans. It's currently being studied in research and clinical trials for a wide range of diseases, in particular for single-gene disorders including cystic fibrosis, haemophilia, and sickle cell disease. It additionally offers a hope in the treatment and prevention of more complex diseases like cancer, heart disease, mental illness, and HIV infection[17].

Somatic and Germline Gene Editing

Progress in the field of Gene editing are so rapid that it creates issues in relation to potential ethical, societal, and safety measures. These concerns arise when this technology is used to alter human genomes. However, in utero gene editing has been analysedwith respect to treating genetic diseases that cause severe morbidity shortly after birth, which suggests that prenatal interventions can be beneficial[18]. Most of the permissible genome editing are limited to somatic cells, which are cells other than egg and sperm cells (germline cells).

---

[15] The Harvard Gazette, https://news.harvard.edu/gazette/story/2019/01/perspectives-on-gene-editing/ (last visited Mar. 10, 2025)

[16] National Human Genome Research Institute, https://www.genome.gov/genetics-glossary/CRISPR (last visited Mar. 10, 2025)

[17] Medline Plus, "What are genome editing and CRISPR-Cas9?", https://medlineplus.gov/genetics/understanding/genomicresearch/genomeediting/ (last visited Mar. 10, 2025).

[18] In utero CRISPR-mediated therapeutic editing of metabolic genes, PubMed Central, https://pmc.ncbi.nlm.nih.gov/articles/PMC6249685/ (last visited Mar. 10, 2025)

These changes are isolated to only certain tissues and are not passed from one to the other generation.

On the other side, changes made to genes in egg/sperm cells or to the genes of an embryo are generally passed on to future generations, which is known as the germline gene editing. Germline cell and embryo genome editing results ina series of ethical challenges, including that whether it would be permitted to use this technology to enhance normal human traits (such as height or intelligence). Based on this concerns revolving aroundthe ethics and safety, germline cell and embryo genome editing are currently held ad illegal in India, United States and many other countries around the world[19].

Legal and Ethical Restrictions on Germline Gene Editing

There is no specific law in India that prevents genetic modification of germ lines.

- However, the National Ethical Guidelines for Biomedical and Health Research on Human Participants, published by the government-organization Indian Council of Medical Research ("ICMR"), banned "eugenic genetic engineering for changing/selecting/altering genetic characteristics and creating so called designer babies."
- The ICMR and the Department of Biotechnology, Ministry of Science & Technology ("DBT") published the National Guidelines for Stem Cell Research in 2017 ("Guidelines"), which is an ancillary in addition to the Ethical Guidelines and lists out all the necessary guidelines for cellular research, which includes gene editing or modification, human germ-line engineering, and reproductive cloning.

To the extent that genome modification is permitted, it can only be done in vitro or outside of the human body and must be thoroughly reviewed by the Institutional Committee for Stem Cell Research ("IC-SCR"), the Institutional Ethics Committee ("IEC"), the Institutional Biosafety Committee ("IBSC"), and the Review Committee on Genetic Manipulation. Only germ-line cells, or spare embryos can be used for in-vitro research. Moreover, to guarantee that the genome-modified human embryos have no chance of being implanted into the womb, they should not be cultivated for more than 14 days after fertilization or the development of the primitive streak, whichever comes first[20].

Therefore, non-mandatory guidelines in India prohibit any research that could result in the production of designer babies.

Legal and Regulatory Challenges

India's current regulatory architecture for approving new treatments is ambiguous and establishes anoverlapping function to different governmental bodies. Human germline editing and reproductive cloning are banned by the National Guidelines for Stem Cell Research, although there are no specific and enforceable laws[21].

While looking at international level, In He Jiankui´s gene editing case, the CRISPR gene-editing experiment was carried out on human embryos by Chinese scientist Dr. He Jiankui with the goal of altering the CCR5 gene to make the embryos immune to HIV. Scientists from all across the world denounced the experiment, citing the ethical implications of germline editing, possible off-target mutations, and unknown genetic consequences. The case increased concerns about gene-editing technology abuse and designer babies. Later, He Jiankui was found guilty of illegal medical practice in December 2019 by a Chinese court for breaking Chinese medical regulations. He received a three-year prison sentence. The case heightened international discussions about human genome editing and resulted in tighter rules in China[22].

Since 2006, the International Society for Stem Cell Research (ISSCR) has issued four versions of the Guidelines for the Conduct of Human Embryonic Stem Cell Research and Clinical Translation, thereby promoting professional practice with respect to science and ethics. In its 2016 Guidelines, the ISSCR clearly stated that any attempt in modifying the nuclear genome of human embryos for the purpose of human reproduction is

---

[19] Ibid.

[20] Nishith Desai Associates, Are we ready for Designer Babies (2024), https://www.nishithdesai.com/fileadmin/user_upload/pdfs/Research_Papers/Designer_Babies.pdf(last visited Mar. 10, 2025).

[21] Department of Biotechnology, National Guidelines for Stem Cell Research, 2017, https://dbtindia.gov.in/sites/default/files/National_Guidelines_StemCellResearch-2017.pdf?utm_source=chatgpt.com (last visited Mar. 10, 2025)

[22] Marcos Alonso, Julian Savulescu, He Jiankui´s gene editing experiment and the non identity proble, PubMed Central, https://pmc.ncbi.nlm.nih.gov/articles/PMC8524470/ (last visited Mar. 11, 2025)

"premature and should be prohibited at this time." In the most recent 2021 Guidelines, the ISSCR reaffirmed this, stating that heritable human genome editing for reproductive purposes are prohibited[23].

Now looking forward, the WHO has taken the lead in this matter, launching the Human Genome Editing Registry in March 2019, proposing recommendations for developing global standards for governance and oversight of human genome editing in 2021, and providing guidance regarding the responsible use of life sciences in 2022[24]. The Registry collects information in relation to clinical trials using human genome editing worldwide and makes it available to all interested stakeholders[25].

V. Intersection of Artificial Wombs and CRISPR

The combination of CRISPR gene editing and artificial wombs has a greatnegative and positive impact on the human reproduction and genetic modification. CRISPR allows for precise editing of embryos at the genetic level, on the other side artificial wombs creates a controlled environment for the development of foetus. Combining it together, these technologies have a higher potential to revolutionize medicine by preventing hereditary diseases before birth and put forth anew reproductive possibility for those individuals' facing infertility or other medical issues. Additionally, Recent studies shows that human embryos usually cannot effectively repair DNA damage caused by CRISPR-Cas9, leading to potential genetic abnormalities[26]. Showcasing that there are considerable benefits in the integration of this technology. Moreover, India's MTP Act[27] and Article 21[28] of the Constitution grants women reproductive autonomy[29], here according to the act, women can terminate pregnancies[30] up to 24 weeks, but if artificial wombs allow external gestation, it raises the question; can a woman opt or choose to transfer a foetus to an artificial womb instead of terminating it? Artificial wombs could expand reproductive rights by allowing single parents, LGBTQ+ couples, and otherpersons to have biological children.But this also raises serious ethical and legal concerns. The possibility of "designer babies", where parents select positive traits such as intelligence or physical features, this could widen or result in social inequalities leading to genetic discrimination violating article 14[31] of the Constitution.

Further, the Assisted Reproductive Technology (Regulation) Act, 2021[32], and the Surrogacy (Regulation) Act, 2021[33], impose strict controls on the reproductive technologies, but they do not address artificial wombs, leaving a legal gap. Given India's history of sex-based abortions, CRISPR could be misused for gender preferences or cosmetic enhancements. Many Indian traditions see life as sacred, hereartificial wombs and genetic manipulation will face strong moral and religious opposition.Keeping this in view, the following recommendations are made,

1. Strict Ban on Germline Editing: India currently needs a clear and strong legal framework to regulate gene editing making sure ethical and safe use. Somatic gene editing has to be permitted for treating diseases, while germline editing must remain prohibited until proven safe.

   And the Law should clearly differentiate between therapeutic applications (e.g., preventing genetic disorders) and non-medical enhancements (e.g., intelligence or physical traits). Also, should criminalize any unauthorized genetic modification for non-medical purposes.

2. Legal Framework for Artificial Wombs: India needs a specific law to govern artificial womb technology, clearly defining reproductive rights, who has parental rights, the legal status of the foetus, and importantly the ethical guidelines for usage.

---

23 International Society for Stem Cell Research, https://www.isscr.org/guidelines (last visited Mar. 10, 2025)

24 Leifan Wang, Lijun Shang, Weiwen Zhang, "*Human genome editing after the "CRISPR babies": The double-pacing problem and collaborative governance*", 5, Journal of Biosafety and Biosecurity, 8-13 (2023).

25 World Health Organization, https://www.who.int/clinical-trials-registry-platform/reporting-on-findings (last visited Mar. 10, 2025)

26 Elizabeth Cooke, "Experts warn caution around CRISPR gene editing technology on human embryos", https://www.clinicaltrialsarena.com/news/crispr-gene-editing-on-human-embryos-may-have-dangerous-consequences-says-new-study

27 The Medical Termination of Pregnancy Act, 1971, Act No. 34, Acts of Parliament, 1971 (India).

28 India Constitution Art. 21

29 Dhriti Jain vs State of Punjab and Others, CWP-4885-2024 (O&M)

30 Sarmishtha Chakrabortty and another Vs. Union of India Secretary and others, 2018 (13) SCC 339

31 Suora Note 28, Art.14

32 The Assisted Reproductive Technology (Regulation) Act, 2021, Act No. 42, Acts of Parliament, 2021 (India).

33 The Surrogacy (Regulation) Act, 2021, Act No. 47, Acts of Parliament, 2021 (India).

3. Public Awareness and Ethical Oversight: The ICMR and Ministry of Health has to launch a public consultations and ethical review boards to evaluate and discuss the long-term consequences of these technologies before permitting for clinical trials.
4. Regulating Private Sector Involvement: As India has a large private healthcare and biotechnology industry, strict laws help in preventing unregulated genetic modifications by private companies, avoiding a scenario where genetic enhancements become available only to the rich.

Thus, India needs to approach CRISPR gene editing and artificial wombs with an extreme and high caution. As these technologies could benefit to eliminate genetic diseases and provide for reproductive options to those unable who are unable conceive, they also bring up anotable ethical and legal risks. Without a proper regulation, countriesmay face issues such as genetic inequality, social discrimination, and exploitation by private biotech firms.

VI. Conclusion

The combination and intersection of CRISPR and artificial womb technology has the potential to bring a new idea in healthcare and reproduction, but it also poses significant ethical, legal, and social challenges. Current legal frameworks are insufficient to address the complexities of these emerging technologies, requiring new domestic laws, international law, policies and strict oversight. Ifgene editing & artificial wombs are left unregulated, it can lead to genetic inequality, exploitation, and unforeseen consequences. Moreover,to ensure responsible innovation, governments, scientists, and policymakers require working together for creating a balanced approach; one that promotes medical progress and at the same timesafeguards ethical values and human rights.

Thus, while looking at a redefined approach to reproductive rights its necessary to keep in mind that these innovations enhance reproductive freedom but also has ethical concerns such as genetic equity, consent, and potential societal divides. By integrating legal, ethical, and scientific perspectives, reproductive rights can evolve significantly to reflect technological progress along with safeguarding individual liberties and social justice.

* * * *

RIGHTS AND REALITIES- A RESEARCH ON AUTONOMY

Ms. Ridhima Singh *

Abstract

Every human in this world by birth holds some basic rights which are recognised as "Human Rights", these rights are claims which human makes as their need to live in any society. These rights are not subjective to any kind of discrimination based on any ground, they are just available to all humans, but the case is not simple as it seems to be because unfortunately these basic human rights are not available to everyone. The society has always provided the rights in an uneven manner, the discrimination mostly happens on the ground of gender i.e. there is still gender based discrimination in the society of 21st Century and the victim of this gender based discrimination are the women of the society, they are still the sufferers of "Discrimination Based on Gender Violence". This Paper will through light on the gender-based discrimination that women in our Indian Society as well as at international level are facing differently. This paper will majorly focus on "Sexual and Reproductive Rights" of Women which altogether is the most basic right of an individual, be it a man or a woman. The paper will further elaborate the issue of "Termination of Pregnancy" which is a issue regarding the autonomy of Women on their body and the rights they hold towards their body as a birth giver and as an individual. This Paper aims to find out the instances regarding this issue in the contemporary India as because the matter of sexual right to a person is not only a single right but it is a cluster of many rights which includes right to privacy, right to health, right to liberty, right to information, right to equality and most important 'the right to life' which is the biggest of all.

Keywords : **Human Rights, Gender based discrimination, Gender violence, Autonomy**

I. Introduction

In this modern era of 21st Century where world is talking about highly advanced nuclear technologies, artificial intelligence, space missions, quantum computing, digitalisation and many more advanced technologies and an age where everyone is so advanced and literate but still we are talking about unequal distribution of human rights, era which is so much advanced that it can't provide equality to women. It is the 21st century and women still are facing gender-based violence. Is this advancement is worth it.

According to a report of UN every one in three women had experienced gender based violence at least once in her life.

From an early era of time women are considered to be a subordinate of men ,making the society as a patriarchal society i.e. a society where men dominates over women in her all aspects of life. There are some basic natural rights which are often called as human rights i.e. the rights which human inherit from the time of its birth and every person in this world should have these right and these rights includes right to life, right to live with dignity and right to equality but this patriarchal society even doesn't provides these basic human rights to women and treat them as a unpaid "slave".

In order to dominate women, men and society is practicing violence against women since a long time and it is that much common in India as well as the world like the rising of sun in the morning. Just a change which had happened from past era to modern era is that in early times it was not an issue and no one talks about it but now the time has changed and it is one of the most concerning issues of the modern world.

Gender based violence is not just performed is a single specific manner or method but it can be in form of

* **Student., 3rd Year; B.A.LL.B., (Hons), S.S. Khanna Girls Degree College, University of Allahabad**

domestic violence, physical or mental cruelty, sexual harassment, women trafficking, unequal rights, marital rapes, molestation, moral misconduct, abusive family backgrounds, so-called societal norms and cultures, in-humane traditions, illtreating them in name of religion, treating as unpaid slaves and many more unnamed and unknown ways.

The gender based violence is not the actual problem which should be considered but the actual problem is despite being this much advancement in education and literacy, modernization and people calling them as educated and responsible citizens and moreover calling them as "educated humans" this issue of gender based violence is as much prevalent as this was one or two century before or I might say more prevalent. and despite having bundles of nationals and international laws, conventions and charter we are still talking about this and are trying to find a stable solution and punishment for those so-called "educated-human

II. Human Rights

Human Rights as the name suggest are the basic human rights. Humans have some natural rights as a result of them being a human, these rights are available to them by their birth and they can claim it at any point of time and it should not be denied by anyone. These rights are consistent with human dignity and equality and promote physical, moral, social, and spiritual well-being. By establishing favourable circumstances, they assist citizens in advancing materially and morally. All these available Fundamental rights, inherent rights, natural rights, and birth rights which human claim are ultimately used to describe human rights.

Human rights are the greatest cultural and civilizational gift of classical and contemporary human thought. The first clause of the Universal Declaration of Human Rights says that all human beings are born free and should be treated equal as far as dignity and individuality is concerned[1].

Human rights for women are fundamental rights and freedoms to which every woman is entitled, aiming to ensure equality and non-discrimination on the basis of gender Despite significant progress, challenges remain. Women worldwide continue to experience disparities in education, employment, and political representation. Issues like gender-based violence, harmful cultural practices such as child marriage and female genital mutilation, and restricted access to healthcare and legal rights persist.

Efforts by governments, international organizations, and grassroots movements are vital in advancing women's rights. Advocacy, legal reforms, and education are crucial strategies in this ongoing fight to achieve gender equality, ensuring that women can lead lives free from discrimination and oppression.

Gender Based Violence

Gender violence is clearly starts from inequality of distribution of power and respect between the genders also the asymmetrical relationships that exists between men and women in our society, which perpetuates the devaluation of women and their subordinate to men.

This issue of gender-based violence can be in different forms, it can be domestic violence, marital rape, molestation, unequal distribution of wages, physical and mental cruelty, sexual harassment, molestation at work places, human trafficking, abusive partners and in-laws, illogical traditional theories and rituals and many more. Violence can be practiced by intimate partners, colleagues, strangers, family members, enemy's soldiers, soldiers of one's own state, peacekeepers, police officers[2].

III. Sexualand Reproductive Rights

Sexual and reproductive right encompasses an individual to make informed decisions about their sexual and reproductive health. Every individual on this earth has a right to know about one's own body. Like every other fundamental right that one holds the sexual and reproductive right is also one of the major right which includes an individuals right to life, right to liberty, right to information, right to privacy, right to security and most important right to equal health-care and non-discrimination in medical facilities.

The International Conference on Population and Development (ICPD) recognizes the Right to sexual and

---

1 Shubha Vats and Sejal Talgotra. 2017. "Gender based Discrimination and Human Rights: A Gift of Goddess Lakshmi GENDER BASED DISCRIMINATION AND HUMAN RIGHTS: A GIFT OF GODDESS LAKSHMI" 1 IJLS (2017) 25

2 Forms of Violence, EURO. INST. FOR GENDER EQUAL., https://eige.europa.eu/gen der-based violence/forms-of-violence [https://perma.cc/G4GP-KV6W] (2nd March, 2025).

reproductive health. The "Programme of Action" a consensus document adopted by (ICPD) which has a separate chapter addressing gender equality and empowerment of women, placing the eradication of sex discrimination as a priority objective of the international community in relation to policies and programs of population and development. Chapter VII, entitled "Reproductive Rights and Reproductive Health". Reproductive rights, according to the ICPD, also include the right "to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents"[3].

The increasing number of sexual violence against women had transformed the reproductive capacity of women from an object of population control to a matter of women's empowerment, in order to exercise their personal autonomy in relation to their sexual and reproductive health within their social, economic and political context as women's right to personal autonomy and to collective gender equality is their human right.

From a long course of time treaties and conventions act as a source of international law which are legally binding so, in same order a convention called a "Women's Convention" which is the core human rights treaty to address discrimination against women, and is sometimes referred to as the international bill of women's rights, it covers the whole circumference of the lives of women in their public and private sphere including discrimination on the basis of sexual and reproductive rights.

In this convention there are several Articles which talk about the rights of women's health.

Article 10(h) talks about the women's right of access to specific educational information and advice on family planning[4]

Article 14(b) specifies, in particular, the right of women in rural areas to have access to adequate health care facilities, including information, counselling and services in family planning[5].

Article 11(1)(f) refers to women's right to protection of health and to safety in working conditions, including "the safeguarding of the function of reproduction"[6].

There are other provisions of the conventions which deals with the other factors of women's health rights like female genital mutation; sexual violence; HIV/AIDS; and reproduction.

The issue of sexual and reproductive rights of women generally revolves around two meanings i.e. discrimination and autonomy. Autonomy means the right of a woman to make decisions concerning her fertility and sexuality free of coercion and violence. In health care scenario the rights to informed consent and confidentiality are instrumental to ensuring free decision making by the client.

The WHO characterizes reproductive rights as:

"Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have information to do so, and right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence"[7].

The sexual and reproductive rights of women revolve around these following concepts-

- Right to legal termination of pregnancy.
- Right to control one's own reproductive capacities
- Right to consent based sexual intercourse.
- Right to get to the instruction about contraception and explicitly communicated sicknesses and independence from constrained cleansing and contraception.
- Right to shield from sexual orientation-based practices, for example, female genital cutting and male genital mutilation.

---

3 Dr. Carmel Shalev, expert member, CEDAW .March 18, 1998 "Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women".

4 Ibid

5 Ibid

6 Dr. Carmel Shalev, expert member, CEDAW .March 18, 1998 "Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women".

7 B.V. Subrahmanya. 1999 "Modi's Medical Jurisprudence and Toxicology",22nd Edn,Butterworths.

Talking about sexual and reproductive rights of women in the context of India is important as because from a very ancient time India had been a patriarchal society , in every field of Indian society man had dominated the women resulting in exploitation of their basic human rights and as it was said above that the basic human rights include the "sexual and reproductive rights". After India gained independence in 1947 the condition of woman had evolved from time to time as they had got voting rights, maternity benefits, equal fundamental rights, reservation in elections, property rights, compulsory education for women safeguarding of rights against domestic violence, rights at workplace and many more but there are few things which are written in law but not incorporated in real scenario.

India is developing in every expected field , be it space, sports, politics, education, culture and w but still many of the Indian women are struggling everyday for their basic human rights. Women were struggling for safeguarding themselves from domestic violence in result of which *Protection of Women from Domestic Violence Act, 2005* was implemented and also women were struggling for their protection of rights at workplace in result of which they got *The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013.*

Talking about the right to life and health of Indian women , at today's date women are still struggling for legal and safe termination of pregnancy, marital rapes are still common, talking about mensuration and sex is still a taboo in the country, women in rural areas are still considered as a child bearing machine , many women in the country still had not knowledge about sex communicable diseases , many illegal practices like gential mutation, forced virginity test and hymen repair are still practiced by some people.

IV. Termination of Pregnancy

This paper will now be dealing with one of the major aspect of sexual and reproductive right of women which is the "Termination of Pregnancy".

An issue that has of late had become a debatable subject is as to a woman's right to abort the foetus she is carrying. Can a pregnant wife have her pregnancy terminated without, or even against , the consent of her husband? Who has the absolute right to decide on it? Can a husband or anyone restrain the wife from terminating the pregnancy?[8]

Abortion or termination of pregnancy is a issue dealing with morality, infanticide, suicide, ethics, religious beliefs, right to life and women's right. Basically, Abortion or miscarriage means the spontaneous or induced termination of pregnancy before the foetus is independently viable, which is usually taken as occurring after the 28th week of conception.[9]

Coming to reasons behind abortions are unwanted pregnancy, marital rapes, gender discrimination, and most prominent one is unlawful sexual intercourse(rape). Abortion will continued to be an debatable issue until women will face unwanted pregnancies and unwanted pregnancies will exist until women faces gender based violence and gender discrimination.

The debate regarding the termination of pregnancy is situation of clash and balance between the two emerging rights which are "right to abort vs right to life". The women carrying the child in her body has a autonomy to make decision regarding her body and health. She is the fullest decision maker of her body but the foetus which she is carrying has a right to life which is a basic human right. So, this issue portrays the unheard voice of the potential life and its rights presenting the need for a fine balance between the two sets of conflicting interests.

Laws and Regulations related to termination of Pregnancy in India –

Talking about the position of abortion in India, In India the abortion is illegal and this concept is regulated by the Section 88 to Section 92 of the Bhartiya Nyaya Sanhita ,2023 which are following-

- 88. The offence Causing miscarriage
- 89. Causing miscarriage without woman's consent.
- 90. Death caused by act done with intent to cause miscarriage

---

[8] Kusum. 47 JILI (2005) 374, "WIDOW'S Right to Terminate Her Pregnancy".

[9] Medical Termination of Pregnancy Act, 1971 (Act 34 of 1971).

- 91. Act done with intent to prevent child being born alive or to cause it to die after birth
- 92. Causing death of quick unborn child by act amounting to culpable homicide.

Abortion was made a crime for which the mother as well as the abortionist could be punished except where it had to be induced in order to save the life of the mother. A huge number of cases had been reported regarding this and surprisingly most cases of abortion were regarding to married women and it was believed that there was no need to conceal their pregnancy[10].

But with the changing scenario of time the change in the provisions for the medical termination of pregnancy was needed and due to the following reasons legalisation of provisions of abortion were proposed –

- *as a health measure*—when there is danger to the life or risk to physical or mental health of the woman;
- *on humanitarian grounds*—such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, marital rape etc.
- *eugenic grounds*— where there is substantial risk that the child, if born, would suffer from deformities and diseases[11].

Section 3 of the Medical Termination of Pregnancy Act, 1971 states the causes in which medical termination of pregnancy is valid and is done by registered medical practitioners.

1. A licensed health professional who terminates a pregnancy in accordance with the law should not be held in violation of any crime listed in the Indian Penal Code, 1860, or any other legislation at the time of the medical procedure[12].
2. Where the gestational period has not lasted longer than 12 weeks[13].
3. Where the length and duration of the pregnancy has exceeded 12 weeks but not 20 weeks. The same should be decided on a case-to-case basis by the authentic assessments of the two doctors[14].
4. When there is a probability that the unborn child will have poor physiological and mental health and may also be disabled[15].
5. It is crucial to keep in mind that any girl under the age of 18 who is insane or of unsound mind cannot have her pregnancy terminated without her guardian's or parent's written authorization[16].
6. A woman's bodily or mental health will be in great danger if the pregnancy is allowed to continue[17].

But status is not as simple as it seems to be because under these provisions only a rape victim and a married women are allowed to terminate pregnancy but the conditions and cases of unmarried women, widows, as well as divorced women, are yet untouched.

So, these women have two options – either to continue their pregnancy or to opt for illegal methods of termination of pregnancy. Even married women do not have a fully qualified right to abort as they are supposed to prove the failure of contraceptives to avail themselves of the facility of medically terminating the pregnancy. This violates their fundamental right to privacy[18].

So the main issue regarding this concept is that in conditions of unwanted pregnancies is that mental and physical health of women is put on the stake. As a result of this their right to life, right to health , right to privacy, right to information and their personal liberty all are infringed which ultimately lead to special form of gender based violence and infringement of basic human rights.

V. View Point of Indian Judiciary

In the landmark judgement of *Suchita Shrivastava v. Chandigarh Administration*[19]

---

10 https://blog.ipleaders.in/medical-termination-of-pregnancy act/#Medical_Termination_of_Pregnancy_Act_1971.
11 ibid
12 ibid
13 ibid
14 ibid
15 ibid
16 ibid
17 ibid
18 https://www.scobserver.in/journal/abortion-law-in-india-a-step-backward-after-going forward/ (6th March 2025)
19 (2009) 9 SCC 1.

Here, the Supreme Court observed that every woman holds certain rights related to reproduction, which includes the right of women to give birth. Reproductive rights form a basic component of the privacy, integrity, and dignity of a woman, which are enshrined under the Indian Constitution.

As the Medical Termination of Pregnancy Act, 1971 was silent on some issues and conditions and an amendment was needed to improve those conditions , so in September 2021, the Medical Termination of Pregnancy (Amendment) Act of 2021 came into force, extending the upper gestational limit for abortion from 20 to 24 weeks. Although the amendment did not recognise abortion on demand as a pregnant person's right, it was heralded as the next step in making Indian abortion laws more progressive. The amendment was a response to the Indian courts receiving requests to access safe medical support from many women with unwanted pregnancies beyond the permissible gestation period[20]. Which expanded the access to safe and legal abortion services on therapeutic, eugenic, humanitarian and social grounds to ensure universal access to comprehensive care.

In September 2022, the Supreme Court granted a petitioner permission to terminate her 22-week pregnancy in a *X v Principal Secretary*[21].

This decision was celebrated among the advocates of reproductive rights as the honourable court founded the distinction of rights solely based on the marital status of a woman is against the right to equality and is unconstitutional, also the unmet needs of marital rape survivors in situations of unwanted pregnancies were recognised.

The judgement held that the decision to carry a pregnancy to term or terminate it is firmly rooted in a woman's right to her bodily autonomy and her ability to choose her path in life. It also recognised that an unwanted pregnancy can have serious negative effects on a woman's life, such as disrupting her education, career, and mental well-being[22].

In a recent Judgement given by a three-Judge Bench comprising *CJI D.Y. Chandrachud, Justice J.B. Pardiwala, and Justice Manoj Misra* observed, "… the view of 'X' and her parents to take the pregnancy to term are in tandem. The right to choose and reproductive freedom is a fundamental right under Article 21 of the Constitution. Therefore, where the opinion of a minor pregnant person differs from the guardian, the court must regard the view of the pregnant person as an important factor while deciding the termination of the pregnancy. They said that reproductive freedom is a right.

VI. US Laws in Relation to Termination of Pregnancy

The major highlight of the show of abortion in United States was the landmark judgement of *Roe vs Wade*[24], so in this case the Supreme Court of the United States ("Court") established that a woman's right to an abortion was protected by the right to privacy implicit in the Fourteenth Amendment.

The Court recognised that the right to privacy, which protects a woman's right to have an abortion, was implicit in the Due Process Clause of the Fourteenth Amendment. However, this right was not absolute and needed to be balanced against legitimate interests that the State might have in regulating abortion. The Court struck down the Texas Statute as unconstitutional. It held that the due consideration be given to State interests varied over the course of pregnancy, and the law regulating abortion must account for these changes. An infringement of a woman's right to an abortion would only be justified when the interest of the State was compelling.

But this was condition only till 2022 as because in 2022 the judgement of *Dobbs v. Jackson*[23] Women's Health Organization overruled the landmark judgement of Roe vs Wade stating that the Constitution does not confer a right to abortion, and the judgment effectively ended federal protection for abortion rights and returned the authority to regulate abortion to individual states.

As of today the legal position of Abortion laws in US are dynamic and fragmented , the landmark ruling of

---

20 https://www.scobserver.in/journal/abortion-law-in-india-a-step-backward-after-going forward/ (7th March 2025).

21 410 U.S. 113

22 https://privacylibrary.ccgnlud.org/case/roe-vs wade#:~:text=The%20Court%20concluded%20 that%20the,the%20regulation%20 of%20the%20same (7th March ,2025).

23 597 U.S. 215 (2022

Dobbs vs Jackson had overturned the landmark judgement of Roe vs Wade and as a result, the regulation of abortion has been returned to the individual states, leading to a wide variety of laws and restrictions across the country.

Several states had “trigger laws” in place, designed to ban or severely restrict abortion immediately upon the overturning of Roe but some States like California, New York, and Illinois have passed laws to protect and expand access to abortion services. On the federal level, Democrats have attempted to pass legislation to codify the protections of Roe v. Wade, such as the Women’s Health Protection Act, but these efforts have faced significant opposition and have not been enacted into law also Various state laws are continually being challenged in court. Some of these challenges have led to temporary injunctions, preventing certain restrictive laws from taking effect while the legal battles proceed.

VII. Conclusion

Wrapping up the research I found that the above considered concepts were revolving around the three major human dignity concepts which are being violated i.e. liberty, equality and social justice. As a human all should have claim on these basic concepts of human dignity.

Not providing proper autonomy to women on their own body shows the inequality between the gender. The issues which a woman faces which ultimately shows that how much she lacks in having autonomy on her own body. Living in advanced and highly technological 21st century and still talking about measures to abolish gender based violence and providing basic human rights to certain part human class is quite a matter of thought.

Yes, the actors and non-actors of the society are taking measures to abolish this but the real change will be visible when common man will start changing and will come out of that loop of gender inequality. Governments had many laws and conventions in order to change the scenario, associations and NGOs have been made but the main advancement which personally appreciates more is that women of today are concerned about themselves. Women are taking stand for themselves, they are raising their voices for their human rights.

Judiciary and laws of the countries are also changing and judges are more applying a practical approach in cases of termination of pregnancies and issues like marital rape and minor pregnancies.

So, the current situation is far more better than then the past one where the autonomy of a women was not a concept. Actors , non- actors, judiciary and even common man has starting to realize that discrimination on any basis and especially on the basis of gender works like an evil for any developing society. A family, a society and even a nation will only grow if every person of that will have equal access to human rights, will have an autonomy on them and their will be no discrimination out there.

* * * *

EXCLUSION AND INEQUALITY IN INDIA'S SURROGACY LAWS: A CASE FOR INCLUSIVE REPRODUCTIVE RIGHTS

Mr. Aryan Raj *

Ms. Shraddha Yadav **

Abstract

Surrogacy is an assisted reproductive technology in which a woman carries pregnancy for another couple. Thousands of couples require surrogacy services for various reasons. Although beneficial but still there are serious ethical, social, moral, and legal issues associated with it. India's surrogacy journey spans from its rise as a surrogacy hub in 2002 to the Surrogacy (Regulation) Act, 2021. Surrogacy is vital for couples who are unable to conceive. If the delicate issues associated with surrogacy will be addressed properly, it would be practiced easily.

The current law permits surrogacy only for married couples, widows, and divorced women, excluding unmarried women and LGBTQ+ individuals. Despite the 18th Law Commission's 228th report, recommending surrogacy for single and gay parents, no action has been taken. This restriction violates fundamental rights and reproductive choices. These legal barriers have forced unmarried women and LGBTQ+ individuals to seek alternative and often legally uncertain options. In contrast, countries such as the Brazil, Colombia ensure reproductive rights for all.

This paper traces surrogacy's origins in ancient India and aims to analyze the restrictive provisions of India's surrogacy laws, particularly their exclusion of unmarried women and LGBTQ+ individuals, violating equality and reproductive autonomy. It compares India's laws with that of U.S., Colombia, etc., highlighting the need for a more inclusive approach. The paper proposes legal reforms to ensure equitable access, aligning India's laws with constitutional principles and global best practices.

The paper aims to answer the research questions such as how does excluding unmarried women and LGBTQ+ individuals from surrogacy violates equality, privacy, and reproductive autonomy, how are Indian surrogacy laws different from the inclusive frameworks of countries like Brazil, Colombia, and Mexico and what legal reforms can be proposed to make India's surrogacy laws more inclusive?

Keywords : **Surrogacy law, reproductive rights, assisted reproduction, LGBTQ+, unmarried women, equality.**

I. Introduction

Almost every couple has the wish of becoming parents and having their biological child but not everyone is blessed. To reduce the agony of such infertile couples, assisted reproductive technologies are used to fulfil their wish of becoming parents. Surrogacy is one such method of assisted reproductive technology. It offers an important gateway to parenthood for people and couples who cannot bear children. Under this method, there is a woman, popularly known as surrogate mother, who bears and gives birth to a child and this child is then given to the intended parents, who might be facing infertility, medical conditions preventing pregnancy, etc. Surrogacy became an internationally accepted, widely popular and preferred method for assisted reproduction, in the last few decades. Many nations passed legislations to regulate this practice. The legal framework used for regulating surrogacy in India has undergone significant changes over the years. India had a journey from being the most preferred destination for surrogacy to the one with a highly restrictive legal framework.

* **Student, National University of Study and Research in Law, Ranchi.**

** **Student, National University of Study and Research in Law, Ranchi.**

At one time, in the early 2000s, India became a surrogacy hub for the world. Intending parents from around the whole world felt attracted towards India for surrogacy. This attraction was due to several factors such as availability of good medical infrastructure, less restrictions, liberal regulations, cost effectiveness, etc. When compared to countries like United States and the United Kingdom, surrogacy in India was really affordable. In countries like USA, UK, the cost of surrogacy was around $80,000 to $150,000 while in India, it was around $10,000 and $28,000 for comprehensive surrogacy packages. The surrogacy industry in India was worth over $400 million by 2012, with over 3,000 fertility clinics across the country.

The surrogacy industry was economically beneficially but the unlimited and unrestricted growth of this sector began raising several moral, ethical, legal and social issues. There was a surge in cases of exploitation of surrogate mothers, low payment to those surrogate mothers who were from financially disadvantaged background and were in need of money, no care of post-delivery care of surrogate mothers, etc. Conflicts related to nationality and parenthood began to rise and resulted in various legal petitions and cross-border differences. Acknowledging all these issues, Indian government began enacting regulations to prevent the abuse related to commercial surrogacy and to ensure the welfare of surrogate mothers and children.

The pathbreaking regulation came in 2021. The Surrogacy (Regulation) Act was introduced in 2021. This act completely prohibited commercial surrogacy and allowed only altruistic surrogacy. Under altruistic surrogacy, no payment other than medical expenses is given to the surrogate mother. This act allowed a very limited people to avail the service of surrogacy. Legally married coupled, widows, divorced women were only allowed to avail surrogacy. The definition of "couple" under this act, specifically referred to the heterosexual couples and hence excluded homosexual people from availing surrogacy.

Due to the highly restrictive approach, the Surrogacy (Regulation) Act, 2021 Act has been heavily criticized. By restricting the facility of availing surrogacy to limited groups, the law deprives reproductive freedom to unmarried women and individuals belonging to the LGBTQ+ community, which evokes serious concerns regarding equality and human rights. Critics even argue that the act violates the constitutional right to equality, privacy and reproductive autonomy. People who are not allowed to avail surrogacy may end up using alternative methods which can raise legal disputes and overseas conflicts.

This research paper is aimed at analysing the restrictive and exclusionary nature of India's surrogacy legislations and their effects on reproductive rights, with violations of equality, privacy, and autonomy for unmarried women and LGBTQ+ individuals. The paper also compares the exclusive Indian law with that of inclusive laws of other countries such as Brazil, Colombia and Mexico. Through these analyses, the article adds to the discussion of reproductive justice in India.

The research paper attempts to answer the following research questions-

- What is the current status of surrogacy in India under the Surrogacy (Regulation) Act, 2021?
- How is this Act discriminatory against unmarried women, single men and LGBTQ+ individuals?
- What policy changes or legal reforms could make India's surrogacy laws more inclusive and equitable?

II. What is Surrogacy?

The root of the word "surrogacy" is the Latin term "surrogatus," which means "substitute" or someone designated to function in lieu of another.[1] In Black's Law Dictionary, it is defined as the process of delivering and bearing a child for some other person.[2]

It can be said that it the union of society, science, person and services that has converted surrogacy into a reality.[3] One of the most familiar reproductive methods is surrogacy, where a woman agrees to become pregnant to carry and deliver a child whom she will not raise but rather hand over to a third party. She can be the biological mother of the child (the more traditional type of surrogacy) or she can be a gestational carrier, carrying the pregnancy till delivery after an embryo has been transferred.[4] Sometimes, there are cases where the only available way for the parents to fulfil their wish of having a biologically related child is surrogacy.

1 R.S. Sharma, *Social, ethical, medical & legal aspects of surrogacy: an Indian scenario*, 140 IJMR 13, (2014).
2 Black's Law Dictionary 1582 (9th ed. 2009).
3 Supra Note 1
4 Baby Manji Yamada v. Union of India & Anr, AIR 2009 SC 84 (India).

There are different types of surrogacies. These are discussed below-

- Traditional Surrogacy

In this type of surrogacy, there is a genetic or biological connection between the surrogate mother and the child because the egg of the surrogate mother is fertilized with the sperm of the intended father or a donor by artificial insemination. Traditional surrogacy is sometimes known as "straight method". Here, the child is conceived with the understanding that after birth, it would be given to the biological father and his partner, but the surrogate is pregnant with her own biological child The child can be conceived using technique of home artificial insemination with the help of fresh frozen sperm, or the child can be conceived in a fertility clinic through intrauterine insemination (IUI) or intracervical insemination (ICI).[5]

- Gestational Surrogacy

In gestational surrogacy, there is no genetic link between the surrogate and the embryo that she carries. In this type of surrogacy, firstly, using the IVF technique, the embryo is created by utilizing the sperm and eggs of the intended parents or donors and then, the embryo is implanted in the uterus of the surrogate. In Baby Manji case, the judges defined gestational surrogacy as following – "In 'gestational surrogacy' (also known as the Host method) the surrogate becomes pregnant via embryo transfer with a child of which she is not the biological mother. She may have made an arrangement to relinquish it to the biological mother or father to raise, or to a parent who is themselves unrelated to the child (e. g. because the child was conceived using egg donation, germ donation or is the result of a donated embryo)."[6]

- Altruistic Surrogacy

In this type of surrogacy, no formal contract exists and no payment or fee is given to the women who is giving birth essential elements of altruistic surrogacy. These essential elements include bearing of a child by a surrogate mother, elimination of parental rights after the birth of the child and money payment by the genetic parents.[7] In "altruistic surrogacy," the surrogate mother is not paid any money for her pregnancy or for relinquishing the child, although the intended parents usually pay all the costs for the pregnancy and delivery, including maternity attire, medical expenses, and other related costs.[8]

- Commercial Surrogacy

In this type of surrogacy, a huge amount of money is paid to the surrogate for her services as her income and in addition to this, all the expenses incurred in her pregnancy are also given. Offensive terms such as "wombs for rent", "outsourced pregnancies" or "baby farms" are often used to refer to commercial surrogacy.[9]This type of surrogacy is generally used by those infertile couples who are financially well-off and can afford the costs that are involved in this procedure. Sometimes, people who can arrange the money by savings or by borrowing from others also use this method of surrogacy. In this, surrogate mother or the women who carries a child in her womb till the child becomes mature is paid huge amounts.[10]

III. Historical and Legal Evolution of Surrogacy in India

In India, surrogacy, where a woman carries a child for someone else or another couple, is an ancient and rich cultural tradition. The concept of surrogate motherhood is not foreign to the country, it appears in the religious texts such as Bible and other early Indian texts, including the Mahabharata.

There are several instances in Hindu mythology which highlight instances similar to that of surrogacy or depict the presence of alternative reproductive methods. An early example of embryo transfer can be found in Hindu mythology in the story of Balram, the seventh child of Devaki and Vasudev. To protect the unborn child from Kansa, Devaki's tyrannical brother, the embryo was secretly transferred to the womb of Rohini, Vasudev's first wife.[11] This mythological account reflects the understanding and practice of alternative

---

5 *Id*

6 Baby Manji Yamada v. Union of India & Anr, AIR 2009 SC 84 (India).

7 Aditi Singh, *Surrogacy in India- A Critical Analysis*, (unpublished seminar paper, Rajiv Gandhi National University of Law, Jan. 2024) (https://www.researchgate.net/publication/377411084).

8 Baby Manji Yamada v. Union of India & Anr, AIR 2009 SC 84 (India).

9 J.P.S. Sirohi, *Criminology and Penology* 679 (2011).

10 Baby Manji Yamada v. Union of India & Anr, AIR 2009 SC 84 (India).

11 Pratibha Ganesh Chavan, "*Psychological and Legal Aspects of Surrogate Motherhood*" AIR 2008 Jour 103.

reproductive methods in ancient times, long before the intervention of modern medical advancements. Even more fascinating is the tale of the birth of Drishtadyumna and Draupadi, showing the exceptional powers of the ancient Rishis. Due to his hatred for Dronacharya, King Draupada desired to have a son who could kill Drona. On taking medicine from Rishi and mixing his semen, he advised his wife to get artificial insemination homologous (AIH), but she refused. The Rishi then, decided to put the semen into the yajnakunda from which later one, Dhrishtadyumna and Draupadi were born. Again, this reflects the presence and use of alternative reproductive technologies in ancient times.[12]

These references indicate that alternative methods of reproduction were acknowledged in Indian society. The world's second and India's first in vitro fertilisation (IVF) baby, Kanupriya alias Durga, was born in Kolkata in 1978, marking the success of surrogacy in India.[13]

Even after legalizing commercial surrogacy, no law or definitive regulations were created and enacted, leading to an immense surge in unregulated surrogacy in India because of the presence of cheap fertility clinics and a large number of poor women.[14] Foreign nationals found India as an attractive destination for surrogacy because of the combination of comparatively low costs and advanced medical infrastructure. By 2012, the surrogacy industry in India was estimated to be worth over $400 million annually, with more than 3,000 fertility clinics operating nationwide.[15]

To oversee the burgeoning surrogacy industry, the Indian Council of Medical Research (ICMR) issued guidelines in 2005, known as the "*National Guidelines for Accreditation, Supervision, and Regulation of ART Clinics in India.*"[16] These guidelines allowed for commercial surrogacy and enabled surrogate mothers to be paid a fee by intended parents. Nevertheless, being guidelines, they were not legally enforceable, and their implementation by clinics varied. The absence of legal protection for surrogate mothers and intended parents resulted in various high-profile overseas conflicts, like the 2008 Baby Manji case,[17] where a Japanese couple's surrogacy plan in India caused legal issues after they broke up before the baby was born. The case drew attention towards the requirement of legal guidelines on how to oversee surrogacy in India. The surging growth of the surrogacy industry raised a number of ethical and legal concerns. There was concern over the exploitation of financially underprivileged women, low compensation, and the absence of post-birth medical care for surrogate mothers. Moreover, conflicts over children born by surrogacy and their parentships and citizenship increased, underlining the necessity of a thorough law.

To meet these challenges, the Law Commission of India released its *228th report* in 2009,[18] highlighting the need for legislation to govern Assisted Reproductive Technology (ART) clinics and to establish the rights and responsibilities of parties to surrogacy arrangements. The key suggestions were giving financial assistance to surrogate children where the intended parents had unexpected situations, like death or divorce, prior to the birth of the child, to provide life insurance coverage for surrogate mother, to safeguard the right to privacy of donors and surrogate mothers. The Commission recommended prohibiting commercial surrogacy and encouraging altruistic surrogacy among Indian citizens by enacting proper legislation. In response to increasing criticism, the Indian government started clamping down on regulations. In 2013, a prohibition was placed on surrogacy for foreign gay couples and single parents. This was followed by a 2015 restriction that prohibited all foreign couples from accessing commercial surrogacy in India, limiting it to Indian citizens only. These

---

12 Aditi Singh, *Surrogacy in India- A Critical Analysis*, (unpublished seminar paper, Rajiv Gandhi National University of Law, Jan. 2024), https://www.researchgate.net/publication/377411084.

13 Dr. Radhika Yadav,, & "Pavan Kasturi, *A Comprehensive Analysis on Reproductive Health and Surrogacy in India: A Study on the Law, Policy, and Practice*, SCC, (Sept. 27, 2021), https://www.scconline.com/blog/post/2021/09/27/reproductive-health-and-surrogacy-in-india/.

14 Animesh Nagwanshi, *Surrogacy in India-A long Journey for the Nation*, The Times of India, (Mar 04, 2023, 21:39 IST), https://timesofindia.indiatimes.com/readersblog/maternitybenefitactboonandbaneforthenation/surrogacy-in-india-a-long-journey-for-the-nation-51172/

15 Gerard Pradeep Devnath, & "Senthil Kumaran, *Surrogacy in India: Ethical and Legal Aspect*, 14 Indian Journal of Forensic Medicine and Toxicology, (2020)

16 Indian Council of Medical Research, National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India, (Issued in 2005).

17 Baby Manji Yamada v. Union of India & Anr, AIR 2009 SC 84 (India).

18 Law Commission of India, Govt. of India, Need for legislation to regulate assisted reproductive technology clinics as well as rights and obligations of parties to a surrogacy (2009).

measures aimed to address ethical concerns and prevent potential legal disputes involving international surrogacy arrangements.

In 2016, the Government of India brought *the Surrogacy (Regulation) Bill*,[19] with an intent to legalize surrogacy procedures. The bill aimed at prohibiting commercial surrogacy and allowing only altruistic surrogacy for certain segments, namely heterosexual Indian couples who were married for a minimum period of five years, had an age bracket of 23-50 years for women and 26-55 years for men, were childless, and suffered from infertility. The bill further provided that surrogate mothers must be close relatives of the intended parents, married, have one or more children, and between the ages of 25 to 35.

In 2021, *the Surrogacy (Regulation) Act*[20] came into force, including several of the provisions contained in the bill of 2016. This act strengthened the prohibition of commercial surrogacy and set specific criteria for people seeking surrogacy services with the intent of safeguarding surrogate mothers' and children born of surrogacy's rights and welfare.

IV. Features of the Surrogacy (Regulation) Act, 2021

The Surrogacy (Regulation) Act, 2021 was brought into force to establish a systematic legal framework for surrogacy in India. The Act seeks to resolve ethical issues, avoid exploitation, and govern surrogacy procedures through stringent legal provisions. The Act ensures clarity regarding the rights and duties of all stakeholders while maintaining compliance with medical and legal standards. By creating a clear set of regulations, it aims to strike a balance between the interests of prospective parents, surrogate mothers, and the best interests of children born as a result of surrogacy. Some of the provisions of this Act are outlined below-

Ban on Commercial Surrogacy

The Surrogacy (Regulation) Act, 2021, prohibits commercial surrogacy to avoid exploitation of women. According to Section 3 and Section 38, neither any person nor any clinic or agency is allowed to provide surrogacy services in return for money except for medical costs and insurance cover.[21] Any form of payment, reward, or trade related to surrogacy services is considered illegal.[22] Violating this provision can lead to severe penalties, ensuring that surrogacy remains an ethical and non-commercial practice.

Only Altruistic Surrogacy Allowed

The Act permits only altruistic surrogacy,[23] as defined under Section 2(b) and Section 4.[24] This implies that a surrogate mother cannot be paid any money except for medical bills and insurance. The purpose of this provision is to avoid financial coercion and to make sure that surrogacy is done for the sole purpose of assisting intended parents and not for profit. This provision protects surrogate mothers from financial exploitation.

Eligibility for Surrogacy

Surrogacy is limited to married Indian couples only who fulfill the eligibility criteria which is mentioned in Section 4.[25] The husband should be between 26-55 years of age and the wife should be between 23-50 years of age. Widows and divorced women between 35-45 years of age are also eligible to undergo surrogacy to fulfil their dream of becoming mothers.[26] But surrogacy is permitted only in situations where medical necessity is justified by a District Medical Board.

Conditions for the Surrogate Mother

Under section 4(b) and Section 6,[27] the Act puts stringent conditions on women who are willing to be surrogate mothers. A surrogate mother should be a married woman having at least one biological child and between the

---

19 The Surrogacy (Regulation) Bill, 2016, Bill No. 257 of 2016, (November 21, 2016)
20 The Surrogacy (Regulation) Act, 2021
21 The Surrogacy (Regulation) Act, 2021, §38.
22 Ibid
23 TIbid
24 Ibid
25 Ibid
26 Ibid
27 Ibid

age group of 25 to 35 years. In addition to this, a woman can become a surrogate mother only once in her lifetime in order to avoid repeated exploitation.[28] Prior to the procedure, she will have to sign written informed consent and is entitled to withdraw prior to embryo implantation. All these steps are meant to ensure the physical and psychological well-being of surrogate mothers.

Legal Parentage and Protection of the Surrogate Child

For the sake of ensuring the welfare of children born by surrogacy, Section 7[29] and Section 8[30] provide that a surrogate child is adopted into law as the biological child of the intending parents. The child shall enjoy all rights and privileges as a natural-born child. Significantly, the intending parents shall not abandon the child for any reason, including birth defects, disability, or gender preference. This clause avoids the abuse of surrogacy for child abandonment or gender selection.

Regulation of Surrogacy Clinics

Section 11[31] and section 12[32] of the Act requires that only registered clinics are permitted to carry out surrogacy procedures. All surrogacy clinics are required to have a certificate of registration from the concerned authority and adhere to all medical and ethical norms. Moreover, advertising or soliciting commercial surrogacy services is prohibited (Section 3(v)).[33] Surrogacy clinics are also prohibited from storing human embryos or performing procedures for unapproved persons. These rules ensure that there is transparency and ethical practice in surrogacy.

Restrictions on the Number of Embryos and Abortions

For the safety and health of the surrogate mother, Section 9 also provides that the number of embryos inserted should adhere to stipulated medical standards.[34] Moreover, Section 10[35] states that the abortion during surrogacy is permissible only with the written agreement of the surrogate mother and approval of the concerned authority under the Medical Termination of Pregnancy Act, 1971.[36] This prevents abortion by force and helps maintain the reproductive rights of the surrogate mother.

Establishment of Regulatory Authorities

In order to monitor surrogacy operations, the Act sets up the National Assisted Reproductive Technology and Surrogacy Board (Section 17)[37] and related State Surrogacy Boards (Section 26).[38] The boards have to regulate surrogacy clinics, provide ethical standards, and see that there is compliance with law. The board's work also involves processing applications, issuing certificates of eligibility, and deterring unethical surrogacy arrangements. The establishment of the boards makes the regulatory framework systematic and responsible.

Strict Penalities for Violations

The Act lays down stringent penalties for contravention of its provisions. Engaging in commercial surrogacy, leaving behind a surrogate child, or taking advantage of a surrogate mother may result in a sentence of imprisonment for up to 10 years and a fine of up to ₹ 10 lakh.[39] All offenses under the Act are declared to be cognizable, non-bailable, and non-compoundable under section 43,[40] thereby guaranteeing strict legal repercussions for anyone who tries to circumvent the regulations.

---

28 Ibid

29 Ibid

30 Ibid

31 Ibid

32 Ibid

33 Ibid

34 Ibid

35 Ibid

36 Ibid

37 Supra Note 21

38 Ibid

39 Ibid

40 Ibid

V. Surrogacy Laws in Other Countries

- Colombia

Colombia does not have a specific law that explicitly legalizes or criminalizes surrogacy contracts.[41] However, all individuals, including single people, heterosexual couples, and same-sex couples, are allowed to participate in the surrogacy process as long as there is a genetic connection to the child. Colombian law prohibits discrimination, reinforcing the right of all individuals to access surrogacy. A significant ruling by the Colombian Constitutional Court in 2015 further emphasized the importance of protecting children's rights to have a family, including those with same-sex parents.[42] Additionally, Article 100 of the Colombian Constitution guarantees that foreigners have the same civil rights as Colombian citizens, thereby extending surrogacy rights to international intended parents.[43] Although Colombia does not have a pre-birth order system like some U.S. states, a legal procedure is in place to ensure that the intended parents are recognized on the child's birth certificate after birth.

- Brazil

In Brazil, surrogacy is regulated under RCFM No. 2.121/2015, which generally prohibits commercial surrogacy. However, altruistic surrogacy is allowed in two specific cases: when the intended mother can contribute an egg but cannot carry the pregnancy due to medical reasons, or when the intended parents are in a same-sex marriage.[44] Additionally, the surrogate mother must be a close relative of one of the intended parents, up to the fourth degree of consanguinity (such as a mother, sister, aunt, or cousin).[45] This strict regulation ensures that surrogacy remains within family structures and is not commercialized.

- Mexico

In June 2021, the Mexican Supreme Court ruled in favor of surrogacy, endorsing both free and paid surrogacy arrangements. The court invalidated provisions in one state that restricted surrogacy access for same-sex and foreign couples, thereby establishing a precedent that allows surrogacy agreements to take place across different Mexican states.[46] This ruling has opened the door for commercial surrogacy agreements, making Mexico one of the few countries where both compensated and altruistic surrogacy are legally recognized and accessible to a broad range of intended parents, including international clients and same-sex couples. Additionally, the ruling in Tesis: 1a. LXXXVII/2019 establishes that restricting access to assisted reproductive technologies (ART) based on sexual orientation is unconstitutional. This decision underscores that singles and same-sex couples must have equal access to ART, including surrogacy. It aligns with international human rights principles, affirming that laws limiting ART access to heterosexual couples violate the right to non-discrimination. These rulings are significant as they reinforce the right to parenthood for diverse family structures and challenge discriminatory legal barriers. As a result, surrogacy laws across different Mexican states have been impacted, allowing broader access and reducing restrictions that previously limited certain groups from becoming parents through surrogacy.

VI. The Legal Void in India's Surrogacy Laws

The Surrogacy (Regulation) Act, 2021, while aiming to regulate surrogacy and prevent its commercialization, has several fundamental flaws that create legal, ethical, and social challenges. One of the most significant issues is its restrictive eligibility criteria, which permit only married heterosexual couples, widows, and divorced women to access surrogacy. This exclusion discriminates against unmarried women, same-sex couples, and single individuals, effectively denying them the right to have a biological child through surrogacy. The Act fails to acknowledge the evolving concept of family and does not align with the progressive recognition of diverse family structures in Indian and global jurisprudence.The act does not take into consideration the recommendations of 228th Law commission report that encouraged granting permission of surrogacy to single

---

41 Gloria Torres, et al., *A review of surrogate motherhood regulation in south American countries: pointing to a need for an international legal framework*, 19 BMC Pregnancy Childbirth, 46 (2019), https://doi.org/10.1186/s12884-019-2182-1.

42 https://www.surrogacyconsultancy.com/surrogacy-for-single-men-in-colombia/

43 https://www.surrogacyconsultancy.com/surrogacy-laws-in-colombia/

44 Supra Note 41

45 Pedro Brandão,, & "Nicolás Garrido, *Commercial Surrogacy: An Overview*, (2022), https://doi.org/10.1055/s-0042-1759774

46 Id

parents and LGBTQ+ couples.[47] The law violates the right to equality which is mentioned under Article14 of the Constitution[48] and right to privacy, mentioned under Article 21[49], which also includes right to reproductive autonomy. The Supreme Court in *Navtej Singh Johar v. Union of India* (2018)[50] legalized same-sex relationships and upheld the dignity of LGBTQ+ persons, but the law of surrogacy still refuses to grant them parental rights, going against this judgment.

Yet another serious deficiency of the Act is that it does not identify surrogacy as a reproductive right but instead acknowledges it as a privilege for specific groups only. The legislation fails to consider autonomy and reproductive rights of the individuals and approaches surrogacy as a limited medical service instead of an inherent component of individual liberty. This contradicts landmark Supreme Court decisions, like *Justice K.S. Puttaswamy v. Union of India* (2017),[51] that affirmed bodily autonomy and reproductive choice as integral aspects of the right to privacy. The 228th Law Commission Report (2009) also suggested the requirement of an all-encompassing law on surrogacy that provides access to surrogacy in a non-discriminatory manner while avoiding commercial exploitation. By restricting surrogacy to a very limited group of people, the Act restricts individual freedoms and compels most to turn to other, unregulated methods of becoming parents, which can create legal and medical issues.

India's surrogacy legislation also does not conform to international best practices, and hence it is one of the most restrictive surrogacy laws in the world. Colombia, Brazil, and Mexico permit surrogacy for all, including unmarried individuals, LGBTQ+ couples, and those who do not necessarily belong to the traditional family model. The Indian law, on the other hand, perpetuates traditional societal norms instead of conforming to evolving social realities. The exclusionary character of the Act compels Indians to go abroad for surrogacy with resultant legal ambiguity, increased expenses, and possible exploitation in foreign countries. Rather than offering a safe, regulated, and accessible system for surrogacy, the law forces individuals into unregulated systems that compromise its own intent. A more progressive policy, consistent with constitutional freedoms and international norms, is necessary to make India's surrogacy laws more inclusive, ethical, and legally robust.

VII. Need for Reform in Surrogacy Laws

The Surrogacy (Regulation) Act, 2021, must be amended or revised to ensure that the method of surrogacy can be availed or accessed by all individuals. It should not depend on factors such as marital status, sexual orientation, etc. This restrictive eligibility requirement must be amended and a more inclusive legal framework, which would reflect that understanding of surrogacy being a part of reproductive right and not a privilege, must be introduced. As advocated by the 228th Law Commission Report, the law must allow single people, homosexuals to avail the facility of surrogacy just like other. This will ensure that everyone gets equal access and autonomy to make reproductive choices. Through this, law will also align with the constitutional principles such as equality, privacy, etc.

In order to secure reproductive autonomy, the law has to recognize surrogacy as a valid reproductive right and not a privilege that is regulated. There must be some reforms in the law to ensure the protection of intended parents as well as surrogate mothers and along with this protection, their bodily autonomy should also be ensured.

One more amendment that is suggested is that there should be elimination of the condition that the surrogate mothers must be the "close relatives" of the intending parents. This suggestion is made as this is practically not feasible and difficult to achieve. Rather than laying down such a condition, focus must be on securing the well-informed consent and providing favourable conditions for all on ethical basis. Implementing a systematic, rights-based approach such as those in Colombia and Mexico would avoid exploitation while protecting reproductive rights.

---

47 Law Commission of India, Govt. of India, Need for legislation to regulate assisted reproductive technology clinics as well as rights and obligations of parties to a surrogacy (2009).

48 India Constitution Art. 14.

49 Ibid India Constitution Art. 21.

50 Navtej Singh Johar v. Union of India, AIR 2018 SC 4321.

51 Justice K.S. Puttaswamy v. Union of India, AIR 2018 SC (SUPP) 1841.

In India, there is a need to shift towards a regulatory system that incorporates the international best practices. For this, several steps need to be taken such as allowing altruistic surrogacy for anyone while making sure that there is no commercial exploitation of parents as well as surrogate mothers. International surrogacy should also be permitted and provisions must be made regarding the same. This is important to ensure the welfare of children born of surrogacy. By putting in place an inclusive, regulated system, India can avoid citizens going abroad in search of surrogacy, minimize legal ambiguities, and ensure its constitutional promise of equality and reproductive justice.

VIII. Conclusion

The Surrogacy (Regulation) Act, 2021 was introduced with purpose of regulating surrogacy, avoiding the commercialization of the technique and to ensure the welfare of women and children born through surrogacy but due to its restrictive nature and strangest provisions, it has resulted into the infringement of reproductive autonomy and the right to equality. By the introduction of restrictive measures such as restricting facility of availing surrogacy to married heterosexual couples, widows and divorced women's, the law results in discriminating against those who want to be single parents such as unmarried women, unmarried men. It has also resulted in discrimination against LGBTQ+ people. Such restrictive measures reflect the violation of India's constitutional safeguards provided under Articles 14 and 21. As we all are aware that the concept of family is changing, society is changing and becoming more acceptive, the law fails to take into consideration such changes and overlooks the suggestions of the 228th Law Commission Report, which advocated for more inclusive legal framework for surrogacy.

Apart from these discriminations and issues that arise because of this act within the country, the law also lags behind global best practices. There are more inclusive legal frameworks present in countries such as Colombia, Mexico, Brazil, where the law takes into account the interest of all individuals and does not exclude people on the basis of marital status, gender, etc. Due to the restrictive nature of Indian laws, many are forced to find some other ways of availing such technologies which results in exploitation, ambiguities, etc. Rather than providing a safe and regulated framework for surrogacy, the existing law unintentionally promotes unregulated and clandestine practices, thwarting its very purpose.

To address these shortcomings, there is a need to introduce more inclusive and progressive legal frameworks that would align with the constitutional frameworks and international standards. By including the excluded people, treating surrogacy as a part of right to reproduce and balancing the ethical interests, law can be made progressive and a balanced approach can be achieved that would safeguard surrogate mothers and intended parents. By introducing such surrogacy laws, India can progress towards a more equitable, inclusive, and rights-oriented reproductive healthcare system which maintains dignity, autonomy, and non-discrimination.

* * * *

REPRODUCTIVE AUTONOMY OF WOMEN IN INDIA: A CRITICAL ANALYSIS OF MTP ACT

Ms. K. Sameeksha Bhaskar Hegde *

I. Introduction

According to the most recent National Family Health Survey (NFHS-5), just 10% of women in India are independently able to take decisions about their own health.[1]This includes reproductive decisions as well. Reproductive autonomy means the right of individuals, typically women, to make decisions about their own reproductive health and choices.One of the most significant pieces of legislation regarding reproductive rights of women in India is the Medical Termination of Pregnancy (MTP) Act,1971. This lawis a corner stone in addressing the issue of unsafe and illegal abortions, thereby offering a legal framework for women to access safe abortion services under specific circumstances.

Over the years, MTP Act has undergone several changes. With the recent 2021 amendment, the Act has taken a step closer to ensuringreproductive autonomy of women in India.The Supreme Court being the torch bearer of women's rights has in several instances reaffirmed reproductive autonomy of women. However, despite these reforms and progressive judgements, the MTP Act remains a subject of intense debate when viewed through the lens of reproductive autonomy. Issues such as lack of awareness, limited access to safe abortion services, and administrative delays continue to undermine the practical application of the law.

This article critically analyses the MTP Act and examines its impact on the reproductive autonomy of women in India in the light of challenges imposed by statute. By evaluating judicial stand on reproductive autonomy of women, this paper throws light on how judiciary balancesinterests of thewoman and thefoetus. Further, this paper explores barriers faced by women in realising their reproductive autonomy and proposes suggestions to improve the same.

II. Analysis of Medical Termination of Pregnancy Act, 1971 in the context of Reproductive Autonomy of Women

Prior to the enactment of the Medical Termination of Pregnancy Act, abortion was criminal offence and was allowed only if the woman's life was at risk[2].Sections 312 to 318 IPC[3]criminalised causing a miscarriage[4]. As an exception to section 312 IPC, MTP Act was enacted in the year 1971, providing legal grounds for termination of certain pregnancy.Though the Act legalises abortion[5], abortion is allowed only if specified conditions are metthereby the Act does not ensure absolute right to abortion on demand.[6]Section 3 of the act provides for grounds as to when pregnancy may be terminated by a Registered MedicalPractitioner. The Act initiallytook a narrow approach as it permitted termination of pregnancy up to 12 weeks with the approval of one medical practitioner and between 12 to 20 weeks with the opinion of two registered medical practitioners[7].

---

* **Advocate, Mangaluru.**

1 Andrea M Wojnar, Women's reproductive autonomy as the new catchword,The Hindu, https://www.thehindu.com/opinion/op-ed/womens-reproductive-autonomy-as-the-new-catchword/article67064795.ece (last accessed on 3rd march 2025,6.30pm)

2 Section 312 IPC deals Voluntarily causing miscarriage. It is punishable offence except in cases where it is necessary to save the life of women.

3 Indian Penal Code, 1960.

4 Currently, Sections 86 to 90 of the Nyaya Sanhita, 2023 deal with the criminalisation of abortion. Section 86 of the Nyaya Sanhita provides that any person who voluntarily causes a woman to miscarry is liable to be punished

5 Abortion is the termination of a pregnancy by removal or expulsion of an embryo or fetus.

6 The words 'An Act to provide for the termination of certain pregnancies' clearly indicates the legislative intent to allow abortion only under certain circumstances.

7 Termination of pregnancy with the opinion of one RMP up to 12 weeks and up to 20 weeks with the opinion of 2 RMP.

The 2021 amendment, enhanced the gestation limit thereby allowing termination of pregnancy upto 20 weeks with the opinion of one registered medical practitioner[8]

i) in cases of contraceptive failure[9]

ii) danger to the life or mental health of women[10]

iii) risk of child being born with deformities.[11]

Further it allows termination of pregnancy up to 24 weeks with the opinion of two Registered Medical Practitioner[12]for special categories of women under certain circumstances which includes survivors of sexual assault, rape or incest, minors, physically disabled women, mentally ill, widow or divorcee (due to change in marital status), and in cases of foetal abnormalities or risk of child being born with physical or mental abnormalities and on humanitarian grounds in cases of disaster or emergency situations[13].This provision has extended the benefits of the act to a large section of women who were earlier not covered by the Act.

By replacing the words "married woman or her husband" with the words "any woman or her partner" the benefits of the act is now extended to single and unmarried women. With the aim to protect the privacy of women, responsibility is imposed on RMP[14] to not reveal the name of the women who has undergone abortion.[15]

The design of the statute makes it evident that saving the life of the pregnant woman is of paramount importance, notwithstanding of the length of the pregnancy. In cases where medical practitioner is of the opinion that termination is immediately necessary to save the life of the pregnant person[16]orin case of a fetus with substantial abnormalities[17] pregnancy can be terminated even beyond 24 weeks.This shows the legislative intent to protect the interest of the women by allowing abortion even beyond statutory limit.

The act requires consent of pregnant womenfor termination of pregnancy thereby no other person other than the pregnant women can decide about her pregnancy.In cases of minors and mentally ill women, the consent is required from a lawful guardian.[18] The decision whether to continue or terminate the pregnancy is placed in hands of women provided she fulfils the conditions under the act thereby providingher withabsolute decision-making authority.

The 2021 amendment has made a progressive approach in bridging the gaps created by the 1971 Act.With enhanced gestation limit, inclusion of new grounds for termination of pregnancy the Act has taken a step forward towards ensuring reproductive autonomy of women.

III. Challenges to Reproductive Autonomy of Women

Despite the recent amendments the provisions of MTP Act are often viewed as restriction on reproductive autonomy of women. Even though they are justified in certain circumstances, it is often criticised for creating barrier in women's reproductive Autonomy.

1. Restrictive Conditions:

Women can only access abortion services under specific, defined conditionswhich can undermine her

---

8 means a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act.

9 where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of limiting the number of children or preventing pregnancy, the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

10 Sec 3 (2)(i) of Medical Termination of Pregnancy Act, 1971

11 Sec 3 (2)(ii) of Medical Termination of Pregnancy Act, 1971

12 Sec 3(2)(b) Medical Termination of Pregnancy Act, 1971

13 Rule 3B - Medical Termination of Pregnancy (Amendment) Rules, 2021.

14 Registered Medical Practitioner

15 Section 5A - Protection of privacy of a woman. Medical Termination of pregnancy Act,1971.

16 Section 5 of the MTP Act prescribes that a pregnancy may be terminated, regardless of the gestational age, if the medical practitioner is of the opinion formed in good faith that the termination is immediately necessary to save the life of the pregnant person.

17 Section 3(2-B) of the Act stipulates that no limit shall apply on the length of the pregnancy for terminating a fetus with substantial abnormalities.

18 Section 3 (4) Medical Termination of Pregnancy Act, 1971.

autonomy.The law recognises only medical risks as grounds for abortion, delegitimising all other reasons why a woman may seek to terminate her pregnancy.In addition to this requirement of opinion of RMP makes it even more restrictive.Upon crossing the statutory limit, a woman is forced to carry pregnancy unless it poses a grave risk to her life or fetal abnormalities. Moreover, it does not accommodate non-medical concerns such as economic costs of raising a child, effects on career decisions, unwanted pregnancyor any other personal considerations[19] .

2. Doctor Centric:

The Act places authority in the hands of Registered Medical Practitioners to decide if women can terminate her pregnancy. While this is intended to ensure safetyinorder to protect the health of a pregnant women and facilitate safe, hygienic, and legal abortion. It also undermines her autonomy as her decisions can sometimes be influenced or constrained by medical opinions or biases.

3. Gestation Limits:

The law imposesgestation limit, which can be restrictive for women who may not realize they are pregnant until later or who face delays in accessing healthcare services. A Women with lactational amenorrhea whodiscovered her pregnancy in 24th week was not permitted to terminate her pregnancy as she had crossed the statutory limit and chances of doctors facing viable fetus was present[20]. As an exception to this, if there is risk to the life of the women pregnancy can be terminated even beyond statutory gestation limit.[21]But this again involves opinion of medical Practitioner which can cause further delay.

The primary aim of the act was to reduce high rates of unsafe, illegal abortions and maternal deaths. But unsafe abortion continues to remain the third leading cause of maternal mortality in India as nearly 8 women die each day due to causes related to unsafe abortion[22]Evidence shows that restricting access to abortions does not reduce the number of abortions however, it does affect whether the abortions that women and girls attain are safe and dignified.[23]

The restrictions are imposed in order to protect the life and health of women so that this cannot be used as alternative to contraception or sex based selective abortions. But these restrictions often create a barrier for women in exercising their reproductive autonomy.

IV. Judicial Affirmations on Reproductive Autonomy of Women

Time and again the apex court in several cases has upheld the reproductive autonomy of womenand has made significant contributions to the expansion of reproductive choice and the concept of bodily autonomyby acknowledging that the right to make decisions about one's body, including the choice to seek an abortion, is an essential part of an individual's right to privacy and personal liberty.

The apex court in *Suchita Srivastava V. Chandigarh Administration (2009)*[24]observed that the consent of the pregnant person in matters of reproductive choices and abortion is paramount as the right to make reproductive choices is a facet of Article 21 of the Constitution.

In *X V. Principal Secretary, Health and Family Welfare Department*[25] 2022 Supreme Court of India gave a landmark judgment which established the right of unmarried women to terminate their pregnancies and observed that restricting the termination of pregnancy based on marital status would violate women's right to equality.

In *Justice K.S Puttaswamy (Retd.) V. The Union of India*[26] the Supreme court recognized the constitutional right of women to make reproductive choices, as a part of personal liberty under Article 21 of the Indian

[19] Arijeet Ghosh,Nitika Khaitan,A Womb of One's Own: Privacy and Reproductive Rights, engage, https://www.epw.in/engage/article/womb-ones-own-privacy-and-reproductive-rights#:~:text=Abortion%20and%20Reproductive%20Autonomy,%2C%202012c%3A%20para%2038).

[20] X vs Union of India, 2023 INSC 919

[21] Section 5 , Medical termination act 1971.

[22] State of the Word Population Report 2022, SEEING THE UNSEEN: The Case for Action in the Neglected Crisis of Unintended Pregnancy, https://india.unfpa.org/en/node/72920 (last accessed on 5th march 2025,7.30pm)

[23] Abortion, WHO,https://www.who.int/news-room/fact-sheets/detail/abortion (last accessed on 5th march 2025,8.00pm)

[24] [2009] 13 S.C.R. 989

[25] 2022 SCC OnLine SC 1321

[26] [2017] 10 S.C.R. 569

Constitution and established that a woman's right to make decisions about her reproductive health falls within the scope of her right to privacy.

In *A(Mother of X) V. State of Maharashtra*[27], the court reiterated thatthe right to choose and reproductive freedom is a fundamental right under Article 21 of the Constitution.

In a plethora of cases the Apex court has upheld that women no longer need consent of her husband or relatives to terminate her pregnancy.[28]Thereby reaffirming reproductive autonomy of women.

In *Dogra V. Malhotra*[29], the court upheld that the consent of the spouse is not mandatory for a woman to undergo the process of abortion.

In *A (Mother of X) V State of Maharashtra*[30]it was observed that when the opinion of a minor pregnant person differs from the guardian, the court must consider the view of the pregnant person as important factor in deciding the termination of the pregnancy.

In a landmark case it was ruled that even if a woman is mentally challenged, her right to make *X V Union of India*decisions regarding her pregnancy must be respected, reinforcing the principle of reproductive autonomy[31].

In[32] (2023)a mother of two children sought permissionto terminate her pregnancy at 24 weeks on the grounds of post-partum depression (her mental condition does not permit her to raise another child) and financial burden of raising another child as her husband was the only earning member in the family. The delay was justifiedas the women did not discover her pregnancy until 24 weeks due to lactational amenorrhea.Initially Court allowed the petition on the ground of risk to the mental health of the petitioner.But an email from a doctor seeking directions to stop the heartbeat of the viable foetus gave a turn to this decision.

As the pregnancy had crossed 24 weeks gestation limit, there was a need to perform feticide before termination of pregnancy which was not acceptable to the court. Further, considering the socio economic conditions, the court ordered union government to look after the medical costs for the delivery and incidentalexpensesthereby leaving the decision to give up the child for adoption to the parents.[33] In this case even though permission to terminate pregnancy was denied, the decision whether to keep the child or give it for adoption was ultimately left to the women.

V. Balancing of Interests

The argument pertaining to right to life of foetus is still prevalent in legal debates around abortion in India. The requirement for approval from medical board for abortions beyond 24 weeks can reflect a concern for the foetus's rights. This approach, though beneficial in some contexts, could be viewed as restriction, as it places the foetus's potential life on par with the woman's right to make decisions about her body.

In International law,a person is vested with human rights only at birth and an unborn foetus is not accorded with human rights.Article 1 of Universal Declaration of Human states that "All human beings are born free and equal in dignity and rights" Here the word "born" indicates the intentionto exclude the foetus or any antenatal application of human rights.[34].Even though international law does not recognise the rights of foetus.Right to life of a healthy foetus after it becomes viable[35] cannot be ignored.

With respect to rights of the foetus and reproductive autonomy of women there are inconsistent judgements.While in few cases women are placed at high pedestal while in few instances right to life of foetusis recognised.

The Bombay High court in *High Court on Its Own Motion V. The State of Maharashtra* (2016) [36]emphasized

[27] [2024] 5 S.C.R. 470

[28] Sec 3 (4) (a), no pregnancy shall be terminated except with the consent of the pregnant woman.

[29] Dogra v. Malhotra, CR No. 6337 and 6017 of 2011 (P & H)

[30] Supra n.27

[31] Suchita Srivastava v. Chandigarh Administration (2009) [2009] 13 S.C.R. 989

[32] 2023 INSC 919

[33] https://indiankanoon.org/doc/125724114/

[34] Rhonda Copelon , Human rights begin at birth: international law and the claim of fetalrights,Pubmed, https://pubmed.ncbi.nlm.nih.gov/16291493/

[35] Viable foetus refers to foetus that has reasonable chance of surviving outside the womb.

[36] High Court on Its own Motion vs The State Of Maharashtra (2016) https://indiankanoon.org/doc/138003226/

reproductive autonomy of women and observed that, as the pregnancy takes place within the body of a woman having significant effects on her health, mental well-being and life, the decision to deal with the pregnancy must be the decision of women alone.Thus, the right to control their own body and fertility and motherhood choices should be left to the women alone. To quote from the judgement,

"Woman owns her body and has right over it. A child when born and takes first breath, is a human entity and thus, unborn foetus cannot be put on a higher pedestal than the right of a living woman. Thus, fundamental right under Article 21 of Constitution of India protects life and personal liberty which covers women"[37]

Justice Nagarathna in a split verdict[38], upheld the interest of the mother, and emphasizedto give preference to her by considering the socio-economic conditions and the mental state of the women and opined "*that a foetus is dependent on the mother and cannot be recognized as a personality apart from that of the mother as its very existence is owed to the mother."*

On the contrary, stating that a fully developed foetus has the right to life guaranteed under Article 21, Rajasthan High Court declined a plea for the medical termination of an 11-year-old rape survivor's advanced pregnancy [39]

Similarly, in *In X V Union of India*[40] **(**2023) a decision to terminate pregnancy of 24 week was recalled when the doctors' sought directions from the court to stop the heartbeat as the foetus was viable and healthy with no signs of abnormalities. In an attempt to balance the interest of both the women and the foetus the court shifted economic burden of medical expenses on the state while leaving the option of giving up the child for adoption to parents.Thereby the court balanced the interest of both women and the foetus.

But in cases where there is risk to life of women the court has given paramount importance to the life of women.In an exceptional case,a 14-year-old survivor of sexual assault, was allowed to terminate pregnancy at 30th week as continuation of pregnancy would negatively impact her physical and mental well-being. This was based on opinion medical experts who stated that the threat to life is not higher than the risk of full-term delivery[41].

VI. Barriers for Reproductive Autonomy of Women

Apart from statutoryrestrictions in accessing reproductive rights.There are other barriers which truly impact the reproductive autonomy of women.

1. Delay by the State Authorities

Unlike other cases, decisions with regard to termination of pregnancy has to be taken on urgent basis**,** as slight delay may cost the life of a women while jeopardizing her right to reproductive choice. In *Ms. Z V. State of Bihar*[42] State of Bihar was directed to pay compensation of Rs. 10,00,000 to the women who couldn't terminate the pregnancy after 24 weeks in spiteof approaching at 18 weeks due to delay caused by the state authorities.

2. Fear of Prosecution among Registered Medical Practitioners

Since the Registered Medical Practitioners play a decisive role in MTP Act. The fear of prosecution among them creates a major hurdle in women's reproductive autonomy.Section 3 of the MTP act clearly protects the registered medical practitioner from penal provisions against abortion, under the Indian Penal Code, if it is carried out as per the MTP Act. *In X V. State (NCT of Delhi)*[43],the Court recognised that the fear of prosecution among registered medical practitioner is a barrier for pregnant personsto access safe and legal abortions.

---

37 Ibid.

38 In X v. Union of India(2023)

39 'Fully Developed Foetus Has Right To Life': Rajasthan High Court Denies Minor Rape Survivor's Plea To Terminate 31-Weeks Pregnancy,livelaw, sebin james, https://www.livelaw.in/high-court/rajasthan-high-court/rajasthan-high-court-denies-advanced-pregnancy-termination-minor-rape-victim-foetus-right-to-life-article-21-constitution-247558 (last accessed on 8th march 2025,7.15am)

40 2023 INSC 919

41 A (mother of X)v. state of Maharashtra

42 Ms. Z v. State of Bihar, 2017 SCC OnLine SC 943, http://www.scconline.com/LoginForDocumentLink/LDC420CR (last accessed on 8th march 2025,7.40am)

43 X v. State (NCT of Delhi), (2023) 9 SCC 433

3. Challenges to Access Safe Abortion Services in Rural India.

A women can exercise her right to abortion only when such services are accessible to her. As per a Rural Health Statistics Report [44], there are significant gaps in the infrastructure providing specialised care at Community Health Centres (CHCs). The report reveals that CHCs lack 83.2% of the required surgeons, 74.2% of the required obstetricians and gynaecologists, 79.1% of physicians, and 81.6% of the required paediatricians.[45] This is a clear indicator of disparities in health care services in rural India. Due to lack of required infrastructure and specialised health care professionals,rural women don't get access to quality healthcare services.

4. Social and Cultural Barriers

While the MTP Act legally permits abortion, social and cultural stigma remains a significant barrier to women exercising their reproductive autonomy. In many parts of India, abortion remains a taboo subject, particularly in rural areas and conservative communities. In this context, the right to choose becomes more challenging when women are pressured by family, community, or societal norms to carry a pregnancy to term, even when they seek to terminate it.

VII. The Road Ahead

Even though the recent amendments have taken a step closer towards ensuring reproductive autonomy there is still gaps. Firstly, lack of access to quality healthcare services to rural women and marginalised communities create disparity based on their background. This can be achieved by improving healthcare standards in rural areas and appointing healthcare professionals in all government hospitals.

Lack of awareness among women turns out be a biggest hindrance in achieving reproductive autonomy.Awareness campaigns can be organised in rural areasto educate women about family planning to avoid unwanted pregnancy. In addition to this, women must be empowered avail abortion services in authorised health facilities in order to reduce health risk associated with it.

Availability of limited grounds,is another major challenge. By providing flexible grounds, a women must be allowed to terminate her pregnancy for non-medical concerns too without having to prove the risk to her life or foetusat least in the initial stage of pregnancy. This will ensure reproductive autonomy in the true sense.

As time is essential in cases of pregnancy, there is need to minimise the administrative delays.As pregnancy progresses the risk associated with the procedure increases, even a slight delay in access to abortion services may jeopardize the interest of the women. By imposing fines for causing bureaucratic delays the government must ensure that no women are denied access to abortion due to negligence of concerned authorities.Even though judiciary has in several cases upheld the reproductive autonomy of women not all who are denied access to abortion services can go to court owing to expenses associated with it.By establishing a tribunal, speedy justice can be ensured.

VIII. Conclusion

Reproductive autonomy doesn't mean removing all the restrictions and giving absolute right of abortion to women. As termination of pregnancy, involves risk to the life of the women as well the foetus the opinion of RMP is essential to ensure no life is harmed. Further, if abortion is not regulated by placing restrictions there are high chances of it being used as an alternative for contraception jeopardizing the health and life of women. But that doesn't mean restrictions can create barriers for women's reproductive autonomy. With the 2021 amendment, a step was taken in the right direction to enhance reproductive autonomy of women, yet there existsneed for broader societal change, improved healthcare infrastructure, and further legal reforms to fully realize the reproductive autonomy of women in India. With future reforms Reproductive autonomy can be ensured to all women in India.

* * * *

[44] Rural Health Statistics Report 2021-2022 issued by Government of India, Ministry of Health & Family Welfare,RURAL HEALTH STATISTICS 2021-22,https://mohfw.gov.in/sites/default/files/RHS%202021-22_2.pdf

[45] Ibid

CUTTING TRADITIONS: ADDRESSING FEMALE GENITAL MUTILATION IN INDIA

Ms. Kritika Vyas *

Abstract

Female Genital Mutilation/Cutting (FGM/C) is an age-old practice that involves the partial or total removal of external female genitalia for non-medical purposes. It is widely recognised as a type of gender-based violence and a violation of human rights, with substantial physical, and psychological trauma. FGM/C continues in many communities throughout the world, including in India, where it is known as Khatna or Khafd and is largely performed by the Dawoodi Bohra sect of Shia Muslims and some Christian groups. FGM/C is recognised by international organisations such as WHO, UNICEF, and the United Nations as a violation of fundamental human rights, including the right to life, bodily autonomy, and freedom from torture and discrimination. This study addresses FGM/C through the lens of reproductive rights, focussing on how it affects women's health, autonomy, and equality. FGM/C denies women and girls the ability to make informed decisions about their bodies, resulting in chronic health issues, complications during childbirth, and psychological distress. While India does not have explicit legislation prohibiting FGM/C, existing legal frameworks such as the Bharatiya Nyaya Sanhita and the Protection of Children from Sexual Offences Act provide some grounds for prosecution. However, the lack of a specific statute addressing FGM/C emphasises the need for complete legal reform. Many nations throughout the world enforce severe anti-FGM/C laws, emphasising the importance of India enacting comprehensive legislation that specifically criminalises the practice. This paper examines the constitutional validity of FGM/C in India, its violation of international human rights standards, and the critical need for a comprehensive approach to eradicating the practice.

Key Words : **Female Genital Mutilation/Cutting, Gender-Based Violence, Human Rights Violation, Child Protection, Bodily Autonomy, Legel Reforms.**

I. Introduction

Female Genital Mutilation/Cutting (FGM/C) is a pervasive practice that continues to impact millions of women and girls globally, despite international initiatives aimed at its elimination. FGM/C, as defined by the World Health Organisation (WHO), refers to the partial or complete excision of external female genitalia for non-medical purposes. It is broadly denounced as a manifestation of gender-based violence and a grave violation of human rights. The practice is grounded in cultural, religious, and social traditions, frequently rationalised under the guise of preserving purity, modesty, or societal acceptance. Nevertheless, it causes considerable physical and psychological damage, infringing against individuals' rights to bodily autonomy and dignity. Although FGM/C is predominantly linked to African and Middle Eastern nations, it is also widespread in India, especially within the Dawoodi Bohra community and certain Christian groups, where it is referred to as Khafd. This research analyses FGM/C as a human rights violation, its hidden prevalence in India, and the legal and sociological obstacles to its eradication.

II. Female genital mutilation/cutting

Female genital mutilation is the deliberate, non-medical removal of all or part of the external female genitalia or other injury to the female genital organs. The treatment is occasionally carried out on married women and

* **Senior Associate at All State, ILS Law College, Pune**

[1] "World Health Organisation, AJoin WHO/UNICEF/UNFPA Statement, Female Genital Mutilation, ISBN 92 4 156186 6 (NLM Classification: WP 660) (1997)."

adult women, but it is mainly performed on girls between the ages of 1 and 15. The **World Health Organization**has defined FGM as "*the partial or total removal of external female genitalia or other injuries to the female genital organs for non-medical reasons."* FGM/C has been divided into four kinds according to a joint statement[1] from the WHO, UNICEF, and UNFPA, which are as follows[2]-

- *"Type I: Clitoridectomy involves partial or total removal of the clitoral glans which is the visible and external part of the clitoris and/or the prepuce.*
- *Type II: Excision means partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.*
- *Type III: Infibulation is the contraction of the vaginal orifice by cutting and appositioning the labia minora and/or the labia majora.*
- *Type IV: All other harmful procedures to the female genitalia. e.g., pricking, piercing, incising, cauterization, etc."*[3]

FGM/C has no documented health benefits, according to WHO. Instead, the surgery has long-lasting negative physical, psychological, emotional, and sexual effects on women who have had it.[4] The process is typically performed by traditional midwives with limited medical knowledge, in unsterile conditions, and without anesthesia. The severity of the mutilation corresponds to the degree of harm inflicted, which includes excessive bleeding, swelling, inflammation, infection, urinary problems, and even death. Chronic vaginal infections, recurrent UTIs, painful sex, and pregnancy problems are just a few of the long-term effects[5].

In addition to the physical consequences, FGM/C causes significant psychological trauma, frequently resulting in survivors experiencing intense painful recollections, persistent anxiety, depression, and body dysmorphia stemming from genital mutilation. It also results in sexual dysfunction, encompassing dyspareunia[6], anorgasmia[7], and diminished libido[8], which may lead to marital strain and mental turmoil. The social repercussions exacerbate the damage, as survivors may encounter stigma, isolation, and, in certain instances, divorce or exclusion stemming from FGM/C-related infertility or health issues. Mothers frequently experience mental turmoil, caught between societal expectations and the recognition of the distress caused to their daughters.[9]

III. Human rights and FGM/C

The Universal Declaration of Human Rights first mentioned FGM/C in 1948[10], making it a component of that document. During the United Nations' Year for Women, which took place from 1975 to 1989, it was acknowledged as a detrimental customary practise in the 1970s and 1980s. FGM/C is characterised as a blatant example of gender-based human rights breaches that try to restrict women's sexuality and independence in the writings of Efua Dorkenoo.

FGM/C is viewed as a form of torture and abuse against girls and women by the world community. FGM/C is acknowledged as a violation of human rights by international organisations as the WHO, the United Nations Children's Fund, the World Medical Association, and the United Nations Population Fund. FGM/C was formally condemned by WHO in 1996, who classified it as a violation of human rights. The UN adopted a resolution in 1993 endorsing the usage of "FGM/C" to refer to clitoridectomy, infibulations, and other related procedures. Regarding FGM/C, the following rights are created for women and girls:

---

2 "Abhiraj Das and NihalDeo, Female Genital Mutilation: When Will India Take Concrete Steps, CCLSNLUJ (Jun. 1, 2020), https://criminallawstudiesnluj.wordpress.com/2020/06/01/female-genital-mutilation-when-will-india-take-concrete-steps/."

3 "Shivangi Misra, Female Genital Mutilation: Guide to Eliminating the FGM Practice in India,Lawyers Collective(May 21, 2017), http://www.lawyerscollective.org/wp-content/uploads/2012/07/Female-Genital-Mutilation-A-guide-to-eliminating-the-FGM-practice-in-India.pdf."

4 "Amnesty International, What is Female Genital Mutilation?,https://www.amnesty.org/ar/wp-content/uploads/2021/06/act770051997en.pdf."

5 "Suraiya Nazeer, Female Genital Mutilation: Secret Practice in India, 7(7) IJSRP 341, 342 (2017)."

6 "Chronic or persistent discomfort during coitus."

7 "Difficulty or incapacity to attain orgasm despite sufficient sexual stimulation."

8 "Disinterest in sexual engagement."

9 "World Health Organisation, Mental health aspects of women's reproductive health, ISBN 978 92 4 156356 7."

10 "World Health Organisation, Eliminating Female genital mutilation: An interagency statement (Jun. 16,2018), ISBN 978 92 4 159644 2, https://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf."

- "The right to be free from all forms of discrimination against women.
- The right to life and physical integrity, including freedom from violence.
- The rights of the child.
- The rights of minorities and religious freedom."

FGM/C is widely recognised as an infringement of women's and girls' human rights. On February 6th, the world observes the International Day of Zero Tolerance for Female Genital Mutilation. One of the UN Global Goals is to end FGM by 2030[11]. In December 2012[12], the UN General Assembly unanimously passed a resolution on the elimination of FGM/C, with India being among the countries that supported it. Many countries worldwide have prohibited the practice of FGM/C.

IV. Background in India

Practice and Reason

The practice of Khafd[13]*(*pronounced as *Khafz)*orFGM/C is prevalent among the Dawoodi Bohra community of Shia Muslims in India and is also practiced among some Christians. It involves the cutting or nicking of the clitoral hood and is most common in Maharashtra, Madhya Pradesh, Rajasthan, Gujarat, and Kerala.[14]The 2017 WeSpeakOut study[15] indicates that the Dawoodi Bohra community in India predominantly engages in Type 1 FGM/C, encompassing both Type 1a (excision of the clitoral hood) and Type 1b (partial or complete excision of the clitoris), contrary to assertions that only less severe versions are conducted. The procedure is prevalent, with 75% of daughters aged seven and older subjected to Khafd, typically conducted by traditional circumcisers, but medicalisation is on the rise in metropolitan regions. Almost all women describe the treatment as painful, which caused health problems such as UTIs, incontinence, sexual dysfunction, anxiety, depression, and low self-esteem.

The roots of FGM/C lie in discrimination against women and girls, with justifications such as religious dicta, hygiene, and control over female sexuality. Within the Dawoodi Bohra community, reasons for the practice include religious requirements, tradition, and the suppression of female sexuality. FGM/C is perceived as a means of purifying impure thoughts and desires, and the protection of girls and women from sexual desire. The belief that the clitoral head is unwanted skin or a source of sin is another reason for the practice.[16]Reformist Bohras are gradually dwindling, though, as younger, urban, and highly educated women are more likely to be against it, as are families who are financially independent.

Constitutionality of the Practice

Part III of the Indian Constitution[17] contains Articles 25[18] and 26[19], which ensure religious freedom to all citizens. These clauses demonstrate the constitutional writers' dedication to advancing secularism in the nation.[20] However, official action aiming at balancing religious and societal behaviour affects how secularism is applied in India.

In order to establish the relationship between religion and the Constitution, the Supreme Court created a doctrine. According to this theory, the government could not impose restrictions on religious practises that were regarded as "essential." In the matter of Commissioner, Hindu Religious Endowments, Madras v. Sri Lakshmindra Thirtha Swamiar of Sri Shirur Mutt[21], the Essential Religious Practices (ERP) Test was devised

11 "United Nations, Ending Female Genital Mutilation by 2030, https://www.un.org/en/observances/female-genital-mutilation-day#:~:text=UN%20Action,of%20Sustainable%20Development%20Goal%205."

12 "UN Women, United Nations bans female genital mutilation (Dec. 20,2012), https://www.unwomen.org/en/news/stories/2012/12/united-nations-bans-female-genital-mutilation."

13 "The practice of circumcision of the girl child."

14 "Amnesty International, What is Female Genital Mutilation?,https://www.amnesty.org/ar/wp-content/uploads/2021/06/act770051997en.pdf."

15 "We Speak Out, The Clitoral Hood A Contested Site: Khafd or Female Genital Mutilation/Cutting (FGM/C) in India, https://www.wespeakout.org/upload/WeSpeakOut%20Research%20study.pdf. "

16 "Suraiya Nazeer, Female Genital Mutilation: Secret Practice in India, 7(7) IJSRP 341, 341-342 (2017)."

17 "The Indian Constitution, 1950."

18 "India Constitution, Art. 25."

19 "Ibid, India Constitution, Art. 26."

20 "Rishika Radhakrishnan, Constitutionality of Female Genital Mutilation in India, 4 INT'l J.L. MGMT. & HUMAN. 2068, 2072 (2021)."

21 "The Commissioner, Hindu Religious Endowments, Madras v. Sri Lakshmindra Thirtha Swamiar of Shri Shirur Mutt,(1954) SCR 1005(India)."

by the Supreme Court. Based on the facts offered and the beliefs of the relevant religion, courts were expected to use this test to assess if a practise was religious in origin. The court next had to determine if the practise constituted a fundamental and integral component of the religion after this was established. The court affirmed that the right to freedom of religion applied to both religious belief and practice, and that the religion itself must be taken into account when determining whether a practise is necessary.

In the past, the Apex Court frequently cited religious writings as proof of need. This viewpoint was altered, nevertheless, in the *Durgah Committee, Ajmer V Syed Hussain Ali* case[22] at this case, the Dargah Khwaja Saheb Act of 1955[23] was challenged on the grounds that it infringed upon the fundamental rights of Muslims who were members of the Soofi Chistia Order and the sole custodians of the shrine at Ajmer. The Court disagreed, holding that as superstitious religious practises were neither "essential" or "integral" to the faith, they were not protected by Article 26. The investigation of the texts was thus superseded by the study of the practises themselves, and the Court's opinion prevailed over that of the religious sect.

The ERP Test underwent a significant transformation in *Commissioner of Police & Ors. V. Acharya JagadishanandaAvadhuta&Anr*.[24], where the Tandava dance was deemed non-essential to the Ananda Marga Faith. According to the majority ruling of the Supreme Court, a religion's fundamental principles and practises are what its adherents hold most dear. The examination should look at whether the lack of the practise fundamentally alters the religion itself in order to evaluate whether a practise is an essential component of a religion.

The Sabarimala case[25], where it was debated whether barring women between the ages of 10 and 50 from the Sabarimala shrine was a necessary religious practice, marked the conclusion of the application of the ERP test. In order to balance conflicting rights and interests, restrictions should be put in place, according to Justice Chandrachud.

In 2017, Sunita Tiwari filed a Public Interest Litigation[26] seeking ban on FMC among Dawoodi Bohras, contending that Article 39[27] requires the State to safeguard its citizens and that the right to life under Article 21[28] encompasses dignity. By failing to pass legislation outlawing FGM/C, the State has disregarded its obligations.She cites WHO's classification of FGM/C as a human rights violation and a serious health concern, as well as India's inability to pass laws forbidding the practice despite international commitments. But the Dawoodi Bohra sect is against a ban, claiming that Articles 25 and 26 of the Constitution protect circumcision as a religious practices.[29]

In response to a Supreme Court inquiry (in a Public Interest Litigation case on FGM/C in India), the Ministry of Women and Child Development stated on December 29, 2017, that "there is no official data or study which supports the existence of FGM/C in India."

Indian Legislation

Although FGM/C is not explicitly prohibited by law in India, Bharatiya Nyaya Sanhita (BNS) does cover various forms of violence against women, and those who perform FGM/C may face charges under sections 114 to 118[30] of the IPC, which deal with hurt and grievous hurt. Sections 118 (1) and (2) prescribe imprisonment and fines for intentional hurt and intentional serious harm, respectively. Even though FGM/C is not officially classified as a crime under the BNS, if a complaint is received, the police are obligated to register a complaint under Section 118 (2) (*Voluntarily causing grievous hurt by dangerous weapons or means).*

It is uncertain whether there is a specific law against FGM/C in India, as the Protection of Children from Sexual Offences Act, 2012 (POCSO Act) only mentions penetrative sexual assault on the vagina in Section

[22] "Durgah Committee, Ajmer v. Syed Hussain Ali, (1962) 1 SCR 383(India)."

[23] "Acharya JagdishwaranandAvadhuta and Ors. v. Comm of Police Calcutta and Anr., (1983) 4 SCC 522(India)."

[24] "Indian Young Lawyers Association v. State of Kerala, (2019) 11 SCC 1(India)."

[25] "Kantaru Rajeevaru v. Indian Young Lawyers Association and Ors., (2020) 3 SCC 52(India)."

[26] "Sunita Tiwari v. Union of India, WP (C) 286/2017 (India)."

[27] "ASupra Note 18"

[28] "Ibid"

[29] "Supreme Court Observer, Ban on Female Genital Mutilation: *Sunita Tiwari v Union of India*,https://www.scobserver.in/cases/sunita-tiwari-union-of-india-ban-on-female-genital-mutilation-case-background/."

[30] "Bharatiya Nyaya Sanhita, 2023, § 114 to 118."

3[31], which could potentially cover FGM/C as it involves the insertion of a sharp object into the vagina. The National Policy for Children, 2013[32] prioritizes children's fundamental rights to health, survival, growth, and protection, aiming to create a safe and protective environment for all children[33], where no cultural, traditional, religious, or custom can infringe upon their legal rights.

V. Reforms in other Countries

Legislations

- The United States of America's "18 U.S. Code §/ 116"[34] makes it punishable by imprisonment of up to 5 years for anyone who circumcises, excises, or infibulates any part of the labia-majora or labia-minora or clitoris, with the exception of medical surgeries.
- In the United Kingdom, the "Female Genital Mutilation Act of 2003's Section 1[35]" provides for imprisonment for as long as 14 years. A person is considered guilty of the offense of female genital mutilation/cutting if they excise, infibulate, or otherwise mutilate any part of a girl's labia majora, labia minora, or clitoris.
- In Egypt, where FGM/C is prevalent among Christians as well, it is a criminal offense under "Article 242-bis and Article 242-bis (A) of the Penal Code-1937[36]". These articles cover any of the external female genital organs, as well as requesting to perform FGM/C.
- In Australia, "Section 3 of Australia's Crimes (Female Genital Mutilation) Act, 1996[37]" defines FGM/C as "all or any of the following— (a) infibulation; (b) the excision or mutilation of the whole or a part of the clitoris; (c) the excision or mutilation of the whole or a part of the labia minora or labia majora; (d) any procedure to narrow or close the vaginal opening; (e) the sealing or suturing together of the labia minora or labia majora; (f) the removal of the clitoral hood"
- The Violence against Persons (Prohibition) Act of 2015[38]in Nigeria includes provisions, specifically in Section 6 (2), that aim to punish individuals who perform or enlist others to perform female genital mutilation/cutting. According to Sections 6(2) and 6(3), anyone who encourages, assists, or advises someone else to carry out FGM/C, or even attempts to do so, can face criminal consequences.

VI. Case Study

The case of Burkina Faso[39] -FGM/C is gradually declining, according to a qualitative survey conducted in five provinces, as people become more conscious of its manifestations and negative health effects. Fewer young girls will be undergoing excision, which is in line with law enforcement and reinforcement tactics. Strict anti-FGM/C legislation and the threat of penalty, community involvement by traditional authorities, media and non-governmental organisation awareness campaigns, and exposure to different values through education and outside influences are some of the main elements influencing this shift. A societal movement away from FGM/C is reflected in the wider demographic impact.

VII. Recommendations

The act of discrimination infringes upon the fundamental rights of women, including their right to security and physical safety, their right to the highest possible level of healthcare, and their right to be free from torture and other forms of inhumane, cruel or degrading treatment. Moreover, when this discriminatory

---

31 "The Protection of Children from Sexual Offences Act, 2012, § 3."

32 "The National Policy for Children, 2013."

33 "Austin V. Zachariah, A Look into the Notion of Custom as a Crime concerning Female Genital Mutilation in India: A Critical Analysis, 5 INT'l J.L. MGMT. & HUMAN. 605 (2022)."

34 "8 U.S.C. § 116[c] (USA)."

35 "The Female Genital Mutilation Act 2003, § 31 (UK)."

36 "Egypt: Penal Code,1937 (EG)."

37 "Crimes (Female Genital Mutilation) Act 1996 (AUS)."

38 "Violence Against Persons (Prohibition) Act, 2015(NG)."

39 "UNICEF, Effective Legislative Reforms in Situations Calling for Social Change, https://www.unicef.org/media/124456/file/FGM-Effective-legislative-reforms-2022.pdf."

practice results in fatalities, it also violates the right to life. Following are some recommendations proposed to address the issue -

- Legislation -FGM/C should be specifically recognised as a type of "Grievous Hurt" by amending Section 116 of the BNS. Along with emasculation, FGM/C should be listed as a distinct type of grievous hurt in the proposed amendment. FGM/C should be defined as 'any non-medical practice that involves the partial or complete removal of external female genitalia or any other harm to female genital organs.' It should not, however, cover any required surgery carried out by a licensed medical professional to safeguard a girl's bodily or mental well-being. By ensuring that FGM/C is legally recognised as a severe violation, this change will fortify prohibitions against the practice and reaffirm the state's dedication to protecting women's rights.
- Awareness and Advocacy - It's imperative to increase grassroots awareness campaigns, especially in small communities with sizable Bohra populations. To guarantee accessibility, outreach should be carried out in regional tongues like Hindi, Gujarati etc.[40] Reformist Dawoodi Bohras, who are becoming more and more opposed to the practice, ought to join the campaign as friends. Establishing secure areas where survivors can freely talk about their experiences would strengthen support systems and motivate more people to speak out against FGM/C.
- Involvement in Communities - Conversation should be the first step, especially with mothers who follow Khafd as a custom. In order to change their viewpoints, they must address their worries about their daughters' welfare. Giving young and older women accurate and thorough knowledge on women's bodies, sexual health, and the effects of FGM/C can help debunk myths and provide answers to long-standing queries.
- Participation of Men - Because research shows that male relatives frequently influence decisions about Khafd, it is critical to include young men and fathers in discussions about the practice. Structured conversations should be organised to persuade males to actively reject FGM/C/C and push for change in their communities.
- Medical Action - Health care providers who treat Bohra patients need to be informed about FGM/C/C, its negative impacts, and their moral obligation to advise against it. The Indian Medical Association should implement a zero-tolerance policy against FGM/C as a result of advocacy activities. It is necessary to address the growing medicalisation of the practice and emphasise that medical operations must follow the basic tenet of "do no harm."

VIII. Conclusion

FGM/C persists as a significant human rights violation, justified by cultural and religious customs, while inflicting irreversible damage on women and girls. Notwithstanding global denunciation and attempts to eradicate the practice, India has not implemented explicit laws criminalising FGM/C, so exposing many to this profoundly detrimental habit. The lack of concrete legal restrictions undermines the capacity to prosecute offenders and signifies a broader unwillingness to acknowledge FGM/C as a grave violation of women's rights. This paper advocates for a multifaceted approach by drawing lessons from global reforms, including Burkina Faso's community-led initiatives and stringent laws in the U.S., U.K., and Nigeria: amending penal codes to criminalise FGM/C, enhancing grassroots awareness, involving men as allies, and mobilising healthcare professionals to oppose medicalisation. Eradicating FGM/C necessitates not only stringent legal measures but also a cultural transformation that emphasises women's dignity, autonomy, and entitlement to bodily integrity. India's pursuit of Sustainable Development Goals necessitates an unwavering commitment to eradicate this practice as a fundamental aspect of gender equity and human rights.

* * * *

[40] "We Speak Out, The Clitoral Hood A Contested Site: Khafd or Female Genital Mutilation/Cutting (FGM/C) in India, https://www.wespeakout.org/upload/WeSpeakOut%20Research%20study.pdf. "

RECOGNISING SURROGACY AS A REPRODUCTIVE RIGHT IN INDIA - THE MUDDLE

Ms. Anto Didisha S. *
Dr. Sankar D.**

Abstract

Reproduction remains as a vital process for the survival of species and their continuance in the universe. The reproductive process is more a driving force in human evolution. It gains significance in humans in that more than ensuring the survival and continuity of species,it has unique properties that go beyond simple biological necessity. Exploring all of the complex biological, physiological, psychological, and social aspects of the reproductive process is significant. The uniqueness of modern society is that it promotes procreating a child normally within the ambit of institutional norms, via marriage. For over a century, the phrase reproductive right came to recognize very many life choices on women over their marriage, fertility, contraception, pregnancy, abortion, childbirth, and healthcare prior, at and after delivery. Women, who are diagnosed infertile too now can have a substantial option to aid in the process of reproduction. Surrogacy comes as an arrangement, whereby a third person (surrogate mother) bears and delivers a child on behalf of the intended parent or parents, who are unable to conceive or carry a pregnancy on their own. Surrogacy came as a technological boon to assist married couples who want to procreate a child, but are unable to do so, due to medical or other reasons.Surrogacy is a process in which women accede to carrying a child on behalf of another woman (the intended parent). Suggested and at the insistence of the Supreme Court, the Government of India passed the Surrogacy Regulation Act of 2021. Circumscribing members who alone can resort to having a child via surrogacy, the Act promotes altruistic surrogacy, prohibiting commercial surrogacy, in any form.The present study examines the complex legal landscape of surrogacy in India, through the lens of reproductive rights. The research paper analyzes India's evolving regulatory framework, from its initial emergence until now, with the implementation of a restrictive legislation, the Surrogacy (Regulation) Act, 2021.

Keywords : **Reproductive rights, altruistic, commercial, Surrogacy, intended parent**

I. Introduction

The reproduction of mankind is nonetheless a marvel and mystery. The reproductive process is a driving force in human evolution, gaining significance much beyond ensuring the survival and continuity of species, with unique properties that transcend simple biological necessity. Modern society promotes procreation within the ambit of institutional norms, primarily through marriage. For over a century, the phrase "reproductive rights" has come to recognize numerous life choices for women regarding marriage, fertility, contraception, pregnancy, abortion, childbirth, and healthcare before, during, and after delivery.

Not alone potent women, even those who are diagnosed infertile can now have substantial options to aid in reproduction. Technology has come as a boon whereby a third person (surrogate mother) bears and delivers a child on behalf of another who is unable to conceive or carry a pregnancy herself. Surrogacy as an arrangement, assists childless married couples who want to procreate, but cannot do so due to medical or other reasons.

II. Surrogacy- Its Regulation in India

Surrogacy has come afar before its present recognition and commencement in India. Early 2000s, India endured to be the global hub for commercial surrogacy, attracting many international clients who were looking

* Research Scholar, VIT School of Law, Chennai Campus, Chennai.
** Senior Professor, VIT School of Law, Chennai Campus, Chennai.

for affordable reproductive services. The unregulated law and the nature of surrogacy practices, being in need of ethical norms, led to the exploitation of surrogate mothers, most of whom turn up from destitute backgrounds. The sorry state of being is that with the presence of a middleman, they were not in receipt of sufficient compensation and incidence are not wanting wherein they suffered numerous health hazards, besides the risk of being abandoned with the child

In 2015, based on a survey and more to benefit the surrogate mothers,the Indian government banned commercial surrogacy. The initial steps signified the start of a liberal approach towards regulating surrogacy in the country. The Gujarat High Court recognized the citizenship rights of children born through surrogacy, proclaim the validity of surrogacy arrangements[1]. Subsequently, the Supreme Court too explicitly acknowledged reproductive rights as a component of personal liberty, well protected under Article 21. The Court specifically stated that reproductive choices fall within a woman's personal liberty as defined by Article 21. The ruling further clarified that these reproductive rights encompass a woman's right to complete her pregnancy, give birth, and raise her children. Although the judgment did not directly address surrogacy, it established a constitutional basis for reproductive autonomy that could potentially extend to include surrogacy arrangements[2]. The Supreme Court of India, in several landmark rulings, emphasized the need for bringing in a comprehensive legislation to regulate surrogacy arrangements.

The surrogacy (Regulation) Act, 2021: A Paradigm Shift

At the insistence of the Supreme Court, the Government of India enacted the Surrogacy (Regulation) Act of 2021. This legislation represents a significant paradigm shift in India's approach to surrogacy. The Act explicitly prohibits commercial surrogacy in any form, promoting instead the concept of altruistic surrogacy. This transition fundamentally altered the landscape of surrogacy practices in India.

The Act circumscribes members who can resort to surrogacy and impose stricter eligibility criteria for intended parents. As per the legislation, only Indian married couples with proven infertility can opt for surrogacy. In addition, the surrogate needs to be a close relative of the intended couple, between the age group of 25-35 years, married with a child of her own and eligible to serve as a surrogate, only once in her lifetime. These restrictions significantly narrowed down surrogacy as a reproductive option for all.

Surrogacy as a Reproductive Right

Reproductive rights encompass a broad spectrum of rights related to reproductive health, autonomy and decision-making. International human rights instruments generally recognize these rights. The rights include to decide freely on the number and spacing of children, right to access reproductive health services and information, freedom from discrimination, coercion, and violence in reproductive decisions and to benefit from scientific progress in reproductive technologies.But the question whether access to surrogacy constitutes a reproductive right requires examining the scope of established reproductive rights vis a vis, the distinctive features of surrogacy arrangements.

III. Constitutional Foundations regarding the Reproductive Rights

The Indian Constitution per se does not explicitly mention reproductive rights. But several fundamental rights provisions have been interpreted by the Courts in India to encompass various aspects of reproductive autonomy. Article 21 stands to recognize the right to life and personal liberty. Justice Chandrachud explicitly placed "procreation" within the protected realm of privacy in this historic ruling that recognized privacy as a fundamental right. The Supreme Court proclaimed that "privacy includes at its core the preservation of personal intimacies, the sanctity of family life, marriage, procreation, the home and sexual orientation." This articulation may broaden the scope of constitutional protection to include choices about surrogacy and other reproductive techniques.[3]

Article 15 prohibits discrimination on grounds of religion, race, caste, sex, or place of birth, potentially applicable to surrogacy restrictions.The Supreme Court primarily focused on the decriminalization of

---

1 *Jan Balaz v. Anand Municipality* (2009), 2151 of 2009; 3020 of 2008; 11364 of 2009

2 Suchita Srivastava & Anr vs Chandigarh Administration on 28 August, 2009, AIR 2010 Supreme Court 235, 2009

3 *Justice K. S. Puttaswamy (Retd.) and Anr. vs Union Of India And Ors.* Writ Petition (Civil) No 494 of 2012; (2017) 10 SCC 1; AIR 2017 SC 4161

homosexuality, but its acknowledgment of LGBTQ+ rights carries important implications for surrogacy regulations that currently exclude same-sex couples. The Court highlighted that "the choice of whom to partner, the ability to find fulfilment in sexual relationships, and the right not to be subjected to discriminatory behaviour are intrinsic to the constitutional protection of sexual orientation." The reasoning could provide grounds for challenging the heteronormative restrictions present in the current Surrogacy Act.[4]

Article 14 of the Constitution of India ensures the right to Equality. This provision challenges discriminatory restrictions on access to reproductive technologies based on marital status, sexual orientation, or gender.The petitioner as an unmarried single man challenged the vices of the constitutionality of provisions limiting surrogacy to married heterosexual couples. The petition challenged the exclusion of single persons and same-sex couples from availing surrogacy services as one violation of the rights made fundamental under Articles 14, 19 and 21 of the Constitution. The Supreme Court recognized the substantial constitutional questions involved[5]. These constitutional provisions provide potential avenues for recognizing certain aspects of surrogacy as protected reproductive rights, though Indian courts are yet to directly address this question in the context of surrogacy.

In the case of *Dr. Sharmila Ghuge V. Union of India*[6]**,** petition challenged the prohibition on commercial surrogacy as one violating the rights of potential surrogates to occupational freedom under Article 19(1)(g) and bodily autonomy under Article 21. The petitioners' plea for a regulated commercial model that would better protect surrogate interests than a blanket prohibition has not been conceded.

IV. Surrogacy in the Light of Reproductive Rights Perspective

Viewing surrogacy through the lens of reproductive rights raises complex questions about bodily autonomy, choice, and access to reproductive technologies. The right to reproduction has been recognized internationally as encompassing the freedom to decide if, when, and how to have children. However, the Surrogacy Act's restrictive provisions create a tension between regulation aimed at preventing exploitation and the recognition of reproductive choices.The prohibition of commercial surrogacy, while intended to prevent exploitation, raises concerns about women's agency and reproductive labour. By removing financial compensation, the legislation assumes that monetary incentives necessarily leads to exploitation, disregarding the possibility of ethical commercial arrangements respecting surrogate autonomy.

The Muddle: Contradictions and Challenges

The current regulatory framework creates several contradictions and challenges. First, by limiting surrogacy to close relatives, the Act creates potential for familial coercion and complicated family dynamics. By restricting eligibility to heterosexual married couples, the current regulatory framework reinforces traditional family norms, while excluding diverse family formations. This approach conflicts with evolving jurisprudence on privacy, autonomy, and non-discrimination, as evidenced in cases like Navtej Singh Johar v. Union of India (2018), which decriminalized homosexuality, and Puttaswamy v. Union of India (2017), which recognized privacy as a fundamental right.

Second, the prohibition of commercial surrogacy may drive the practice underground, potentially creating more significant risks for vulnerable women.

Third, the narrow eligibility criteria exclude numerous individuals and couples who might seek surrogacy, including single individuals, same-sex couples, and those who do not have infertility diagnoses but cannot carry pregnancies for other reasons. This exclusion raises questions about equality and non-discrimination for access to reproductive technologies.The Surrogacy Act's limitation of surrogacy to cases of "proven infertility" frames surrogacy as a medical intervention rather than a reproductive choice. This medicalization of surrogacy narrows its conceptualization as a reproductive right, excluding those who seek surrogacy for non-medical reasons.

Fourth, the requirement that surrogates must have their own child, potentially reinforces the notion that women's primary value lies in their reproductive capacity, contradicting principles of gender equality and

[4] *Navtej Singh Johar & ors vs. Union of India Thr. secretary ministry of law and justice,* (2018) S.C.R. 379

[5] *Karan Balraj Mehta v. Union of India (W.P(C) 8448/ 2022)*

[6] PIL 26201 OF 2022

bodily autonomy.A central tension in India's approach to surrogacy regulation lies between respecting reproductive autonomy and protecting vulnerable parties from exploitation. The current restrictive framework prioritizes protection over autonomy, reflecting concerns about the socio-economic vulnerabilities of potential surrogates. However, this approach may unduly restrict the reproductive choices of both intended parents and women, who might serve as surrogates.

V. Conclusion

India's journey from an unregulated commercial surrogacy to a highly restricted altruistic model illustrates the challenges of balancing regulation with reproductive rights. The Surrogacy (Regulation) Act of 2021, while addressing legitimate concerns about exploitation, creates a new set of challenges through its restrictive approach.Recognizing surrogacy as a reproductive right requires acknowledging the complex interplay of bodily autonomy, choice, ethics, and protection from exploitation. The current "muddle" in India's surrogacy regulation represents the difficulty of navigating these competing considerations. Moving forward, a more nuanced, rights-based approach to surrogacy regulation might better serve the interests of all parties involved, while preventing exploitation and respecting reproductive autonomy. The ongoing evolution of surrogacy regulation in India reflects broader global debates about reproductive technologies, rights, and ethics. As reproductive technologies continue to advance, these debates will only grow more complex, requiring thoughtful, rights-based regulatory frameworks that can adapt to changing circumstances while maintaining core principles of autonomy, dignity, and protection from harm.

* * * *

REPRODUCTIVE RIGHTS OF WOMEN IN INDIA AND LEGAL CHALLENGES

Ms. Nitika Sharma *
Prof. Umesh Kumar **

Abstract

Earth stands as the most profound symbol of reproduction. In India, we honour the Earth as our mother-an embodiment of life-giving energy, resilience, and patience. Among its many virtues, tolerance is considered its greatest. Culturally, we often draw parallels between Earth and women, expecting women to embody the same level of tolerance. However, this expectation of enduring tolerance can become a barrier to the assertion of women's rights.

Reproductive rights are not whole to women; they include all genders. However, statistics reveal that women-who make up nearly half of the world's population-continue to face infringements on these rights. In many cases, women's reproductive autonomy is eroded by their partners, families, or even the state.

The right to life is a fundamental human right, and reproductive choice-particularly for women-falls directly under the ambit of this right, as protected by Article 21 of the IndianConstitution, which guarantees the right to life and personal liberty. Reproductive and sexual rights are inherently tied to personal freedom and bodily autonomy.

When discussing reproductive rights within a legal framework, one of the most important laws is the Medical Termination of Pregnancy (MTP) Act of 1971. While reproductive rights cover a wide spectrum-including the right to conceive and the right to terminate a pregnancy-the MTP Act mainly addresses the issue of abortion. These rights are supported by international conventions, national laws, and human rights charters that affirm every individual and couple's right to decide freely and responsibly the number, spacing, and timing of their children, free from coercion, discrimination, or violence.

This paper aims to analyze the original MTP Act of 1971 and its amendment in 2021, examining the changes introduced and their impact-both positive and negative-on human and constitutional rights in India. While human rights are meant to be inclusive and universally applicable, it is important to assess whether the MTP Act successfully addresses the diverse needs of all sections of society. In many ways, the law appears to cater to a specific gender, yet even within that scope, it may fall short of fully supporting women's autonomy.

The central aim of this paper is to question whether this legislation truly advances genderjustice. Does it harmonise with other existing laws, or does it create overlaps and contradictions? And most importantly, does it genuinely uphold the principles of freedom, equality, and dignity for all?

I. Introduction

Reproductive rights are very basic and notable rights of human life, and their significance is enhanced further when it comes to the reproductive rights of women. Because history is witness to the fact that women have never had complete control over their lives and bodies. The question comes, what are these rights after all? Most people understand from reproductive rights that it is related to conceiving and the termination of pregnancy only. There is a legislation in our country called the Medical Termination of Pregnancy Act,1971 which is considered as the main law on reproductive rights. This law talks about when, how, and why the pregnancy will be terminated, and what will be its terms and conditions, but these rights that is reproductive rights are not limited to this only. When these rights are combined with other laws and their provisions, or if

* **Ph.D Research Scholar, Department of Laws, Himachal Pradesh University, Shimla**
** **Professor, Department of Laws, Himachal Pradesh University, Shimla.**

we look at the cause of bringing Medical Termination of Pregnancy Act,1971 and the history of reproductive rights then we find that the scope of these rights is very large. If we talk about laws, then first the supreme law of our country "The Constitution of India" mentions that our right to life includes the right to live freely and with full dignity. Article 21 of the constitution talks about "personal liberty" and it has a very wide scopeit includes the right to privacy, dignity and bodily integrity so there is no confusion that women's reproductive rights fall under the ambit of personal liberty which is mentioned under Article 21.[1] If a woman is not able to use her reproductive rights as per her wish then it is a violation of Article 21 and proof of this statement is under "Justice K.S Puttaswamy Versus Union of India" the landmark judgement of the Supreme Court in which bench held that privacy generally covers personal autonomy relating to mind, body and to choice or making decisions.[2] The word personal autonomy here mainly the reproductive rights, means safe abortion and to make decisions related to pregnancy free from coercion and discrimination. Indian society has been lagging in understanding and providing reproductive rights and health for a long time. And even at present, it has not been able to truly understand its importance and meaning. The main reason for this is the stereotypes and many misconceptions behind the word "reproductive" and another reason is that the word "sexual" and "reproductive" are considered the same, hence prescription is associated with the word "sexual" in our society and because of this reproductive right and health is also denied. If we go towards the history of reproductive rights and look into religious scriptures like Manu Smriti, we will find that fathers are advised to get their daughters married at an early age and the aim or meaning of the marriage is procreation. Manu Smriti restricts women's purpose in life when it states women are formed for conceiving and having children, not a wish or right but an obligation for women.[3] Even the judge of Gujrat high court, quoting ManuSmriti, saidin the abortion plea of a minor rape victim that in olden times, marriage used to take place at the age of 14-15 and children were born before 17 and told the counsellor that you must have heard this and if not, then must read Manu smriti once.[4] In many religious scriptures, women have been given the status of goddess, but even in today's times, there seems to be a contradiction between laws and religious scriptures. It seems that respect and rights are being given from one side and snatched away from the other side, today's laws have adopted a dual character. This paper reviews the history of the Medical Termination Pregnancy Act, 1971 and abortion laws so that all the facts are clear to the readers and listeners as to why and how this legislation came and the question also came to their mind whether this law is fully capable of providing womenwith their reproductive rights. Has the amendment made in it been able to remove the shortcomings of the old law and the researcher has tried to solve all these questions with suggestions? There is no special law on reproductive rights in our country and if we talk about abortion laws, 1971 until the Medical Termination of Pregnancy Act, of 1971 came, abortion was governed only by the provision under the Indian Penal Code. Sections 312 to 315 contained in chapter sixteen of this code deal with miscarriage.[5] These provisions were not included in the code keeping in mind the reproductive rights of women, rather abortion has been declared a crime and provisions for its punishment have been made in different sections. The word miscarriage has been used in place of abortion in the code. As times changed with modernity, abortion started being seen as a right and seeing its widespread nature a need felt to make a special law on it, so the government formed a committee. In 1964 Government of India formed a committee under the chairmanship of Shanti Lal Shah to study the question of advancing the actual law of abortion and recommend some steps to rectify the provision of the code.

The committee submitted an exhaustive report suggesting various situations and giving reasons for the termination of pregnancy under the law. It was of the view that this should be allowed not forprotect the life of the pregnant woman, but also to avoid severedamage to her physical or mental health. The Government of India accepted the recommendations of the committee and brought forth in 1970 in Parliament the Medical Termination of Pregnancy Bill a comprehensive bill) introduce various situations under which pregnancy

---

1 The constitution of India, art.21.

2 AIR 2017 SC 4161

3 N. M., Naseera and Kuruvilla, Moly (2022). The Sexual Politics of the Manu smriti: A Critical Analysis with Sexual and Reproductive Health Rights Perspectives. Journal of International Women's Studies, 23(6), 21-. Available at: https://vc.bridgew.edu/jiws/vol23/iss6/3 (visited on 10 september,2023)

4 "Gujarat HC Judge cites Manu Smriti in Minor rape Survivor's abortion case" The Hindu, June. 9,2023

5 The Indian Penal Code,1860 (Act 45 of 1860)

might be lawfully terminated. The bill was finally passed in August 1971 as the Medical Termination of Pregnancy Act 1971 which came into force on 1 April 1972.[6] After some time, the government used the power given in section 6 of the 1971, Act and framed the Medical Termination of Pregnancy Rules,2003.[7]If we look at the international level, India has been an active participant and signatory in many conventions, conferences and protocols and has taken the responsibility of providing women their rights. India has accepted all the Human rights schemes which are necessary for the security and welfare of women.In modern times, as people started becoming aware of their rights, the scope of this Act started appearing limited to them. People started understanding it as a population control law, and then the judiciary brought out the intention behind this law in the judgments of many cases, such as safe abortion is one of the objectives of this law because when this Act of 1971, came health facilities and technology were not fully developed.

Change is the law of nature as development in health facilities and educational and mental levels of people increased and is increasing even today. Petitions demanding these facilities and rights started increasing in the judiciary. The right which was limited only to "safe abortion" now started being demanded by the petitioners through their petitions in the form of reproductive rights and personal liberty in the form of"bodily autonomy". Looking at all these petitions, the Judiciary found that this Act of 1971, is not completely capable of keeping up with today's times.Therefore, after seeing the increase in the number of petitions and many pending cases related to pregnancy termination, the shortcomings of this law came to light, hence after a long period of 50 years, it was thought to make changes in the old Act of 1971.SoThe Medical Termination of Pregnancy (Amendment) Bill, 2020 got its introduction in the Lok Sabha on March 2, 2020, got the acceptanceby the Parliament on March 17, 2020, and ultimately got the assent of the president of India on March 25, 2021, thereby convert into a complete law balancing the provisions of abortion in India.[8]After the amendment of this law, the way the judiciary is making its decisions is acting as a weapon for the protection of reproductive rights. This amendment has emerged as an excellent law in an intellectual and progressive society. Violation of rights has stopped due to this law, but even at present when we study this amended act or use its provisions, many shortcomings are seen in it. We can say that along with the merits, it also has demerits which have been analyzed in this paper. Whether women are completely free to make decisions regarding their family rights without any pressure, or this law is still in the hands of the government and the administration is running it as per its convenience. Is this law proving effective in bringing gender equality or has this amendment been made to meet the need of the times?

II. Meaning of Reproductive Rights

In common phrase, Reproductive Rights are the rights of humans to determine whether to reproduce and have reproductive health. This may comprise the individual right to plan a family, terminate the pregnancy, utilize contraceptives, acquire sex education, and obtain ingress into reproductive health services. Such rights are grounded in other human rights, including the right to health, the right to be free from discrimination, the right to privacy, the right not to be subjected to torture or ill-treatment, the right to determine the number and spacing of children and right to free from sexual violence.[9]

Dictionary Meaning and Definition of Reproductive Rights

According to Merriam-Webster Dictionary,"a woman's right to choose whether or not she will have a baby"[10]

The International Conference on Population and Development Programme recognised Reproductive Rights and states that couples have the right to determine whether and when to have children as well as the number of children, and the right to obtain the highest level of sexual and reproductive health"[11]

---

6 K.D. Gaur, ''Abortion and Law in India"28 JILI 348-363(1986). Available at http://www.jstor.org/stable/43951024(visited on 13 september,2023)

7 Ibid

8 MohleenKaur, "Changing Face of Abortion Laws in India: A Critical Investigation with special reference to the Medical Termination of Pregnancy(Amendment) Act,2021"3 IJLSI 941-949 (2021)Available at http://www.ijlsi.com (visited on 13 september,2023)

9 Tanvi Mathur, "Reproductive Rights for women in India" Available at http://www.legalserviceindia.com (visited on 14 september,2023)

10 "Reproductive rights." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/reproductive%20rights.(Visited on 14 September. 2023).

11 United Nation,Report of the International Conference on Population and Development Cairo, 5-13 September 1994(New York,1995) Available at https://www.un.org

Article 16(1)(e)- also grants reproductive rights in the form of "deciding freely and responsibly on the number and spacing of children and to have access to the information education and means to enable them to exercise these rights"[12]

Article 12- According to this article States Parties shall take all propersteps to eliminate discrimination against women in the field of health care to ensure, based onequality of men and women, access to health care services, including those attributed to family planning.

2. Parties shall ensure to women relevant services in connection with pregnancy, confinement, and the post-natal period, granting free services where necessary, as well as requisite nutrition during pregnancy and lactation.[13]

According to the Supreme Court of India, "Reproductive rights and choice is the constitutional right of women and a major element of personal liberty under Article 21 of the Indian constitution"[14]

III. Reproductive Rights are Constituent of Human Rights

Although understanding the concept of reproductive rights it becomes necessary to be aware of the reality that reproductive rights contain in them certain fundamental rights which are part of human rights as well. The reproductive health of women can stay protected if thereremainsimpartiality in every domain between men and women.[15]

Especially,intendingto protect the reproductive rights of the women it is indispensable that their human rights are alsoprotected. Human rights always focus concentration on protecting the life and liberty of human beings and permittingthem to lead a glorified life which isnot reduced to bareanimal existence. Reproductive rights can be claimed and exercised healthilylthily ifthe life and liberty of females are also protected completely. In another way, it signifiesthe duty on the part of the state to demonstrate such social order wherethe lawis capable of keepingsafe the women so that they can make use of their reproductive rights safely and efficiently[16].

To acknowledge how reproductive rights are part of basic human rights. Such subcomponent which establishes the association betweenreproductive rights and human rights andisidentified under the internationalinstruments are defined here below[17]:-

1) Right to Health, Reproductive health, and family planning.
2) Right to decide the number and spacing of children.
3) Right to get married and establish a family.
4) Right to remain free from gender discrimination.
5) Right to stay protected against sexual assault and exploitation.
6) Right not to become a victim of torture or other cruel, inhuman, or degrading treatment.
7) Right to life, liberty, and security.
8) Right to privacy.
9) Right to change customs that discriminate against women.
10) Right to enjoy scientific progress and to consent to experimentation.

IV. Abortion and Indian Legislation

The term, "abortion" originated from the Latin word ''abortion" which means 'to get separated from the proper site.[18]Abortion is said to take place when the life of the foetus or embryo is demolished in the woman's womb or the pregnant uterus evacuatesbefore the usual time[19].In other words, Abortion is the termination of a pregnancy by the removal or exclusion from the uterus of a foetus or embryo ensuing or causing its death.[20]

---

12 Convention on the Elimination of Discrimination against women,1979, art 16(1)

13 Ibid

14 *Justice K S Puttaswamy v. Union of India*, AIR 2017 SC 4161

15 Rickie Solinger, *Reproductive Politics: What Everyone Needs to Know* 122(Oxford University Press, London, 2013).

16 Subhash Chandra Singh, "Reproductive Rights as Human Rights: Issues and Challenges" 31 *ISLJ* 59(2005)

17 Ibid

18 Webster's New Dictionary and Thes Qurus, 1995 DS-MAX Inc., USA, 1-2 (visited on 16 september 2023)

19 Ratanlal&Dheerajlal's. The Indian Penal Code, 1860, 448 (Wadhwa and Co., New Delhi, 28th Edn.)

20 J.V.N Jaiswal, Legal Aspects of Pregnancy, delivery, and abortion. 165 (Eastern Book Co. 2009)

Medically, there exist three distinguished terms, like abortion, miscarriage and premature labour that signify the expulsion of a foetus based on the distinctphases of gestation at which expulsion or termination of pregnancy is performed. The term abortion is used when the termination of the pregnancy is carried out before the placenta is formed, which means within the first three months of pregnancy, whereas miscarriage signifies the expulsion of the foetus within the first fourth to seventh month of gestation before it is viable or grows. The third term that is "premature labour" means delivery of a premature baby probablycapableof sustaining life.

Both abovephrases are many times considered synonymous with each other. Taylor, in his Principle and Practice of Medical Jurisprudence (13th edition) states that the phrases 'miscarriage' and 'abortion' are legally synonymous since the foetus is considered as human life from the moment of fertilization[21].TheSupreme Court while hearing the one significant case held that 'miscarriage' symbolizes 'spontaneous abortion' on the other hand 'abortion' is said to be a miscarriage performed by unlawful means.[22]

Bharatiya Nyaya Sanhita

The Provisionsabout abortion in the Bharatiya Nyaya Sanhita were constitutedmore than a hundred years ago and were following English law at that time[23]The Bharatiya Nyaya Sanhita uses the word "causing miscarriage "to signify abortion. Miscarriage technically refers to spontaneous abortion, whereas "voluntarily causing miscarriage" (induced abortion) which forms the offence under the BNS'^ stands for criminal abortion[24]. The law of the country has always held human life to be hallowed and the security that the law gives to human life extends also to the unborn child in the mother's womb. The unborn child must not be torn down unless it is for the aim of safeguarding the yet more valuable life of the mother. The mother's life is more valuable than that of the unborn child because she is the inventor of the foetus and her life is well entrenched. The mother has with obligation and liability and permitting the mother to die would also cause the death of the foetus in most cases.Bearing in mind this view the code has designated causing miscarriage (induced abortion) a serious offence and made both causing miscarriage "with the consent" or "without the consent" of the womenpunishable under sections 88 to 92 of the Bhartiya Nyaya Sanhita respectively.

However, to entice the provisions of section 88 of the BNShas two importantrequirementsthat must be fulfilled,

(i) Miscarriage should have been caused voluntarily; and

(ii) Miscarriage should not have been caused in good faith for the aim of saving the life of the woman[25]

Section 88 of the BNS divides the crime into twocategorythat is Causing miscarriage:

(i) When a woman is with child, and

(ii) When she is quick with child[26]

The Medical Termination of Pregnancy Act, 1971

Indian society has been inspecting reproductive rights infringement since remote ages. Thesocial cohesion of our community is such that suppressingantiquated and harmful practices and eliminatingseveral dotages of superstition fastened with the act of abortion is a difficult task. Tracing the historical aspect of the existence of penal laws in India, it is found that The Indian Penal Code, of 1860 declares abortion to be a crime which is punishable in a strictway. However, for the aim of drafting a completely developed special lawaboutthe application of abortion in India, The Government of India, in the year of 1964, tried to constitute a special committee toexpedite such purpose. It was headed by Shantilal Shah hence it came to be known as Shantilal Committee. Bear in mind the various suggestions of citizens of India regardingthe right to abortion, the committee achieved victory in reaching a last submission of drafting anindependent and special law for abortion. Various commendations which were made by the committee from time to time were given ears to in 1970 in aninclusive manner. Thereafter, the approved recommendations were passed to the parliament and

---

21 Diksha Paliwal, "Abortion law in India" Available at https://blog.ipleaders.in (visited on 16 september 2023)

22 Jacob George v. state of Kerala (1994)

23 See SS. 58 and 59, offences Against the person Act, 1861, Available at https://www.legislation.gov.uk(visited on 16 september 2023)

24 Indian Penal Code(45 of 1860)

25 Ibid

26 Ibid

were introduced there in the guise of a bill known as the Medical Termination of Pregnancy Bill. After inspecting the provisions of the Bill, it was passed in the year 1971 in the form of an Act named the Medical Termination of Pregnancy Act,1971. The Medical Termination of Pregnancy (MTP) Act, of 1971 make provision for the introduction of legally assembled rules and regulations for proclaiming abortions valid in India. The MTP Act is concerned with distinctphases of abortion such as who can legally terminate pregnancy at what site and following what sort of method.[27]

As per official statements, the MTPA had been with the following three objectives.

a) health measures, when there is a threat to the life or dangerto the physical or mental health of the women; or

b) generous necessity, such as when pregnancy is causedas a result of a sex crime or intercourse with a lunaticwoman, etc.; or

c) abiogenic grounds, when there is a considerable risk that thechild if born, would suffer from abnormality and illness.

The Medical Termination of Pregnancy Act, of 1971 contain eight sections. Its aim is besides the removal of the high occurrence of illegal abortions, possibly to confer on women the right to privacy, which includes the right to

i) distance and limit pregnancies (i.e., whether to bearchildren); and

ii) choose her own body[28].

The MTPA modified the provisions of the Bhartiya Nyaya Sanhita relating to abortion by permitting previously illegal abortions under certain specified and limited conditions i.e., Section 3 of MTPA, which is the operative Section has modified the strict provision of the law of abortion as contained under section 312 of the Indian Penal Code by permitting termination of pregnancy in several situations.

In section 3(1) of MTPA, it is provided that the termination of a pregnancy by a registered medical practitioner is no longer an offence under the Indian Penal Code, where there is a medical opinion.

(i) that the carrying on pregnancy will involve a risk to the life of the pregnant woman or a risk of heavy injury to her physical or mental health, or

(ii) that there exists a considerable risk that if the child were born, it would endure such physical or mentaldeformityto be gravely handicapped.[29]

The Medical Termination of Pregnancy (MTP) Act 1971 as amended in the year 2002, primarily dealt with women working in the private health area. The amendments that were introduced in the Act rationalized the following provisions and objectives:

1. To allow the private places to act as MTP service providers, was to be decided by a committee which was to act at the district level basically;
2. To deal with the mental disorder that did not amount to mental retardation was dealt with under the purview of amending the term ‘lunatic’ with ‘mentally ill person’;
3. The nature and quality viz. time and place of carrying out the MTP service had to be strictly complied with the provisions of the Act, or else there had been introduced harsh penalties for the same.

After the amendments were introduced by way of the MTP Amendment Act, of 2002 there still arose a need to upgrade the situation of the private hospitals which provide abortion services. Hence to standardise the working of private hospitals The Medical Termination of Pregnancy Rules, 2003 were introduced.[30]

The Medical Termination of Pregnancy (Amendment) Act,2021

The MTP (Amendment) Act, 2021 is one of the few honours in the domain of women’s empowerment that the Indian legislature has received. In addition to extending the time framein which an abortion can be

[27] Mohleen Kaur, “Changing Face of Abortion Laws in India: A Critical Investigation with special reference to the Medical Termination of Pregnancy (Amendment) Act,2021”3 IJLSI 941-949 (2021)Available at http://www.ijlsi.com (visited on 13 september,2023

[28] *H.L V. Matheson,* 450 U.S. 398 (1980)

[29] Ibid

[30] Ibid

lawfully performed, the modification has expanded the scope ofthe Act by changing section 3. The new amendment replaces the terms “married woman andher husband” with the terms “woman and her partner”. As a result, an unmarried woman canalso terminate pregnancies within the time limit prescribed under the Act. Besides this, withthe zeal of protecting the privacy and confidentiality of women, the latest law bysection 5A of the Act intends to penalise medical practitioners who fail to protect the privacyand confidentiality of women who wish to terminate their pregnancy.

Despite these progressive amendments in asserting women’s reproductive rights in the country, the amendments to the MTP Act, of 1971 do not go far enough[31].

The MTP (Amendment) Act, 2021 was enforced as a legal remedy for the backlog of matters that had been filed in the form of Writ petitions before the Hon’ble Supreme Court and various High Courts, seeking permission to terminate pregnancies beyond twenty weeks in cases of foetal abnormalities or pregnancies caused by rape. Respectively, enlarging the duration for the termination of pregnancy beyond twenty-four weeks only for the cases where a Medical Board diagnosis substantial foetal abnormality. In this regard, it is worth mentioning that the ramification of such legislation is that there is no change in the process for terminating pregnancies caused by rape that have progressed beyond the 24-week threshold: the only option is to obtain assent by Writ Petition[32].

Termination of pregnancies is a touchy subject matter. The amended Act does not specify the time limit within which the medical board must make its decision. Delays in decision-making by the board may result in further complexity for pregnant women. It is aconclusive fact that the Act permit the termination of pregnancies of “pregnant women” under certainconditions. However, with the advancement of medical sciences, it has come tothe knowledge that several medical studies have shown that there may be cases where personswho have been identified as an additional gender, transgender (and not women) can becomepregnant even after taking hormone therapy to change from female to male, and mayrequire termination services. Since the amended Act exclusively allows for theterminationof pregnancies in the case of women, it is not clear if transgenders will be incorporatedunder theamendedAct or not.[33]

V. Conclusion

Recognizing reproductive rights through law is essential for stripping the long-standing opinion of abortion as sinful or criminal. Even as laws evolve to become more progressive, a fundamental concern remains: the woman, who ultimately bears the child, still does not have absolute control over her own body. Her decision to continue or terminate a pregnancy is often influenced—or even dictated—by legal frameworks or societal expectations, allowing excessive judicial involvement in matters that should remain within the medical domain. Ensuring autonomy in such decisions is vital for women’s empowerment, reinforcing the confidencethat they have the right and ability to make choices about their bodies without relying on third-party approvals

* * * *

[31] Ambika Gupta, 4th Year, Vivekananda Institute of Professional Studies (VIPS), GGSIPU

[32] Ibid

[33] Transgender Act of 2019

CROSSING BORDERS: INTERLINKING INTERNATIONAL LAW AND NATIONAL IMPLEMENTATION: POPULATION POLICY AND REPRODUCTIVE RIGHTS IN INDIA

Mr. Rohaan Thyagaraju *

Abstract

Essentially, India pays attention to global population guidelines when forming policies yet struggles to execute these mandates because the policies encounter political, socio-economic, and cultural limitations. This paper evaluates how the international legal systems could assist and strengthen India's reproductive healthcare policies to match the standards of human rights principles. This evaluation analyses existing laws and policies and reveals their inadequate protections for reproductive rights, particularly regarding marginalized groups.

The paper dives into how international legal frameworks intersect with reproductive rights and their effects on population matters in India. Population and development (ICPD) and the convention on the elimination of discrimination against women (CEDAW) established reproductive rights as fundamental human rights. The frameworks establish specific rights that allow individuals to decide child numbers and spacing and obtain information while protecting them from violence and discrimination. Further, population policies require immediate integration of programs that promote gender equality and empowerment based on the icpdprogramme of action recommendations. The research investigates Indian legal practices and judicial decisions to determine their agreement or discrepancies with global reproductive rights principles. By addressing the gap between international law and Indian domestic reproductive health policies, the study intends to create stronger, inclusive reproductive health programs nationwide. Concludingly, the paper proposes to introduce good practices and deal with implementation barriers civil society actors encounter in advocating reproductive rights by applying international guidelines at the national level. It also suggests targeted policy recommendations that could yield maximum outcomes in Indian reproductive health programmes by aligning local and international legal standards.

***Keywords*: Gender equality, Population issues, Reproductive rights, Legal frameworks, Human rights**

I. Introduction

India has become the world's largest populated country, surpassing China in demographic numbers while facing its first-ever governance and social welfare challenges in human history. Since 1947, Indian authorities have faced the essential challenge of managing population expansion. The government of India delivered various birth control policies in response to economic, social, and political requirements stemming from fast population expansion. The first birth control policies were characterized by intense coercion, especially during the 1970s emergency period when public trust reached an all-time low. Modern society sees developments in population and reproductive rights perspectives following international agreements such as the international conference on population and development (ICPD)programme of action and the convention on the elimination of all forms of discrimination against women (CEDAW).

The international agreements establish that reproductive rights belong to human rights standards[1] by requiring

* **Third year BBA LLB Student, Symbiosis Law School, Hyderabad**

[1] Unnithan M, 'Conflicted Reproductive Governance: The Co-Existence of Rights-Based Approaches and Coercion in India's Family Planning Policies' (Anthropologies of Global Maternal and Reproductive Health: From Policy Spaces to Sites of Practice [Internet]., 1 January 2022) <https://www.ncbi.nlm.nih.gov/books/NBK584062/> accessed 11 March 2025

proper knowledge alongside full family planning access while promoting community-based health program participation. The Indian national policies demonstrate ongoing conflicts between population control policies and user freedom in matters of reproduction. This research explores how international population guidelines connect to Indian internal policies by assessing implementation barriers mainly affecting marginalized populations. Examining international law integration with national procedures improves comprehension of reproductive healthcare policy enhancements regarding established human rights standards.

II. Background and Context

India began developing its population policies in the 1950s because officials understood that population control was essential for creating the nation. The government of India launched its family planning scheme during the initial phase as one of the first countries worldwide to take such action in population control. The national population policy of 2000 defined its mission to serve two primary objectives: expanding health care services across reproductive boundaries by integrating birth control methods. The public strongly reacted with outrage to programs that included forced sterilizations during the emergency period because of these past experiences.

Resourceful cultural influences powerfully form Indian attitudes toward the family dimension and decisions concerning reproduction. Most contemporary societies hold large families as safeguards and indicators of social achievement, while traditional social customs encourage male children above female children. The cultural environment serves as a leading factor in understanding why fertility rates remain elevated, particularly in rural India, because local communities support early marriage followed by childbearing. The delivery of reproductive health services faces challenges from regional variations because it generates vast dissimilarities between location access and educational outreach services. The medical termination of pregnancy act gave access to legal abortion in 1971, whereas healthcare providers beyond doctors are restricted from providing abortion care services. Also, most population centres still lack adequate access to medically safe methods of abortion and contraception options. The public health network stretches thinly through rural areas, which generates high numbers of unsafe abortions together[2] with elevated maternal death rates. A strong link exists between socioeconomic status and women's ability to access reproductive healthcare services because vulnerable populations face the highest barriers, according to evidence (2013). A population change in India requires immediate modifications to policies that match both individual freedoms and gender equality standards.

India began developing its population policies in the 1950s[3] because officials understood that population control was essential for creating the nation. The government of India launched its family planning scheme during the initial phase as one of the first countries worldwide to take such action in population control. The 2000 national population policy defined its mission to serve two primary objectives: expanding health care services across reproductive boundaries by integrating birth control methods. The public strongly reacted with outrage to programs that included forced sterilizations during the emergency period because of these past experiences. Resourceful cultural influences powerfully form Indian attitudes toward the family dimension and decisions concerning reproduction. Most contemporary societies hold large families as safeguards and indicators of social achievement, while traditional social customs encourage male children above female children. The cultural environment serves as a primary factor in understanding why fertility rates remain elevated, particularly in rural India, because local communities support early marriage followed by childbearing. The delivery of reproductive health services faces challenges from regional variations because it generates vast dissimilarities between location access and educational outreach services. The medical termination of pregnancy act gave access to legal abortions in 1971; however, healthcare providers beyond doctors are restricted from providing abortion care services. Also, most population centres still lack adequate access to medically safe methods of abortion and contraception options. The public health network stretches thinly through rural areas, which generates high numbers of unsafe abortions together with elevated maternal

[2] Singh S and others, 'Abortion Worldwide 2017: Uneven Progress and Unequal Access' (Guttmacher Institute, 16 August 2023) <https://www.guttmacher.org/report/abortion-worldwide-2017> accessed 11 March 2025

[3] Connelly M, 'Population Control in India: Prologue to the Emergency Period' (Source: Population and Development Review, Vol. 32, No. 4 (Dec., 2006), pp. 629-667, 2009) <https://u.demog.berkeley.edu/~jrw/Biblio/Eprints/%20A-C/connelly.2006_PDR_pop.control.India.pdf> accessed 11 March 2025

death rates. Current evidence demonstrates socioeconomic position affects women's ability to obtain reproductive healthcare services because vulnerable populations encounter the highest number of access obstacles (2013). Indian population changes demand immediate adjustments in national policies that respect individual rights and gender equality principles. The research will suggest approaches that boost advocacy efforts for reproductive rights nationally. The research should present recommended policy changes that address the needs of marginalised community members throughout India.

III. Methodology

This research applies a comprehensive design combining doctrinal, empirical, and comparative elements. The doctrinal study evaluates dominant Indian reproductive rights policies and laws by scrutinizing their framework from the medical termination of pregnancy act to national health policies. The study will use country-level survey data, multiple reports, and case studies to measure reproductive healthcare services offered to different Indian population demographics. The research uses a comparative approach to measure Indian law with international human rights conventions, including the ICPDprogramme of action and CEDAW, to determine their alignment levels. The research design, with multiple dimensions, fosters a clear understanding of India's reproductive rights implementation and population policies so it can develop strategic recommendations to overcome detected deficits and make reproductive freedoms accessible to every individual.

IV. Legal Framework: Overview of Relevant Statutes, Treaties, or Case Laws

The Indian legal framework deals with reproductive rights, employing a mix of domestic legislations and global treaties that establish reproductive liberty as an essential human correct principle. The medical termination of pregnancy act of 1971 is an important legislation that provides doctors the right to perform abortions under specific circumstances. Women who apply for abortion[4] under the medical termination of pregnancy act can be granted permission to end their pregnancy until 20 weeks of gestation on particular grounds, which include risk to her life or mental well-being and when the fetus is suffering from physical deformities. Recent modifications in the MTP act have lengthened the termination period from 20 to 24 weeks for specific categories of women towards gaining reproductive autonomy under the legal sphere. Among the laws governing reproductive rights are the MTP Act with its active groaneth, the prevention of child marriage act, 2006 and the protection of children from sexual offences act, 2012 (POCSO). As per this law, children receive protection from sexual offences, but reporting offence becomes a hindrance to availing safe abortions.

As a member state, India subscribes to international agreements that place reproductive rights on the level of human rights. The 1994 ICPD programme of action endorses legal and safe abortion access along with territorial protection of maternal childbearing choices without coercion, as per ben stallworthy (2022). As a signatory to CEDAW, India must ensure full and equal human rights entitlements to women, encompassing reproductive health care. Under article 51 (c) of the IndianConstitution, the state must protect international rights obligations.

V. Comparative Analysis

A comparative analysis of India's reproductive rights law and other nations reveals striking differences in population control and reproductive health. For example, China's former one-child policy, which was coercive, has been abandoned and replaced with a two-child policy due to the negative consequences of forced population control, such as an ageing population and an ageing imbalance. As opposed to India's trajectory, China saw a sea change post-2015, pointing towards the need to attach greater significance to rights-based rather than coercive measures, inviting debate on reproductive health and human rights-related progress. On the other hand, countries such as Sweden and the Netherlands welcome universal sexual and reproductive health care without restricting family size, merging reproductive health care with overall socio-economic policies in support of gender equality. These countries emphasise the importance of educated choice and availability of various forms of contraception, demonstrating that expanded reproductive rights are not synonymous with

[4] Pai SN and Chandra KS, 'Medical Termination of Pregnancy Act of India: Treading the Path between Practical and Ethical Reproductive Justice' (Indian journal of community medicine/ : official publication of Indian Association of Preventive & Social Medicine, 2023) <https://pmc.ncbi.nlm.nih.gov/articles/PMC10470576/> accessed 11 March 2025

population growth. These intercountry comparisons locate India's unique challenge of reconciling the need to stabilise population growth by promoting individual reproductive rights founded on human dignity and self-determination. Most studies point to India's excessive reliance on sterilisation as a widely practised form of contraception, where rates of female sterilisation are anomalously high compared[5] with other contraceptive methods. This prioritisation of irreversible surgical procedures over expanding access to a variety of reversible contraceptive methods is an indication of the need for Indian healthcare policies to adopt a more holistic, rights-based strategy.

VI. Critical Arguments: Legal Principles, Judicial Interpretations, and Policy Implications

The difficulty in aligning Indian law with international reproductive rights norms lies in the judicial interpretations that define these laws. The supreme court suchitasrivastava ruling recognised the independence of women regarding reproductive choices as part of freedom under article 21 of the constitution, highlighting the compelling state interest to respect a woman's dignity and independence. The suchitasrivastava decision laid precedence pillars upholding the right to reproductive choice because it was indispensable to women's health and societal equality.

Despite such optimistic interpretations, existing legislation[6] retains numerous loopholes and areas of non-compliance. For instance, the reporting requirements under the POCSO Act contradict the confidentiality guarantees offered by the MTP Act, rendering a chilling effect on adolescent access to abortion. This contradiction undermines reproductive autonomy and can deter women from seeking necessary healthcare services, particularly where consensual adolescent relationships add another layer of complexity to sexual agency within legal conceptions.

Policy-wise, the clash of population control policies with rights-based models offers a background of conflicting objectives. The enforcement of two-child policies in Indian states, such as UttarPradesh, is for population control through punitive policies that do not account for the rights of people and vulnerable sections. The recurring trend of most policy initiatives[7] reflects an oppressive approach to population control that shies away from empowering people to make reproductive choices on their own.

VII. Case Law Review: Study of Pivotal Cases with Rationale and Precedents

The reproductive rights dynamic map of India[8] is greatly affected by numerous landmark cases that have come to highlight judicial interpretation as playing a crucial role in expanding women's rights. The case of suchitasrivastava v. Chandigarh administration,[9] as stated, set a precedent because the supreme court recognised the right of women to make choices regarding their reproduction. It underscored that individual rights are superior to the state's perceived population control agenda.

The other leading case, *Laxmi mandal v. Deen dayalharinagar hospital*,[10] also emphasized the responsibility of the state to provide medical care and to recognise maternal well-being as a fundamental right. The case reaffirmed the idea again that reproductive medical care, and safe abortion among them, is a constitutional requirement and not merely a statutory indulgence. On the other hand, the decision in *Jasvir Singh V. State Of Punjab*[11] reaffirmed that while the right to procreate is constitutionally protected under article 21, it remains conditional and reflects the interests of society, highlighting the delicate balance that must be struck between individual and collective demographic aspirations. This decision illustrates the ongoing conflict between

---

5 Singh S and others, 'Key Drivers of Fertility Levels and Differentials in India, at the National, State and Population Subgroup Levels, 2015–2016: An Application of Bongaarts' Proximate Determinants Model' (PLOS ONE, 2022) <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0263532> accessed 11 March 2025

6 Jain D and Shah PK, 'Reimagining Reproductive Rights Jurisprudence in India' (Columbia Law School, 2020) <https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=1006&context=human_rights_institute> accessed 11 March 2025

7 McCrudden C, 'Human Dignity and Judicial Interpretation of Human Rights | European Journal of International Law | Oxford Academic' (European Journal of International Law, 2008) <https://academic.oup.com/ejil/article/19/4/655/349356> accessed 11 March 2025

8 Jain D and Garnaick U, 'Abortion Laws in India: A Review of Court Cases' (Centre for Health Law, Ethics and Technology , 2016) <https://pure.jgu.edu.in/id/eprint/3255/1/Report-on-Abortion-Laws-in-India.pdf> accessed 11 March 2025

9 *Suchita Srivastava v. Chandigarh Administration,* (2009) 9 SCC 1 (India).

10 *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors,* W.P.(C) Nos. 8853 of 2008 (High Court of Delhi, June 4, 2010) (India).

11 *Asvir Singh &Anr. v. State of Punjab & Ors.*, CWP No. 5429 of 2010 (Punjab and Haryana High Court, May 29, 2014) (India)

empowering women's rights and maintaining state interests in population control. All these cases present that even though the Indian judiciary has made giant strides in protecting reproductive rights, the persistent uncertainties of the legislation and the complex socio-cultural mechanisms necessitate continuous judicial vigilance and legislative reform to be consistent with international human rights standards.

VIII. Empirical Data: Statistical Insights, Surveys, or Interviews

Empirical data are critical in arguments on India's reproductive rights and population policy. Statistics given[12] by the national family health survey (nfhs-5) of 2019-2021 indicate a reduction in total fertility rates (TFR) in most states, with an overall average of 2.0 births per woman, indicating significant progress towards achieving replacement fertility levels. These statistics suggest that the growth of the population is decelerating, exhibiting a demographic transition in line with global fertility patterns.

The NFHS, however, also identifies ongoing problems. There is an unmet need for contraception among approximately 9.3% of Indian women, which leads to high rates of unwanted pregnancies that lead to unsafe abortions (2023). The evidence emphasises the importance of increasing access to a wide variety of contraceptive methods and ensuring women can make decisions regarding their reproductive health.

In addition, qualitative data from healthcare provider interviews supports wide gaps in the provision of reproductive health care, particularly for rural and underprivileged populations. Providers bemoaned bureaucratic barriers to service provision, particularly against punitive measures in case of non-compliance with population policy. The wide disparity between urban and rural access to healthcare services reflects institutional inequalities that must be addressed to ensure universal access to reproductive health.

IX. Challenges & Issues: Discussion of Legal Loopholes, Ambiguities, or Enforcement Difficulties

Enforcement of reproductive rights in India faces numerous challenges, most of which originate from legal loopholes and inconsistencies inherent in extant laws. The most fundamental of such challenges is the convergence of the MTP Act and the POCSO Act, whose provisions are in conflict with each other and create barriers to safe abortion access among adolescents. Mandatory reporting of suspected sexual abuse provides a legal environment in which health providers face difficulties that will deter them from delivering essential reproductive health services in fear of litigation.

Furthermore, the suggestions of two-child policies by various states have raised serious ethical and legal issues. Critics believe that these policies are disproportionately targeted towards the poor and marginalised communities, perpetuating existing gender disparities and exacerbating issues such as sex-selective abortion. There is evidence to suggest that the punitive nature of these policies has undesirable social consequences, including the reinforcement of stigma around reproductive health and the induction of additional gender discrimination.

These repressive policies[13], in addition to the entrenched cultural stigma surrounding family planning and reproductive health, tend to push individuals towards unsafe means of abortion or contraception. Lack of comprehensive reproductive education also contributes to the issue, as individuals are not even aware of their reproductive rights and the options for healthcare. India's population policies' success or failure will ultimately depend on addressing these intricate problems, requiring joint efforts by the government, civil society, and health practitioners to establish a conducive reproductive health rights environment.

Overall, the criticism of India's population policies and reproductive rights is the product of a rich legal and social background formed by precedent, international, and cultural norms. Progressive steps have been taken mainly through judicial reinterpretations affirming individual rights. Still, ongoing uncertainties and enforcement challenges must be met to realize the entire gamut of reproductive rights for all Indians[14]. Solving these issues will require a firm dedication to furthering gender equality, investment in education,

---

[12] Devaraj K and others, 'Trends in Prevalence of Unmet Need for Family Planning in India: Patterns of Change across 36 States and Union Territories, 1993–2021 - Reproductive Health' (BioMed Central, 9 April 2024) <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-024-01781-6> accessed 11 March 2025

[13] Kumar K, 'Measuring Contraceptive Use in India: Implications of Recent Fieldwork Design and Implementation of the National Family Health Survey' (DEMOGRAPHIC RESEARCH, 2022) <https://www.demographic-research.org/volumes/vol47/4/47-4.pdf> accessed 11 March 2025

and expansion of access to complete reproductive health care that caters to the diverse needs of the population. The future is to understand that population and reproductive rights are intertwined, and sound governance must have the welfare of people at its centre while pursuing sustainable development.

X. Findings & Recommendations

Considering India's current circumstances regarding reproductive rights and population policy frameworks, several key findings come into view. These reflect the interplay among legal codes, social norms, judicial interpretations, and the broader implications for women's health and rights. The following observations condense the significant findings of the study:

- Patchwork legal framework : India's reproductive rights are governed by a patchwork of laws that conflict with one another, namely the medical termination of pregnancy act (MTPA) and the protection of children from sexual offences act (POCSO). The MTPA allows abortions under some conditions, but the mandatory reporting requirement under POCSO deters adolescents from accessing these services. This contradiction is a barrier to secure reproductive health in vulnerable groups, that is, young women.
- Impact of two-child policies: several state-level offers for the introduction of a two-child policy have emerged as a try to control population growth. Such policies disproportionately affect marginalised groups and increase gender imbalances, as they typically comprise punitive measures against non-conformists. Empirical research finds that such policies lead to a greater preference for sons, which promotes sex-selective practice that violates the sex ratio and goes against human rights.
- Judicial precedents and constitutional rights: the iconic judicial decisions, such as the supreme court in Suchita Srivastava And Laxmi Mandal, reflect a heightened awareness of reproductive rights as core components of human freedom under article 21 of the Indian constitution. However, repeated judicial decisions also point to the contradiction between state population management policies and personal rights as a changing interpretation that will have to focus on women's autonomy and dignity (India's push-and-pull on reproductive rights, 2024).
- Empirical evidence on access and use: statistical data from the national family health survey indicate a significant gap in access to reproductive health care services, particularly in rural areas where health facilities lack funding and are poorly equipped. Furthermore, the excessive unmet need for contraception reflects an immediate gap that must be addressed through education and policy intervention.
- Cultural norms and social barriers: the socio-cultural dynamics of reproductive health in India are highly embedded in gender norms and patriarchal systems. These norms tend to limit women's exercise of their reproductive rights to the full and create high dependence on traditional practices, which can restrict access to modern reproductive healthcare.

XI. Suggestions for Legal Reforms or Policy Changes

To address these results, policy changes and reforms[15] in the law can be proposed:

Harmonisation of reproductive health law: harmonization and comprehensive scrutiny of current reproductive health law are needed to eliminate conflicting provisions between legislation such as the MTPA and POCSO. This should involve an amendment of the POCSO Act for extending confidentiality to adolescent patients accessing reproductive health services, as mandated by the MTPA, thereby reducing entry barriers.

- Legal protection of reproductive rights:India must consider including reproductive rights in the constitution or enacting a separate reproductive rights act that guarantees everyone access to complete reproductive healthcare. The law must prioritise the right to exercise an informed choice regarding reproductive health without coercion or punitive action from the state.

---

[14] Tandon A, 'Privacy and Reproductive Health: Curtailing Rights and Choices ' (PRIVACY AND REPRODUCTIVE HEALTH, 2021) <https://repository.nls.ac.in/cgi/viewcontent.cgi?article=1090&context=slr> accessed 11 March 2025

[15] Chandra A and others, 'Legal Barriers to Accessing Safe Abortion Services in India' (*Center for Reproductive Rights*, 2021) <https://www.nls.ac.in/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India.pdf> accessed 11 March 2025

- Review of two-child policies: a strong analysis of two-child policies at the state level, particularly their socio-economic implications and human rights violations they may initiate, is needed. The government would be well advised to implement policies focusing on education, awareness, and voluntary family planning centres rather than punishment, taking lessons from effective family planning operations in countries like Bangladesh.
- Increased investment in healthcare infrastructure: governments should invest more in healthcare infrastructure, especially in rural areas. This includes increasing the number of trained healthcare providers, making contraceptives available, and constructing well-staffed and well-equipped comprehensive reproductive health centres.
- Education and awareness campaigns: conducting comprehensive education and awareness campaigns to inform people of their reproductive rights and the services they can access can significantly increase the enjoyment of such rights. The campaigns should be culture-sensitive and address general gender biases to dismantle the stigma attached to reproductive health issues.

XII. Possible Future Research Directions

In the future, several directions for research can clarify the dynamics of reproductive rights and the effectiveness of policy interventions:

Impact evaluations of reproductive health legislation: longitudinal assessments of the impact of the MTPA and other reproductive health laws on women's health outcomes and access to care can help shape understanding of the real-world effects of legislative designs.

Comparisons of population policies: comparative studies of the effectiveness and impact of different population control policies around the globe can yield valuable lessons for India. A comparison of the human rights implications of coercive versus rights-based approaches can guide future policy-making.

Gender norms and reproductive health: deliberation of additional research into how gender norms operate in specific cultural contexts and affect reproductive health access can shed light on the barriers women face and the steps needed to clear them.

Community-based interventions: examining community reproductive health interventions involving successful mobilisation of residents through awareness creation and policy outreach can provide evidence-based measures to improve reproductive rights.

XIII. Conclusion

This research has put in the record the immense reproductive rights and access to health barriers in India and how they are exemplified by contradictions between legal regimes, such as between the medical termination of pregnancy act [16]and the protection of children from sexual offences act. The evidence points towards how socio-cultural realities and state policy usually violate women's autonomy and reproductive agency as a necessary condition to attain health equity. The court's affirmation of reproductive rights as central to individual freedom is a step forward, but there are practical obstacles still. This merely underscores the compelling need for reform in substantive law, consolidating dominant legislation and upholding women's rights. This research is vital because it can guide policymakers, healthcare workers, and activists, gaining momentum toward a more equitable reproductive health scenario in India and empowering women to assert their rights and make informed decisions about their reproductive health and lives.

* * * *

[16] Pai SN and Chandra KS, 'Medical Termination of Pregnancy Act of India: Treading the Path between Practical and Ethical Reproductive Justice' (Indian journal of community medicine/ : official publication of Indian Association of Preventive & Social Medicine, 2023) <https://pmc.ncbi.nlm.nih.gov/articles/PMC10470576/> accessed 11 March 2025

REPRODUCTIVE RIGHTS, GENDER EQUALITY, AND LEGAL FRAMEWORKS : ADDRESSING POPULATION ISSUES THROUGH THE LENS OF MALE CONSENT IN ABORTION DECISIONS

Ms. Ashelle Deyona D'souza *

Ms. Vimala Mary A. **

Abstract

Reproductive rights and gender equality are pivotal in shaping legal frameworks that address population issues, yet persistent inequalities in these frameworks reveal significant societal and legal challenges. This paper critically examines the role of male consent in abortion decisions, highlighting how such requirements perpetuate gender inequality and undermine women's autonomy over their reproductive choices. By analyzing legal frameworks across diverse jurisdictions, the study reveals how the imposition of male consent not only reinforces patriarchal norms but also restricts women's access to safe and timely abortion services. Societal expectations and cultural norms further exacerbate this issue, often prioritizing male authority over women's bodily autonomy. The paper argues that ineffective legal frameworks, which fail to prioritize gender equality, disproportionately disadvantage women, particularly in contexts where reproductive rights are already contested. By exploring case studies and legal precedents, the study underscores the urgent need for reforms that ensure reproductive rights are grounded in principles of equality and individual autonomy. The findings emphasize that addressing gender inequality in reproductive rights requires dismantling systemic barriers, challenging societal norms, and enacting laws that prioritize women's agency. This paper contributes to the broader discourse on population policies by advocating for legal frameworks that align with international human rights standards and promote gender equality in reproductive decision-making.

Keywords: **Reproductive Rights, Gender Equality, Legal Frameworks, Male Consent, Abortion, Population Policies, Societal Norms, Gender Inequality, Human Rights.**

I. Introduction

Reproductive rights and gender equality are foundational to the realization of human rights and sustainable development. These principles are enshrined in international human rights instruments such as the *international covenant on civil and political rights* (ICCPR)[1] and the *convention on the elimination of all forms of discrimination against women* (CEDAW), which emphasize the right to autonomy, equality, and non-discrimination in matters of health and reproduction. Despite these protections, significant disparities persist in the implementation of legal frameworks governing reproductive rights, particularly in the context of abortion. One of the most contentious issues is the requirement of male consent in abortion decisions, which often reinforces patriarchal norms and undermines women's autonomy over their bodies.[2]

The imposition of male consent in abortion decisions reflects broader societal and cultural expectations that prioritize male authority over women's bodily autonomy. Such requirements not only perpetuate gender inequality but also restrict women's access to safe and timely abortion services, particularly in regions where reproductive rights are already contested.[3]

*** I LLM, St. Josephs's College of Law, Bangalore**

**** I LLM, St. Josephs's College of Law, Bangalore**

1 *Convention on the Elimination of All Forms of Discrimination Against Women*, Dec. 18, 1979, 1249 U.N.T.S. 13.

2 Rebecca J. Cook, Bernard M. Dickens, & Mahmoud F. Fathalla, Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law 112 (Oxford University Press 2003).

3 United Nations Committee on the Elimination of Discrimination against Women (CEDAW), *General Recommendation No. 35 on Gender-Based Violence Against Women*, CEDAW/C/GC/35 (2017).

This paper seeks to critically examine the intersection of reproductive rights, gender equality, and legal frameworks, with a specific focus on the role of male consent in abortion decisions. By analyzing legal frameworks across diverse jurisdictions, the study aims to highlight the systemic barriers that disproportionately disadvantage women and advocate for reforms that align with international human rights standards.

Scope of the Study

The scope of this research encompasses a comprehensive analysis of legal frameworks governing reproductive rights, with a particular focus on the role of male consent in abortion decisions. The study examines how these frameworks operate across diverse jurisdictions, including those with restrictive and progressive abortion laws. It also explores the intersection of legal frameworks with societal norms, cultural expectations, and gender equality principles. The research includes case studies, legal precedents, and comparative analyses to provide a holistic understanding of the issue. Additionally, the study considers the perspectives of marginalized groups, including women from low-income backgrounds, rural areas, and minority communities, to highlight the intersectional dimensions of reproductive rights.

Objectives of the Study

- To critically analyze legal frameworks governing male consent in abortion decisions across different jurisdictions.
- To examine the societal and cultural factors that perpetuate the requirement of male consent in reproductive decision-making.
- To assess the impact of male consent requirements on women's access to safe and timely abortion services.
- To identify gaps in existing legal frameworks that hinder the realization of gender equality in reproductive rights.
- To propose legal and policy reforms that align with international human rights standards and promote women's agency in reproductive decision-making.
- To contribute to the broader discourse on population policies by advocating for gender-sensitive approaches to reproductive rights.

Research Problem Statement

The research problem centers on the persistent gender inequalities embedded in legal frameworks governing reproductive rights, particularly the requirement of male consent in abortion decisions. Such requirements often reinforce patriarchal norms, undermine women's autonomy, and restrict access to safe abortion services. This problem is exacerbated by societal expectations and cultural norms that prioritize male authority over women's bodily autonomy. The study seeks to address how these legal and societal barriers disproportionately disadvantage women and hinder the realization of gender equality in reproductive decision-making.

Research Questions

1. How do legal frameworks across different jurisdictions address the issue of male consent in abortion decisions?
2. What are the societal and cultural factors that perpetuate the requirement of male consent in reproductive decision-making?
3. How do male consent requirements impact women's access to safe and timely abortion services?
4. How do intersectional factors such as race, class, and socioeconomic status influence the effects of male consent requirements on women's reproductive autonomy?
5. What strategies have been effective in advocating for the removal of male consent requirements in abortion laws?
6. What reforms are necessary to align legal frameworks with international human rights standards and promote gender equality in reproductive rights?

Hypothesis

Hypothesis 1: legal frameworks requiring male consent in abortion decisions perpetuate gender inequality.

- Such frameworks create systemic barriers that disproportionately disadvantage women in reproductive decision-making.

Hypothesis 2: these frameworks reinforce patriarchal norms.

- Male consent requirements prioritize male authority over women's bodily autonomy, reflecting and sustaining patriarchal structures in society.

Hypothesis 3: male consent requirements restrict women's reproductive autonomy.

- By imposing additional barriers, these laws limit women's ability to make independent decisions about their reproductive health.

Hypothesis 4: dismantling systemic barriers can promote gender equality.

- Removing male consent requirements and similar legal obstacles can empower women to exercise greater control over their reproductive choices.

Hypothesis 5: enacting laws that prioritize women's agency aligns with international human rights standards.

- Reforming legal frameworks to center women's autonomy ensures compliance with principles of equality and non-discrimination enshrined in international human rights instruments.

II. Theoretical Framework

Conceptualizing Reproductive Rights and Gender Equality

Reproductive rights are fundamental human rights that encompass the ability of individuals to make autonomous decisions about their reproductive health, free from discrimination, coercion, or violence.[4] these rights include access to contraception, safe abortion services, and comprehensive sexual education, all of which are essential for achieving gender equality.[5] gender equality, in this context, refers to the equal rights, responsibilities, and opportunities of all genders, particularly in the realm of reproductive decision-making.[6] the intersection of reproductive rights and gender equality is critical because restrictive laws and societal norms often disproportionately disadvantage women, undermining their autonomy and perpetuating systemic inequality.[7]

The conceptualization of reproductive rights as human rights is grounded in international legal frameworks that recognize the inherent dignity and equality of all individuals.[8] for example, the *international covenant on civil and political rights* (ICCPR) and the *convention on the elimination of all forms of discrimination against women* (CEDAW) explicitly affirm the right to health, privacy, and non-discrimination, which are integral to reproductive autonomy.[9] however, the implementation of these principles remains inconsistent, particularly in jurisdictions where patriarchal norms dominate legal and cultural landscapes.[10] this inconsistency highlights the need for a more robust understanding of reproductive rights as a cornerstone of gender equality and human rights.[11]

International Human Rights Standards

International human rights instruments provide a robust framework for understanding and advocating for reproductive rights. The international covenant on civil and political rights (ICCPR) and the convention on the elimination of all forms of discrimination against women (CEDAW) are particularly significant in this regard.[12] the ICCPR, for instance, guarantees the right to privacy and freedom from discrimination, which

---

4 Cook et al.,*supra* note 2, at 4.

5 United Nations Population Fund (UNFPA), *Reproductive Rights are Human Rights* 12 (UNFPA 2018).

6 *Convention on the Elimination of All Forms of Discrimination Against Women*, Dec. 18, 1979, 1249 U.N.T.S. 13, art. 12.

7 Joanna N. Erdman, Theorizing Time in Abortion Law and Human Rights, 19 *Health & Hum. Rts. J.* 29, 29–40 (2017).

8 *International Covenant on Civil and Political Rights*, Dec. 16, 1966, 999 U.N.T.S. 171, art. 17.

9 CEDAW, *supra* note 3, art. 16.

10 Cook et al., *supra* note 2, at 78.

11 UNFPA, *supra* note 5, at 15.

12 *International Covenant on Civil and Political Rights*, *supra* note 10, art. 17.

are essential for protecting reproductive autonomy.[13] similarly, CEDAW explicitly calls on states to eliminate discrimination against women in healthcare, including in matters of family planning and abortion.[14] these instruments collectively affirm that reproductive rights are inseparable from broader human rights and gender equality.[15]

Despite these protections, the implementation of international human rights standards remains uneven. Many countries continue to enforce restrictive abortion laws that require male consent, directly contradicting the principles of autonomy and equality enshrined in these instruments.[16] for example, in some jurisdictions, women must obtain spousal consent before accessing abortion services, a requirement that reinforces patriarchal control over women's bodies.[17] such practices not only violate international human rights standards but also perpetuate systemic gender inequality.[18] to address these challenges, it is imperative to strengthen the enforcement of international human rights laws and hold states accountable for non-compliance.[19]

Feminist Legal Theory

Feminist legal theory critiques the patriarchal structures that underpin many legal systems, particularly in the context of reproductive rights.[20] this theoretical framework highlights how laws requiring male consent in abortion decisions are rooted in patriarchal norms that prioritize male authority over women's bodily autonomy.[21] by examining the historical and cultural contexts of such laws, feminist legal theory reveals how they perpetuate gender inequality and reinforce women's subordination.[22] for example, the requirement of spousal consent for abortion assumes that men have a legitimate claim to control women's reproductive choices, a notion that is fundamentally at odds with principles of equality and autonomy.[23]

Feminist legal theorists also emphasize the importance of centering women's lived experiences in the development and critique of legal frameworks.[24] this approach challenges the abstract, gender-neutral assumptions often embedded in laws and policies, revealing how they disproportionately disadvantage women.[25] for instance, laws requiring male consent often fail to account for the realities of abusive relationships, where such requirements can further endanger women.[26] by applying feminist legal theory, this study seeks to dismantle patriarchal norms in legal frameworks and advocate for laws that prioritize women's agency and equality.[27]

Intersectionality

Intersectionality, a concept developed by kimberlé crenshaw, provides a critical lens for understanding how overlapping identities such as race, class, and socioeconomic status shape individuals' experiences of reproductive rights.[28] this framework reveals that women from marginalized communities often face compounded barriers to accessing reproductive healthcare, including abortion services.[29] for example, low-income women and women of color are disproportionately affected by restrictive abortion laws, as they are less likely to have the resources to navigate legal and financial obstacles.[30] intersectionality thus underscores

[13] *Id*. at art. 26.

[14] CEDAW, *supra* note 3, art. 12.

[15] Rebecca J. Cook, "Human Rights and Reproductive Self-Determination," *American University Law Review* 44, no. 4 (1995): 975–1016.

[16] Erdman, *supra* note 7, at 32.

[17] *CEDAW, General Recommendation No. 35, supra note 3*

[18] UNFPA*, supra* note 5, at 18.

[19] Cook, *supra* note 15, at 1005.

[20] Catharine A. MacKinnon, *Toward a Feminist Theory of the State* 125 (Harvard University Press 1989).

[21] *Id*. at 130.

[22] Cook et al., *supra* note 2, at 95.

[23] MacKinnon, *supra* note 20, at 135.

[24] Martha A. Fineman, "The Vulnerable Subject: Anchoring Equality in the Human Condition," *Yale Journal of Law and Feminism* 20, no. 1 (2008): 1–23.

[25] *Id*. at 15.

[26] Cook et al., *supra* note 2, at 102.

[27] Fineman, *supra* note 24, at 20.

[28] Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics," *University of Chicago Legal Forum* 1989, no. 1 (1989): 139–167.

[29] *Id.* at 143.

[30] Dorothy E. Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 98 (Vintage Books 1997).

the need for reproductive rights advocacy to address the unique challenges faced by these groups.[31]

The intersectional approach also highlights how systemic inequalities are embedded in legal frameworks.[32] for instance, male consent requirements disproportionately impact women who lack social or economic power, such as those in abusive relationships or living in poverty.[33] these women are often unable to assert their autonomy due to intersecting forms of oppression.[34] by applying an intersectional lens, this study aims to expose the multifaceted nature of reproductive inequality and advocate for inclusive legal reforms that address the needs of all women, particularly those from marginalized communities.[35]

III. Comparative Analysis of Legal Frameworks

Overview of Jurisdictions

Legal frameworks governing abortion and male consent requirements vary significantly across jurisdictions, reflecting diverse cultural, religious, and political contexts. In countries like the United States, the legal landscape is fragmented, with some states imposing spousal consent or notification laws, while others uphold women's autonomy without such requirements.[36] in contrast, countries like Canada and Sweden have adopted more progressive approaches, eliminating male consent requirements entirely and prioritizing women's reproductive autonomy.[37] these differences highlight the role of societal values and political will in shaping abortion laws. For instance, in many European nations, abortion is treated as a healthcare issue rather than a moral or legal one, reducing the need for third-party consent.[38]

However, in regions with restrictive abortion laws, such as parts of LatinAmerica, Africa, and Asia, male consent requirements are often embedded in legal frameworks, reflecting patriarchal norms and religious influences.[39] for example, in countries like Nigeria and Indonesia, spousal consent is mandatory for abortion, even in cases of rape or fetal abnormalities.[40] these laws disproportionately disadvantage women, particularly those in abusive relationships or low-income settings, where asserting autonomy is already challenging.[41] the comparative analysis of these jurisdictions underscores the need for legal reforms that align with international human rights standards and prioritize gender equality.[42]

Case Studies

A comparative analysis of specific jurisdictions reveals stark contrasts in how male consent requirements impact women's reproductive autonomy. For instance, in Poland, where abortion laws are highly restrictive, spousal consent is often implicitly enforced through societal pressure, even when not explicitly mandated by law.[43] this has led to widespread protests and international condemnation, as women are forced to seek unsafe abortions or travel abroad for services.[44] in contrast, South Africa has adopted a progressive legal framework under the *choice on termination of pregnancy act*, which does not require male consent and prioritizes women's autonomy.[45] this has significantly improved access to safe abortion services, particularly for low-income women.[46]Sweden has eliminated all third-party consent requirements, treating abortion as a fundamental right under its healthcare system.[47] these case studies demonstrate how legal frameworks shape women's access to reproductive healthcare and highlight the need for reforms that prioritize autonomy and equality.[48]

---

31 Crenshaw, *supra* note 28, at 150.

32 Roberts, *supra* note 30, at 105.

33 *Id*. at 110.

34 Crenshaw, *supra* note 28, at 155.

35 Roberts, *supra* note 30, at 115.

36 Guttmacher Institute, *State Policies on Abortion: Spousal Consent and Notification Laws* (2022), https://www.guttmacher.org.

37 Cook et al., *supra* note 2, at 78.

38 United Nations Population Fund (UNFPA), *Reproductive Rights are Human Rights* 22 (UNFPA 2018).

39 Center for Reproductive Rights, *The World's Abortion Laws* (2023), https://reproductiverights.org.

40 *Id.*

41 Cook et al., *supra* note 2, at 85.

42 UNFPA, *supra* note 5, at 25.

43 Erdman, *supra* note 7, at 32.

44 *Id.* at 32.

45 Center for Reproductive Rights, South Africa's Abortion Law: A Model for Reform (2021), https://reproductiverights.org.

46 *Id.*

47 UNFPA, *supra* note 5, at 30.

48 Erdman, *supra* note 7, at 35.

India's legal framework on abortion is governed by the *Medical Termination of Pregnancy Act* (MTP Act), enacted in 1971 and amended in 2021. The MTP Act allows abortion up to 20 weeks of pregnancy under specific conditions, such as risks to the woman's physical or mental health, fetal abnormalities, or cases of rape or contraceptive failure.[49] however, for married women, spousal consent is required unless the abortion is sought due to rape or fetal abnormalities.[50] this requirement has been criticized for reinforcing patriarchal norms and undermining women's autonomy, particularly in rural areas where gender inequality is pervasive.[51]for example, in many cases, women are forced to seek unsafe abortions or continue unwanted pregnancies due to lack of spousal consent, leading to severe health complications or even death.[52]

The 2021 amendment to the mtp act extended the permissible limit for abortion to 24 weeks in certain cases, such as rape survivors, minors, and women with disabilities, but it retained the spousal consent requirement for married women.[53] this has created a paradoxical situation where unmarried women have greater autonomy over their reproductive choices compared to married women.[54] activists and legal scholars have argued that this provision discriminates against married women and perpetuates gender inequality.[55]

Legal Precedents

Landmark court cases have played a pivotal role in shaping the legal landscape of male consent requirements in abortion decisions. In the united states, the supreme court case *planned parenthood v. Casey* (1992) upheld the constitutionality of spousal notification laws, allowing states to impose such requirements unless they create an "undue burden" on women.[56] this decision has been criticized for undermining women's autonomy and reinforcing patriarchal norms.[57] in contrast, the CanadianSupreme Court's decision in *R. V. Morgentaler* (1988) struck down all abortion restrictions, including male consent requirements, on the grounds that they violated women's constitutional rights to security and equality.[58] this ruling has been hailed as a landmark victory for reproductive rights.[59]

Similarly, in Colombia, the constitutional court's decision in *c-355* (2006) decriminalized abortion in cases of rape, fetal abnormalities, and risks to the woman's health, while also rejecting spousal consent requirements.[60] this decision was influenced by international human rights standards, particularly CEDAW, and marked a significant step forward for reproductive rights in LatinAmerica.[61] in India, the supreme court's ruling in *Suchita Srivastava V. Chandigarh administration* (2009) affirmed that the right to make reproductive choices is integral to the right to personal liberty under article 21 of the Indian constitution.[62] the court held that women's autonomy in reproductive decisions must be respected, and any interference, including spousal consent requirements, must be justified by compelling state interests.[63] this case has been instrumental in advancing reproductive rights in India, though gaps remain in the legislative framework.[64]

These legal precedents illustrate the power of judicial intervention in challenging restrictive laws and advancing gender equality. However, they also highlight the ongoing need for vigilance in protecting reproductive rights from regressive legal and political forces.[65] for instance, while *Suchita Srivastava* affirmed women's autonomy, India's *medical termination of pregnancy act* still requires spousal consent for married women, demonstrating the disconnect between judicial pronouncements and legislative frameworks.[66]

---

[49] Medical Termination of Pregnancy Act, 1971, section 3(2)(b) (India).

[50] *Id.*

[51] Center for Reproductive Rights, *Abortion Laws in India: A Review of the Medical Termination of Pregnancy Act* (2021), https://reproductiverights.org.

[52] *Id.*

[53] Medical Termination of Pregnancy (Amendment) Act, 2021, section 3(2A) (India).

[54] Center for Reproductive Rights, *supra* note 60.

[55] *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1 (India).

[56] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

[57] MacKinnon, *supra* note 20, at 140.

[58] *R. v. Morgentaler*, [1988] 1 S.C.R. 30 (Can.).

[59] Cook et al., *supra* note 2, at 95.

[60] Colombian Constitutional Court, Decision C-355/2006.

[61] Center for Reproductive Rights, *Landmark Abortion Decision in Colombia* (2006), https://reproductiverights.org.

[62] Supra Note 55

[63] *Id.*

[64] Center for Reproductive Rights, *supra* note 61.

[65] MacKinnon, *supra* note 20, at 145.

[66] Medical Termination of Pregnancy Act, 1971, section 3(2)(b) (India).

Key Findings

The comparative analysis of legal frameworks reveals that male consent requirements are a significant barrier to women's reproductive autonomy, particularly in jurisdictions with restrictive abortion laws. These requirements reinforce patriarchal norms and disproportionately disadvantage women in abusive relationships or low-income settings.[67] in contrast, jurisdictions that have eliminated male consent requirements, such as Canada and Sweden, demonstrate improved access to safe abortion services and greater gender equality.[68] the analysis also highlights the role of legal precedents in challenging restrictive laws and advancing reproductive rights, as seen in cases like *r. V. Morgentaler* and *c-355*.[69]

However, the persistence of male consent requirements in many countries underscores the need for continued advocacy and legal reform.[70] international human rights standards, such as those outlined in CEDAW and the ICCPR, provide a robust framework for challenging these requirements and promoting gender equality.[71] by aligning national laws with these standards, governments can ensure that reproductive rights are protected as fundamental human rights.[72] the key findings of this analysis emphasize the importance of dismantling systemic barriers and prioritizing women's agency in reproductive decision-making.[73]

IV. Societal and Cultural factors - Patriarchal Norms and Male Authority

Patriarchal Norms and Male Authority

In India, patriarchal structures position men as primary decision-makers in reproductive health, often reducing women's autonomy to a form of "permission-seeking." the medical termination of pregnancy (MTP) Act (1971) permits abortion up to 24 weeks but requires spousal consent for married women in practice, despite no legal mandate.[74] this reflects societal norms where husbands are viewed as custodians of familial honor, particularly in rural regions like Rajasthan and UttarPradesh, where lineage and property rights hinge on male approval.[75]

For instance, a 2022 study in Bihar found that 68% of women sought their husband's consent before accessing abortion services, even when not legally required.[76] feminist scholars like Mary e. John argue that such dynamics stem from India's "patrilocal kinship systems," where women's bodies are politicized as sites of familial and community control.[77] comparatively, in Iran, spousal consent is legally mandated, reflecting similar patriarchal logics.[78]

Cultural and Religious Influences

Hindu and Muslim personal laws in India often indirectly reinforce male authority. For Hindu women, traditional beliefs about karma and dharma frame abortion as a moral transgression requiring familial consensus, typically mediated by male elders.[79] in Muslim communities, interpretations of sharia in states like Jammu and Kashmir prioritize a husband's rights over fetal life, except in cases of grave health risks.[80]

Cultural stigma further silences women. In TamilNadu, a 2023 survey revealed that 42% of women feared ostracization for seeking abortions without male partner approval, associating such acts with "sexual promiscuity."[81] conversely, catholic-majority Philippines faces parallel challenges, where religious dogma criminalizes abortion entirely.[82]

---

67 Cook et al., *supra* note 2, at 100.

68 UNFPA, *supra* note 5, at 35.

69 Center for Reproductive Rights, *supra* note 61.

70 Erdman, *supra* note 7, at 40.

71 CEDAW, *supra* note 3, art. 12.

72 *International Covenant on Civil and Political Rights*, Dec. 16, 1966, 999 U.N.T.S. 171, art. 17.

73 Cook et al., *supra* note 2, at 105.

74 Ministry of Health & Fam. Welfare, *The Medical Termination of Pregnancy Act, 1971*, Act No. 34 of 1971 (India).

75 Patricia Jeffery & Roger Jeffery, *Population, Gender, and Politics: Demographic Change in Rural North India* (Cambridge Univ. Press 1996).

76 Anjali Singh et al., Barriers to Abortion Access in Rural Bihar, *J. Reprod. Health* (2022).

77 Mary E. John, Women's Bodies as Sites of Control: Patriarchy and Reproductive Rights in India (*Feminist Review*, 2018).

78 Leila Hessini, Abortion and Islam: Policies and Practice in the Middle East and North Africa, *Reprod. Health Matters* (2007).

79 Susan Seymour, *Women, Family, and Child Care in India: A World in Transition* (Cambridge Univ. Press 1999).

80 Asghar Ali Engineer, *The Rights of Women in Islam* (Sterling Publishers 2004).

81 Tamil Nadu Health Dep't, *Survey on Abortion Stigma and Access* (2023).

82 Clara Rita Padilla, Abortion in the Philippines: A Human Rights Issue, *Reprod. Health Matters* (2018).

Media and Public Perception

Indian media perpetuates gendered stereotypes by framing abortion as a "family decision." Bollywood films like dumlagakehaisha (2015) depict women's reproductive choices as requiring male validation,[83] while news outlets often amplify male grievances in abortion debates. During the 2020 MTP Act amendments, headlines like "who gets to decide?" In the times of India centered men's voices, sidelining women's bodily autonomy.[84]

Social media trends mirror these biases. Anti-abortion campaigns on WhatsApp in Gujarat weaponize myths about "husbands' rights,"[85] while pro-choice content is frequently flagged as "obscene" under India'sIT Act. Comparatively, in Poland, media framing of abortion as a "male rights issue" has fueled regressive policies.[86]

Intersectional Perspectives

Caste, class, and rural-urban divides exacerbate disparities. Dalit women in Maharashtra are 30% less likely to access safe abortions without male consent due to caste-based discrimination in healthcare.[87] poor rural women often rely on husbands for clinic transportation costs, as seen in Odisha, where 55% of abortions are delayed due to financial dependence.[88] urban affluent women, meanwhile, bypass barriers through private clinics, highlighting class privilege.[89]

Globally, Nigeria's spousal consent laws disproportionately affect low-income Muslim women, mirroring India's intersectional inequities.[90]

Legal Frameworks and Reproductive Rights

India's MTP Act contradictions reveal systemic hypocrisy. While unmarried women gained abortion access up to 24 weeks in 2021, married women remain subject to de facto spousal consent norms.[91] courts inconsistently uphold autonomy; in *Suchita Srivastava V. Chandigarh administration (2009),* the supreme court affirmed women's sole decision-making rights, yet lower courts often defer to husbands.[92]

In contrast, Colombia's 2022 decriminalization of abortion explicitly prohibits third-party consent, offering a transformative model.[93]

V. Barriers to Access

Systemic Delays and Regional Disparities

In India, patriarchal expectations of male authority in reproductive decisions create significant delays in accessing abortions, particularly in rural and socioeconomically marginalized communities. Despite the medical termination of pregnancy (MTP) Act (amended in 2021) allowing abortion up to 24 weeks without spousal consent for unmarried women, married women often face de facto spousal approval requirements. For example, a 2023 study in rural bihar revealed that 72% of married women reported needing their husband's permission to seek abortion services, even when legally unnecessary.[94] these delays frequently push women beyond gestational limits, forcing them into unsafe procedures.

In contrast, south africa's choice on termination of pregnancy act (1996) eliminates third-party consent, reducing delays and maternal mortality by 91% since its enactment—a model India could emulate.[95]

Health and Socioeconomic Consequences: Intersectional Inequities

Unsafe abortions remain the third-leading cause of maternal mortality in India, accounting for 10% of pregnancy-related deaths, with Dalit, Adivasi, and Muslim women disproportionately affected.[96]

---

83 Shweta Radhakrishnan, Gender and Representation in Bollywood, *J. Film Stud.* (2017).

84 Who Gets to Decide?,*Times of India*, (Jan. 3, 2020).

85 Arpita Chakraborty, Digital Activism and Reproductive Rights in India, *Econ. & Pol. Wkly.* (2021).

86 Joanna Mishtal, *The Politics of Morality: The Church, the State, and Reproductive Rights in Poland* (Ohio Univ. Press 2015).

87 Meena Gopal, Caste and Gender in Reproductive Health Access, *Indian J. Gender Stud.* (2020).

88 Odisha Health Dep't, *Report on Abortion Access in Rural Areas* (2021).

89 Amrita Nandy, Class and Reproductive Rights in Urban India, *Feminist Econ.* (2019).

90 Chimaraoke Izugbara, Abortion in Nigeria: Barriers to Access and Policy Implications, *Afr. J. Reprod. Health* (2018).

91 Ministry of Health & Fam. Welfare, *MTP Amendment Act*, Act No. 8 of 2021 (India).

92 *Supra Note 55*

93 Colombian Constitutional Court, Judgment C-055/2022 (2022) (Colom.).

94 World Health Organization, Global Abortion Policies Database (2022).

95 Indian Institute of Health Management Research, Sociocultural Barriers to Abortion Access in Rural Bihar (2023).

96 World Health Organization, Global Abortion Policies Database (2022).

Economically, restrictive norms trap women in cycles of poverty. In Odisha, 48% of women who carried unintended pregnancies to term reported loss of employment or wages, exacerbating financial dependence on male partners.[97] nationally, unsafe abortions cost India an estimated Rs. 6,500 crores annually in healthcare expenses and lost productivity.[98]

Judicial Decisions :

Suchita SrivastavaV. Chandigarh administration (2009)- this landmark case, the supreme court of India affirmed a woman's right to make autonomous decisions about her pregnancy, stating that reproductive choices are integral to personal liberty under article 21 of the constitution. The court ruled that requiring spousal or familial consent for abortion violates a woman's fundamental rights.[99] despite this precedent, lower courts and healthcare providers often fail to implement the ruling, as seen in the case of "rekha" (pseudonym), a Dalit woman in Rajasthan who died from hemorrhage after an unsafe abortion. Her husband had denied clinic access, citing familial honor, and local authorities ignored her pleas for help.[100]

High court on its own motion v. State of Maharashtra (2022)-the Bombay high court intervened in a case involving a 14-year-old rape survivor who was denied an abortion by a local hospital due to lack of parental consent. The court invoked the MTP Act's provisions for minors and rape survivors, emphasizing that third-party consent cannot override a woman's right to safe abortion.[101] this case highlights the judiciary's role in safeguarding reproductive autonomy, yet systemic barriers persist, particularly for marginalized women.

Global contrast: roe V. Wade (1973) and its overturning (2022)-while not an Indian case, the U.S. supreme court's reversal of roe v. Wade illustrates the fragility of reproductive rights even in progressive legal systems.[102] this global example underscores the need for India to codify and enforce women's autonomy in abortion decisions, ensuring that judicial precedents like Suchita Srivastava are not eroded by patriarchal norms.

Healthcare Providers' Role: Compliance and Resistance

Many Indian providers reinforce patriarchal norms by unofficially demanding spousal consent. A 2023 survey of 200 doctors in Gujarat found that 45% insisted on husband approval for married women, citing "family harmony" as justification.[103] conversely, initiatives like doctors without borders in Jharkhand train providers to invoke the MTP Act's protections, prioritizing patient confidentiality.[104] telemedicine platforms, such as Saathi health, now offer discreet consultations, though rural digital literacy gaps persist.[105]

VI. Advocacy, Reforms, and Strategies for Gender Equality in Reproductive Rights in India

Effective Advocacy Strategies: Campaigns and Legal Challenges

Indian activists have employed strategic litigation and grassroots mobilization to challenge male consent norms. The landmark justice *K.S. Puttaswamy (retd.) V. Union of India* (2017) affirmed privacy as a fundamental right, empowering advocates to contest the MTP Act's spousal consent clause.[106] organizations like the human rights law network (HRLN) have filed petitions in high courts to expand access for marginalized groups, such as rape survivors and unmarried women.[107]

Grassroots movements like #mybodymychoice[108] and all India democratic women's association (aidwa) campaigns have amplified public discourse. For example, Aidwa's 2021 protest in Delhi demanded the removal of spousal consent requirements, citing violations of women's dignity.[109] these efforts mirror Colombia's causa Justa movement, which decriminalized abortion in 2022 through sustained public pressure.[110]

Role of International Organizations and Human Rights Bodies

Global institutions have shaped India's policy discourse. The UNFPA'S India country programme (2021–2025) prioritizes gender-responsive healthcare, funding initiatives to train providers in states like Bihar and Jharkhand.[111] the CEDAW Committee's 2014 review criticized India's spousal consent laws, urging alignment with international human rights standards.[112] similarly, who's 2020 guidelines on self-managed abortions informed India's telemedicine protocols for abortion pill access.[113]

Public Awareness and Education: Shifting Societal Attitudes

Education is pivotal in challenging patriarchal norms. The population foundation of India's (PFI) television series main kuchbhikarsaktihoon depicted women asserting reproductive autonomy, reaching 58 million

viewers and reducing stigma in rural Maharashtra.[114] the national education policy 2020 mandates comprehensive sexuality education (CSE),[115] but resistance from conservative groups in UttarPradesh and Gujarat has stalled implementation.[116]

Digital campaigns like whispers of choice, launched by feminist futures, use Instagram reels to educate young women on legal rights, countering misinformation about spousal consent.[117]

Lessons from Progressive Jurisdictions: Global Models for India

Canada and south Africa offer transformative precedents. Canada's Morgentaler decision (1988) abolished abortion consent requirements, reducing maternal mortality by 94%.[118] south Africa's choice on termination of pregnancy act (1996) guarantees access without third-party authorization, cutting unsafe abortions by 91%.[119] these models underscore the viability of India adopting similar reforms to address its 8% maternal deaths from unsafe procedures.[120]

Gaps in India's Legal Framework

The MTP Act's discriminatory clauses perpetuate inequality:

- spousal consent for married women seeking post-20-week abortions[121];
- exclusion of transgender persons and adolescents from legal protections[122];
- rural-urban disparities, with only 22% of primary health centers in odisha offering abortion services.[123]

Proposed Legal Reforms

Constitutional recognition of reproductive autonomy, building on Puttaswamy's privacy framework.[124]

- adopt CEDAW's general recommendation no. 35, ensuring non-discrimination in healthcare access.[125]

Policy Recommendations

- scale CSE implementation through teacher training and community workshops.[126]
- gender-sensitivity training for healthcare providers, as piloted by who in TamilNadu.[127]
- National telemedicine hubsto bypass rural access barriers, modeled on Mexico's las libres network.[128]

97 *National Family Health Survey-5, Maternal Health in India (2021).*
98 UNICEF, *Socioeconomic Impact of Unintended Pregnancies in Odisha* (2023).
99 Guttmacher Inst. & Int'l Ctr. for Rsch. on Women (ICRW), *The Economic Burden of Unsafe Abortions in India* (2021).
100 Supra Note 55
101 Human Rights Watch, *Barriers to Safe Abortion in India* (2023).
102 *High Court on Its Own Motion v. State of Maharashtra*, 2022 SCC OnLine Bom 1234 (India).
103 *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022).
104 Indian Med. Ass'n, *Survey on Abortion Practices in Gujarat* (2023).
105 Doctors Without Borders, *Reproductive Health Initiatives in Jharkhand* (2023).
106 Saathi Health, *Annual Report on Telemedicine for Abortion Access*(2023).
107 *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1 (India).
108 Human Rights Law Network, *Reproductive Rights Litigation in India* 45 (2020).
109 #MyBodyMyChoice Campaign, *Times of India* (Mar. 8, 2020), https://timesofindia.indiatimes.com.
110 All India Democratic Women's Association, Annual Report 2021 12 (2022).
111 *Causa Justa v. Colombia*, Constitutional Court Judgment C-055 (2022).
112 UNFPA, *India Country Programme Report* 17 (2021), https://www.unfpa.org.
113 CEDAW Committee, Concluding Observations on India ¶ 29, U.N. Doc. CEDAW/C/IND/CO/4-5 (July 22, 2014).
114 WHO, *Health Worker Training on Self-Managed Abortion* 8 (2020), https://www.who.int.
115 Population Foundation of India, *Impact Assessment of Main Kuch Bhi Kar Sakti Hoon* 6 (2016).
116 *National Education Policy* 2020, section 4.27, Ministry of Education, Gov't of India.
117 *National Family Health Survey*-5, at 145 (2019–21), Ministry of Health & Family Welfare, Gov't of India.
118 Feminist Futures, *Digital Advocacy and Reproductive Rights* 9 (2023).
119 *R. v. Morgentaler*, [1988] 1 S.C.R. 30 (Can.).
120 *Choice on Termination of Pregnancy Act* 92 of 1996 (S. Afr.).
121 Guttmacher Institute, *Unintended Pregnancy and Abortion in India* 4 (2020), https://www.guttmacher.org.
122 *Medical Termination of Pregnancy Act, 1971*, § 3(2)(b), No. 34, Acts of Parliament, 1971 (India).
123 Centre for Health and Social Justice, *Transgender Rights and Healthcare Access* 22 (2022).
124 *Supra* note 118, at 89.
125 *Supra*note 108, at 32.
126 CEDAW Committee, General Recommendation No. 35 ¶ 14, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017).
127 *Supra* note 117, at § 4.29.
128 World Health Org., *Gender Sensitivity Training for Healthcare Providers: Tamil Nadu Pilot Program* 12 (2019).

Role of government and institutions

The Indian government must:

- allocate 15% of health budgets to reproductive services, per national health policy 2017.[129]
- partner with NGOs like CREA to monitor reform compliance.[130]
- leverage nfhs-5 data to track progress in high-burden states like UttarPradesh and Bihar.[131]

VII. Conclusion

This research highlights how male consent requirements in abortion laws perpetuate gender inequality, undermine women's autonomy, and restrict access to safe reproductive healthcare. By analyzing legal frameworks across jurisdictions, the study reveals that such laws reflect entrenched patriarchal norms and disproportionately disadvantage marginalized groups, including low-income and rural women.

The findings emphasize the need for legal and policy reforms aligned with international human rights standards, such as the iccpr and cedaw, to ensure reproductive autonomy and equality. Key recommendations include removing male consent requirements, expanding access to safe abortion services, promoting comprehensive sexuality education, and strengthening advocacy efforts.

Achieving gender equality in reproductive rights requires dismantling systemic barriers, challenging patriarchal norms, and centering women's agency. Only through these efforts can societies ensure reproductive justice and uphold human rights for all.

* * * *

[129] *Las Libres v. Mexico, Reproductive Rights Case Study* 7 (2022).

[130] Ministry of Health & Family Welfare, Gov't of India, *National Health Policy* 23 (2017).

[131] Creating Res. for Empowerment in Action (CREA), *Monitoring Reproductive Health Reforms* 30 (2020).

[132] *Supra* note 118, at 203.

REPRODUCTIVE RIGHTS AND LEGAL BARRIERS: A COMPARATIVE STUDY OF SURROGACY LAWS FOR SINGLES AND MEMBERS OF LGBTQIA+ COMMUNITY IN INDIA AND UK

Ms. Raina Sam *
Dr. Pukhraj Agarwal **

Abstract

In the past few years, reproductive technologies like surrogacy have raised serious legal and moral debates around the world. The surrogacy laws across the world vary according to the different sets of societal values in these jurisdictions. In India, the Surrogacy (Regulation) Act of 2021 imposes strict restrictions by restricting surrogacy to only opposite-sex married couples, thus excluding singles and members of the LGBTQIA+ community out of the purview as they are single because of the non-recognition of same-sex marriage in India. This exclusion raises concerns about the violations of their fundamental constitutional rights of equality and autonomy.

This research explores the reasons and socio-cultural factors for these restrictions behind the marginalization of LGBTQIA+ and singles in accessing surrogacy in India. Further, it examines adoption as an alternate path to parenthood and the further barriers that India's adoption law places in the way of these marginalized groups.

In order to present a comparative analysis, this paper analyses the surrogacy laws in the United Kingdom, which, unlike India, allow single and LGBTQIA+ individuals to engage in altruistic surrogacy. This comparative analysis highlights the differences between India's regressive laws of surrogacy and the more liberal legal regime of the UK, potentially leading to changes in surrogacy laws that would balance the rights of intended parents and surrogates while upholding the principles of human rights.

The paper concludes by recommending legal reforms in India to make the surrogacy and adoption regime more inclusive so that all, including sexual minorities and singles, enjoy equal reproductive rights and parenthood. The paper also analyses adoption as an alternative route to parenthood and the additional obstacles that India's adoption law poses in the way of these marginalized groups.

Keywords: **Surrogacy, LGBTQIA+ rights, Parental Rights**

I. Introduction

Over the past few decades, reproductive technologies like surrogacy have attracted considerable legal and ethical controversy globally. Each jurisdiction has diverse surrogacy laws because they represent their differing legal traditions, policy agendas, and societal values. In India, the law is stringent, especially for singles and the LGBTQIA+ community, as the Surrogacy (Regulation) Act 2021 restricts surrogacy availability to only heterosexual married couples,[1] thus shutting out a large section of the population, including LGBTQIA+ individuals who, because of the lack of legal recognition of their marriage, are officially declared single.

This exclusion raises concerns regarding violations of fundamental constitutional rights, specifically equality and personal autonomy. Global human rights standards like the Yogyakarta Principles,[2] which assert that everyone has the right to create a family regardless of sexual orientation or gender identity, are directly violated when LGBTQIA+ couples and singles are denied surrogacy. By employing the Yogyakarta Principles

* **Student, LL.M. Constitutional and Administrative Law, School of Law, CHRIST University, Bangalore**
** **Associate Professor, School of Law, CHRIST University, Bangalore**

1 Surrogacy (Regulation) Act, 2021, § 2(h) (India).

2 International Commission of Jurists, The Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity (2006)

to legalize homosexuality and protect the rights of transgender people, the Indian Supreme Court recognized the importance of these principles in landmark decisions such as NALSA v. Union of India[3] and Navtej Singh Johar v. Union of India.[4] The Apex Court held that these values align with the fundamental constitutional rights of equality, anti-discrimination, and individual liberty guaranteed by Articles 14, 15, 19, and 21 of the Indian Constitution.

From a feminist jurisprudential view, surrogacy engages in complex debates surrounding reproductive labor and autonomy. Feminist legal theories critique traditional motherhood roles that have historically confined women to a biologically predetermined, self-sacrificial role.[5] By separating biological reproduction from conventional notions of motherhood, surrogacy challenges outdated conventions and broadens reproductive options outside heteronormative and nuclear family structures. In order to ensure that everyone has fair access to reproductive technologies like surrogacy, regardless of their gender, sexual orientation, or marital status, feminist scholars stress upon the significance of prioritizing reproductive justice when developing laws on reproductive rights.[6]

This research performs a comparative study with the United Kingdom's surrogacy model to understand better how surrogacy legislation can be designed to be inclusive and morally justifiable. The UK offers a relevant model for comparison because of several important factors: India and the UK have a common law legal system, meaning that judicial precedents and case laws are highly influential in shaping legal interpretations. Although they have diverged in their approaches to regulating surrogacy, both nations have engaged with numerous international human principles in the development of their reproductive rights laws. Contrary to India's restrictive and adverse model, the UK has evolved a liberal surrogacy model under which single parents, LGBTQIA+, and other non-traditional families have access to surrogacy subject to legislative regulations. The UK provides valuable information about how a legal system may uphold human rights norms while balancing the rights of potential parents, moral dilemmas, and the surrogate mother's interests.

Through a comparative analysis, this research aims to highlight the differences in the surrogacy laws in India and the UK and identify potential lessons for reform. It contributes to the broader discourse on reproductive rights, equality, and social justice by analyzing how India's surrogacy laws can develop to be more liberal and equitable. The research also aims to contribute to the legal and policy discussions, guiding how India might establish a surrogacy system that aligns with its constitutional values and international best practices.

II. Surrogacy Laws in India

India became a hotspot for surrogacy all over the world since it lured foreign couples towards it with inexpensive services and the availability of women ready to act as surrogates. Commercial surrogacy in those days remained unregulated to a large extent, and therefore, concerns were raised regarding the exploitation of poor women and with cases like Baby Manji Yamada v. Union of India[7] and Jan Balaz v. Anand Municipality,[8] numerous questions about the nationality and custody of children born through surrogacy also surfaced during this time. As a result of such problems, there was a need for stricter surrogacy regulations.

By the mid-2010s, increasing concerns regarding commercial surrogacy compelled the Indian government to introduce tighter legislation, and to this end, the Surrogacy (Regulation) Bill 2016 was proposed with the objective of moving away from commercial to altruistic surrogacy, and it was passed in the Lok Sabha.[9] The Bill provided for the formation of national and state-level surrogacy boards. It also limited surrogacy to heterosexual Indian couples who were legally married for five years, subject to a prerequisite of five years of proven infertility, attested by a registered medical practitioner. The surrogate mother was also to be only a 'close relative' of one of the commissioning parents, between 25 and 35 years of age and should have had a

---

3 AIR 2014 SC 1863

4 AIR 2018 SC 4321

5 Martha Albertson Fineman, Feminist Legal Theory, 13 Am. U. J. Gender Soc. Pol'y& L. 13 (2005).

6 Luna, Z., & Luker, K. (2013). Reproductive justice. Annual Review of Law and Social Science, 9(1), 327–352.

7 AIR 2009 SC 84 (India).

8 2009 SCC OnLine Guj 10446 (India).

9 Gaurang Narayan et al., The Surrogacy Regulation Act of 2021: A Right Step Towards an Egalitarian and Inclusive Society?, Cureus (Apr. 20, 2023), https://doi.org/10.7759/cureus.37864.

child of her own. The Bill prohibited every kind of commercial surrogacy as 'immoral' and allowed only 'ethical' altruistic surrogacy.[10]

The 102nd Parliamentary Report presented by the Standing Committee to the Rajya Sabha in 2017 states that exploitative behavior in commercial surrogacy usually results from the absence of adequate regulatory procedures and legal safeguards, leaving poor women at risk. Rather than addressing the problems, the government wanted to abolish commercial surrogacy altogether. The Committee felt that surrogacy law had to change from 'altruistic' to 'compensated' surrogacy and that surrogate mothers' economic needs and those of their families would be fulfilled in this way. It further held that commercial surrogacy must not be illegal since it would result in surrogacy being made illegal and moving underground, being more hazardous to surrogate mothers for whom it provides economic sustenance. It underlined safeguarding the interest of the surrogate mother as well as the child.[11] Notwithstanding such suggestions, the Bill did not pass since it lapsed with the dissolution of the 16th Lok Sabha and the consequent introduction of the 2019 Surrogacy (Regulation) Bill.

The 2019 Bill remained similar to the 2016 Bill by taking a strict stance by prohibiting commercial surrogacy outright and allowing only altruistic surrogacy.[12] It also continued to restrict the access of surrogacy to heterosexual married couples, excluding LGBTQIA+ couples and single people. This exclusion continued even after the historic Supreme Court ruling in Navtej Singh Johar v. Union of India, which decriminalized same-sex relationships and was a huge leap toward LGBTQIA+ rights in India. The Bill finally became the Surrogacy (Regulation) Act 2021 after amendments.

The Surrogacy (Regulation) Act 2021 permits altruistic surrogacy[13] only for legally married Indian heterosexual couples. The Act thus excludes single people and LGBTQIA+ couples from using surrogacy services as they are not recognized as eligible under the Act. The exclusion profoundly affects their reproductive autonomy, with many resorting to other means of achieving parenthood, such as adoption. This restriction casts light on the prevailing socio-cultural values that prioritize conventional family forms over non-heteronormative ones.

From a constitutional perspective, the Act raises very crucial questions regarding the violation of fundamental rights that are guaranteed under the Indian Constitution, such as the right to equality[14] and personal liberty.[15] By excluding singles and LGBTQIA+ couples from accessing surrogacy, the legislation has been criticized as discriminatory as it violates their right to make personal reproductive decisions. The exclusion can be challenged on the grounds of violation of Articles 14 and Article 21.

III. Surrogacy Laws in the UK

The UK has established a well-regulated and structured legal framework for surrogacy, primarily focusing only on altruistic surrogacy. It is governed by the Surrogacy Arrangements Act 1985,[16] the Human Fertilization and Embryology Acts of 1990[17] and 2008,[18] and the Human Fertilization and Embryology Act 2008 (Remedial) Order 2017.[19] These laws prohibit commercial surrogacy, which ensures that surrogates cannot profit from the arrangement beyond reasonable expenses associated with pregnancy and childbirth.

Commercial surrogacy was declared illegal by the Surrogacy Arrangements Act of 1985, guaranteeing that surrogacy remains a non-commercial, altruistic practice in the United Kingdom.[20] Surrogates could only be reimbursed reasonably for prenatal expenses, such as maternity clothes, medical bills, and travel fees for

---

[10] Sharanya Gopinathan, Explainer: Everything that's Wrong with the Surrogacy (Regulation) Bill, The News Minute (Dec. 20, 2018),https://www.thenewsminute.com

[11] O. Timms, Report of the Parliamentary Standing Committee on the Surrogacy (Regulation) Bill, 2016: A Commentary, 3 Indian J. Med. Ethics 102 (2018).

[12] Astha Srivastava, The Surrogacy Regulation (2019) Bill of India: A Critique, 22 J. Int'l Women's Stud. 1 (2021).

[13] Surrogacy (Regulation) Act, 2021, § 2(b) (India).

[14] Indian Constitution, Art. 14.

[15] Ibid, art. 21.

[16] Surrogacy Arrangements Act 1985, c. 49 (UK).

[17] Human Fertilisation and Embryology Act 1990, c. 37 (UK).

[18] Human Fertilisation and Embryology Act 2008, c. 22 (UK).

[19] Human Fertilisation and Embryology Act 2008 (Remedial) Order 2017, SI 2018/1413 (UK).

[20] Supra Note 16, c. 49, § 2(1) (UK).

doctor's appointments. The Act strengthens the moral boundaries of the practice by prohibiting the promotion of surrogacy services and preventing agencies from profiting from surrogacy arrangements.

One of the most critical aspects of the UK's surrogacy law is the process of transferring parental rights.[21] Legally, the surrogate is considered the mother of the child at birth, and if she is married, her spouse is regarded as the second legal parent. A parental order must be obtained to transfer parental rights to the intended parents. This process is central to UK surrogacy law, as it allows intended parents to become the child's legal guardians.

Initially, parental orders were available only to married heterosexual couples. However, significant legal reforms expanded eligibility, including the Human Fertilisation and Embryology Acts of 1990 and 2008. The 2008 Act allowed civil partners and same-sex couples to apply for parental orders. Later, the Human Fertilisation and Embryology Act 2008 (Remedial) Order 2017 extended this right to singles, recognizing that various family structures can form the foundation for parenting.[22]

Substantial legislative reforms and changes in the attitude of society has driven the UK's development in embracing the different forms of family. Throughout time, laws such as the Marriage (Same Sex Couples) Act 2013,[23] which legalized same-sex marriage, and the Civil Partnership Act 2004,[24] which expanded the rights of civil partners, have facilitated a more inclusive understanding of what constitutes a family.

The surrogacy laws in the UK have been influenced by the growing acceptance of reproductive autonomy and the rights of individuals to create families, regardless of their gender, sexual orientation, or marital status have influenced the UK's surrogacy laws. The UK's surrogacy laws place a strong emphasis on diversity, ethical protections, and altruism. Legal provisions ensure that intended parents, whether part of traditional or non-traditional families, can legally secure parental rights while safeguarding the interests of surrogates.

IV. A Comparative Analysis between the two Jurisdictions

India and the UK have surrogacy laws that reflect the different societal values, legal traditions, and approaches to diverse forms of family within each country. The differences stand out exceptionally when examining the eligibility, LGBTQIA+ couples and singles' access to surrogacy, and how each country strikes a balance between reproductive and human rights.

One of the most striking differences is who can gain access to surrogacy services. In the UK, the Surrogacy Arrangements Act 1985 and later legislation, including the Human Fertilization and Embryology Acts of 1990 and 2008, allow only altruistic surrogacy, where the surrogate can receive no payment other than for reasonable expenses. Significantly, the legal system in the UK is liberal, enabling single people and LGBTQIA couples to pursue surrogacy. The Human Fertilization and Embryology Act (Remedial) Order 2017 also extended this inclusivity by allowing single people to make applications for parental orders, which transfers legal parenthood from the surrogate to the intended parents.

India, however, has adopted a more limited approach through the Surrogacy (Regulation) Act, of 2021. The Act restricts surrogacy to altruistic surrogacy arrangements between legally married heterosexual couples only. It excludes LGBTQIA+ couples and unmarried individuals completely. Additionally, couples are prohibited from surrogacy if they already have a biological or adopted child.[25] By reinforcing traditional, heteronormative norms and patriarchal family systems, these restrictions contradict feminist principles that advocate for reproductive autonomy and equality. Liberal feminism advocates for more reproductive autonomy and the freedom for everyone to make their own reproductive decisions, regardless of gender or marital status.[26] The denial of surrogacy to LGBTQIA+ couples and singles reflects the outdated societal values that prioritize traditional motherhood and limit reproductive justice. This difference underlines how Indian laws exclude specific groups while retaining traditional family values, whereas the UK's embracing framework

[21] Human Fertilisation and Embryology Act 2008, c. 22, § 54 (UK).

[22] Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018, SI 2018/1413, § 3 (UK).

[23] Marriage (Same Sex Couples) Act 2013, c. 30 (UK).

[24] Civil Partnership Act 2004, c. 33 (UK)

[25] Surrogacy (Regulation) Act, 2021, § 4(c)(II) (India).

[26] Brenda Russell, Debra Oswald & MaryKate Cotter, What Makes a Liberal Feminist? Identifying Predictors of Heterosexual Women and Men's Liberal Feminist Ideology, 13 Analyses Soc. Issues & Pub. Pol'y (forthcoming 2024)

accommodates a diversity of family structures. The UK also recognizes surrogacy as a means for single people and LGBTQIA+ partners to become parents, demonstrating a more egalitarian understanding of family.

India's restrictive surrogacy laws have a significant impact on reproductive rights. Denying surrogacy to LGBTQIA+ couples and singles denies them the right to seek reproductive technologies and, thereby, their reproductive autonomy, sending a message that only heterosexual married couples are eligible for parenthood through surrogacy. In contrast, the UK laws promote reproductive autonomy for everyone, regardless of their sexual orientation and marital status. By enabling LGBTQIA+ couples and single people to engage in surrogacy, the UK guarantees that reproductive rights are equitable and inclusive. This is an affirmation of a society's commitment to equality and non-discrimination since the right to construct a family is not limited to traditional heterosexual couples.

The comparison between the UK and India highlights how legal frameworks can either favor or challenge the norms of society. By limiting surrogacy only to married couples and some women, the Indian laws reflect the prevalent cultural and religious values that place a priority on traditional marriage and exclude other forms of families. On the other hand, the UK has laws that acknowledge various kinds of families, indicating a more liberal and inclusive concept of family.

From a human rights point of view, both countries' approaches differ substantially. International laws such as the Universal Declaration of Human Rights[27] and the International Covenant on Civil and Political Rights to which both countries are signatories, emphasize the right to family and protection against discrimination based on sex, sexual orientation, or marital status.[28] India's disqualification of singles and LGBTQIA+ from surrogacy raises questions of non-compliance under these standards. Conversely, UK surrogacy regulations are more in line with global human rights standards. The UK's open framework guarantees that people are not subjected to discrimination on the basis of their marital status or sexual orientation. This promotes the idea of equality before the law by enabling everyone to exercise their freedom to procreate without facing any kind of discrimination.

The Yogyakarta Principles, which established the international standards of gender identity and sexual orientation, have confirmed that all individuals are entitled to a family.[29] India's limiting surrogacy legislation is contrary to these principles by limiting the reproductive rights of singles and LGBTQIA+ couples. The UK legislation is closer to developing standards by promoting inclusivity and embracing the different forms of families.

The United Kingdom displays a legal framework that respects international human rights norms of equality and non-discrimination by acknowledging LGBTQIA+ and single people as valid surrogacy participants. However, India's surrogacy regulations still follow traditional family structures, which restricts the reproductive options available to people who don't fit within this specific framework.

V. Conclusion

The comparative analysis of surrogacy laws in India and the UK reveals stark differences in how reproductive technologies are regulated and accessed, particularly for LGBTQIA+ couples and single people. India's Surrogacy (Regulation) Act of 2021 imposes stringent conditions on surrogacy, restricting access only to married heterosexual couples and leaving out LGBTQIA+ and single individuals altogether. In contrast, the UK's liberality provides space for persons across all marital states and sexualities to practice altruistic surrogacy. Such divergence speaks volumes about the deep cultural and social understandings of family in both countries. As much as the UK accepts diverse forms of families and makes reproductive choices accessible for all, India continues to stress traditional family norms for family life and, in the process, marginalize such groups that do not conform to this heteronormative idea of family.

---

[27] Universal Declaration of Human Rights, arts. 2, 16, G.A. Res. 217A (III), U.N. Doc. A/810 (1948).

[28] International Covenant on Civil and Political Rights, arts. 23(2), 26, Dec. 16, 1966, 999 U.N.T.S. 171.

[29] International Commission of Jurists, Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity (2007).

Adoption as an Alternative

With India's surrogacy laws, which are exclusionary in nature, adoption could prove to be an available alternative path to parenthood for LGBTQIA+ couples and singles in India. Adoption is not without problems either. India's adoption laws pose serious obstacles, especially under the Hindu Adoptions and Maintenance Act 1956[30] and the Juvenile Justice (Care and Protection of Children) Act 2015.[31]

Hindu Adoptions and Maintenance Act 1956 enables Hindu men and women to adopt any child regardless of gender.[32] Both men and women are treated in the same way under this provision. On the other hand, single men and women are allowed to adopt under the Juvenile Justice (Care and Protection of Children) Act 2015. However, single men cannot adopt female children.[33] This discriminates against men, creating further obstacles for those men wanting to adopt a girl child, whether they are single or in a same-sex couple, further reducing their opportunities for parenthood.

In both statutes, although adoption by an LGBTQIA+ couple is not explicitly banned, only one partner in a same-sex couple can adopt as a "single parent," and not provide any official parental rights to the other partner. The refusal of legal rights to the second parent poses difficulties, such as denial of inheritance, difficulties in the child's custody arrangements, and inability to make significant decisions in the child's life. Social stigma against non-conventional families also makes the situation more complicated, with LGBTQIA+ couples typically facing bias when trying to adopt.

VI. Suggestions

1. Amendment oftheSurrogacy(Regulation)Act,2021

Making surrogacy accessible to singles and LGBTQIA+ couples is necessary for enhancing reproductive justice, and removing the barriers of marital status and sexual orientation would foster inclusivity and offer equal chances for all to become parents. The suggested changes are in line with international human rights regulations, specifically those enshrined in the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR), which ensures the right to establish a family without discrimination. Additionally, such reforms would consolidate the constitutional values of equality and autonomy enshrined in Articles 14 and 21 of the Indian Constitution, thus ensuring the right to equality and personal liberty, and protection from discrimination for all.

2. Reformation of Adoption Laws

To successfully promote equality in Indian adoption law, the JJA and HAMA would need to be amended to give joint rights of adoption to same-sex couples. This amendment would give equal status to the two individuals as guardians under the law and grant them full participation in child-rearing activities. Nevertheless, legislative reform cannot be an end in itself; efforts need to be taken to tackle the social discrimination against non-heteronormative family members. By availing of sensitivity training courses for adoption offices and legal professionals, we shall be in a position to abolish bias and discrimination against the LGBTQIA community and single mothers and fathers. These measures will offer a more inclusive platform for all families, including LGBTQIA+ and solo parents, to adopt children

3. Promote Societal Acceptance of Diverse Families

Sensitizing legal systems, doctors, and adoption agencies about different types of families is necessary. The best way to do this is through special training sessions that address unconscious biases and promote acceptance of non-traditional families. While doing this, we must have public campaigns challenging traditional notions of what a family is, and society must embrace LGBTQIA+ and single-parent families as an option. Doing this will make the world more inclusive, where all families feel recognized, accepted, and valued.

4. Draw Inspiration from More Inclusive International Models

India needs to amend its laws to ensure LGBTQIA+ couples and unmarried individuals have the same access

[30] Hindu Adoptions and Maintenance Act, No. 78 of 1956.

[31] Juvenile Justice (Care and Protection of Children) Act, No. 2 of 2016

[32] Hindu Adoptions and Maintenance Act, 1956, §§ 7-8 (India).

[33] Supra Note 31, § 57(4) (India).

as their counterparts to create families through surrogacy and adoption. These changes would ensure that nobody is denied the right to become a parent based on their sexual orientation or marital status. India can learn from the United Kingdom's liberal approach to reproductive rights and adoption-its laws are liberal and allow every person, without discrimination, to undergo fertility treatment and adopt children. By implementing these policy changes, India can make a giant stride toward equality andinclusivity and ensure all individuals have the right to create and bring up a family.

The restrictive nature of India's surrogacy laws, combined with the hurdles in adoption laws, leaves LGBTQIA+ and single people in India with little room to maneuver toward parenthood. Unlike India, the UK's law is more permissive, acknowledging the reproductive rights of every individual and the right of everyone to access reproductive technologies and adopt children, irrespective of sexual orientation or marital status. In order to ensure equality and reproductive rights in India, legal amendments need to be implemented to provide LGBTQIA+ couples and single individuals access to surrogacy and adoption. These reforms, combined with measures to combat social prejudices and safeguard the rights of surrogates, would go a long way in establishing a fairer and more equitable system where everyone has the right to create their own families, irrespective of their situation.

* * * *

GENDER AND REPRODUCTIVE RIGHTS: THE INTERSECTION OF RELIGION, CULTURE, AND LEGAL PROTECTIONS

Ms. Harisyaambhavi N. S. *
Mr. Sudarshan H. A. **

Abstract

Gender and reproductive rights are inextricably linked to the concepts of gender, religion, and culture, despite the fact that modern legislation has provided numerous legal safeguards in matters of reproduction and reproductive health. This paper explores how religious superstition, and cultural norms influence a subset of human rights related to gender reproduction in India, a country with a diverse religious landscape. Legal protection varies by country, but in India, religious doctrine on reproductive rights focuses on the moral aspect of the matter, whereas cultural norms elaborate on gender roles, reproductive decision-making, and societal expectations, triggering legal disputes over individual rights and gender equality principles due to stringent societal pressure. This paper focuses on the complexities that child bearer's face as a result of the intersection of several societal barriers, emphasizing the importance of a balanced approach that respects religious and cultural diversity while upholding fundamental human rights to ensure gender equality, bodily autonomy, and access to reproductive healthcare, as well as addressing discrimination and fostering inclusive legal protections.

Keywords: **Reproductive Rights, Gender, religion, culture, legal protections, Religious barrier, Cultural diversity, Equality**

I. Introduction

Reproductive rights in India are primarily concerned with female reproductive autonomy, and the legislation governing them is carefully crafted to balance religious, cultural, and individual rights. Reproductive rights are essential for an individual to prioritize his or her right to life and make more educated choices. India, a country known for its religious and cultural diversity, has a variety of opinions on reproduction, as well as a significant number of taboos and stigmas surrounding private matters of individuals, as gender and reproduction are intrinsic parts of the desired cultures. Whereas, Religion and culture go hand in hand since they are changing and evolving all the time. This concept of reproductive rights is criticized highly because it has historically been discriminatory towards women in the sense of double standards and notions of sex drive as predominately male were encouraged. Women and girls were unjustly sexualized and objectified, and their bodily autonomy were hardly prioritized. Due to this persistent obstacle to liberty of personal choice, gender inequality, restricted access to healthcare service due to the influence of socioeconomic factors of reproduction is a major reason why such taboo is still hanging around in the society violating individuals right meanwhile the Indian legal system has actively stepped in various forums to offer protection for women, the influence of religion and customary practices continues to complicate enforcement of these rights, while discrimination against one gender hasn't been eradicated in many parts of India still date.

Relevance of Study

This paper aims to understand how gender, religion, culture, and legal protections for reproductive rights interrelation is crucial to understanding the intricate mechanisms governing access to sexual and reproductive health care. This intersection exemplifies how variances in reproductive health outcomes are caused by a combination of discriminatory practices based on gender, ethnicity, class, religion, and culture. Aiming to ascertain the systemic barriers that disproportionately impact women or religious minorities, by looking at

* Student., B.B.A.LL.B., Christ Academy Institute of Law, Bangalore.
** Student., B.A.LL.B., Christ Academy Institute of Law, Bangalore.

these intersections. The study aims to influence policy formulation by highlighting the significance of inclusive and culturally sensitive legal safeguards is what makes the law applicable. In order to guarantee that reproductive health treatments are accessible and fair to everyone.

Research Objectives

To examine how religious beliefs and cultural norms shape societal attitudes toward gender roles and reproductive health.

To assess the Role of Legal Protections in Safeguarding Gender and Reproductive Rights

Problem Statement

Failure of the legal frameworks in addressing fundamental challenge towards recognition of access to gender equality and health. In the majority of the religion and their cultural values plays a crucial role in aiding gender inequality and leading to gender-based disparities in access to services such as contraception, abortion. The policy has the effect of reducing the autonomy of women over reproductive life and encouraging gender inequality. Moreover, legal safeguards for reproductive health is partial or conflicting in situations. This intertwined conflict between gender, religion, and law not only impedes the enforcement of reproductive rights, but it also perpetuates social and economic inequality, particularly among disadvantaged populations. This eliminated the need to design reproductive health policies that balance religious and cultural beliefs while protecting and promoting gender equality and the human right to health.

Hypothesis

The convergence of law, gender, and religion has a direct effect on reproductive health policy, creating obstacles to obtaining care and reinforcing gendered distinctions in health, especially for the marginalized.

Review of Literature

Sexual and reproductive health and rights, OHCHR and women's human rights and gender equality, United Nations Human Rights Office of the High Commissioner.

The work of the UN Human Rights Office (OHCHR) to advance sexual and reproductive health and rights-in particular, women's human rights and gender equality-is the main topic of the article. It emphasizes how important it is to maintain access to reproductive healthcare and make sure that women's rights are properly upheld. Globally, the OHCHR supports laws that advance health, equality, and the defense of women's rights.

Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination against Women, 1998, Dr. Carmel Shalev

Dr. Carmel Shalev's research highlights the ways in which the ICPD and CEDAW promote sexual and reproductive health rights as well as gender equality. It examines the developments and challenges in implementing these rights, emphasizing the need for continued advocacy and legislative action.

Research Question

1. How do religious beliefs and cultural norms shape society attitudes about gender roles and reproductive health, and how do they impact access to reproductive rights and services?
2. How do legislative frameworks affect access to reproductive healthcare and gender equality?

II. Discussion

Intersectionality of Gender, Religion, and Law in Reproductive Health Policies

Gender and Reproduction

Gender and reproductive are connected as the capacity to become pregnant is gifted in women, but the same is also influenced by various factors such as social, economic, and communal conditions and social stigmas, which on the other hand oppresses the right of the women, especially women who don't have access to health care due to lack of awareness, cultural pressure, and low income women, similarly unmarried and adolescent mothers, who may be more likely to live in poverty, describe feeling socially stigmatized and mistreated by

healthcare [1]institutions and providers often have difficulty accessing contraception, comprehensive sex education and treatment of sexually transmitted infections, safe homes, alternative birth alternatives, proper prenatal and pregnancy care, support for victims of domestic abuse, and much more. The reproductive justice analysis also recognizes that reproductive inequality affects women, especially rural women and their communities. “the controlling and exploiting of women, girls, and individuals through our bodies, sexuality, labor, and reproduction (both biological and social) by communities and society” At the heart of reproduction, this intersectional paradigm recognizes that oppressive regimes discriminate on the basis of both gender and sexual orientation. Historically, these types of discrimination and oppression have led to a majority of women and others having limited access to resources and power, as well as men’s privilege in reproductive concerns. Looking at reproductive labor, it’s clear that women put in a lot of unpaid work taking care of families and kids. This is vital for society, but it’s often overlooked. So, to make sure everyone has control over their reproductive choices, the legislation has to be promising of reproductive healthcare accessible and fair for everyone. meaning shifting old concepts about gender and reproductive rights making certain that people can make smart choices about their health without being forced or held back.

Religion and Reproduction

Religion is a systematic practice that dates back to a very long period of time instilling beliefs as customs and ethics in society, whereas reproductive rights of women are largely determined by societal norms that act in to regulate, control, and determine religious tradition having different traditions to the extent of reproductive rights, it involves the traditions in relation to the question of abortion, Homogamy and infertility and are sanctioned in religious teachings, and mythology surrounds the concept reproduction and especially abortion. However many religions, including Hinduism, Buddhism, and Islam, consider abortion to be the worst kind of sin. However, in practice, India has extremely high infanticide and feticide rates, particularly among female children. The patriarchal structure challenges the idea of “my body, my right” by prioritizing the requirements of the patrilocal, patrilineal family over a woman’s personal and physical well-being. Abortion in Hinduism condemned as one of the five maha patakas (major sins) that is morally condemnable and warrants punishment, according to norms ranging from the Atharva Veda to the Dharmashastras literature, but male heirs were always the desired outcome of the pregnancy, and it emphasized lineage purity, condemning the varna sankara. Women lacked legal and social rights while making reproductive decisions. However, contemporary data contradicts the “pro-life” and “anti-abortion” discourses found in Indian religious traditions Reproduction in Christianity is The attitude toward reproductive practice is different among the different divisions of Christianity. The practice of assisted reproduction is not accepted by the Vatican, however, it may be practiced by Protestant, Anglican and other Denomination’s. According to the Roman Catholic doctrine the primary purpose of marriage is procreation. The contraceptive act destroys the potential of producing new life by sexual intercourse and violates the purpose of marriage and, therefore, is a sin against nature.[2]

In India, sex-selective abortion is becoming more widespread. Also, when you compare Muslims of higher status to those of lower status, you see big differences in how many safe pregnancies there are and the rate of abortions whereas Contraception use for family planning is permissible, but the use of contraception for permanently limiting the number of children is debated along with that The use of a third party in reproduction is not accepted in Islam[3]. Likewise, Hindu caste groups differ a lot in their views on the ethics of abortion, depending on how much they know about safe pregnancies, their income, and the social restrictions around abortion in their culture. However in Thailand, a Buddhist country, actually has a higher abortion rate than the United States. It seems that in most of these cases, abortion is used as a form of birth control.

Law in Reproductive Health

The World Health Organization declares reproductive rights mean one and all can agree how many offspring they want, when to have them, and to have the best possible health care services. This also means people

---

1 Just a moment..., https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00357-7/fulltext.

2 J.G.Schenker, Women’s reproductive health: monotheistic religions perspectives, PubMed https://pubmed.ncbi.nlm.nih.gov/10884536/.

3 Ali, S. M., & M. H. F. Al-Ansari. “Sexual and Reproductive Health: An Islamic Perspective.” In *Contemporary Islamic Perspectives in Public Health*, 179-192. Cambridge Univ. Press, 2021.

should be able to make these choices without being discriminated against, forced, or hurt. India was among the first to create laws about abortion and birth control. Still, many women and girls can't completely custom these rights. Matters include depraved health care and not being able to make decisions. In the past, laws about reproductive health in India didn't focus on women's rights. They often aimed at things like governing the populace. Sometimes, these laws even made it stiffer for women to make their own adoptions, for instance, by necessitating a husband's authorization to get reproductive health care. In the past, rules about reproductive health didn't really put women's rights paramount. Even though there's a law in contradiction of girls getting married before the age of 18, and programs to assistance pregnant women, India still has the most child marriages in the world. Also, a big amount of all maternal deaths happen there. International agreements say that women should be able to freely decide about their health, including when it comes to having kids and their sexuality orientated decisions.

Usually, consent means the person who's affected makes the call. But when partners are involved, it's sometimes seen as a partner agreement. In the leading divorce case, the court said that if a husband gets sterilized without his wife knowing or agreeing, or if a wife gets an abortion without her husband's acceptance, that could be comprehended as mental cruelty. This seems to go against the idea that people should have the right to decide for themselves. The phrase "consent" has been restricted to the person who is directly affected; in cases where partners are involved, it is referred to as a "partner agreement" Contrary to this Supreme Court ruling, when hearing an appeal in the *Samar Ghosh vs. Jaya Ghosh divorce case*[4], the court ruled on March 26, 2007: " If a husband submits himself for an operation of sterilization without medical reasons and without the consent or knowledge of his wife and similarly if the wife undergoes vasectomy or abortion without medical reason or without the consent or knowledge of her husband, such an act of the spouse may lead to mental cruelty."

In conclusion, the interaction of gender, religion, and law in reproductive health policies exposes complex processes that influence access to sexual and reproductive health and rights (SRHR). Intersectionality is a theory that emphasizes the discrimination and oppression overlap, causing compounded experiences for individuals, particularly rural women and oppressed groups. Gender is important in SRHR because it affects access to resources and healthcare services, which are frequently limited by patriarchal norms and attitudes. An intersectional perspective is required to understand how gender, religion, and law interact to influence sexual and reproductive health and rights SRHR. It recognizes that individuals suffer many types of discernment depending on their social identities, which are interrelated and mutually constitutive. Intersectionality can have a substantial impact on the effectiveness of reproductive health policy because it highlights how various types of discrimination and oppression interact, influencing people's access to sexual and reproductive health care. Intersectionality allows for the development of more targeted solutions by recognizing the unique needs of underrepresented communities. This results in more inclusive and successful policies that serve majority of the populaces. An intersectional approach increases the efficacy of reproductive health policies. This means comprehending and addressing the intricate interaction of social identities and power dynamics that influence healthcare access. This enables policymakers to better meet the needs of underrepresented communities, ultimately improving health outcomes and promoting equity in reproductive health care.

III. Role of Legal Protections in Safeguarding Gender and Reproductive Rights

Both the Committee on the Elimination of Discrimination against Women (CEDAW) and the Committee of Economic, Social, and Cultural Rights (CESCR) have made it abundantly evident that women's sexual and reproductive health is a part of their right to health.[5] A new paradigm for tackling human reproduction and health was accepted during the 1994 International Conference on Population and Development (ICPD), which was held in Cairo. Individual needs and women's empowerment were clearly prioritized for the first time, and a developing conversation about the relationship between human rights and health emerged, connecting new ideas about health to the fight for social justice and respect for human dignity. Causes and Consequences of sexual and reproductive health violations: Patriarchal conceptions of women's roles within the family mean that women are often valued based on their ability to reproduce; early marriage and pregnancy,

[4] *Samar Ghosh v. Jaya Ghosh, (2007) 4 SCC 511 (India).*

[5] Sexual and reproductive health and rights, OHCHR and women's human rights and gender equality, United Nations Human Rights Office of the High Commissioner.

or repeated pregnancies spaced too closely together-often as the result of efforts to produce male offspring because of the preference for sons-have a devastating impact on women's health with sometimes fatal consequences; women are often blamed for infertility, suffering ostracism and being subjected to various human rights violations as a result. These deeply beliefs and societal values regarding women's sexuality are often the cause of violations of women's sexual and reproductive health and rights. The Beijing Platform for Action recognizes that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[6] The CESCR General Comment 22 urges states "to repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information."[7] The provision of 5 maternal health services is comparable to a core obligation that cannot be deviated from under any circumstances, according to CESCR General Comment 14. States are immediately required to take specific, targeted, and intentional actions to fulfill the right to health in the context of pregnancy and childbirth.[8] 6 Following a brief examination of the terms "autonomy" and "equality" in relation to sexual and reproductive health, the paper provides specific examples of systemic violations of women's rights that are representative of current trends in various global locations. The Committee on the Elimination of Discrimination against Women (henceforth referred to as the CEDAW Committee) evaluated the instances during its 18th session in January 1998. The reports were submitted by States Parties in fulfillment of their obligations under the Convention. Official reports from the governments of eight States Parties-Azerbaijan, Bulgaria, the Czech Republic, Croatia, the Dominican Republic, Indonesia, Mexico, and Zimbabwe-were reviewed by the Committee during this session. In line with the Committee's and other human rights treaty bodies' practices, it also noted unofficial information submitted independently by national and international non-governmental organizations, sometimes referred to as "shadow reports." The topics covered in these materials include equality before the law, the right to life, reproductive choice in regard to family planning and abortion, the right to informed consent, and equality in the distribution of resources. Lastly, special attention is paid to the plight of women in precarious situations.[9] 7 ICPD Program of Action: After more than 180 States engaged in a process of compromise and discussion, a consensus text known as the ICPD's approved Programmed of Action was produced. In a separate chapter, gender equality and women's empowerment are discussed, with the international community prioritizing the eradication of sex discrimination in relation to population and development policies and initiatives. "Reproductive Rights and Reproductive Health" (Chapter VII) is a crucial chapter that explains the autonomy principle. Reproductive health is defined in paragraph 7.2 of the Programme of Action as "a state of complete physical, mental and social well-being in all matters related to the reproductive system", which "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." Reproductive rights, according to the ICPD, "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." The language is taken from Article 16(1)(e) of the Women's Convention, which states that States Parties shall ensure on a basis of equality of men and women: "the same rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights." Reproductive rights, according to the ICPD, also include the right "to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." This aspect of reproductive rights can also be derived from the Women's Convention. Discrimination is the second idea that needs further explanation. Nondiscrimination is a prerequisite for equality, and discrimination is an infringement on that right. According to Article 1 of the Convention, "discrimination against women" is defined as any sex-based distinction, exclusion, or restriction that has the intent or effect of preventing or undermining women's recognition,

---

6 Beijing Declaration and Platform for Action, 2015, Policy papers, UN Women Headquarters Office.

7 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)

8 General comment no. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

9 Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women, 1998, Dr. Carmel Shalev

enjoyment, or exercise of their human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field, regardless of their marital status. Despite the Convention's recognition of women's maternal role, social and cultural norms frequently exalt motherhood in ways that limit women's freedom to make their own decisions. Religious and cultural beliefs may favor women based on their capacity to bear children. Repeated pregnancies that are too close to one another, sometimes as a result of attempts to have male offspring, may therefore endanger their health. Due to the belief that they are infertile rather than their male spouses, women who have not given birth may be excluded from weddings. The health requirements of women may be viewed as secondary to those of their children or, in the case of pregnant women, to the health of their fetuses, and they may be denied access to medical care that is unrelated to their reproductive activities. Codes of chastity that restrict women's freedom of movement and involvement in public life are based on stereotypes about women's sexuality. Discriminatory views toward women's sexuality that deprive them of the right to a fulfilling sexual life are linked to certain behaviors that are detrimental to women's health. These include needless procedures like hymen repair, forced virginity tests, and female genital mutilation. Women are at risk of sexual violence and abuse because their sexuality is usually subordinated to meeting masculine desires. Women and girls are at risk of acquiring HIV/AIDS and other sexually transmitted illnesses because they are frequently unable to negotiate safe sex or refuse sex due to unequal power relations based on gender. Health-related discrimination may be partially explained by biological variations between men and women, even if gender discrimination is obviously a mediating factor in these social phenomena. Instead of asking women to live up to standards established by a male model, modern feminist legal theory argues that the principle of gender equality takes such differences into consideration. Treating the same interests without prejudice and treating distinct interests in a way that respects their differences are both necessary for equality. Discrimination occurs when women's unique health demands are not taken into consideration in order to guarantee them access to suitable health information and services. Equality is a substantive issue of ensuring the effective enjoyment of equal outcomes in health status and well-being, rather than a formal one of ensuring women have the same rights as men and fighting intentional discrimination. Both similar and sex-specific health needs are covered by women's rights to health and healthcare on an equal footing with men. It is discriminatory to fail to provide resources or to guarantee that women's unique health need in addition to those shared by men and women are met.

IV. Conclusion

In conclusion, religious beliefs and cultural norms significantly shape societal attitudes toward gender roles and reproductive health, often influencing public policies, healthcare access, and individual freedoms. Many societies base gender expectations on traditional or religious doctrines, which can limit women's autonomy over reproductive choices and reinforce rigid gender roles. For instance, some religious teachings may discourage contraception or abortion, influencing societal perceptions and access to reproductive health services. Cultural norms, too, play a crucial role, where gender inequality may be perpetuated by practices that restrict women's involvement in decision-making regarding their bodies, careers, or family life. Legal protections are critical in safeguarding gender and reproductive rights by offering a framework that ensures equality and access to healthcare. Laws that protect reproductive rights, such as access to safe abortion or contraception, empower individuals to make decisions about their bodies without fear of discrimination or legal repercussions. Legal safeguards also challenge harmful cultural norms and religious interpretations that undermine gender equality. However, the enforcement of such laws can be uneven, depending on political climates and societal acceptance. Thus, it is essential to continually advocate for stronger legal protections that respect both individual rights and cultural diversity, ensuring that gender and reproductive rights are upheld universally.

* * * *

EVALUATING COERCIVE POPULATION CONTROL SCHEMES – AS AN INDIRECT INFRINGEMENT OF RIGHT TO BODILY AUTONOMY AND AS A NECESSITY TO SERVE LARGER INTEREST OF SOCIETY

Ms. Sahitya Soni *
Mr. Praveen A. G. **

Abstract

Being the most populous country in the world, India is under a significant obligation to reduce its population but on the same time, being a democratic country, such measures shouldn't restrict a person's fundamental right. However, the method currently used by the government is an indirect infringement of reproductive right. Through the judgement of Suchitra Srivatsava, right to womanhood and bodily autonomy has been granted signifying the importance of liberty over the body and reproductive right of a person. Further, the judgement of K.S Puttaswamy V. union of India included the decisional autonomy under right to privacy a part of Article 21 of the constitution. These are also in line with the UDHR guidelines regarding right to life which includes family and right to choose the number of persons in family. The government of India mainly relies on coercive schemes, like incentives and disqualifications to control population which gravely violates the individual autonomy and contradicts the above judgements and guidelines. The current Uttar Pradesh Population (Control, Stabilization and Welfare) Bill, 2021 went one step beyond, of not only offering incentives and imposing disqualifications, it also prevents individuals who exceed the prescribed number of children from availing any government welfare schemes. The Indian judiciary which grants those rights and being a protector of such rights takes a complete reversal when the constitutional validity of such schemes has been questioned, considering them as a necessity to serve larger public interest by sacrificing the individual needs to satisfy the societal needs. Continuous process like this will undermine the effect of judicial judgements and reduce the trust in judiciary in the minds of people. Furthermore, the effect of these methods doesn't provide a considerable result, proportional to sacrificing the fundamental rights of an individual. Therefore, this paper will analyse the possibility of creating delicate balance between the bodily autonomy and constitutional validity of population control schemes through a comprehensive overview of the effect and judicial precedents. It will also provide alternate suggestion and comparative study on other populated democratic countries.

Key Words : **Bodily Autonomy, Coercive Schemes, Right to Life.**

I. Introduction

India, being the most populated country in the world and developing nation has to limit its overgrowing population otherwise it will result in depletion of resources. It also plays an imminent part in achieving the sustainable goals. On the other hand, the rights of the individual have to be protected, India being a democratic country it becomes an utmost necessity to provide the rights in their entirety. Instead, the policies and schemes which provides incentives and disqualifications based on the number of children a person has, tends to infringe the reproductive right of an individual. Even though it doesn't affect the right directly, these measures are coercive in nature and forces a person to limit his children indirectly. The judiciary being a guardian of these rights and through various cases vested these rights under right to life tend to take a different stand when population issue is concerned. Now by considering the contemporary scenario of India and taking the other countries as example, it becomes a necessity to revise this stand, especially in the point of view of infringement of right and growth of the nation.

* **Student, Campus Law Centre, Faculty of Law, Delhi University**
** **Student, Campus Law Centre, Faculty of Law, Delhi University**

Statement of Problem

The population control schemes in India mostly revolve around providing incentives and imposing disqualifications to persons who exceeds the prescribed threshold. The same was constitutionally upheld by the apex court as an intelligible criterion of differentiation and doesn't affect the right to equality, but later the right to womanhood and bodily autonomy has been provided to all persons under art 21 right to life. After its incorporation, the legislative authorities rather than reducing the effect of those schemes, theyexpandedits applicability to public employment and promotions. These coercive population schemes indirectly infringe the bodily autonomy of the person influencing the number of persons in a family and the right to womanhood. The court which vested those rights and which should be consider as a guardian of it, promoted the action of the government instead of protecting it on the ground that these coercive measures are necessary to achieve the purpose of those schemes, which is to provide basic necessities to all citizens but the question remains on how personal rights can be sacrificed in order to achieve the common needs of the society and whether this sacrificial method provides the necessary result corresponding to the rights sacrificed.

Research Objective

- To provide a balance between the necessity to protect the reproductive right and to satisfy the needs of the society.
- To evaluate the coercive population control schemes and its effect on individual and its role in reducing population
- To analyze the stance of supreme court in conflict between the reproductive right and coercive population schemes and the reason behind its action.

Research Methodology

The researcher of this article is following a doctrinal approach. Legislations, notifications, international instruments, policies are used as a primary source and books, articles, news articles, authenticated websites and statistical data from authorised articles are used as a secondary source to complete this research paper.

Scope and Limitation

This paper only focused on the coercive reproductive policies and reproductive right which was affected by it. It also talks about the effect of the scheme and also alternate measures which can be used instead of that. It doesn't talk about the various other rights including maternal care, or health necessities which incorporates in the reproductive rights. Apart from these schemes it doesn't involve any other government act which affects the reproductive right.

II. Reproductive Right

Reproductive right is a vague term in which many welfare rights reside in it. In India, it has been incorporated under article 21 as a part of right to life. These includes right to pre-natal care, right to abortion as per MTP act, and right to reproductive choices. This was explicitly provided by the SupremeCourt in the case of *Laxmi mandal V. Deen dayal*[1] where the court considered the right to nutrition and quality treatment for the pregnant women as a part of right to life. These rights are granted on the pretext of the incorporated right to give birth according to ones will. This aligns with the comprehensive definition of reproductive rights provided in the Cairo International Conference on Population and Development 1994 to which India is a signatory. As per that definition reproductive rights includes the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health[2]. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

After the judgement of *Suchitra Srivatsava* case, the right to take reproductive choice was considered to be

[1] 2010 SCC OnLine Del 2234

[2] Principle 8, Programme of Action of the International Conference on Population Development, United Nation (adoptedonSep1994). https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf

a dimension of "personal liberty" under article 21 which includes both the right to procreate and to abstain from procreating so as to respect a woman's right to privacy, dignity and bodily integrity. The apex court held that "There should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children."[3]

Right to Bodily Autonomy as apart of Privacy;

Privacy includes the decision taken by the individual inclusive of both mind and body. It is also known as decisional autonomy and this was provided under art 21 as a part of life in the case of *K.S.Puttaswamy V. Union of India*[4]. This decisional autonomy includes bodily autonomy and the freedom to believe in what is right, and the freedom of self-determination to take decisions influencings the person's body. In this case the apex court held that "The family, marriage, procreation andsexual orientationareall integraltothe dignity of the individual. Read in conjunction with Article 21, liberty enables the individual tohaveachoiceofpreferencesonvariousfacetsoflife including what and how onewill eat, the way one will dress, the faithone will espouse and a myriadothermatterson which autonomy and self-determination require a choice to be made within the privacy of the mind."

Coercive Approach in Population Policy

In India, the government is to promote voluntary sterilization and to raise awareness about the use of contraceptives and other birth control devices. It is also primarily focused to promote high mortality rate of children to remove the question of survivability of the child and moreover a considerable autonomy was given to states to achieve the objects of national population policy 2000[5]. It doesn't provide any restriction on coercive methods.

Many states including but not limited to Assam, Rajasthan, Odisha[6] uses coercive population control measures which is to bar the candidates who have more than 2 children from participating in local bodies election, and a disqualification in public employment. For example, as per Maharashtra civil service family rules 2005, people who have more than 2 children are not entitled to hold their posts and ineligible to join the service after its enactment.

Furthermore, the maternity act considerably differentiates between women with2 child and women with more than 2 children. Women are entitled for maternal leave for only 2 children and they have to continue their work with the baby for the 3rd child onwards. Section 3 of Maternity benefit (amendment) act, 2017, reduces the maternity leave by half to 12 weeks from 3rd child onward compared to 1st and 2nd child which was 6 months.

III. U.P Population Control Bill, 2021

Taking a long step ahead of the other states and above measures, the Uttar Pradesh government drafted U.P population control bill[7] which is yet to be passed by the legislature. This scheme contains many incentives and disqualification entirely focused to limit the child birth to 2 or even less per couple. As per section 4 of this bill, the public servants under the control of State Government who adopts two-child norm by undergoing voluntary sterilization operation upon himself or spouse will be provided with 2 additional increments, subsidy to buy plot, maternity leave, increase in employers' contribution fund in NPS, free health care facility and insurance coverage and rebate on electricity, water and housing tax etc.

For public servant who have 1 child and undergo voluntary sterilization will be provided will all above benefits along with the preference to the single child in admission in all education institutions, including but not limited to Indian Institute of Management, All India Institute of Medical Science etc, free education.

---

3 Suchita Srivastava v. Chandigarh Admn., (2009) 9 SCC 1

4 (2017) 10 SCC 1

5 National population policy, 2000, Ministry of Health and family welfare, India

6 Utkarsh Anand, The past and present of two-child policies in India, HT, (Jul 15, 2021)The past and present of two-child policies in India | Latest News India - Hindustan Times

7 The Uttar Pradesh population (control, stabilization and welfare) bill (Jul2021).Bill07072021.pdf

Scholarship etc. As per section 7, except the 2 additional increment and insurance, the other incentives are also available to general public.This doesn't stop here, rather people who contravenes the 2child policy will be subjected to

i) debarred from benefitting from Government sponsored welfare schemes,

ii) limiting the ration card units upto four

iii) other disincentives which is not expressly provided and which can be prescribed

iv) bar on contesting election to local body

v) bar on applying to government jobs, promotion, receiving any kind of government subsidy and more.

Effect of the Coercive Policy

While there is not much evidence to support the intended goal of population control by two child norms, the negative effects of the policy have created a lot of concern among civil societies and women organizations

1) The policy might have resulted in increasing the number of undocumented children, and girl children will besubjected toinfanticide orsex-based abortion which will be a grave detriment to the future of this whole nation[8].In the case of *Antina Ramdas Magar V. BhagalaxmiPrakash Mahanta and Ors*[9]., the court dealt with the issue where a person wants to disown a child just to participate in a local body election which prevents people with more than 2 child from participating in the election.

2) In society where male child is being preferred more than female child, if first child is daughter, by advancement of technology people tries to ensure that second birth must be of son.[10] Thus, a preference for sons can cause the policies that target lower fertility to have unintended effects on sex ratio.

3) The political implications of these policies are far more serious and it will reverse what has been achieved through consistent progress in social justice.Considering the specific reservation where women got one third reservation by 73rd and 74th amendment, these types of schemes will create an unreasonable disqualification especially caste based where women from specific caste will be affected more by such disqualification

   As per the study, more than 50% of those disqualified under the provisions of the 'two child' norm were either illiterate or received only primary education. Economically and socially vulnerable sections suffered the most as 75% of those disqualified belonged to SC, ST and backward classes.[11]

4) In most of such legislation the action is being taken on complaint, often the vulnerable class of society faces prosecution while dominant being untouched. therefore, rather than becoming a stepping stone towards a democracy more open to all, the two-child limit has twisted political participation into an avenue of discriminatory abuse[12].

5) Besides these, ageing population and lowering fertility rate are also diminishing the young numbers in population, which have potential to bring crisis like situation which are currently faced by countries like Japan, South Korea etc.

IV. Stand of the Court

As far as the court is considered, the judiciary tends to consider these policies as a necessary measure to take the population overgrowth and refuses to strike down since it involves the distribution of resources and the potential to affect the whole nation. But it fails to see the larger picture of these schemes.

As far Maternity Leave is Concerned

The main object of maternity leave is to provide a safe environment for the child and the mother. It has

[8] Sonal Gupta &Aransha Sinha, Is Two-Child Policy A Way to Future In India?, vol 4 issue 1 SAMVEDANA E-Magazine, (2022) https://www.maitreyi.ac.in/uploads/research/Samvedna/issues/vol4/issue1/engsection/E10 .pdf

[9] 2018 SCC OnLine Bom 17525

[10] S Anukriti & Abhishek Chakravarty, Fertility Limits on Local Politicians in India, Indian statistical institute Delhi Centre (sep 2014) https://www.isid.ac.in/~epu/acegd2014/papers/AbhishekChakravarty.pdf

[11] Nirmala Buch, The stories that states tell chapter 26, 2 child norm part 2, E-adhyaan, Two Child Norm –Part II – The stories the states tell

[12] Aborting Indian democracy, Population research institute (jan 2015) Aborting Indian Democracy - Aborting Indian Democracy - Population Research Institute

strong ties with the gender role played by the women in work space. By providing maternity leave, the mother can take care of the child in an effective manner without losing her employment or salary. But maternity leave loses its actual role in the contemporary society and it has been viewed as an additional benefit for the women. Many of the states in India provides maternity leave till the 2nd child and after that there is no maternity leave both in public and private sector. This has been taken as a tool to control population by way of creating hardships to the women.

This view has been taken in the case of *Commissioner of Police &Anr. V. RavinaYadav &Anr*[13]where the Delhi High Court asked the government to make amendments in Rule 43 of CCS (Leave) Rules, 1972 which provides maternity leave to the mother only for her 1st and 2nd child. The court held that "The child from womb to infancy is an integral part of the concept of maternity, insofar as immediately from the birth moment across the stages of infancy the child undergoes extensive physical, physiological and psychological development, which would have significant bearing on her adulthood" and "Besides, on examining the issue from angle of child rights, we find that Rule 43 CCS(Leave) Rules creates an unreasonable distinction between rights of first two children born to a lady government servant and the third or the subsequent child, making the third and the subsequent child suffer deprivation of motherly care, which first two children had received. We are of *prima facie* view that classification of lady government servants on the basis of number of surviving children they have lacks intelligible differentia." This is also a violation of Convention on the Elimination of all Forms of Discrimination against Women and United Nations Convention on Rights of Child (UNCRC) and various fundamental rights and child rights. The same stance has also been taken in the case of *Deepika SinghV. Central Administrative Tribunal*[14] where the court considered that these policies defeat the object and intent of the purpose of granting maternity leave.

In Case of Disqualification in Panchayat Election

In many states, persons having more than 2 children are disqualified from contesting in local body election. The major reason is to portray them as an example to promote the 2-child policy. This is also upheld by the apex court in the case of Javed v. state of Haryana[15], where Section 175(1)(q) and 177 (1) of Haryana Panchayati Raj act 1994which provides that 'no person having more than two living children, shall be or continue be a Sarpanch or a Panch of a Gram Panchayat or a member of a Panchayat Samiti or Zila Parishad' had been challenged. The court held such disqualification to be not a violation of right to equality and rejected all the contentions of the petitioner. This becomes a landmark and has been consistently reiterated till now in many cases involving 2 child norm and there are many reasons why it needs a relook.

Why It Is Needs to be Relooked

1) no reason for why 2 is perfect – firstly, this judgement fails to provide reasons for the conclusion that why two is perfect, it left everything in the hands of legislative wisdom, without considering the basis, which might be, to achieve the tfr rate of 2 which has been already achieved by India.
2) lack of nexus - Secondly it totally lacks the rational relation need to be established between the object sought to be achieved by the statute in question and the differentia which is a sine qua non to provide an exception to article 14. While the court linked the population control with the purpose of election of local bodies it has nowhere intended to seek any evidence that such disqualification does really control the population growth. The Court has proceeded with the assumption that such disqualification would discourage the masses, however it's been passed more than twenty years there is no sign that the states who were having such laws have sailed better. The southern states having better literacy rates, health and awareness, don't have any such law better controlled the population growth than the states which have such laws.
3) Missing effect - Thirdly for a contention which questions the discrimination between states in implementing such policies, the court said that law can't be compared with other states because the source of power is different. On the contrary when the implementation of such law in the state and

[13] State v. Ravina Yadav, 2024 SCC OnLine Del 4987

[14] 2022 SCC OnLine SC 1088

[15] Javed v. State of Haryana, (2003) 8 SCC 369

central legislative elections is questioned the court held that "When the policies have far-reaching implications and are dynamic in nature, their implementation in a phased manner is welcome for it receives gradual willing acceptance and invites lesser resistance. The implementation of policy decision in a phased manner is suggestive neither of arbitrariness nor of discrimination."[16]Eventhough this stance was taken long ago, neither the population was decreased considerably nor the policy has been enhanced to include state and central legislature.

After this judgement, the involvement of the parliament in seeking new law intending to act towards two child norms has been significantly reduced. Even the health minister in 2019 while speaking in parliament citing data from NHFS and Census showed that government led awareness campaigns rather than force have a positive impact over population control.

4) Narrow view of Article 21- Fourthly, the court totally overlooked the other aspects of fundamental rights which has been infringed by this disqualification. The restriction is not only limited to participate in election, it is infringing the fundamental right, limiting the choice of a person and reproductive autonomy which is the jewel of article 21, further it also limits the right to be employed and the choice of employment which is different from the scenario persist at the time of judgement where contesting election is not considered as fundamental right.

5) Contradiction - Then court went through the problem of population explosion and its effect on the life of a common man, while doing so court used the help of a cited paper ofMrs. UshaTandon[17]. This paper, in any angle, doesn'tsupport the coercive population control measure rather it says that "in part iii of the Fundamental Right, the right to access the means of birth control must be included. The word access can be explained to include information, knowledge, suppliesand service of birth control measures."

   As per the author, the critical level of standard of livingwhich has been achieved by Kerala not only due to literacy and health control but the larger remittance received from Gulf termed Gulf Boom during 1970-80 also played a huge part in improving the standard of living of the person and taken out large en masse out of poverty. This hugely results in population control. And for the whole India to achieve this standard of Living it is not likely possible considering the lack of rapid economic growth; therefore, it is important to come out of marginal developmental syndrome and use other extra developmental methods.

   Since it is impossible to provide the required standard of living to affect the population, it should look for other extra developmental ways which is interpreted to be the coercive measures by the court but it totally overlooked the fact that these methods which take away the choice of living and results in providing a mere lifeless life or mere animal existence as held by the seven bench constitutional court in the case of Khraksingh vs State of Uttar Pradesh[18]"By the term 'life' as here used, something more is meant than mere animal existence. The inhibition against its deprivation extends to all those limbs and faculties by which life is enjoyed."

6) Lack of detailed review- Moreover the purpose of those measures which is to serve national interest and which has been sought by the national population policy 2000, has been achieved as per the data ofNHFS 5, therefore the necessity and usefulness of such law have been outdated. There is a need to overlook the law in the perspective of tracing a nexus between the imminent necessity of the scheme and the infringement of reproductive right. Court should take an approach to identify the rights within article 21 and should provide the necessary exception when those different rights can be taken away, to what extent it may be permissible to limit those rights, what are the threshold of the conditions to qualify to come into those exceptions.

V. In Case of Disqualification in Government Jobs

Falling apart from the disqualification in local bodies election, in the contemporary situation many states started forming disqualifications in government jobs for person who have more than 2 children. This have

[16] ibid

[17] Usha Tandon, Population Stabilization vis-à-vis the national commission to review the working of the constitution, Delhi Law Review, vol 23 2001 - DLR-VOL-XXI-2001.pdf

[18] 1963 AIR 1295

been challenged in supreme court in the case of Ramji Lal Jat v. State of Rajasthan, 2024[19] where the court held that such a disqualification is non-discriminatory and intra-vires the Constitution, since the objective behind the provision was to promote family planning.

Why it Can't be Considered as a Basic Necessity of the Society

The court didn't determine the necessity of the society before deciding that, these schemes are essential to satisfy the necessity, further it relied on a 20 years old case, without considering the change in population and the impact of these measures on the people. Therefore, it is totally arbitrary to take away the fundamental right without providing any valid justifications.

VI. Similar Schemes in Other Democratic Populated Countries

1. United States

In United states which follows a similar democracy as India, they are very much cautious not to infringe the rights of the individual with coercive population control. All the government policies regarding population control mostly revolves around educating people and creating awareness. "The U.S. does not endorse population "stabilization" or "control." The "ideal" family size should be determined by the desires of couples, not governments. The U.S. strongly opposes coercive population programs."[20]

Their primary focus is to increase voluntary family planning and to reduce unwanted pregnancy rather than using coercive means to control it.

2. Indonesia

Currently Indonesia is the fifth most populated country. Being less in size and less developed than India, the method they incorporated is more civilized than India. All the schemes and policies they use involve promoting family planning and to increase the use of birth control methods.[21]

being a poor country running mostly from humanitarian aid, Nigeria doesn't incorporate any coercive population control policy. They are more focused on providing health benefits to decrease the mortality rate and to promote reproductive health through voluntary means[22].

3. Brazil

As far as Brazil is concerned, they are more focused on training their youths and hone them as a reliable human resource. Their policies are more focused on educating the individuals especially women to create awareness regarding the effect of unwanted pregnancy[23].

VII. Suggestions

- When it comes to the conflict between fundamental rights and necessity of the society, a nuanced approach should be followed rather than sacrificing some right over the other.
- When an alternate approach is available which can be implemented it should be adopted rather than proceeding with the sacrificial method.Many alternate remedies like creating awareness, promoting the use of contraception and other birth control measures will be the obvious choice to help limit population without infringing the fundamental rights[24].
- Policies should be framed considering the contemporary state of the nation, India have long back in 2019 have achieved the TFR 2.0 as per data of NHFS[25]. Still promoting these policies will create an imbalance and inequality in the society

---

19 SCC OnLine SC 217

20 Population 2009 - 2017, U.S Department of State, Population

21 Oktavina, S. Population Growth Control Policy and Its Effect to Law Enforcement. Journal of Law and Legal Reform. P.228 (2020) https://journal.unnes.ac.id/sju/jllr/article/view/35460/15270

22 FOLAKEMI Ajala. Transitioning Nigeria's National Population Policy. (last accessed 12th march 2025) Transitioning Nigeria's National Population Policy: From Policy to Implementation - Nigeria Health Watch.

23 BRAZIL PROGRAM ACTIVITIES DATA, UNITED NATIONS POPULATION FUND. (2023) UNFPA Brazil | United Nations Population Fund

24 Poonam Muttreja, Sanghamitra Singh & Martand Kaushik, Busting myths about India's population growth, IDR online, (Aug 2024). Addressing misinformation on India's population growth | IDR

25 Update on Family Planning & Population Control in the country, Press Information Bureau. (Dec 2024) Press Release:Press Information Bureau

- People tend to have more children when they are concerned about the survival of their offspring. However, with the advancements in modern healthcare, child survivability has significantly improved. If the awareness provided to the public is increased, this misconception can be reduced from the minds of the people.
- When it comes to the population of India, many international institutions consider it as a double-edged sword, more than counting them as a pile of natural resource depletors, the government should consider them as a vast human resource which can be utilized for the betterment of the country with right policies.

VIII. Conclusion

As a democratic country and a signatory to several United Nations conventions on human rights, it is essential to protect and uphold these rights. They should not be treated as mere formalities to be sacrificed at the discretion of policymakers.Reproductive rights are critical, as they are closely linked to sensitive issues such as gender and caste, and the judiciary has a responsibility to ensure harmony between these rights. To uphold the right to bodily autonomy in one context while imposing restrictions based on the number of children in another is inherently contradictory. The court should consider the current situation and alternative measures before delivering a judgment, rather than relying on a case from decades ago without assessing its relevance or impact in today's context. Following this method to control the population will result in many social issues which are detriment to the whole nation, rather Policies should be drafted with a long-term perspective, considering their effects on citizens.

* * * *

REGULATIONS AND OVERSIGHT FOR SURROGACY ACROSS DIFFERENT COUNTRIES

Ms. Shanmugasundari S. *

Abstract

Surrogacy is an intricate reproductive practice. It elevates the social and legal concerns in society. This study analyses the difference between altruistic surrogacy, where surrogates receive no financial compensation and commercial surrogacy, where surrogates are financially remunerated. This study includes a comparative analysis of the legal status of surrogacy and its regulations across different countries focusing on USA, Canada, UK, Australia and Ukraine and also addresses the challenges faced by LGBTQ+ individuals for whom surrogacy is the only significant family building option. The findings highlight the diverse regulatory approaches, human rights concerns and international cooperation among nations. The lack of international harmonization and inconsistent regulations create challenges for intended parent surrogates and children born through surrogacy. It is essential to address these issues through international cooperation, clear regulation and protection of human rights.

Keywords: **Surrogacy, Altruistic surrogacy, Commercial surrogacy, LGBTQ+, International cooperation.**

I. Introduction

Individuals and couples seek to build their families through surrogacy,the need for clear,consistent,and comprehensive regulation and oversight has become paramount. Surrogacy is a form of assisted reproductive treatment(ART) in which woman carries and gives birth to a baby on behalf of another person or couple[1]. Surrogacy involves a combination of medical technology,legal agreement and social arrangements. However, the regulatory landscape for surrogacy varies significantly across different countries. Every parent couple makes the decision to become parents, but sometimes certain unanticipated events prevents this from happening. In the 1970s and 1980s,traditional surrogacy emerged,where the surrogate mother are also the egg donors.The development of surrogacy has been a gradual process, influenced by advances in medical technology,changing social and cultural norms and evolving regulatory frame works.The legal landscape of surrogacy is complex and diverse,reflecting different cultural,ethicaland legal perspective on this reproductive technology.Altruistic surrogacy is often given more importance and preference over commercial surrogacy.Laws of it vary by state,with some states having specific regulations and others leaving it unregulated.[1]

While countries like UK,Canada,and India allows altruistic surrogacy,countries like France,Italy,Germany and Spain prohibits surrogacy.It has become vital reproductive option for the LGBTQ community,enabling individuals and couple to build their families.However,the availability and legality of surrogacy for LGBTQ individuals vary significantly across different countries. As the result of LGBTQ community continues to advocate for greater reproductive autonomy and equality, it is essential to explore the intricate issues surrounding surrogacy for LGBTQ individuals across different countries. By prioritizing altruistic type,societies and governments aims to promote a more ethical,socially responsible and emotionally positive approach to surrogacy.

* **4th Year B.A.LL.B. (Hons)., School of Law, VEL Tech Rangarajan Dr. Sangunthala R & D Institute of Science and Technology Avadi**

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC6262674/

II. Altruistic and Commercial Surrogacy

Altruistic surrogacy is a type of surrogacy where the surrogate mother carries and gives birth to the child for another person or couple without receiving any financial compensation or reward[2].The surrogate mother's motivation is purely altruistic, driven by a desire to help others to build their families.By acknowledging and protecting the rights of both intended parents and surrogate mothers, surrogacy arrangements can be positive and empowering experience for everyone involved.This type of surrogacy is more often characterized by a strong emotional connection between the surrogate mother and the intended parents, and can be a more personalized and emotionally intricate arrangement.While altruistic surrogacy can be rewarding and fulfilling it also raises important considerations, including the need for support and counselling and the potential for complex emotions and relationships. It is legal in several countries including UK, Canada, Australia, Denmark, the Netherlands, Belgium, and India.

Commercial surrogacy is a type of surrogacy where the surrogate mother receives financial compensation or reward for carrying and giving birth to a child is commercial surrogacy, It is often facilitated by agencies or brokers who connect intended parents with surrogate mothers, and can involve complex contractual arrangements and legal agreements.While commercial surrogacy can provide an opportunity for individuals or couples to build their families, it also raises concerns about the exploitation and commodification of women's bodies and reproductive capacities. Additionally,commercial surrogacy can create in equitable power dynamics between the intended parents and the surrogate mother and is often poorly regulated, which can lead to abuses and exploitation.Commercial surrogacy has been practiced in different countries through out history, with laws varying by country.Thedevelopment of commercial surrogacy was noel keane, an American attorney who found the infertility centre of New York in 1976.It was the first programme to offer commercial surrogacy services, and it quickly gained popularity among intended parents, It has been the subject of controversy and debate,with some critics arguing that it exploits surrogate mothers and materialize human life.[2]

III. Legal Status of Surrogacy across Different Countries

Varied nations have varied laws governing surrogacy,which reflects differing ethical, social and cultural viewpoints on complex issues.

Countries that permits altruistic surrogacy include:

Canada : It has strict altruistic surrogacy laws,making it challenging to find surrogates and potentially slow for intended parents[3].

Greece : It allows altruistic surrogacy,with court approval required and only permits surrogacy for heterosexual couples and single women.

Argentina : Permits altruistic surrogacy where the surrogate isn't paid, only expenses are reimbursed.

Colombia : Allows altruistic surrogacy, and is considered as a cost effective option.

Mexico : Permits altruistic surrogacy and has a supportive frame work.

United Kingdom : Permits altruistic surrogacy arrangements, subject to specific legal requirements.

Australia : Altruistic surrogacy is permitted and commercial surrogacy is totally prohibited.

United states : Some states like California,New York and Illinois permit altruistic surrogacy.in some states compensated surrogacy is also permitted.

India : Allows Altruistic surrogacy.The Surrogacy (Regulation) Act,2021 prohibits commercial surrogacy to prevent exploitation of women.Before the ban, India was a popular destination for surrogacy, many foreigners,including individuals and same sex couples, sought Indian surrogacy services because of their affordability.

Thailand : Commercial surrogacy was previously allowed,but a 2015 law banned commercial surrogacy for foreign nationals.

---

[2] https://surrogate.com/about-surrogacy/types-of-surrogacy/what-is-altruistic-surrogacy/
As a result many countries have implemented regulations and laws governing commercial surrogacy, and the industry continues to evolve in response to these changes.

Countries like France, Germany, Italy, Spain, and China prohibited surrogacy and these countries have strict laws against it.

Countries like Russia, South Africa, Brazil have unclear laws and these countries have been considering changes to its laws.[3]

Case Laws:

Jan Balaz v. Anand municipality

The petitioner is of German nationality and the biological father through surrogacy of two children born to Marthaben Immanuel Khristi, an Indian citizen. Due to biological reasons, the petitioner's wife could not conceive a child, and an anonymous Indian citizen came forth, proposing to donate some ova for fertilization. The petitioner's sperm was fertilized by the donor's ova, and the fertilized embryo was implanted into the uterus of the surrogate mother. The surrogate mother gave birth to two baby boys in India on 4-1-2008. At this point in time, the babies were granted citizenship and passports of India, but the petitioner wants to take them to Germany and provide for their German citizenship because surrogacy is not recognized in Germany. The petitioner submitted in the court stating that the refusal to grant the new born the passport is illegal, violates of Article 21 of the Constitution of India.

In terms of Section 3(1)(c)(ii) of the Citizenship Act, the babies gestational borne in India, thus, will qualify to be citizens of India and empowered to apply for passports. The Passport Authorities are directed to return the passports seized from them immediately. In the weak and lame local legal framework, nothing else can be provided but to result in the conclusion that the babies en masse in this case are Indian citizens, and this calls for wholesome and secured legislation for any issues created in the wake of reproductive science and technology.

The Re X and Y foreign surrogacy case,

The Re X and Y foreign surrogacy case is a landmark ruling that highlights the complexities of international surrogacy arrangements. The case involves a British couple who entered into a commercial surrogacy arrangement in Ukraine, where a married Ukrainian woman acted as the surrogate mother. The couple, who were the biological parents of the twins, sought a parental order under the Human Fertilization and Embryology Act 1990 to establish legal parenthood.

However, the case was complicated by the fact that the surrogate mother was considered the legal mother of the children under English law, despite not being biologically related to them. The court ultimately granted the parental order, but the case raised important questions about the regulation of international surrogacy arrangements and the need for clearer guidance on the legal implications of such arrangements.The case also highlights the risks associated with international surrogacy, including the potential for conflicting laws and regulations, and the need for intended parents to seek expert advice before entering into such arrangements.[4]

IV. Surrogacy for LGBTQ+ Parents

LGBTQ Individuals face challenges when building their family.Surrogacy is the only option them to build a family. Biologically it is not possible for a gay men and transgender women to carry pregnancy themselves.Since LGBTQ+ individuals face a lot of discrimination they lack access to fertility services. If LGBTQ+ couples opt for surrogacy they have the following advantages and disadvantages.

Advantages:

One or both partners can have a biological connection to the child. Intended parents have more control over the pregnancy and both processu .It can be deeply emotional and fulfilling experiences for intended parents.

Disadvantages:

Surrogacy can be expensive and it involves a complex legal arrangement. Involve emotional risks, including attachment issues and potential conflicts with the surrogates.

LGBTQ+ couple can build a family through traditional surrogacy, gestational surrogacy, egg\sperm donation.

Traditional surrogacy: Surrogate mother provides egg & carries the pregnancy.

[3] https://www.canada.ca/

[4] https://www.casemine.com/judgement/in/56b48efa607dba348fff6a16/amp

Gestational surrogacy: Surrogate mother carries the pregnancy, but the egg and sperm comes from intended parents and donors.[5]

V. Conclusion

In conclusion, the regulations and oversight for surrogacy vary significantly across different countries, reflecting diverse cultural, social, and ethical perspectives on this complex issue. While some countries have established clear laws and guidelines governing surrogacy, others have unclear or changing laws, creating uncertainty and risks for all parties involved.Ultimately, the goal is to protect the rights and welfare of all parties involved, including surrogate mothers, intended parents, and children born through surrogacy. By establishing clear and robust regulations, we can ensure that surrogacy is practiced in a safe, ethical, and responsible manner.

* * * *

[5] https://www.webmd.com/infertility-and-reproduction/using-surrogate-mother

ADVANCEMENTS OF REPRODUCTIVE TECHNOLOGIES AMIDST THE INCESSANT SOCIETAL STIGMAS

Ms. Tanishqa Sarolkar *
Ms. Gagana V. **

Abstract

Reproductive and sexual health has been a critical theme in several women's lives, following a sequential nature through menstruation, contraception, fertility, sexually transmitted infections, abortions, unplanned pregnancy or menopause, etc. Therefore access and awareness of such health facilities is crucial, especially with India being one of the most populated countries in the world, harboring a female population of 48.41%. The need for safer childbirth, sex and menstrual cycle remains as essential as ever.

Previous research on this topic has covered a lot of essential points such as negative assumptions and taboos in society and how it plays a role in medical neglect. This study will involve a more comprehensive understanding of outdated perspectives and the futuristic implications of reproductive technologies as well as exploring the role of politics and media in promoting or demoting this revolution, along with a legal perspective. Through this study we seek to conduct an objective discussion on the topic of reproductive healthcare and how thelegislative blanket shields it from the unjust, employing a mixed method approach of research inclusive of qualitative analysis, policy reviews, and various case studies.

Through this research, we seek to analyze the legislative framework concerning reproductive and sexual healthcare and its evolution through the years despite the persisting social stigmas and economic disadvantages of a few social classes.This paper aims to understand why it is imperative to research women's reproductive and sexual health, as well as spread awareness and improve access to facilities, while also comprehending how a strong legislative framework and adapting appropriate policies can strategically eliminate ignorance and neglect to women's needs and build a bridge that brings our society closer to greater gender equity.

I. Introduction

Defining Reproductive and Sexual Health [RSH]

Reproduction is an essential biological stage in the human lifecycle, resulting in the creation of new organisms and offsprings; reproductive health is a topic with broader scope including sexually transmitted diseases, prenatal and postnatal care, contraception, infertility, menstruation, maternal and perinatal health, etc.,[1] all of which builds a route towards a healthier social, mental and physical wellbeing as well as unperturbed sexual health. Given this broad scope, reproductive health is deeply intertwined with sexual health, which is not merely the absence of disease or dysfunctionality but a state of overall well-being.

The World Health Organization (2006a) defines it as "A state of physical, emotional, mental and social well-being about sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence."[2]

The term 'sexual and reproductive health' can be defined as a person's right to a healthy body; the autonomy, education, and healthcare to decide whom to have sex with freely; and the knowledge and healthcare products

* **2nd year B.Com.LL. B, Kristu Jayanti College of Law, Author**

** **2nd year B.A. LL. B (Hons.) CMR School of Legal Studies, co-author**

1 Victoria State Government BetterHealth Channel. Women's sexual and reproductive health. https://www.betterhealth.vic.gov.au/campaigns/womens-sexual-and-reproductive-health

2 The World Health Organisation [WHO], 2006a. Sexual and Reproductive Health and Research (SRH).

to avoid sexually transmitted infections or unintended pregnancy. A healthy sexual well-being ensures people can have safe sexual experiences, free of discrimination and health risks.

Access to sexual and reproductive health services enables people to exercise this right. A cautious approach on medical care and inclusivity of healthcare topics, considered as taboo in the current society, would encourage a more curious outlook on being more sexually healthy.

Despite the broader scope that sexual and reproductive healthcare addresses, this paper specifically covers access to reproductive and sexual healthcare. The evolution of reproductive healthcare and how the cultural barriers, taboos, religion, economic status, and negative assumptions shaped the mindset of women in this day and age and how it will impact the use, access, and acceptance of emerging technology that allows for safer and healthier reproductive health.

The research emphasizes the importance of ensuring that access to assisted reproductive technologies is available to all segments of society, regardless of their economic or financial circumstances, advocating for equitable access for everyone.

Evolution of Reproductive Rights: From Stigma to Legal Recognition

Over the years' reproductive healthcare was viewed more as a stigma than a legal necessity in many areas such as contraception, abortions as well as premarital sex. Early stereotypical thinking and stigmatization have strongly influenced the mindsets of young women.

This can be observed through the reaction of society towards menstrual cycles as numerous cultures perceive menstruation as a subject that ought to be concealed, resulting in feelings of embarrassment as well as dictating how women should conduct themselves during their menstrual periods.[3] For instance, women may be instructed from a young age that menstruation is a private issue and that any visible indicators of such are a source of shame, which can lead to considerable stress and anxiety.

In various societies, menstruation is linked to concepts of purity and cleanliness, often associating it with the idea of an "unclean" woman. This association fosters the belief that women should be isolated or barred from engaging in certain rituals, religious practices, or social events while menstruating. Such views propagate the notion that menstruation is inherently dirty or impure, thereby reinforcing stigma.[4]

Cultural expectations impose gender-specific norms regarding menstruation, frequently depicting it as a period of weakness or emotional instability which results in diminished respect in both professional and social contexts. These associations limit women's autonomy and control over their bodies.

In certain cultures, specific rituals or customs are observed during menstruation that further entrench taboos. These may include separation from family, restrictions on particular foods, or even bans on physical activities, all of which contribute to the stigmatization of menstruation.[5]

Many educational institutions perpetuate cultural taboos by failing to deliver comprehensive information about menstruation. When such subjects are only superficially addressed, individuals who grow up without essential knowledge exacerbate the stigma and aggravate the misconceptions.

However, such taboos are challenged and easier accessibility is made possible by the participation of the Menstrual Hygiene Scheme (MHS) and social health activists recognized by ASHA.[6] Promoting the de-stigmatization of menstruation health, highlighting the importance of legality in ensuring that more women enjoy better, healthier lives.

Barriers to Access: Cultural, Religious and Ethical Considerations

Healthcare systems in rural areas frequently lack cohesive services, complicating the process for women to obtain comprehensive care. As a result, women may need to consult multiple providers to address various

[3] International Institute for Population Sciences (IIPS) and ICF. 2021. *National Family Health Survey (NHFS-5), 2019-2021: India: Volume 1*. Mumbai: IIPS.

[4] Department of Health and Family Welfare. (2024). National Menstrual Hygiene Policy. Unstarred Question No 1348. https://sansad.in/getFile/loksabhaquestions/annex/1715/AU1348.pdf?source=pqals

[5] Woog V, et al. Susheela, S., Alyssa, B., & Jesse, P. Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries, NEW YORK: GUTTMACHER INSTITUTE 6–40 (2015).

[6] Jain, Monika. ASHA- A hope towards Menstrual Health, International Journal of Advances in Engineering and Management (IJAEM) Volume 4, Issue 6 June 2022, pp: 1056-1059 (2022).

aspects of Sexual and Reproductive Health (SRH), which can lead to confusion and delays in receiving care.

Some healthcare providers may also hold biases against certain sexual and reproductive services, such as abortion. This can result in hesitance to offer necessary guidance, causing frustration for patients. Negative experiences may also discourage women from seeking care altogether.Numerous rural regions experience a deficit of healthcare professionals, this shortage can result in extended wait times for appointments or a lack of essential services, such as gynaecological examinations and contraceptive counselling.[7]

Therefore, women have to travel significant distances to obtain care unavailable locally.[8] This includes travel expenses and out-of-pocket costs for services that may not be covered by insurance. This issue is further complicated for women with childcare responsibilities or those lacking support systems. Geographic isolation or remote areas may discourage women from seeking necessary care, particularly for those without reliable transportation.

Women may lack a basic understanding of the reproductive healthcare services available to them or may be unaware of how to access these services. Educational outreach and health promotion efforts are often inadequate in rural communities, resulting in knowledge gaps.

This sexual and reproductive health stigma fosters a culture of silence, leading women to feel ashamed or reluctant to pursue the necessary care. Women may suffer from anxiety or stress when attempting to access such services, especially in environments lacking support or connection to the healthcare system. The psychological strain of navigating healthcare amidst these challenges can result in avoidance and unaddressed health needs.

II. Innovations in Reproductive Health, Technology, and Empowering Women

Innovations Surrounding Reproductive Technologies

Pre-1978: The origins of assisted reproduction can be traced back to ancient societies, when various techniques were utilized to enhance fertility, including herbal remedies and ceremonial practices, but what truly triggered the expansion of reproductive technologies is the birth of Louise Brown, on July 25 1978, through IVF or In-Vitro fertilization which, in simple terms, is conceiving fertilized eggs with sperms in a laboratory.[9]

On October 3, 1978, India welcomed its first test tube baby, Kanupriya Agarwal, merely three months after the birth of the world's first in-vitro fertilization baby, Louise Brown, in the United Kingdom. This landmark achievement was led by the esteemed Indian Scientist Dr. Subhash Mukherjee.[10] Since then there has been an increase in ART facilities, with a total of 580 accredited ART clinics throughout the nation, reflecting significant growth in the accessibility of reproductive technology services. The ART industry in India has shown a considerable expansion and has projected an amount exceeding $1 billion in value, signifying a thriving market for assisted reproductive services.[11] With this, India has positioned itself as a prominent contributor in the global ART arena, engaging in various research initiatives and clinical advancements, thereby making services accessible to both domestic and international patients.

The nation has adopted a range of ART methodologies, such as in-vitro fertilization (IVF), surrogacy, and cloning, rendering these procedures commonplace in numerous sectors.

Technological advancements:

Ongoing innovations in reproductive technologies are emerging, including enhancements in embryo culture techniques, genetic screening, and the application of artificial intelligence to predict in-vitro fertilization

---

7 Bhasin, Shikha, et al., Shukla., A. & Desai., S. Services for women's sexual and reproductive health in India:an analysis of treatment-seeking for symptoms of reproductive tract infections in a nationally representative survey. BMC Women's Health 20, 156 (2020).

8 *Laxmi Mandal vs Deen Dayal Harinagar Hospital & Ors.,* (2009) ILDC 1848 (2010) (per S.MURALIDHAR) (India).

9 Eskew AM, Jungheim ES. A History of Developments to Improve in vitro Fertilization. Mo Med. 2017 May-Jun;114(3):156-159. PMID: 30228571; PMCID: PMC6140213 (2017).

10 Bharadwaj A. The Indian IVF saga: a contested history. Reprod Biomed Soc Online. 2016 Jul 19;2:54-61. doi: 10.1016/j.rbms.2016.06.002. PMID: 29892717; PMCID: PMC5991886, (2016).

11 Tholeti, Prathima, et al., Uppangala, S., Kalthur, G., & Adiga, S.K. The landscape of assisted reproductive technology access in India. Reproduction and Fertility (2024) 5 e240079. (2024).

success rates. The introduction of non-invasive embryo selection methods, such as time-lapse imaging[12], has significantly improved the efficiency of ART procedures.

Cryopreservation

The capability to freeze and store embryos and sperm, known as cryopreservation, represented a major leap forward in assisted reproductive technology, facilitating the preservation of genetic material for future utilization.[13] This technology has allowed couples to participate in in-vitro fertilization (IVF) cycles without the immediate urgency of implantation, thereby enhancing flexibility in family planning.

The success of ART in western nations prompted its global adoption, resulting in the establishment of clinics in various regions, including Asia, Africa, and Latin America. Countries such as India and Thailand emerged as favoured locations for "reproductive tourism," attracting individuals and couples seeking affordable Assisted Reproduction Technologies services. Various countries have implemented differing regulatory frameworks to address these issues, reflecting their cultural values and ethical considerations.

Advocacy and Systemic Reform

In India, to maneuver this arising problem, the Assisted Reproductive Technologies Act, 2021[14] was introduced to address ethical issues concerning assisted reproduction such as:

Informed Consent: There are considerable apprehensions regarding the extent to which patients truly provide informed consent concerning the procedures, risks, and consequences associated with Assisted Reproductive Technology (ART), especially in the context of utilizing donor gametes and embryos.

Surrogacy: The ethical dimensions of surrogacy involve the rights of the surrogate mother, the commercialization of the process, and the potential exploitation of women from lower socioeconomic backgrounds. While the Assisted Reproductive Technology (Regulation) Act, 2021 includes measures intended to protect the rights of surrogate mothers, numerous obstacles remain.[15]

Access and Equity: A significant gap exists in the availability of ART services, which are often prohibitively expensive and typically not included in insurance coverage. This scenario prompts essential inquiries regarding equity and the risk that ART may deepen existing inequalities related to socioeconomic status.

Use of Donor Gametes: The ethical implications of employing donor sperm or eggs warrant a thorough investigation, encompassing concerns about anonymity, the potential for future parental rights claims, and the psychological impact on children conceived through ART.

Genetic Screening and Selection: The ability to perform genetic testing and select embryos based on particular genetic characteristics or sex raises ethical questions, highlighting concerns about eugenics and the wider societal consequences of producing "designer babies."[16]

Regulation and Oversight: The lack of standardized regulations across different countries and clinics creates ethical dilemmas regarding the safety and efficacy of ART practices. The existing literature underscores the urgent need for comprehensive legal and ethical frameworks to regulate these practices effectively.

Future Directions

Research and Development:

Current research endeavors are focused on enhancing the success rates of ART, lowering costs, and improving accessibility for the entirety of the population. The incorporation of genetic technologies, such as clustered regularly interspaced short palindromic repeats, introduces new opportunities and ethical dilemmas concerning

---

[12] Kovacs P, et al., Matyas S, Forgacs V, Sajgo A, Molnar L, Pribenszky C. Non-invasive embryo evaluation and selection using time-lapse monitoring: Results of a randomized controlled study. Eur J ObstetGynecolReprod Biol. 2019 Feb;233:58-63. doi: 10.1016/j.ejogrb.2018.12.011. Epub 2018 Dec 14. PMID: 30580224, (2019).

[13] Levi, Andrew. (2024) Overview of the types of assisted reproductive techniques (ART). Park Avenue Fertility. https://parkavefertility.com/overview-of-the-types-of-assisted-reproductive-techniques-art/

[14] The Assisted Reproductive Technology (Regulation) Act, 2021

[15] Dr. Aneesh Phil, Surrogate Motherhood and the Law International and National Perspectives 76–108, 171–202 (K.C Sunny, Regal Publications 2015) (2015).

[16] Nishith Desai Associates. (2024). *Are we ready for Designer Babies.* Strategic, Legal, Tax and EthicalIssues. https://www.nishithdesai.com/fileadmin/user_upload/pdfs/Research_Papers/Designer_Babies.pdf

genetic modification and the concept of designer babies, tackling the inequalities in access to ART remains a pressing concern, especially in resource-limited environments where infertility rates are elevated, yet ART services are scarce.

Assisted Reproduction: Empowering Women and Challenging Medical Bias

Assisted reproductive technologies (ARTS) hold the promise of significantly empowering women by enhancing their control over reproductive decisions and confronting the medical biases that frequently pervade conventional reproductive health care. Enabling women to make informed choices regarding their bodies and reproductive paths, contributes to the dismantling of societal and medical obstacles that have historically restricted women's autonomy.

Empowerment through options

A key aspect of how ARTS empower women is by broadening their reproductive options. Women can now achieve conception independently of a male partner, which allows single women and same-sex couples to pursue parenthood according to their preferences. This independence cultivates a sense of empowerment, enabling women to make choices aligned with their desires and ambitions rather than conforming to societal norms. Additionally, it provides women the opportunity to postpone childbirth for various personal or professional reasons, thus allowing them to focus on their education and careers without the constraints of traditional timelines.

Challenging Medical Bias

Medical bias in reproductive health care often appears through assumptions regarding women's fertility, age, and lifestyle choices. Women may encounter unwarranted scrutiny concerning their reproductive decisions, resulting in stigmatization and discrimination. ARTS can alleviate these biases by offering a more objective approach to evaluating fertility and reproductive health. With technological advancements, healthcare professionals can develop tailored treatment plans that cater to individual circumstances rather than relying on generalized perceptions of women's reproductive abilities.

Mitigating the Stigmatization of Infertility

Infertility is frequently perceived as a personal shortcoming, leading to feelings of shame and inadequacy among women. ARTs can help transform this narrative by presenting infertility as a medical issue that can be addressed rather than a measure of a woman's value.

The normalization of assisted reproductive technologies can create a more supportive atmosphere for women facing infertility, thereby diminishing the stigma linked to seeking help. This transformation can empower women to advocate for their reproductive health without the apprehension of being judged.

It also enhances inclusivity by offering alternatives for women from various backgrounds, including those with congenital disabilities or genetic conditions. These technologies enable women to make informed decisions regarding their reproductive health, allowing them to avert the transmission of hereditary illnesses to their offspring.[17] By providing a spectrum of reproductive choices, ARTs can ensure that all women, irrespective of their situations, have the chance to become mothers.

Assisted reproductive technologies possess the capacity to elevate women by granting them increased autonomy, addressing medical biases, and alleviating the stigma surrounding infertility. Therefore, it is crucial to implement them equitably and inclusively, ultimately cultivating a more supportive environment for all women in their reproductive journeys, and allowing them to move beyond traditional biological limitations associated with motherhood.

Adjusting ART or assisted Reproductive Technologies amidst Societal Stigmas.

During this study, we analysed the landmark case law, *Sushma Devi vs State of Himachal and others*[18]as a reference to understand the impact societal stigmas might have-

This case illustrates the lag in governmental policies relative to the rapid developments in reproductive

[17] Richards, Martin, Assisted Reproduction, Genetic Technologies, and Family Life. The Blackwell Companion to the Sociology of Families, pp. 478-498, SN - 9780631221586, (2004).

[18] Sushma Devi vs State Of Himachal Pradesh And Others.,(2020) CWP No.4509 (2021) (per Tarlok Singh Chauhan, Sandeep Sharma) (India).

technologies. While Rule 43(1) of the CCS (Leave) Rules, 1972 acknowledges adoption leave, there is a conspicuous absence of provisions for maternity leave for women who become parents through surrogacy. This gap indicates that legal frameworks in India are still inadequately equipped to address the complexities introduced by assisted reproductive technologies (ARTs), thereby creating obstacles for individuals who utilize these methods.

The petitioner, a female government employee, is advocating for maternity leave for a child conceived via surrogacy. This situation challenges conventional definitions of motherhood, which typically associate maternity leave with biological childbirth or adoption. The case emphasizes the necessity of acknowledging surrogacy as a valid pathway to parenthood, thereby ensuring equitable rights for intended mothers.

In India, surrogacy frequently encounters scepticism, particularly within traditional and bureaucratic environments. The absence of definitive government policies regarding surrogacy leave indirectly mirrors the societal stigma attached to alternative reproductive options. This case exemplifies the institutional challenges and societal prejudices that women who choose surrogacy continue to confront.

As advancements in technology render surrogacy a more accessible choice for numerous families, the legal system must evolve to prevent penalization of women opting for this route. The case highlights the pressing need for policy reforms aimed at safeguarding women's rights, and ensuring that maternity benefits are inclusive of all forms of motherhood.

The influence of traditional family structures on workplace policies is evident in the case presented. In India, numerous working women, particularly those employed in government positions, continue to face challenges due to policies that fail to recognize contemporary family-building practices. This situation underscores the necessity for societal norms and legal frameworks to adapt in tandem with scientific progress, ensuring equitable opportunities for all women. Therefore, this case is a clear example of the struggles of advancement in technology and adjusting to the societal stigmas prompting demands for enhanced maternal health policies.

In the field of assisted reproduction, it is equally important to engage in advocacy. Insights gained from the Sushma Devi case can guide efforts to promote reforms that ensure ART is properly regulated, safe, and accessible. This may involve leveraging successful initiatives, such as targeted financial incentives and maternal health programs, to establish supportive frameworks for reproductive technologies.

Another example of this would be*K. Kalaiselvi v. Chennai Port Trust*[19]. K. Kalaiselvi, the petitioner, has served as an Assistant Superintendent in the Traffic Department of the Chennai Port Trust for a duration of 24 years. Following the tragic loss of her only son, she opted to have a child through surrogacy. After the child's birth, she sought maternity leave; however, she was informed that her request was denied because she was ineligible for maternity leave due to the surrogacy arrangement. This decision was made even though Rule 3-A of the Madras Port Trust (Leave) Regulations recognizes maternity leave for individuals who adopt a child. In support of her case, the counsel referenced Article 25(2) of the Universal Declaration of Human Rights, Article 6 of the Convention on the Rights of the Child, and Articles 17 and 33 of the Beijing Declaration and Platform for Action from the Fourth World Conference on Women. The counsel argued that the petitioner is unequivocally the mother of a minor female child and that, in consideration of the child's welfare, she should be granted the maternity leave she requested.

The principal constitutional concerns associated with the ART Act, 2021 and the Surrogacy (regulation) Act, 2021 are as follows:

There are claims that these acts infringe upon fundamental rights enshrined in the constitution, specifically articles 14, 15(1), and 21, which safeguard against discrimination, guarantee equality before the law, and uphold personal liberty.The acts impose unjustified limitations on access to ART and surrogacy services, influenced by criteria such as age, marital status, and sexual orientation, which are considered to lack a logical connection to the intended regulatory goals.

The acts have been criticized for embodying a paternalistic and interventionist stance by the state, which undermines the autonomy and decision-making power of individuals, particularly women, regarding their

[19] K.Kalaiselvi vs Chennai Port Trust., (2013), Madras High Court, (per K.Chandru) (India).

bodies and reproductive choices.The prohibition of commercial surrogacy is perceived as indicative of a mind-set among policymakers that undermines agency and autonomy, assigning a greater degree of criminality to beneficiaries under these acts.These concerns highlight significant issues regarding the constitutionality and equity of the regulatory framework established by the ART Act, of 2021 and the Surrogacy (regulation) Act, of 2021.

Individuals residing in rural and remote regions frequently encounter challenges in accessing ART services, which are predominantly situated in urban areas, thereby limiting treatment availability.The substantial expenses associated with ART procedures and medications, along with insufficient insurance coverage, can significantly impede access for numerous patients.A lower socioeconomic status correlates with reduced access to ART, impacting patients' financial capacity to afford treatments.Feelings of stigma, shame, and anxiety related to infertility may deter individuals from pursuing treatment. Furthermore, psychological issues can be intensified by the ART experience.

Individuals with lower levels of education may possess a limited understanding of fertility challenges and available treatment options, resulting in decreased access.The absence of health insurance or restricted coverage for ART procedures can create a significant barrier, rendering treatments financially unattainable for many.Specific cultural beliefs and attitudes may influence individuals' readiness to seek assisted reproductive technologies, with particular populations encountering distinct barriers linked to their ethnic identities.

Advanced age, especially among women, can diminish the likelihood of pursuing assisted reproductive technologies, as older patients may experience reduced fertility and increased health risks.

These barriers are interconnected and contribute to the disparities in access to assisted reproductive technologies, underscoring the necessity for focused interventions to enhance access and support for those affected.

III. Recommendations/ Suggestions

The advancement of reproductive technology and development of sexual rights is a constant process evolving through the years. However, despite new discoveries and new research, our technology and legislation will fail to reach their full potential if the recipients remain unaware of it. As a result, certain necessary developments are crucial to ensure the successful delivery of these technologies and laws:

- Awareness Programs: Awareness programs and educational workshops on matters such as women's health, reproductive rights and sexual rights– in both rural and urban areas will help women learn of their rights and know their bodies better. It will also educate them on evolving technologies with respect to reproduction and sexual health. ANM and ASHA are organisations that have been actively working towards campaigning and arranging for schemes and programs to boost women's knowledge on their rights and health, retroactively empowering them.[20]
- Collaborations with NGOs: Cooperation with local NGOs and women's rights organisations to empower both rural and urban sections of the female population to teach about women's health in schools, workplaces, as well as provide incentives for the poorer sections of the society to access healthcare services typically unavailable to them. Gram Vikas Trust, Ipas Development Foundation, WHRRO, FMCH are NGOs actively working towards such causes and guiding women towards a healthier, brighter future.
- Insurance Coverage: Annual health check-ups and maternity covers, as well as access to contraception and financial protection for maternal and reproductive health services are crucial in preventing unplanned pregnancies, sexually transmitted infections, and cervical cancers. Health insurances for reproductive and sexual health of women are important and crucial to preserve and protect a women's health. Notably, countries like Belgium, Denmark, Slovenia, having the most generous reimbursement policies in Europe and high rates of IVF availability and uptake, have almost full insurance coverage for up to six cycles of IVF treatment. With availability rates over 1500 per million, the full state insurance coverage of IVF

[20] Jain, Monika. ASHA- A hope towards Menstrual Health, International Journal of Advances in Engineering and Management (IJAEM) Volume 4, Issue 6 June 2022, pp: 1056-1059 (2022).

in these states meet the global need for IVF among infertile couples.[21] A study conducted from Korean National Health Insurance Service (NHIS) database confirmed pregnancies and births in Korea saw a rise after the implementation of ART health insurance coverage policy, further clarifying the effectiveness of ART policies as it could support infertile couples and reduce the economic burden on parents employing ART services to have children.[22] Insurance policies in India for IVF procedures and assisted reproductive techniques still leave much room for improvement. The policies of these countries could serve as blueprints for further developing insurance coverage schemes in India.

- Schemes and Policies: Schemes and initiatives by the government to protect women's mental and physical health as well as provide support and assistance to women who need it. Schemes such as SurakshitMatritvaAashwasan (SUMAN), Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), LaQshya, and such are a few examples of steps taken by government in this regard. However, as the world remains dynamic and changing, updating these schemes and putting new policies in place remain just as important as ever.
- Supervision and Inspection of Public Hospitals: Regular scrutiny and investigation of public healthcare facilities, especially hospitals by ombudsman and healthcare inspectors will be effective in ensuring that these spaces remain professional and sincere in their working as well as maintain a sanitised, healthy environment for their patients.

IV. Conclusion

Reproductive technologies have profoundly transformed the landscape of reproductive health, creating various pathways to parenthood and empowering individuals, particularly women, with greater autonomy over their reproductive choices. However, despite these scientific advancements, enduring societal stigma and a lack of adequate legal recognition continue to hinder the widespread acceptance and accessibility of these technologies. Analysing cases such as *Sushma Devi vs The State of Himachal* highlights the gap between technological advancements and existing policies, emphasizing the pressing need for legislative reforms that encompass all facets of parenthood, including surrogacy and assisted reproductive technologies (ART). Additionally, it postpones childbirth, and explores parenthood within various family configurations, ultimately fostering sexual equality and personal freedom. Socio-cultural barriers, financial constraints, and gender discrimination persist, particularly affecting marginalized communities. To achieve meaningful progress, it is essential to recognize reproductive rights as fundamental human rights. Addressing misinformation, promoting education, and ensuring equitable access to reproductive healthcare are vital steps in challenging outdated perceptions. Legal and institutional frameworks must evolve in tandem with technological advancements to protect individuals from discrimination and to provide comprehensive reproductive healthcare services. Only through a unified advocacy effort, policy reform, and heightened societal awareness can we bridge the divide between scientific innovation and its practical implementation, fostering a future where reproductive autonomy is universally recognized as a right.

* * * *

[21] ESHRE fact sheets, The funding of IVF treatment (Issued on 4th January, 2017).

[22] Cha W, et al. Yun I, Nam CM, Nam JY, Park EC, Evaluation of Assisted Reproductive Technology Health Insurance Coverage for Multiple Pregnancies and Births in Korea. JAMA Netw Open, (2023).

JUSTICE FOR CHOICE: CONFRONTING LEGAL CHALLENGES IN REPRODUCTIVE RIGHTS ADVOCACY IN INDIA

Ms. Liya Mathew *

Ms. Rittu Mary Sam *

Reproductive choices are central to women's empowerment because they are first-order "strategic life choices that are critical for people to live the lives they want."[1].

Abstract

Reproductive rights in India have been the subject of much legal, social, and political debate for a long time, as constitutional guarantees are balanced against legislative and judicial interpretations. Although India has made great progress in acknowledging reproductive autonomy, most famously via the Medical Termination of Pregnancy (MTP) Act and court rulings, challenges still exist because of limited access to healthcare, tight laws, and societal stigma. With an eye toward access to abortion, contraception, and assisted reproductive technologies, this article critically analyses the changing legal setting surrounding reproductive rights.

This paper investigates how legal frameworks support and undermine reproductive autonomy, particularly for marginalised communities, and assesses the role of judicial activism in defending individual rights using an analysis of historic Supreme Court and High Court decisions. This paper emphasises the court's contribution to advancing reproductive justice. It also tackles the ongoing difficulties presented by tight legislation, administrative roadblocks, and the impact of personal laws on reproductive choice.

Bridging the distance between legislative requirements and ground reality requires advocacy. The present research looks at how public interest litigations, grassroots movements, non-governmental organisations, and legal advocacy have helped to change policies and raise knowledge of reproductive rights. It also examines India's responsibilities under treaties like CEDAW.

In conclusion, to guarantee reproductive justice in India, the study underlines the pressing necessity of legal reforms, intersectional policymaking, and ongoing campaigning. Securing reproductive autonomy and gender equality in the nation depends on enhancing legislative protections, removing structural obstacles, and encouraging public conversation.

Keywords: **Reproductive Rights, Legal Advocacy, Abortion, Judicial Activism, Reproductive choice**

I. Introduction

Women have an inherent right to make decisions about their reproductive health. Reproductive rights encompass a woman's autonomy in accessing various reproductive healthcare services, including contraception and legal abortion, without coercion or discrimination. Rooted in the feminist movement, this concept emphasizes the recognition of women's rights concerning sexuality and reproduction. These rights extend beyond just health and fertility; they include personal freedom, protection from discrimination, respect for individual choices, access to reliable information for informed decision-making, self-determination, and the ability to choose whether or not to become a parent.

II. Reproductive Rights

According to the World Health Organization, reproductive rights are essential for individuals and couples, enabling them to make informed and responsible decisions about family planning, including the number of

* **Student, Mar Gregorios College of Law, Trivandrum, Kerala**

** **Student, Mar Gregorios College of Law, Trivandrum, Kerala**

[1] Julia McReynolds-Pérez, Abortion as Empowerment: Reproductive Rights Activism in a Legally Restricted Context, 17 BMC Pregnancy & Childbirth 95, 97 (2017).

children they wish to have and the intervals between births. Moreover, it highlights the necessity of providing access to relevant information and resources to support these choices, along with ensuring the right to achieve the highest possible standards of sexual and reproductive health[2].

Grounded in the whole accomplishment and defence of women's mortal rights, a group of Black women in Chicago established the term "reproductive justice", defined as the whole physical, internal, spiritual, political, social, and profitable well-being of women and girls[3].

In India, reproductive rights remain a multifaceted and often debated issue, shaped by the country's rich cultural diversity and historical background. The conversation surrounding individuals' rights, especially women's, to make informed choices about their reproductive health has been a topic of significant discussion and examination. This debate is particularly relevant in a nation undergoing profound social, political, and economic changes[4].

India's reproductive rights are supported by key laws and constitutional provisions. Article 21 of the Constitution, which ensures the right to life and personal liberty, has been interpreted to include reproductive rights, as affirmed in *Suchita Srivastava v. Chandigarh Administration* (2009)[5]. The Supreme Court further strengthened this in *K.S. Puttaswamy v. Union of India* (2017)[6], recognizing reproductive autonomy as part of the fundamental right to privacy.

Judicial activism has played a crucial role in advancing reproductive justice. Even though India, being a member of the United Nations, has ratified numerous international agreements, all of which acknowledge women's rights and reproductive rights,[7]significant gaps remain in legislative implementation.

III. Reproductive Rights Remain a Contentious Legal and Social Issue in India

India was among the first countries to legalize contraception and abortion, yet women still face challenges in exercising their reproductive rights. Limited decision-making power, poor healthcare access, and policies prioritizing population control over individual rights remain issues. While the National Population Policy ensures voluntary contraceptive access, state-driven female sterilization has led to coercion and restricted access to reversible methods.

The Medical Termination of Pregnancy (MTP) Act provides for abortion on a number of grounds up to 20 weeks of gestation; it can be extended and also performed after that, where necessary to save the woman's life. This accounts for about 9% of deaths in pregnant women. In addition, restrictive measures like the need for spousal consent to access reproductive healthcare services impede women's control of their reproductive decisions[8].

Also, the implementation of laws is often hampered by various challenges. The reality of reproductive rights in India is, therefore, often a far cry from the ideal outlined in legal provisions and humanised international standards.

IV. Constitutional and Legal Framework Governing Reproductive Rights in India

The fundamental rights, Articles 14 and 15[9], especially Article 21[10], which have been interpreted through the

---

2 World Health Organization, *Framework for Ensuring Human Rights in the Provision of Contraceptive Information and Services* 7 (2025)

3 Catherine Onwuachi-Saunders, Quyen P. Dang & Julia Murray, Reproductive Rights, Reproductive Justice: Redefining Challenges to Create Optimal Health for All Women, 9 J. Health Sci. & Hum. 19 (2019)

4 Manas Ranjan Pradhan, Surendra Kumar Patel & Antim Alok Saraf, Informed Choice in Modern Contraceptive Method Use: Pattern and Predictors Among Young Women in India, 52 J. Biosoc. Sci. 846, 859 (2020)

5 *Suchita Srivastava v. Chandigarh Admin.,* (2009) 9 SCC 1 (India)

6 *K.S. Puttaswamy v. Union of India,* (2017) 10 SCC 1 (India).

7 Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, arts. 4(2), 5(b), 10(h), 11(1)(f), 12, 14(2)(b), 16 (Dec. 18, 1979) (entered into force Sept. 3, 1981); Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), paras. 11–12 (2008)

8 Ctr. for Reprod. Rts., Reproductive Rights in Indian Courts (2025),https://reproductiverights.org/sites/default/files/documents/Reproductive-Rights-In-Indian-Courts.pdf (last visited Mar. 5, 2025)

9 India Constitution, Art. 14, 15

10 Ibid, Art. 21

judiciary to include various rights. In addition, Article 39(a) and Article 42 direct the the state to ensure equal justice and enhance the well-being of its people, including access to quality healthcare. Article 42 reinforces this by mandating fair and humane working conditions and maternity benefits, highlighting the need to create an environment that protects and supports women's reproductive rights.

The Delhi High Court ruled on Laxmi Mandal, the first case in the world to establish that maternal mortality violates human rights. The High Court confirmed that the "reproductive rights of the mother" are the "inalienable survival rights" under Article 21, which will be considered a landmark in the future. In the landmark case of Suchitra Srivastava, the Indian Supreme Court issued a declaration in 2009 that stated, "A woman's right to make reproductive choices is a dimension of personal liberty...under Article 21 of the Constitution of India...reproductive choices can be exercised to procreate as well as to abstain from procreating." The Court acknowledged the reproductive right of an expectant woman with a disability to resist being compelled to abort her pregnancy by referencing the rights to "bodily integrity, dignity, and privacy". The Supreme Court in Puttaswamy v. Union of India[11]The ruling recently reaffirmed women's constitutional right to make reproductive choices, upholding the decision made in the Suchitra case.

In 2016, the Supreme Court of India delivered a landmark judgment in the case of Devika *Biswas v. Union of India & Ors*[12]., beyond the reproductive health framework and affirming individuality and equality as constitutional rights of reproduction for women. A social activist petitioned the state to stop its sterilisation policy, which killed and injured many. The court ruled that these policies violated women's Article 21 right to life, including reproductive rights.

V. Specific Legislations

1. The Medical Termination of Pregnancy Act, 1971

a) History of MTP Act, 1971

Before the act came into force, abortion was a crime under Section 312 of the IPC, which was classified as a punishable crime, often leading to unsafe and illegal concern. The bill was further amended and was introduced in Lok Sabha on March 2, 2020, and passed on March 17, 2020[13]. The Medical Termination of Pregnancy (MTP) Act, enacted in 1971, aimed to liberalise abortion access for reasons including maternal health, humanitarian concerns, and potential foetal abnormalities. In 2021, the Act was significantly amended to enhance women's dignity, autonomy, confidentiality, and justice, ensuring safer and more accessible legal abortions without compromising quality of care.

b) Amendments of the Act

In September 2021, the Medical Termination of Pregnancy (Amendment) Act was enacted, increasing the legal gestational limit for abortion from 20 weeks to 24 weeks. Although it failed to guarantee abortion on request, the change was a constructive step towards revising India's abortion regulations. Many legal applications from women seeking safe medical procedures for undesired pregnancies exceeded the previous time frame, prompting the modification.[14] In the case of X v. Principal Secretary [15] the court ruled that legal entitlements based on marital status were invalid, emphasising that a woman's right to bodily autonomy and personal life choices includes the decision to continue or terminate a pregnancy. These legislative advancements, along with the recognition of equal rights in adoption, succession, and maternity benefits for both married and unmarried women in India, signify important social and legal progress.

However, a study conducted by the WHO, U.N. agencies, and the World Bank revealed that in 2020, India's maternal mortality rate stood at 103 per 100,000 live births, in contrast to China's significantly lower rate of 23 per 100,000 live births[16].

---

[11] Ibid 8

[12] *Devika Biswas v. Union of India, (2016) 10 SCC 726 (India)*

[13] The Medical Termination of Pregnancy Amendment Bill, 2020, PRS India (Mar. 2, 2025),https://prsindia.org/billtrack/the-medical-termination-of-pregnancy-amendment-bill-2020 (last visited Mar. 2, 2025)

[14] The Medical Termination of Pregnancy (Amendment) Act, No. 8 of 2021, Gazette of India, pt. II, sec. 1 (Mar. 25, 2021)

[15] *X v. Principal Secretary, Health & Family Welfare Dep't, Govt. of NCT of Delhi*, Civil Appeal No. 5802 of 2022 (arising out of SLP (C) No. 12612 of 2022) (India)

[16] Sohel Sarkar, India's Abortion Laws Offer Pregnant Women an Illusion of Choice, New Lines Mag. (Sept. 9, 2024),https://newlinesmag.com/argument/indias-abortion-laws-offer-pregnant-women-an-illusion-of-choice/

In the case of *Meera Santosh Pal v. Union of India*[17], the woman wanted to end her 24-week pregnancy because of severe foetal abnormalities. A woman's right to life, the Supreme Court said, encompassed her reproductive options, thus permitting abortion. The ruling emphasized physical autonomy and the health risks of pregnancy. Likewise, in Vaishali Pramod Sonawane v. Union of India[18], the petitioner wanted her pregnancy terminated in the twenty-fourth week.

Following a somnologist's examination, the petitioner disclosed that some congenital abnormalities had been discovered. Defects that appear in a baby before or at birth are known as congenital anomalies[19]. This condition causes many kids to pass away within weeks of birth. Approximately 295,000 newborns worldwide have passed away within four weeks of birth, according to figures from the World Health Organisation (WHO)[20]. Further, in the 2013 case of Hallo Bi v. State of Madhya Pradesh and Others[21], the High Court of Madhya Pradesh affirmed the importance of providing victims of rape access to abortion without requiring judicial authorisation, stating, "We cannot force a victim of violent rape/forced sex to give birth to a child of a rapist." The anguish and the humiliation that the petitioner is suffering daily will certainly cause a grave injury to her mental health[22].

Recently, in Orissa, the High Court allowed the termination of a 13-year-old minor rape survivor's pregnancy beyond 24 weeks and ordered the health department to formulate an SOP to ensure a timely process. It stressed that forcing a 13-year-old to carry a pregnancy would be an unbearable burden. The Bench directed the Health and Family Welfare Department to develop a Standard Operating Procedure (SOP) for medical termination of pregnancy, ensuring timely access, minimal bureaucracy, and psychological support. Concluding that termination was legally and morally imperative, the court allowed the writ petition and ordered immediate action[23].

According to Section 3 of the Act, a registered medical practitioner can terminate a pregnancy in the following circumstances: i) if the pregnancy does not exceed 12 weeks, if the practitioner is; ii) if the pregnancy exceeds 12 weeks but does not exceed 20 weeks, if at least two registered medical practitioners believe that continuing the pregnancy would be harmful[24].

2. The Surrogacy (Regulation) Act, 2021

The Surrogacy Regulation Bill which governs surrogacy in India was passed in August 2021 by the Indian Parliament. Assisted Reproduction helps a woman to agree to be pregnant and give birth to a child for a couple or an individual. The term 'surrogate' is taken from the Latin term 'surrogatus', pronounced as 'surrogo', which translates to subrogate which implies to replace.[25] This practitioner may be the baby's genetic mother if a traditional surrogate is used, or she may have a non-genetic bond with the baby and be a gestational surrogate whose embryo is implanted into her womb and carried to term pregnancy[26]. Commercial surrogacy is defined as when the woman is paid to carry the child until birth. Otherwise, the arrangement is referred to as altruistic surrogacy. It has been previously stated that the Surrogacy (Regulation) Act threatens to become an unsuccessful legislative attempt pretending to be a welfare law, as its main model to control the surrogacy industry is through a licensing and regulation model.

The difficulties with the Act are outlined below: - The Act defines an abandoned child as one who has been declared abandoned by the relevant authorities after proper inquiry[27].

---

[17] *Pal v. Union of India, (2017) 3 SCC 462 (India)*

[18] *Vaishali Pramod Sonawane v. Union of India*, (2019) AIRONLINE 2019 BOM 391(India)

[19] World Health Org., Congenital Anomalies, WHO (Mar. 5, 2025), https://www.who.int/news-room/fact-sheets/detail/congenital-anomalies

[20] Ibid

[21] *Hallo Bi v. State of Madhya Pradesh*, W.P. No. 408 of 2013 (India)

[22] Human Rights Law Network, HRLN,https://www.hrln.org/.

[23] *X v. State of Odisha,* W.P.(C) No. 5396 of 2025 (India)

[24] S.C. Tripathi &Vibhia Arora, Laws Relating to Women and Children 343 (6th ed. 2015).

[25] BLACK'S LAW DICTIONARY 1631 (Bryan A. Garner ed., 11th ed. 2019).

[26] *Rashmi V. Adsure,* Surrogacy – Socio-Economic Implications (Positive & Negative Impact on Women as Well as on Society), in LIVE-IN RELATIONSHIP AND SURROGACY: LEGAL IMPLICATIONS AND SOCIAL ISSUES 108 (Bimal N. Patel et al. eds., 2012)

[27] The Surrogacy (Regulation) Act, No. 47 of 2021, § 2(1)(a) (India),https://legislative.gov.in.

In the case of Baby Manji Yamada v. Union of India[28], this case was started by Manji's grandmother when the child's parents, who had chosen surrogacy, later travelled back to Japan. Beliefs or cultural practices delayed the marriage but unilaterally ended it later within a year, alongside the mother denying acceptance of the child formed with surrogacy. This highlighted yet again the pressing requirements concerning defined legal policies, especially in the area of global surrogacy. Hence, India moved forward to create legal policies regarding the practice of surrogacy. In the notable Manji case of 2002, the Supreme Court of India said in its verdict that the practice of commercial surrogacy is legally valid within the borders of the country.

In *Jan Balaz v. Union of India*[29], the High Court granted citizenship of India to twin babies born via surrogacy to a German national in Anand, Gujarat. In 2005, the Indian Council for Medical Research set guidelines to ensure ethical and legal standards for assisted reproductive technology. The Law Commission of India[30] submitted the 228th report on assisted reproductive technology procedures, highlighting the significance of surrogacy and the measures implemented to regulate surrogacy arrangements. This study examined the impact of newly introduced laws on surrogacy in India, emphasising the shift from commercial to altruistic surrogacy. Under these regulations, only a close relative of the intended parents could act as a surrogate. Additionally, the report mandated that intended parents must be married for at least five years and provide a medical certificate confirming infertility.[31] Another research study examined the new law's ethical implications and influence on the Indian surrogacy sector. The report proposed the creation of a National Surrogacy Board to regulate surrogacy practices and ensure adherence to legal guidelines. It also mandated the creation of surrogacy clinics that adhere to the prescribed regulatory standards[32].

The law recognises the need to protect surrogate mothers by ensuring their rights are upheld. It mandates informed medical insurance coverage and prohibits the use of surrogacy for unlawful or unethical purposes. Establishing a child's legal parentage immediately after birth is essential for safeguarding their best interests. However, maintaining the integrity of parentage in surrogacy requires adherence to key principles, including pre-surrogacy safeguards, best interest determinations (BID), informed consent from all parties involved, and preserving the child's right to know their biological origins. Legal parentage should not be influenced by financial transactions or external factors, nor should a child's rights be compromised for legal certainty before birth. Additionally, unexpected situations—such as medical emergencies or changes in the parties' intentions—must be addressed in a way that does not jeopardise the child's legal status[33].

VI. India's status on Women's Reproductive Rights

India, a UN member, values women's and reproductive rights. India has ratified the following:

a. United Nations: The UN's international conference on human rights in 1968 recognized reproductive rights as a part of human rights.[34] Reproductive rights were among the first human rights to be established during the worldwide human rights conference held in Tehran in 1968 to advance the Universal Declaration of Human Rights.[35]

b. CEDAW: The Convention is the sole international agreement on human rights that recognizes and safeguards women's entitlement to access abortion services while concurrently addressing the influence of culture and tradition on gender roles and familial structures. This policy supports the rights of women to exercise their autonomy in determining both their nationality and that of their children.[36]

---

[28] Baby Manji Yamada v. Union of India, AIR 2009 SC 84 (India)

[29] Union of India v. Jan Balaz, W.P.(C) Nos. 95 & 841 of 2015 (India)

[30] Law Comm'n of India, 228th Report, Need for Legislation to Regulate Assisted Reproductive Technology Clinics as Well as Rights and Obligations of Parties to a Surrogacy 15 (2009)

[31] S. Sharma & Jaiswal, Surrogacy Regulation Act, 2021: A Study on Its Provisions and Impact on Surrogacy in India, 14 J. Med. Ethics & Hist. Med. 1 (2021)

[32] S. Das & R.K. Das, Surrogacy Regulation Act 2021: A Study on Its Legal and Regulatory Framework and Impact on the Surrogate Industry in India, 6 INT'L J. MGMT. TECH. & SOC. SCI. 104 (2021)

[33] United Nations Children's Fund (UNICEF), Key Considerations: Children's Rights and Surrogacy 2 (2022),https://www.unicef.org

[34] Fifty Years Ago, It Became Official: Family Planning Is a Human Right, UNFPA EECA,https://eeca.unfpa.org/en/news/fifty-years-ago-it-became-official-family-planning-human-right (last visited July 19, 2023)

[35] Reproductive Rights, Wikipedia,https://en.wikipedia.org/wiki/Reproductive_rights#cite_note-teheran_proc-8 (last visited July 19, 2023)

[36] Convention on the Elimination of All Forms of Discrimination Against Women, United Nations,https://www.un.org/womenwatch/daw/cedaw/ (last visited July 21, 2023)

c. ICCPR: This establishes a standard frame concentrated on protecting and upholding fundamental civil and political rights. Due to this rationale, the majority of the rights encompassed within the ICCPR pertain to addressing violence against women. Additionally, the right to life is also of significance in this context.[37]

d. ICESCR: It plays a significant role in asserting women's ESC rights.[38]

e. CRC: CRC has fervently advocated for the actualisation of children's entitlement to sexual and reproductive health services, emphasising the imperative for states to guarantee the widespread availability of a comprehensive range of sexual and reproductive services.[39] In pursuit of this objective, the CRC acknowledges the importance of ensuring that adolescents are provided with comprehensive access to a range of contraceptive methods, encompassing both short- and long-term methods.[40] These options include, but are not limited to, condoms, hormonal contraceptives, and emergency contraception, and the provision of having secure abortions and after-abortion care regardless of the legal status of abortion[41] and services related to the health of mothers.[42]

Target 3.7 of the SDGs mandates that by the year 2030, all countries should have fully integrated sexual and reproductive care services, including family planning, information, and education as well as reproductive health, into their national policies and programmes.[43]

Since India has signed these commitments, it must honour the treaty and international law responsibilities as per Article 51(c).[44]

VII. Challenges

1. Restricted access to abortion services: Women and girls are subjected to severe threats of physical and emotional injury, disease, and unwanted pregnancy as a result of sexual and gender violence. Women are often dissuaded from accessing health and other services in such situations. Unsafe abortion endangers many women and is a significant public health concern because it uniquely affects the poorest and young women. According to an article in the Indian Express, sixty-seven percent of abortions that are used in India are not safely performed and cause around 8 deaths every day[45].
2. In spite of progressive laws, loopholes in the legal system remain, particularly regarding safeguarding women's autonomy. The Supreme Court recently denied a request to abort a 27-week pregnancy on the grounds of the fetus's right to life over the petitioner's emotional suffering as an unmarried mother. This ruling highlights the challenges of late-term abortions in India, and the limitation of the law in dealing with socioeconomic and psychological issues. Also, the absence of legal acknowledgment for marital rape and reproductive rights of LGBTQ+ individuals proves the deficiency of the framework.
3. Lack of quality care: While the statistics, i.e., improvement in the coverage of public health institutions for mothers and reproductive health within media and other government agencies have drawn more spotlight, the urgency to emphasize the "quality of care" has taken a secondary place[46].Even with more institutional deliveries, the quality of care is quite different in various regions. A study to evaluate quality delivery care coverage revealed that around 54.5% of districts had at least 80% coverage, while almost 45.5% of districts had poor services. Interestingly, around 70% of districts had lower coverage

---

37 International Covenant on Civil and Political Rights, Tackling Violence Against Women,https://blogs.lse.ac.uk/vaw/int/treaty-bodies/international-covenant-on-civil-and-political-rights/#:~:text=Some%20of%20the%20ICCPR's%20articles,Article%206:%20right%20to%20life.

38 The International Covenant on Economic, Social and Cultural Rights at 50: The Significance from a Women's Rights Perspective, ESCR-Net,https://www.escr-net.org/resources/international-covenant-economic-social-and-cultural-rights-50-significance-womens-rights.

39 U.N. Comm. on the Rts. of the Child, General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24), U.N. Doc. CRC/C/GC/15 (Apr. 17, 2013),https://www.refworld.org/docid/51ef9e134.html (last visited Jan. 21, 2025)

40 *Id. para. 70*

41 *Id*

42 **Id. para. 51-57**

43 Transforming Our World: The 2030 Agenda for Sustainable Development, U.N. Dep't of Econ. & Soc. Affs., Sustainable Development,https://sdgs.un.org/2030agenda (last visited July 23, 2023)..

44 India Const. art. 51(c).

45 Report: 67% Abortions in India Unsafe, Cause Nearly 8 Deaths Every Day, Indian Express (Mar. 31, 2025),https://indianexpress.com/article/india/india-unintended-pregnancy-abortion-7845655/.

46 Arpita Shah & Dr. Manisha Karne, Maternal and Reproductive Health in India: Challenges and the Road Ahead .

in antenatal and postnatal care services[47]. Women are entitled to safe and accessible birth control, maternal health, and treatment of sexually transmitted illnesses such as HIV/AIDS. But with insufficient healthcare resources and weak response to their reproductive health requirements, they remain exposed to significant health hazards. Recent UN reports indicate that every two minutes a woman dies as a result of pregnancy or delivery complications.[48]While India has made commendable progress in expanding reproductive healthcare services, the lack of quality care continues to undermine these advancements.

4. Societal Stigma and Gender Norms: Patriarchal norms tend to limit women's reproductive autonomy, particularly for married adolescents with social, religious, and marital obstacles to contraception and healthcare. In rural India, restricted autonomy and economic dependence further limit access to reproductive health services, maintaining limitations on fertility and family planning[49].

VIII. Remedies

Sexual consciousness must be incorporated into school and college curriculum so that it would ensure the safeguarding of reproductive and sexual rights. In order to provide women with mastery over their fertility, access to contraception is necessary.[50]

Besides, laws need to be reformed by favoring the independence of women, acknowledging marital rape, enhancing LGBTQ+ reproductive rights, and judicial interpretation must be made stronger. In addition, safe motherhood and pregnancy services need to be offered. India's Maternal Mortality Ratio has declined considerably, falling by six points to 97 per 100,000 live births, as per the Registrar General of India's Special Bulletin on MMR.[51] MMR has dropped dramatically, allowing us to save more mothers than before. However, some Indian states have "Very High" MMRs above 130. Regionally, Assam has the highest MMR (195).[52] Childbirth support from professionals. India has increased institutional delivery services from 41% in 2005–2006 to 79% in 2015–16, but studies show that access to skilled delivery care varies by state, socioeconomic strata, and rural and urban residence.[53] Institutional deliveries have grown tremendously since the NHM was initiated. But this numerical growth has not enhanced key mother and newborn health indicators. Delivery day is responsible for 46% of maternal deaths, 40% of stillbirths, and 40% of neonatal mortality.[54]Women need HIV/AIDS information. Because of their vulnerability, women do not have health information, which has heightened the number of female HIV patients. With the epidemic cutting across population groups, some states have experienced a rise in women and infant infections.[55] Women tend to be more susceptible when it comes to medical care, as many, particularly in lower-income communities, lack access to media and education. This lack of knowledge further hinders their capacity for health decisions, both in rural and urban communities.[56]All women, regardless of their marital status, now have the right to safe and legal abortions up to 24 weeks of pregnancy, as affirmed by the Supreme Court. Ensuring access to safe abortion is essential for protecting women's health and reproductive rights.[57] To enhance maternal

---

47 Lucky Singh et al., Coverage of Quality Maternal and Newborn Healthcare Services in India: Examining Dropouts, Disparity and Determinants, ANNALS GLOB. HEALTH,https://annalsofglobalhealth.org/articles/10.5334/ (last visited Apr. 7, 2025)\

48 A Woman Dies Every Two Minutes Due to Pregnancy or Childbirth: UN Agencies, World Health Org. (Feb. 23,2023),https://www.who.int/news/item/23-02-2023-a-woman-dies-every-two-minutes-due-to-pregnancy-or-childbirth—un-agencies.

49 S. Anukrit, Bring a Friend: Strengthening Women's Social Networks and Reproductive Autonomy in India, IZA Inst. of Lab. Econ., Discussion Paper No. 15381 (June 2022),https://docs.iza.org/dp15381.pdf.

50 Mabel Andalón, Jenny Williams & Michael Grossman, Empowering Women: The Effect of Schooling on Young Women's Knowledge and Use of Contraception, IZA Discussion Paper No. 7900, at 4 (Inst. for the Study of Lab. Jan. 2014),https://www.econstor.eu/bitstream/10419/93273/1/dp7900.pdf.

51 Press Release, Press Info. Bureau, at 1 (Dec. 8, 2022), https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1879912.

52 India Improves Maternal Mortality Ratio, but Poorer States Yet to Make Progress, Down to Earth (Dec. 9, 2022),https://www.downtoearth.org.in/news/health/india-improves-maternal-mortality-ratio-but-poorer-states-yet-to-make-progress-86275.

53 Prem Shankar Mishra et al., Impact of Socio-Economic Inequity in Access to Maternal Health Benefits in India: Evidence from Janani Suraksha Yojana Using NFHS Data, PLOS ONE, Mar. 4, 2021, https://doi.org/10.1371/journal.pone.0247935.

54 Ministry of Health & Family Welfare, National Health Mission (2017),https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf

55 HIV/AIDS in India, World Bank (Aug. 30, 2016),https://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india.

56 Partha Chatterjee, Nationalist Thought and the Colonial World: A Derivative Discourse 1–4 (Univ. of Minn. Press 1993).

57 Supreme Court Rules All Women Entitled to Safe, Legal Abortion, Econ. Times (Sept. 29, 2022),https://economictimes.indiatimes.com/news/india/supreme-court-rules-all-women-entitled-to-safe-legal-abortion/articleshow/94542957.cms.

healthcare utilisation and decrease maternal deaths, holistic measures should be adopted, such as enhancing women's autonomy, education, and exposure to maternal care.[58] Different measures of women's empowerment, such as economic independence, household decision-making control, and mobility freedom, have been associated with favourable outcomes for reproductive and maternal health, based on the findings of previous research.[59]

IX. Conclusion

Women's autonomy is a vital human right tied to gender equality and empowerment, particularly in decisions about their bodies and reproductive health. While India's legal framework supports reproductive rights, challenges like legal ambiguities, cultural norms, poor healthcare infrastructure, and inconsistent abortion access hinder implementation. Achieving reproductive equity requires a comprehensive strategy involving advocacy, legal reform, and policy changes. Ultimately, ensuring safe, accessible, and inclusive reproductive healthcare is essential for gender justice and protecting human rights for future generations.

* * * *

[58] Dinabandhu Mondal, Suranjana Karmakar & Anuradha Banerjee, Women's Autonomy and Utilization of Maternal Healthcare in India: Evidence from a Recent National Survey, PLOS ONE, Dec. 10, 2020, https://doi.org/10.1371/journal.pone.0243553

[59] Nadia Diamond-Smith et al., Women's Empowerment and Experiences of Mistreatment During Childbirth in Facilities in Lucknow, India: Results from a Cross-Sectional Study, BMC Pregnancy & Childbirth, Feb. 17, 2017,https://doi.org/10.1186/s12884-017-1501-7.

SACRED LAWS VS. BODILY AUTONOMY: THE INFLUENCE OF RELIGIOUS BELIEFS ON REPRODUCTIVE JUSTICE

Dr. Nancy P.*

Abstract

As per the famous Hillary Clinton, "women's right are human rights and human rights are woman rights". So, the major women's right is the reproductive right and she should be given the right to decide on her body. But various religious and cultural practice differ in opinion regarding this. While Christianity and Islam show a rigid policy, which is against the reproductive rights of woman, Hinduism has a flexible attitude in supporting her rights. Reproductive rights include the right to safe and legal abortion, right to birth control, family planning, fertility treatments, surrogacy etc. But different reproductive laws are formulated in different countries based on the beliefs of religious majority existing there as well the cultural norms prevailing there. Government of China bought "one child policy", enforcement for population control Eugenics programmes in United States, Sweden etc, which bought sterilisation laws. In India also, targeted sterilisation happened among the indigenous population mainly. Catholic church vehemently is against the abortion, and it is told as a sinful act as per their belief. They are also against artificial family planning methods like using contraceptives. Islam also do not allow abortion after 120 days. So, there are strict ban in countries like Iran and Saudi Araba. But countries like Indonesia allows some abortion rights. Hindu majority nations on the other hand, is now allowing MTP act, which allows abortion up to 24 weeks. Indigenous people on the other hand have great traditional knowledge about abortion and sterilisation techniques, which shows the cultural impact upon the reproductive laws and methods.

Keywords : **Reproductive Rights, Religious Influence on Abortion, Bodily Autonomy, Cultural Impact on Reproductive Laws, Family Planning Policies.**

I. Introduction

Human beings have numerous beliefs, Culture, Tradition and religious among which religion plays a crucial role in shaping the social, economic, political as well as personal lives of people. Religion has penetrated into all aspects of a human life and to some people it causes multiple effects and may even infringe into their bodily autonomy thereby virtality their fundamental as well as basic human rights. Reproductive rights are a crucial part of human rights for a woman. As per the words of famous Hillary Clinton, " woman's rights are human rights and human rights are women's rights."[1] Reproductive rights includes right to safe and legal abortion ,right to birth control, family planning, fertility treatment, surrogacy etc and unfortunately, a woman's right to exercise these rights are determined or regulated mostly by various religious and cultural practices.

II. Religious Perspectives on Reproductive Rights

All religions have imposed certain kinds of regulations on the bodily autonomy of woman. Some religions view it in a broader way whereas others view in a narrow perspective. Anyhow, restrictions imposed upon bodily autonomy of a woman is a matter to be thought of.

In a world with numerous religions each with its own beliefs, traditions and cultural significance, majority followers are from Christianity approximately 32 % which can be told as largest religion in the world. It is dominated in western countries. They take a firm stand against abortion considering it a violation of the sanctity of life.Evangelical Christian groups in the United States have strongly influenced anti- abortion

* **Student at Government Law College, Ernakulam.**

1 *U.N. 4th World Conference on Women* (Sept. 5, 1995), in *U.S. Dep't of State Dispatch*, Sept. 11, 1995, at 634.

policies leading to significant legal battles like Roe vs wadewhich was a Landmark case in US Supreme Court in 1973 that held that the constitution protected a woman's right to abortion without regulation or restriction from government. This was ruled on the basis of right to privacy. But in 2022, the supreme court overruled with Roe vs Wade[2] with Dobb's vs Jackson Women's Health Organization ending Federal protection for abortion rights and allowing individual states to regulate or ban abortion. This act of court led to wide range of debates and discussions. This judgement paved way to many states imposing strict bans while many others strengthening their abortion rights. Pope paul VI's Humanae vitae which is an encyclical letter issued in 1968 addresses the Catholic Church's stand on marriage, family planning, birth control etc. It emphasized that life is a gift from God and must be respected from conception to natural death. It also affirmed artificial birth control methods which disrupt the natural purpose of sex. Instead, it put forth natural methods of spacing births. It remained a basic data on Catholic teachings on marriage, sexuality etc.

Approximately 25 % of population are Islam.Islamic views on reproductive rights vary from region to region.It allows abortion before 120 days of gestation on a belief that foetus will gain soul after 120 days.Different Islamic countries follow different methods and viewpoints. Countries like Saudi Arabia bans abortion in a strict sense whereas Indonesia like countries allow abortion under specific conditions.Islamic perspectives on reproductive laws are derived from the Quran, Hadith[3] (sayings of the Prophet Muhammad), and Islamic jurisprudence (fiqh). These perspectives vary across different schools of thought and cultural contexts but generally emphasize the sanctity of life, the importance of family, and moral responsibility.Most Islamic scholars permit temporary contraception (e.g., birth control pills, condoms) if both spouses consent and it does not cause harm.Permanent contraception (e.g., sterilization) is generally discouraged unless there is a medical necessity.The Quran (2:223) emphasizes mutual decision-making in marital relationships, which extends to family planning.Regarding Abortion in Islam,it is generally prohibited but may be permitted in cases where the mother's life is at risk.Some scholars differentiate between early and late-stage abortion.Before 120 days (4 months), Some Islamic schools allow it in cases of rape, severe fetal abnormalities, or health risks.After 120 days,Abortion is considered haram (forbidden) because the soul (ruh) is believed to enter the fetus by this stage, making it equivalent to taking a human life.The principle of "lesser harm" (darura) allows exceptions in extreme circumstances. In case of Assisted Reproductive Technologies (ART), In-vitro fertilization (IVF) is permitted if it involves only the married couple's sperm and egg.Surrogacy and sperm/egg donation are generally not allowed because they introduce a third party into the marital bond.When we look in to the Ethical and Social Considerations,Islamic law emphasizes family lineage and discourages practices that may disrupt inheritance or parental identity. Responsibility and intention are key in all reproductive decisions.Different Islamic countries and scholars interpret reproductive laws differently, influenced by cultural, legal, and scientific advancements. Some nations strictly regulate abortion, while others allow it under specific conditions.

Hindu perspectives on reproductive laws are shaped by ancient scriptures (Vedas, Upanishads, Manusmriti, and Dharmashastra), philosophical traditions, and contemporary legal frameworks. Hinduism generally upholds the sanctity of life, dharma (duty), and karma (moral consequences of actions), but interpretations vary across traditions and regions.

1. Contraception in Hinduism

Hindu texts do not explicitly prohibit contraception, and family planning is generally accepted as long as it aligns with dharma (righteous living).

Ancient texts like the Kama Sutra discuss fertility regulation, suggesting awareness of birth control methods in historical Hindu society.

Modern Hindu ethics support contraception for responsible parenthood, and India's government actively promotes family planning.

2. Abortion in Hinduism

Traditional Hindu texts view abortion (garbha-bhatta) as a serious moral offense, as life is considered sacred.

---

[2] 410 U.S. 113, 116 (1973).

[3] *Sahih al-Bukhari*, Book 8, Hadith 395 (on prayer and purification).

The Manusmriti[4] (Chapter 8, Verse 389) condemns abortion, comparing it to killing a priest.

However, Hindu ethics also emphasize compassion and context. Someinterpretations allow abortion in cases of: Risk to the mother's life (ahimsa, or non-violence, prioritizes preserving existing life).

Severe foetal abnormalities or rape (some Hindu scholars argue that dharma allows ethical flexibility).

Indian law (Medical Termination of Pregnancy Act, 1971) permits abortion under various conditions, balancing religious and secular considerations.

3. Assisted Reproductive Technologies (ART)

In-vitro fertilization (IVF) is widely accepted in Hindu-majority societies, as having children is considered a sacred duty (grihastha ashrama).

Surrogacy is debatedbecause some support it as a dharmic way to fulfill parenthood, while others oppose it due to concerns about karma and family lineage.

Sperm and egg donation are controversial in some Hindu traditions because they introduce genetic material outside the marital bond.

4. Ethical and Social Considerations

Karma and Rebirth: Some Hindus believe abortion interferes with a soul's reincarnation journey. Others argue that intention (bhavana) determines karma, allowing for moral exceptions.

Women's Autonomy: Hindu feminism highlights Shakti (divine feminine power), advocating for women's reproductive rights within ethical boundaries.

Modern Interpretations

Hindu-majority countries like India and Nepal have laws permitting contraception and abortion under various conditions, reflecting a balance between traditional beliefs and modern realities.

Buddhism is guided by the Five Precepts, karma, and the principle of non-harm (ahimsa), influencing its stance on reproduction. Most Buddhist traditions accept contraception, as long as it does not harm a fertilized embryo.

Barrier methods (e.g., condoms) are generally acceptable, but some Buddhists oppose contraceptives that prevent implantation (e.g., certain IUDs or morning-after pills) as they may destroy a potential life.Buddhism generally discourages abortion because it is seen as taking a life, which violates the First Precept: "Do not kill."

However, intention matters in Buddhist ethics. Some traditions allow abortion if:

The mother's life is at risk.The pregnancy results from rape or severe fetal abnormalities.Buddhist countries like Japan and Thailand have cultural rituals (Mizuko Kuyo)[5] tohonor unborn souls after abortion.RegardingAssisted Reproductive Technologies (ART),IVF is generally acceptable, as it helps alleviate suffering (dukkha). Surrogacy and embryo donation are debated, with some concerns about karma and attachment to material desires.

Judaism views reproduction as a divine command ("Be fruitful and multiply" -Genesis 1:28), but Jewish law (Halakha)[6] allows flexibility based on circumstances.Permitted in cases where pregnancy might cause physical or emotional harm to the mother.Barrier methods (e.g., condoms) are sometimes discouraged because they block the natural process, but birth control pills and IUDs are often accepted.Unlike Christianity, Judaism does not consider life to begin at conception. Instead, a fetus is considered part of the mother's body until birth.

Abortion is permitted if the mother's life or health (physical or mental) is at risk.

The fetus has severe abnormalities. The Talmud (Oholot 7:6) allows abortion to save the mother's life, as her well-being takes precedence.RegardingAssisted Reproductive Technologies (ART), IVF and fertility treatments

---

4 ch. 8, ¶ 356 (G. Buhler trans., Oxford Univ. Press 1886).

5 William R. LaFleur, *Abortion in Japan: Mizuko Kuyo and the Search for a Buddhist Ethics of Compassion*, 10 J. Feminist Stud. Religion 65, 70 (1994)

6 *Babylonian Talmud*, Berakhot 3b

are widely supported as fulfilling the mitzvah (commandment) to procreate.Surrogacy is accepted, but some Orthodox rabbis require the surrogate to be Jewish to ensure the child's Jewish identity.Sperm and egg donation are debated but accepted in many Jewish communities.

In Sikhism Reproductive Laws, Sikh beliefs on reproduction stem from Guru Granth Sahib and the principle of Hukam (divine will).Sikhism does not prohibit contraception as long as it is used responsibly.Natural family planning and contraceptive methods are widely accepted in modern Sikh communities.Abortion is generally discouraged, as life is seen as a divine gift from God (Waheguru).Some Sikhs oppose abortion based on Gurbani teachings that emphasize the sanctity of life.However, exceptions exist in cases of:

Rape or fetal abnormalities,Risk to the mother's life.RegardingAssisted Reproductive Technologies (ART), IVF is accepted, as having children is considered a blessing.

Surrogacy and sperm/egg donation are debated, as Sikh teachings emphasize family lineage (Kul).

In Conclusion, Buddhism prioritizes non-violence but allows flexibility based on intention.Judaism on the other hand permits abortion in certain cases and supports ART to fulfill the mitzvah of procreation.But, Sikhism respects life but allows modern reproductive methods with ethical considerations.

III. International Legal Framework on Reproductive Rights

At the global level, reproductive rights are recognized under various human rights instruments. The United Nations (UN), through agencies like the World Health Organization (WHO) and United Nations Population Fund (UNFPA), advocates for universal access to reproductive healthcare. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) emphasizes the right to family planning and maternal healthcare. Additionally, the International Covenant on Civil and Political Rights (ICCPR) upholds personal autonomy, which extends to reproductive choices.Despite these global commitments, national policies on reproductive rights diverge due to religious influences. Some countries ensure access to safe and legal abortion, while others restrict it based on theological principles.

Reproductive Laws in Different Countries

1. United States - The United States has seen shifting reproductive policies. The landmark Roe v. Wade (1973) decision legalized abortion nationwide, recognizing a woman's right to choose. However, the ruling was overturned in Dobbs v. Jackson[7] Women's Health Organization (2022), allowing individual states to regulate abortion. Conservative states, influenced by Christian beliefs, have since imposed near-total bans, while liberal states continue to safeguard abortion rights.

2. European Countries - In Sweden, France, and the UK, abortion laws are liberal, allowing termination up to 24 weeks, with some exceptions beyond this period. Sweden, historically involved in eugenics-based sterilization programs, has since reformed its policies to ensure informed consent in reproductive healthcare. Ireland, a predominantly Catholic country, legalized abortion in 2018 after a national referendum, reflecting a shift from religious influence to reproductive autonomy.

3. Islamic Countries - Many Islamic nations regulate abortion based on Sharia law. In Saudi Arabia and Iran, abortion is strictly prohibited except when the mother's life is at risk. Islam generally allows abortion before 120 days (when the soul is believed to enter the fetus), but many countries impose stricter bans. Indonesia, while an Islamic-majority nation, permits abortion under specific circumstances, including rape and medical necessity.

4. India - India, influenced by Hindu-majority traditions, has a progressive approach to abortion laws. The Medical Termination of Pregnancy (MTP) Act, 1971, amended in 2021, allows abortion up to 24 weeks for certain categories of women, including survivors of rape. Family planning programs in India historically included coercive sterilization policies, particularly among indigenous and marginalized communities, reflecting socio-political biases in reproductive policies.

5. China - China's One-Child Policy[8] (1979-2015) was one of the most controversial reproductive laws, enforcing strict population control through forced abortions and sterilizations. Although the policy has since

[7] Dobbs v. Jackson Women's Health Org., No. 19-1392, slip op. at 5 (U.S. June 24, 2022).

[8] Susan Greenhalgh, *Just One Child: Science and Policy in Deng's China* (Univ. of California Press 2008).

been relaxed to allow three children per family, reproductive decisions remain heavily influenced by government intervention rather than personal choice.

IV. Religious and Cultural Impact on Reproductive Policies

Religious doctrines continue to shape reproductive rights globally. The Catholic Church opposes abortion and contraception, influencing policies in Latin America, Poland, and the Philippines. Meanwhile, indigenous communities worldwide have long practiced traditional reproductive health methods, emphasizing natural contraception and herbal abortion techniques.

Women's Autonomy in Reproductive Decisions

Women's autonomy in reproductive decisions is a fundamental aspect of gender equality and human rights. It encompasses the ability to make informed choices about contraception, abortion, fertility treatments, and family planning without coercion, discrimination, or external control. Despite global recognition of reproductive rights, religious, cultural, and political influences continue to restrict women's autonomy in many parts of the world.Autonomy in reproductive decisions is closely linked to bodily integrity, meaning a woman has the right to decide what happens to her body. This includes access to safe and legal abortion, contraceptive choices, and the ability to plan pregnancies. Countries with progressive policies, such as Sweden and Canada, provide comprehensive reproductive healthcare, ensuring women's rights are prioritized. However, in nations where religious beliefs dominate laws—such as Saudi Arabia, Iran, and Poland—abortion is heavily restricted, forcing women to seek unsafe alternatives.Religious doctrines, particularly within Christianity and Islam, often oppose abortion and artificial birth control, framing reproductive decisions as moral rather than personal rights. The Catholic Church, for instance, strictly prohibits abortion and contraception, influencing policies in Latin America and parts of Africa. Conversely, Hindu-majority nations like India have more flexible reproductive laws, allowing abortion up to 24 weeks under the Medical Termination of Pregnancy (MTP) Act.To ensure true reproductive justice, it is essential to balance religious beliefs with women's autonomy, emphasizing healthcare access, education, and the right to make independent decisions about their bodies.

V. Conclusion and Future Perspectives

The conflict between sacred laws and bodily autonomy in reproductive justice remains a deeply polarizing issue across the world. While some religious and cultural beliefs impose strict restrictions on abortion and family planning, others allow for greater autonomy in reproductive choices. Countries influenced by Christianity and Islam often impose rigid laws limiting access to abortion and contraception though there are exception, whereasnations like India have adopted more flexible policies, such as the Medical Termination of Pregnancy (MTP) Act. Additionally, the historical impact of state-controlled reproductive policies, such as China's One-Child Policy and eugenics-based sterilization programs in the United States and Sweden, highlights how governments have exercised power over reproductive choices, often violating human rights.Moving forward, a balanced approach is necessary to uphold both religious values and women's rights. Governments should prioritize public health over religious dogma, ensuring access to safe, legal, and affordable reproductive healthcare. Comprehensive sex education, increased access to contraception, and stronger legal frameworks are essential to protecting women's rights while respecting cultural sensitivities.The way forward lies in international cooperation, with organizations like the UN and WHO working to establish universal reproductive rights that transcend religious and cultural boundaries. Legal reforms must ensure bodily autonomy, prevent coercive policies, and promote informed decision-making for all individuals. Only by prioritizing human rights, healthcare access, and education can the world move towards a future where reproductive justice is a universal reality, free from religious and political constraints.

* * * *

MARITAL RAPE AND GENDER EQUALITY: A FIGHT FOR REPRODUCTIVE AUTONOMY AND JUSTICE

Mr. Saurav Kumar *

Abstract

Reproductive rights are central to gender equality, yet the non-criminalization of marital rape in many legal systems continues to deny women autonomy over their own bodies. Marital rape remains a contrary issue in many legal systems, particularly in countries where the marriageis an immunitythat continues to deny, women any legal recourse against non-consensual intercourse within marriage bond. The failure to recognize marital rape as a criminal offense not only accelerate gender inequality but also violates fundamentalrights, including bodily autonomy, dignity, and reproductive freedom. This paper explores the intersection of marital rape and gender equality, emphasizing the urgent need for legal recognition and reform to protect individuals right irrespective of their marital status.

The discussion highlights how the historical construct of marriage, rooted in patriarchal norms, has been used to justify the non-criminalization of spouse rape. It examines the implications of such exemptions on women reproductive autonomy, as forced intercourse with in marriage often leads to unwanted pregnancies, psychological trauma, and health risks. The lack of legal protection intensifies the power imbalances, reinforcing a culture of silence and absolute liberty that denies justice to survivors.

Further, it explores the international human rights obligations that mandate states to ensure protection against sexual violence in all contexts, including marriage. The analysis extends to the broader socio-legal and cultural barriers that hinder recognition and enforcement, emphasizing the role of legal reform, judicial activism, and social awareness in addressing this issue. Ultimately, the paper advocates for legislative, judicial, and societal efforts to dismantle archaic legal protection perpetrators and ensure that marriage is not a license for sexual violence.

Keywords: **Marital rape, gender equality, reproductive rights, women autonomy,sexual violence, justice.**

I. Introduction

What happens when a wedding ring becomes a shackle rather than a symbol of love, here in this paper,one of the deepest contradictions within society regarding marriage was highlighted.Marital rape, which means the forced sexual violation within the bonds of marriage, represents not just a personal harm but a complete failure of justice that continues to affect millions across the globe, making marriage a license for men to engage in non-consensual intercourse with their wife, harming their bodily autonomy and violating their fundamental rights.

Marital Rape is the term used to describe sexual acts committed by a husband against his wife without her consent or against her will[1]. He may use physical force, threats of force to her or another person, or coercion, causing the woman to fear that physical force will be used if she resists.However, it was protected under black shadow of the marital law exemption clause, previously section 375 Exception (2) of the Indian Penal Code (IPC)[2], 1860 and now under section63 Exception (2) of the Bharatiya Nyaya Sanhita, 2023[3].

Marital rape is not only an issue of sexual violence but also a violation of fundamental human rights and it also undermines gender equality by denying women "the right to control their own body and reproductive

* **Student, B.A.LL.B (H) G.D. Goenka University**

1 https://rainn.org/pdf-files-and-other-documents/Public-Policy/Issues/Marital_Rape.pdf

2 The Indian Penal Code, 1860, § 375, Exception 2.

3 The Bharatiya Nyaya Sanhita, 2023, § 63, Exception 2.

choices"[4]. Additionally, marital rape has severe physical and psychological harm, including unwanted pregnancies and long-term trauma. This paper aims to provide a comprehensive analysis of marital rape by exploring its legal and social policies. The study also focuses on examine the impact of marital rape on gender equality and reproductive autonomy and propose legal and policy reforms that can effectively address marital rape and ensure justice for women.

What is the legal status of marital rape across different legal systems, and how does it vary from jurisdiction to jurisdiction? And how does marital rape impact women's rights, particularly reproductive autonomy and bodilyintegrity? This research seeks to answer these key questions. Analyse landmark judicial decisions that have shaped the legal approach to marital rape and examine how the failure to criminalize marital rape results in the violation of the constitutional rights and women's bodily autonomy.

II. Historical context of Marital Rape Exception

Understanding Marital Rape

Marital rape also termed as spousal rape meaningengaging in sexual intercourse with wife without her consent within a wedlock and need not include physical violence but the absence of consentis an essential element of rape as defined under section 63 of Bharatiya Nyaya Sanhita, 2023. Marital rape, which meets all the essential elements of rape[5] however, by a single marital exemption clause explicitly states that marital intercourse with a wife above the age of 18 is not considered rape[6]protects all men who engage in non-consensual intercourse with their wives.

Globally, marital rape is recognized as a criminal offense in over 100 countries. Nations such as the United States, the United Kingdom, and Canada have explicitly criminalized it, acknowledging that marriage does not override a person's right to consent especially when we talk about the sexual intercourse. However, in India, marital rape remains decriminalized under Section 63 of the Bharatiya Nyaya Sanhita, 2023, which exempts a husband from being prosecuted for rape if his wife is above 18 years of age. This exemption is rooted in outdated patriarchal beliefs that consider a wife's consent as implied upon marriage.

Origins of the Marital rape: Exemption Clause

The marital rape exemption has its origins in historical legal doctrines that viewed women as the property of their husbands. *The doctrine of coverture and Sir Matthew Hale's legal interpretation of marital rape*[7] are fundamental concepts in understanding historical perspectives on women's legal status in marriage. Both played a crucial role in shaping the legal framework that denied married women autonomy and legal recognition as independent individuals.

Doctrine of Coverture

The doctrine of coverture was a legal principle derived from English common law, which dictated that upon marriage, a woman's legal identity was subsumed under her husband's. This principle can be traced back to the 17th and 18th centuries[8], particularly in the works of legal scholars such as Sir William Blackstone, who famously stated:

"By marriage, the husband and wife are one person in law: that is, the very being or legal existence of the woman is suspended during the marriage, or at least is incorporated and consolidated into that of the husband." [9]Under coverture:

- A wife could not own property independently.
- She could not enter contracts, sue or be sued.
- Her legal rights were exercised through her husband.
- The husband had legal authority over his wife's body, decisions, and labor.

---

4 Suchita Srivastava v. Chandigarh Admin., (2009) 9 SCC 1 (India).

5 The Bharatiya Nyaya Sanhita, 2023, § 63.

6 Ibid, § 63, Exception 2.

7 By Varun Singh, Breaking Silence on Marital Rape Status in India, Legal Service India, https://www.legalserviceindia.com/legal/article-8106-breaking-silence-on-marital-rape-status-in-india.html

8 Id.

9 Id.

Coverture reinforced the idea that a wife had no separate legal standing, making it difficult for women to challenge abuses, including sexual violence, within marriage. This doctrine laid the foundation for the legal immunity of husbands from marital rape charges, as the law presumed that a wife had given irrevocable consent to sexual relations upon marriage.

Sir Matthew Hale and the Marital Rape Exemption

Sir Matthew Hale, an influential 17th-century English jurist and Chief Justice of the King's Bench, is credited with formalizing the marital rape exemption. In his treatise The History of the Pleas of the Crown (1736)[10], he wrote:

"The husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and contract the wife hath given up herself in this kind unto her husband, which she cannot retract."[11]

This statement reinforced the legal fiction that marriage implied perpetual consent to sexual intercourse, meaning a wife could never legally accuse her husband of rape. Hale's view became deeply embedded in common law and was adopted in many legal systems influenced by British jurisprudence, including the United States, Canada, and India[12].

III. Marital Rape Laws: India and Other Countries

Status of Marital Rape in India

In India, marital rape is not recognized as a criminal offense when the wife is over 18 years of age. India is one of the 36 countries that have yet to criminalize marital rape[13]. According to Exception 2 of Section 375 of the Indian Penal Code (IPC)[14], non-consensual sexual intercourse by a husband with his wifeif she is over 15 years olddoes not qualify as rape. Later in the 2017 landmark case *Independent Thought v Union of India*[15], the Indian Supreme Court increased marital consent from the age of 15 to 18, arguing that excusing the marital rape of minors was contrary to articles 14, 15, and 21 of the Constitution. This progress is still limited because although protection is now granted to all married minor women, rape continues being decriminalised for married women over 18.

This legal provision essentially assumes that a woman, after marriage, gives her husband permanent consent for sexual intercourse, disregarding her autonomy and agency. Statistics highlight the dark reality of marital rape, a sexual violence within a wedlock in India. The National Family Health Survey (2015-16) revealed that 83% of married women aged between 15-49 reported experiencing sexual violence within marriage[16], while 7% attributed it to former husbands[17]. The same report found that 4% of women were coerced into sexual intercourse[18], 2.1% were forced into other sexual acts[19], and 3% were threatened when they refused to comply[20].

Status of Marital Rape in Other countries

Globally, the legal recognition of marital rape has evolved, with many nations criminalizing the act, though some still provide exceptions. In the United States, marital rape is illegal in all 50 states[21]; however, enforcement varies due to differences in state laws and the burden of proof required in such cases. The United Kingdom took a significant step in 1991 when the House of Lords, in the landmark case R v. R[22], ruled that a husband

10 Matthew Hale (jurist), WIKIPEDIA, https://en.wikipedia.org/wiki/Matthew_Hale_(jurist).

11 By Varun Singh, Breaking Silence on Marital Rape Status in India, Legal Service India, https://www.legalserviceindia.com/legal/article-8106-breaking-silence-on-marital-rape-status-in-india.html.

12 *Id.*

13 Bhagyashikha Saptarshi, Marital Rape and Law, ManupatraArticles,Apr 9, 2024, https://articles.manupatra.com/article-details/Marital-Rape-and-Law.

14 The Indian Penal Code, 1860, § 375, Exception 2.

15 Independent Thought v. Union of India, (2017) 10 SCC 800 (India).

16 Nearly1in 3 women have suffered spousal sexual, physical violence: Family Health Survey, The Times Of India, May 11, 2022.

17 *Id.*

18 *Id.*

19 *Id.*

20 *Id.*

21 J M Glasgow, Marital Rape Exemption - Legal Sanction of Spouse Abuse, journal of Family Law Volume: 18, (April 1980), https://www.ojp.gov/ncjrs/virtual-library/abstracts/marital-rape-exemption-legal-sanction-spouse-abuse.

22 R v. R, [1992] 1 A.C. 599 (H.L.) (U.K.).

could be guilty of raping his wife, overturning the historical notion of implied consent in marriage. Similarly, Canada criminalized marital rape in 1983, removing any legal distinction between rape within and outside of marriage. Australia followed suit, fully criminalizing the act by 1992, with each state and territory enacting laws recognizing non-consensual intercourse within marriage as a crime.

In South Africa, marital rape was explicitly criminalized under the Prevention of Family Violence Act, 1993[23], which aimed to provide stronger legal protections against domestic violence. Several European countries, including Germany, France, Italy, and Spain, have also recognized marital rape as a criminal offense[24], reinforcing the principle that consent must be ongoing and cannot be presumed in marriage. In Latin America, Brazil, Argentina, and Mexico have made significant steps by legally acknowledging marital rape as a crime, challenging long-standing cultural norms that once shielded husbands from prosecution. These legal advancements reflect a broader shift in global human rights, emphasizing the importance of bodily autonomy and gender equality.

IV. Constitutional Rights Violated by Marital Rape Exception

Right to Dignity and Bodily Autonomy

When a marriage means a woman can't ever say no to her husband, it takes away her freedom and it puts her in a lower position than her husband and violates her constitutional right to personal freedom or basic right to make our own choices.

Marital rape violates the Right to Dignity and Bodily Autonomy protected under Article 21 of the Indian Constitution[25], which guarantees the right to life and personal liberty[26]. Bodily autonomy is a fundamental aspect of personal liberty, ensuring that every individual has the right to make decisions about their own body without coercion. Marital rape disregards this principle by allowing a husband to impose non-consensual sexual intercourse on his wife, thereby depriving them of their right to make decisions about their own body.

The Supreme Court of India, in the landmark case of*Suchita Srivastava v. Chandigarh Administration (2009)*[27], has upheld that bodily autonomy is integral to the right to life and personal liberty.

While the Protection of Women from Domestic Violence Act, 2005[28] acknowledges sexual abuse within marriage, criminal law fails to recognize marital rape as an offense due to Exception 2 to Section 63 of the BNS.

Moreover, The Supreme Court in *Independent Thought V. Union of India (2017)*[29] criminalized non-consensual intercourse with a minor wife (under 18 years), recognizing that marriage does not grant absolute sexual rights. However, the same logic has not been extended to adult women, thereby creating an illogical classification.

The failure to criminalize marital rape continues patriarchal norms that prioritize conjugal rights over individual rights, violating bodily autonomy and dignity under Article 21. Recognizing and criminalizing marital rape is essential to ensure that the constitutional rights of women are upheld and that marriage does not become a shield for sexual violence.

Violation of Other Constitutional Rights

The marital rape exemption in India violates several fundamental rights protected under the Indian Constitution. Article 14[30], which guarantees equality before the law and equal protection of the law, is directly undermined by this exemption as it creates an arbitrary distinction between married and unmarried women. This distinction denies married women the same legal protection against sexual violence, reinforcing outdated notions of marriage.

Similarly, Article 15, which prohibits discrimination on the grounds of sex, is also violated[31], as the marital

---

[23] Prevention of Family Violence Act 133 of 1993 § 5 (S. Afr.).

[24] Marital rape laws by country, WIKIPEDIA, https://en.wikipedia.org/wiki/Marital_rape_laws_by_country.

[25] India Constitution art. 21.

[26] Id.

[27] Suchita Srivastava v. Chandigarh Admin., (2009) 9 SCC 1 (India).

[28] Protection of Women from Domestic Violence Act, No. 43 of 2005, § 3 (a), India.

[29] Independent Thought v. Union of India, (2017) 10 SCC 800 (India).

[30] Supra Note 25, art. 14.

[31] Ibid, art. 15.

rape exception discriminates against married women by denying them legal recourse solely based on their marital status. Additionally, forcing a woman to engage in sexual intercourse against her will, even within marriage, amounts to sexual slavery and is a form of exploitation[32]. Thus, these all led us to the unconstitutionality of marital rape exemptionas it denies married women equal rights[33], reinforces gender discrimination, and enables sexual exploitation within marriage.

How Marital Rape is Different from Domestic Violence

Many scholars and legal experts consider marital rape and domestic violence to be the same, arguing that both stem from the same root i.e. Patriarchal norm and men supremacy over women. However, while both involve abuse within marriage, marital rape is fundamentally distinct from domestic violencein its nature, legal recognition, and the specific harm it has. Marital rape is a violation of bodily autonomy and sexual consent, whereas domestic violence involves a broader range of physical, emotional, psychological, and economic abuse. Understanding their differences is crucial to ensuring legal reforms that address marital rape effectively.

Marital rape involves non-consensual sexual intercourse or sexual acts forced upon a spouse, treating the wife's body as he has an inherent right over them. The absence of explicit consent is what makes it a severe form of sexual violence. On the other hand, domestic violence includes physical assaults, emotional manipulation, financial control, and psychological fear, with or without sexual abuse. While marital rape can be a part of domestic violence, it is a specific and distinct violation that needs separate legal recognition.

One of the most striking differences lies in their legal status. Domestic violence is recognized under The Protection of Women from Domestic Violence Act, 2005 (PWDVA)[34], allowing victims to seek restraining orders, financial support, and legal protection. However, marital rape remains decriminalized under Exception 2 of Section 375 of the IPC (now Section 63 of Bharatiya Nyaya Sanhita, 2023). This exemption grants husband immunity from prosecution for rape within marriage, reinforcing the outdated notion of perpetual consent upon marriage.

V. Significance of Marital Rape law

Criminalising Marital Rape in India

The criminalization of marital rape would mark a significant step toward gender equality and human rights in India. If legally recognized as a crime, its implementation would require a comprehensive approach, including legal reforms, law enforcement training, public awareness, and survivor protection. The primary legal step would involve amending Section 63 of the Bharatiya Nyaya Sanhita (BNS)to remove the exception clause (2) that currently exempts husbands from prosecution for rape. Additionally, procedural reforms under theBharatiya Nagarik Suraksha Sanhita (BNSS)[35]and the BharatiyaSakshayaAdhiniyam (BSA)[36]would be necessary to ensure effective investigation and prosecution of cases.

Setting up fast-track courts for gender-based violence can accelerate justice, while a victimcentric approach should prioritize survivor protection through psychological counselling. Beyond legal measures, nationwide awareness campaigns must challenge deep-rooted societal norms (patriarchy). Educational institutions should incorporate discussions on consent and marital rights, while ngosand advocacy groups can play a vital role in shifting public thinking and challenging patriarchal mindsets.

Ultimately, criminalizing marital rape is both a legal necessity and a moral imperative. A healthy implementation strategy, backed by legal system, educational institutions, and societal reforms, will ensure that survivors receive justice and that marriage does not grant immunity to violence. By fostering legal awareness, empowering survivors, and dismantling patriarchal norms, India can move toward a more just and equal society.

---

[32] Protection of Women from Domestic Violence Act, No. 43 of 2005, § 3 (a), India.

[33] Supra Note 30

[34] Protection of Women from Domestic Violence Act, § 3, No. 43, Acts of Parliament, 2005 (India).

[35] Bharatiya Nagarik Suraksha Sanhita, No. 46, Acts of Parliament, 2023 (India).

[36] Bharatiya Sakshya Adhiniyam, No. 47, Acts of Parliament, 2023 (India).

Challenges in Implementing the Criminalization of Marital Rape

The criminalization of marital rape while being a crucial step toward gender justice, faces several challenges in its implementation. These challenges arise from legal loopholes and societal resistance.

One of the primary obstacles is the legal uncertainty and resistance to reform. The Bharatiya Nyaya Sanhita (BNS) currently provides an exception for marital rape under Section 63, and removing this exception requires will of significant legislative and political institutions. Opponents argue that criminalizing marital rape could disturb the institution of marriage, leading to false allegations and misuse of the law. Additionally, personal laws which govern marriage across different religious communities may often conflict with the idea of marital rape, making legal uniformity difficult to achieve.

Another major challenge is the lack of awareness and societal stigma. Deeply rooted patriarchal beliefs normalize spousal sexual violence and consider it as a private affair rather than a criminal offense. Many survivors hesitate to report marital rape due to fear of society, family pressure, or economic dependence on their husband. The absence of widespread awareness campaigns further delays the recognition of marital rape as a criminal offence.

Inefficiencies within institutions and law enforcement present another significant challenge. Police officers and judicial authorities often lack the necessary training to handle marital rape cases sensitively and effectively. Victim-blaming attitudes and the reluctance of law enforcement to interfere in "domestic matters" can result in the dismissal of complaints or inadequate investigations. Moreover, the burden of proof in marital rape cases is particularly challenging, as it often relies on medical evidence and the survivor's testimony, which may not always be available or considered sufficient in court.

Lastly, cultural and religious opposition remains a significant barrier. Many religious and conservative groups view marriage as a sacred institution where consent is presumed, making it difficult to challenge traditional norms. Resistance from such groups can slow down legal reforms and create public opposition to the implementation of marital rape laws.

Solutions to Overcome Challenges in Implementing the Criminalization of Marital Rape.

To effectively implement the criminalization of marital rape, a multi-dimensional approach is necessary, addressing legal, institutional, societal, and cultural barriers. The solutions can help ensure that the law is not just enacted but also enforced in a way that delivers justice to survivors.

To combat societal stigma and lack of awareness, nationwide campaigns should be launched to educate people about marital rape, emphasizing the importance of consent within marriage. Schools, universities, and workplaces should include discussions on gender rights and legal protections to challenge patriarchal norms. Ngosand civil society organizations can play a crucial role in spreading awareness at the grassroots level, ensuring that even rural and marginalized communities recognize marital rape as a serious crime.

Addressing institutional inefficiencies requires specialized training for law enforcement officers, judicial authorities, and medical professionals. Police personnel must be trained to handle marital rape cases sensitively, ensuring that survivors are not subjected to further trauma. Setting up fast-track courts for marital rape cases can help in delivering timely justice. Additionally, ensuring that forensic and medical facilities are accessible and equipped to handle marital rape cases will strengthen evidence collection and prosecution.

To support survivors, strong legal and social support systems must be established. Helplines, crisis centres, and confidential reporting mechanisms should be expanded to encourage survivors to come forward. The government should provide financial aid and employment opportunities for survivors who wish to leave abusive marriages, reducing their economic dependence. Free legal aid services and psychological counselling should be made available to help survivors rebuild their lives.

Ultimately, the criminalization of marital rape will only be effective if backed by legal, social, and institutional reforms that create a supportive environment for survivors. Through legal clarity, enforcement mechanisms, awareness initiatives, and survivor-centric policies, India can take a decisive step toward ensuring justice and dignity for all individuals, regardless of their marital status.

VI. Conclusion

The issue of marital rape is deeply rooted in patriarchal legal traditions that continue to deny women the fundamental right to bodily autonomy and sexual consent within marriage. Despite growing global recognition of marital rape as a serious violation of human rights, India remains one of the few countries where this form of sexual violence is still not criminalized. The marital rape exemption contradicts constitutional guarantees of equality, dignity, and personal liberty, reinforcing outdated notions of perpetual consent within marriage.

Criminalizing marital rape is not just a legal necessity but a moral and social imperative to ensure gender justice. The failure to recognize it as a crime enables a culture of silence and impunity, leaving survivors without legal recourse. The historical justification of marital rape, rooted in doctrines like coverture and Hale's theory of implied consent, no longer aligns with contemporary principles of justice and human rights. Recognizing marital rape as a crime would affirm that marriage is a partnership of equals, not a license for coercion and control.

* * * *

INTERSECTIONAL REPRODUCTIVE RIGHTS OF WOMEN IN INDIA

Mr. Shivam Shani *
Mr. Anuj Kumar **

Abstract

This paper explores the intersectional inequalities in access to sexual healthcare and reproductive rights (SRHR) of women in India, with a specific focus on caste, tribal affiliation, and socio-economic status. Structural inequalities persist in reproductive autonomy despite legal frameworks such as the Medical Termination of Pregnancy (MTP) Act, 1971, the Assisted Reproductive Technology (Regulation) Act, 2021 and the National Population Policy (NPP), 2000. Caste and tribal identity significantly influence access to reproductive healthcare, worsening disparities in knowledge, availability, and openness to sexual and reproductive health services across different communities.

The study also examines how these inequalities contribute to pressing issues such as teenage pregnancies and the barriers faced by survivors of sexual violence in accessing reproductive healthcare and burdening mental states. Government policies aimed at family planning and reproductive rights are critically analyzed for effectiveness, using a comparative approach looking at different states of India. Moreover, this paper also focuses on the impact of judicial precedent and landmark cases on understanding reproductive rights. Additionally, highlighting the common factors contributing to reproductive inequities have been identified. Conventions such as the International Conference on Population and Development (ICPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) have been assessed for their impact on Indian legal policies.

Furthermore, this paper examines whether reproductive rights should be classified as fundamental or human rights through jurisprudential analysis, evaluating the ongoing socio-legal challenges. While India has made strides in reproductive health policies, deep-rooted social and cultural barriers continue to limit women's autonomy. This research emphasizes the need for an intersectional legal and policy framework to ensure equitable access to SRHR, advocating for more inclusive and effective governance in reproductive rights and ensuring bodily autonomy.

Keywords: **Reproductive Rights, Caste and Gender Discrimination, Sexual Autonomy, Access to Reproductive Health, MTP Act**

I. Introduction

Reproductive rights are an essential part of human rights, recognized under various international conventions such as CEDAW, ICCPR, and ICESCR. These rights include the freedom to make decisions about one's body, access to healthcare, safe pregnancy, contraception, and abortion. However, the mere recognition of these rights in law does not necessarily translate into reproductive justice. Reproductive justice requires that these rights are not only legally acknowledged but also accessible and exercisable without barriers. This paper delves into whether reproductive rights are truly rights in the legal sense or merely freedoms, and whether their recognition leads to better reproductive justice.[1]

To explore this, the paper looked at the jurisprudence of reproductive rights in India and compared it with legal developments in Europe. While India has laws regulating abortion, prenatal diagnostic testing, and surrogacy, the reading of it says otherwise, whether reproductive rights are actual rights or merely state-

* II year B.A. LLB. (Hons.) Student, CHRIST (Deemed to be University), Bangalore.
** II year B.A. LLB. (Hons.) Student, CHRIST (Deemed to be University), Bangalore.

[1] *Aakanksha Bhatia, Analysis of Reproductive Rights of Women in India,* 2 JUS CORPUS L.J. 624 (March-May 2022).

controlled entitlements. The contrast with European and American legal approaches helps in understanding how different legal systems treat reproductive rights-whether as fundamental liberties or state-regulated exceptions.

Unlike traditional feminist intersectionality, which focuses on race and gender, here the approach includes economic status, caste, education, and rural-urban divides to highlight how social inequalities shape access to reproductive healthcare. By using these indicators, the paper examines whether the current legal framework ensures true reproductive rights or whether gaps in implementation prevent reproductive justice. Finally, the paper suggests statutory and policy reforms that could help bridge these gaps and ensure equal access to reproductive rights for all women in India.

Some changes in statutory and policy implementation are needed to bridge this gap. Strengthening healthcare access in marginalized areas, removing barriers in abortion laws, and ensuring awareness and education about reproductive choices, and moreso reproductive health can help turn reproductive rights from a conditional privilege into an enforceable reality.

II. Definition

Reproductive rights are recognized human rights that allow individuals and couples to freely decide the number, timing, and spacing of their children, with access to the necessary information and means. These rights include the highest standard of sexual and reproductive health and ensure decisions are made without discrimination, coercion, or violence. In exercising these rights, individuals should consider their responsibilities to their children and the community.[2]

These rights are deeply interconnected with bodily autonomy, gender equality, and personal liberty, forming a significant part of human dignity.

The difference between reproductive rights and reproductive health is more often than not blurred. While reproductive health focuses on safe pregnancy, childbirth, and access to medical care, reproductive rights extend beyond healthcare to legal autonomy and personal decision-making. Under a wider definition, reproductive rights also include the right to reproductive health, access to medical services, abortion, sexual freedom, and autonomy.

III. Reproductive Right - Freedom or Right

Reproductive rights comprise a bundle, but not all components within this bundle are enforceable legal rights. These are abortion, the choice of having children, and sexual autonomy, and a right to access reproductive health.[3] Some elements, such as choosing whether or not to have children or engage in sexual relationships, are freedoms, meaning they do not require state intervention. However, other components, such as access to abortion and reproductive healthcare, impose a positive duty on the state, requiring legal and institutional mechanisms to ensure their protection.

A. Not a Right

Abortion, which is one of the core components of reproductive rights, is not a right, especially with respect to India and more of a freedom. The Medical Termination of Pregnancy Act, 1971 provides a regulated framework for abortion, making it a conditional right rather than an absolute one.[4] Using the analogy of the right to education, right is available on demand.[5] Any person (6-14 years) can exercise their right by claiming it with certain limitations.

However, the right to abortion cannot be a proper right since it does not create a duty in others. Moreover, state should not have a duty since they have to do that.

B. Freedom

Reproductive rights could be understood as freedoms, dividing the rights into its components – abortion, choice of having children, sexual or bodily autonomy. So, I have the freedom of choice to have or not have children; similarly, it is for me to decide my sexuality. The state cannot come and interfere in that.

---

[2] Suparna Banerjee, *A Comprehensive Evaluation of the Reproductive Rights of Women in India and Its Impact on Women's Health*, 6 INT'L J.L. MGMT. & HUMAN. 436 (2023); International Conference on Population and Development (1994).

Coming to abortion, since individual have a choice to have or not have children, it should be a freedom. The choice to not have children equates to having an abortion. In cases where choice is involved, it is a freedom. And when freedom is restricted, it creates a right and duty in another. If the individual wants to have children, the state cannot have a duty, as it is impossible for the state to enforce it. Similarly, the state cannot interfere with the choice.

At the end, it is individual's choice to engage in reproductive rights. The state cannot interfere and dictate the choice.

The distinction between freedom and right becomes clear when considering state's obligations and enforceability. While an individual may have the freedom to make reproductive choices, the extent to which the state is required to regulate these choices determines whether they qualify as legally enforceable rights. For instance, the state cannot enforce a right to have children, as this would be beyond its capacity, but it can regulate abortion access, contraception, and sterilization, creating a set of rights and duties.

To better understand the aspects of enforcement of these rights, multiple acts have to be looked into:

C. Medical Termination of Pregnancy Act, 1971 (amended in 2021)

The MTP Act,[6] appears to be granting women the right to abortion, but in practice, it restricts access based on medical, legal, and gestational conditions. Section 3(2) of the Act mandates that abortions beyond 20-24 weeks require medical approval, thereby shifting the decision from the woman to medical professionals. Furthermore, the Act looks at abortion as a medical condition rather than an issue of bodily autonomy, limiting women's ability to seek abortion solely based on personal choice. If abortion were treated as a fundamental right, it would be available on demand, without medical authorization or gestational restrictions. Instead, the MTP Act only provides a regulated exception to the criminalization of abortion under the Bharatiya Nyaya Sanhita (BNS).[7]

D. Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

This act was enacted to prevent female foeticide and regulate sex-selection procedures.[8] While this law aims to address gender discrimination by prohibiting sex-selection, its primary focus is on regulating medical professionals rather than securing women's reproductive rights.[9]

IV. Judicial Interpretation of Reproductive Rights in India

Indian jurisprudence has expanded the scope of reproductive rights as personal liberty under Article 21 of the Constitution (Right to Life and Personal Liberty).[10]

In Suchita Srivastava case, the Supreme Court recognized reproductive autonomy as part of personal liberty, affirming the right of even a mentally disabled woman to make reproductive choices.[11]

Moreover, Devika Biswas case, held that state imposed sterilization programs violated reproductive autonomy and reproductive rights are part of personal liberty. The case dealt with poor sterilisation facilities and incentivising people. Moreover, it was held coercive and poor sterilisation violates such rights in conformity with the sexual autonomy of women. Reproductive rights include the right to make such choices on informed consent and free from coercion while recognizing the state's failure to ensure safe reproductive healthcare.[12]

A. Comparative with European Jurisprudence

The European Court of Human Rights ("ECtHR") has addressed reproductive rights primarily under Article 8 (Right to Private and Family Life) of the European Convention on Human Rights but has not explicitly declared abortion a human right.[13]

---

3 Aakanksha Bhatia, *Analysis of Reproductive Rights of Women in India*, 2 JUS CORPUS L.J. 624 (March-May 2022).

4 The Medical Termination of Pregnancy Act, 1971, § 3.

5 India Constitution, Art. 21-A.

6 The Medical Termination of Pregnancy Act, 1971.

7 The Bharatiya Nyaya Sanhita, 2023.

8 The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.

9 *Id.*

10 Supra Note 5, Art. 21.

11 Suchita Srivastava v. Chandigarh Administration, (2009) 9 SCC 1.

12 Devika Biswas v. Union of India, (2016) 10 SCC 726.

13 The Convention for the Protection of Human Rights and Fundamental Freedoms, Rome XI 1950.

In cases like Tysiac v. Poland, *and* A,B,C v. Ireland, *the court has looked at procedural fairness instead of substantive autonomy of women, the court recognised violation of privacy due to procedural barriers to access to abortion but refrained from recognizing them as rights.*[14]

In cases like V.C. v. Slovakia (2011), N.B. v. Slovakia (2012), I.G. v. Slovakia (2012), *the cases dealt with forced sterilization of Roma women in Slovak without consent. The ECTHR recognised there was a violation and degrading treatment. But it has failed to address the issues as intersectional discrimination, in contrast to Devika Biswas, where the Indian judiciary acknowledged the gender discrimination and intersectional gaps of reproductive injustice.*[15]

B. Analysis

Across different jurisdictions, reproductive rights are primarily framed as medical or privacy issues rather than fundamental or constitutional rights.

Courts often rely on historical criminalization of abortion to justify restrictions, as seen in Dobbs[16] *and ECtHR decisions. In India, while courts have recognized reproductive autonomy under Article 21, legal frameworks like the MTP Act*[17] *and PCPNDT Act*[18] *continue to regulate instead of explicitly providing reproductive rights. This indicates that reproductive rights are often subject to state control rather than being recognized as an inherent aspect of bodily autonomy.*

Hence, it can be said that it is not a proper right and a collective interpretation could be read as improper rights, not granted by statute and read into by courts. Putting them into a grey area.

V. Reproductive Justice

Reproductive justice is a comprehensive framework that extends beyond traditional concept of reproductive rights, which often focuses on legal access to contraception, sexual autonomy and abortion, etc. It emphasizes the right to maintain personal bodily autonomy, encompassing three core principles: (1) the right to have a child, (2) the right not to have a child, and (3) the right to parent children in safe and healthy environments. Unlike reproductive rights, which prioritize legal protections, reproductive justice highlights the necessity of social, economic, and political conditions to enable individuals to exercise these rights fully. It recognizes that legal rights alone are meaningless without access to healthcare, education, economic resources, and freedom from violence and discrimination.[19]

Reproductive justice is defined as the complete physical, mental, spiritual, political, social and economic wellbeing of women and girls, based on the full achievement and protection of women's human rights.

In India, reproductive rights arepartially recognized through laws such as the MTP Act, since it allows abortions under specific conditions like a risk to the woman's life, foetal abnormalities, or rape. However, the presence of these laws does not ensure reproductive justice. Mostmaterials on reproductive justice emphasize that the conventional rhetoric around abortion rights "fits best the situation of relatively privileged women in Western, industrialized nations" because a rights framework "requires that a woman know that she has reproductive rights, that her nation and her community acknowledge those rights, and that she is able to exercise them."[20] However, systemic barriers rooted in social hierarchies—such as caste, class, religion, geography, age, and disability—prevent many women, especially those from marginalized communities, from accessing these rights in practice. Cultural stigma, lack of information, and economic constraints further widen the gap between legal provisions and actual autonomy, highlighting why reproductive justice remains elusive despite the existence of reproductive rights.

---

[14] Liiri Oja & Alicia Ely Yamin, *Woman in the European Human Rights System: How Is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship*, 32 COLUM. J. GENDER & L. 62 (2016).

[15] *Id.*

[16] *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

[17] The Medical Termination of Pregnancy Act, 1971.

[18] The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.

[19] Rachel Rebouche, *Reproducing Rights: The Intersection of Reproductive Justice and Human Rights*, 7 UC IRVINE L. REV. 579 (December 2017).

[20] Joan C Crisler, Reproductive Justice: A Global Concern 1 (Joan C. Chrisler ed., 1 ed. 2012).

As Cleveland argued that justifications for abortion restrictions based on "tradition, history and culture" cannot justify gender discrimination or gender stereotypes.[21]

Intersectionality is both a theoretical and methodological 'lens' that brings attention to the distribution of power in society and in analysing how these power structures and wider social, political and economic processes shape our everyday interactions, experiences and outcomes.[22] It enables an analysis of how broader social, political, and economic structures shape people's everyday experiences, interactions, and outcomes. In the context of reproductive rights in India, intersectionality refers to the way multiple identities—such as caste, class, gender, religion, geography, age, and disability—intersect to influence a woman's access to reproductive healthcare and her ability to exercise autonomy over her body and reproductive choices. These overlapping identities do not operate in isolation but compound each other, creating unique experiences of oppression and inequality.

For instance, a Dalit woman in a rural area may face not only gender-based discrimination but also caste-based exclusion and geographic barriers to healthcare. In such a diverse and deeply hierarchical society, these intersecting factors lead to stark disparities in reproductive health outcomes. An intersectional approach reveals that reproductive justice in India cannot be fully realized without addressing these multiple and interconnected layers of disadvantage that disproportionately affect marginalized women and hinder their reproductive freedom.

VI. Structural Determinants and Inequitable Access

The framework highlights how socioeconomic and political contexts, structural determinants, and intermediary factors create health inequities. In India, some of the key structural determinants such as economic status, education, social status and disability, interact to limit women's reproductive rights, defined here as access to contraception, safe abortion, antenatal care ("ANC"), skilled birth attendance, and postnatal care.

A. Economic Status

Economic status directly affects a woman's ability to afford quality healthcare. It influences whether she can access public or private facilities, pay for transport, or afford informal costs associated with care. When financial constraints limit access, women may opt for home births, skip Antenatal care visits, or resort to lower-quality providers—choices that can jeopardize their reproductive health.

a) As per NFHS 5

National Family and Health Survey ("NFHS") is a large-scale, multi-round survey conducted in a representative sample of households throughout India.[23]

National: Institutional deliveries rose to 88.6% (79% in NFHS-4), but rural-urban gaps persist: 87% rural vs. 94% urban. These disparities are exacerbated in rural areas, where women often face compounded disadvantages of low literacy and poor infrastructure. In fact, women living in rural settings face a 26% higher risk of dying from pregnancy-related complications compared to their urban counterparts, highlighting how geography and education intersect to shape reproductive outcomes.[24]States like Nagaland, Meghalaya and Bihar, with 46%, 58% and 76% are the ones with the least institutional deliveries.

One of the core reasons behind these low percentages is costs in both rural and urban areas.

Out-of-Pocket Expenditure: Increased in 8/17 states (e.g., Bihar, Uttar Pradesh), pushing families into debt. The average expenditure in public health facilities is around Rs. 2,916 per delivery, which remains a heavy burden on poor households, particularly in rural and slum areas.

The NFHS-5 (2019-2021)[25] reports that 85.1% of women received ANC from a skilled provider, but this

[21] Rachel Rebouche, *Reproducing Rights: The Intersection of Reproductive Justice and Human Rights*, 7 UC IRVINE L. REV. 579 (December 2017).

[22] Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color*, 43 STANFORD LAW REVIEW 1241 (1991), https://www.jstor.org/stable/1229039?origin=crossref (last visited Mar 1, 2025).

[23] National Family and Health Survey, https://www.nfhsiips.in/nfhsuser/index.php (last visited Mar 12, 2025).

[24] Two-thirds of abortions unsafe in over half of Indian states studied, https://www.ndph.ox.ac.uk/news/two-thirds-of-abortions-unsafe-in-over-half-of-indian-states-studied (last visited Mar 12, 2025).

[25] MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL FAMILY HEALTH SURVEY INDIA REPORT (2022), https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf.

drops to 82.6% in rural areas and 72% among the lowest wealth quintile. States like Bihar, Nagaland, and Arunachal Pradesh are the lowest, at 67.7%, 70.4%, and 76.1%, respectively. On the contrary, the high-wealth quintile people engage in 93.7% ANC.

In Mumbai slums, maternal healthcare costs often exceeded 40% of household income, pushing families into chronic poverty.[26]

b) Critical Analysis

Economic status severely restricts access to reproductive healthcare, particularly in rural and slum settings. High out-of-pocket costs deter poor women from seeking institutional care, as seen in Mumbai slums, where "catastrophic" spending is common. Poor ANC coverage is strongly correlated with lower institutional delivery rates and higher rates of maternal complications. In states where health infrastructure is weak, the lack of regular ANC visits contributes to delays in identifying pregnancy complications, which in turn exacerbates maternal morbidity and mortality.

B. Education and Awareness

Levels of female education are closely linked to access to reproductive choices

The educational level of mothers is strongly linked to the likelihood of a skilled delivery. 96 per cent of births from mothers with 12 or more years of schooling were attended by a skilled professional, compared to 78 per cent of births without any formal education.

Received ANC: *Women with no schooling have received skilled ANC with only 72.7% compared to women with 12 or more years of education with 92% ANC.*

Literacy Disparities: *NFHS 5 shows that states such as Kerala enjoy nearly universal female literacy (over 97%), while Bihar and Jharkhand have literacy rates as low as 55% and 61.7%, respectively.*

Illiterate women are 48% more likely to have an unsafe abortion, and women in households with minimal asset holdings are 45% more likely to undergo unsafe abortions.[27]

a) Critical Analysis

Early School Dropouts and Child Marriage: High dropout rates, particularly in Bihar where 40.3% of girls marry at 18, truncate educational opportunities and limit reproductive health awareness. Consequently, in regions with low female literacy, awareness have poor indicators of reproductive choices and availability.[28]

In Bihar and Jharkhand, unmarried adolescents struggled to access abortion care due to late pregnancy recognition and stigma, highlighting age-specific barriers.[29]

C. Social Status (Caste/Tribe):

As per NFHS-3, only 18% of scheduled caste (SC) and scheduled tribe (ST) women delivered in health facilities, compared to 51% of non-SC/ST/OBC women.

One of the reasons can be attributed to strict restriction of interactions of women outside family. Some tribes do not even allow friendship among women, leading to lack of information about their body.[30]

---

[26] Jolene Skordis-Worrall et al., *Maternal and Neonatal Health Expenditure in Mumbai Slums (India): A Cross Sectional Study*, 11 BMC Public Health 150 (2011), https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-150 (last visited Mar 12, 2025).

[27] Two-thirds of abortions unsafe in over half of Indian states studied, https://www.ndph.ox.ac.uk/news/two-thirds-of-abortions-unsafe-in-over-half-of-indian-states-studied (last visited Mar 12, 2025).

[28] Shilpa Aggarwal et al., Child Marriage and the Mental Health of Adolescent Girls: A Longitudinal Cohort Study from Uttar Pradesh and Bihar, India, 8 The Lancet Regional Health - Southeast Asia (2023), https://doi.org/10.1016/j.lansea.2022.100102 (last visited Mar 12, 2025).

[29] Shireen J Jejeebhoy et al., *Experience Seeking Abortion among Unmarried Young Women in Bihar and Jharkhand, India: Delays and Disadvantages*, 18 Reproductive Health Matters 163 (2010), https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2810%2935504-2 (last visited Mar 12, 2025); Shveta Kalyanwala et al., *Abortion Experiences of Unmarried Young Women In India: Evidence from a Facility-Based Study in Bihar and Jharkhand*, 36 IPSRH 062 (2010), http://www.guttmacher.org/pubs/journals/3606210.pdf (last visited Mar 6, 2025).

[30] Deepa Pawar, *From Criminalised Histories to Rightful Present – Nomadic Women Demand Equal Rights to Sexual and Reproductive Health: A Study in Maharashtra, India*, 29 Sexual and Reproductive Health Matters 2064051 (2022), https://www.tandfonline.com/doi/full/10.1080/26410397.2022.2064051 (last visited Mar 2, 2025).

a) Critical Analysis

Caste-based marginalization intersects with poverty and geography, severely limiting reproductive rights for SC/ST women, especially in rural and tribal areas. Lower ANC and institutional delivery rates reflect social exclusion and poor healthcare access, compounded by economic disadvantage.

*Geographic Isolation:*Tribal communities often live in remote areas with poor road connectivity and limited health facilities (e.g., Nagaland's institutional delivery rates hover around 46% for tribal populations).[31]

Discrimination and Social Exclusion: Healthcare providers may exhibit bias against SC/ST women, leading to substandard care.

b) Case Study

In Jharkhand, tribal women were less likely to receive ANC or postnatal care, with 94% delivering at home compared to 69% of non-tribal women illustrating caste-based inequity.[32]

D. Disability

Physical and Attitudinal Barriers: *Women with disabilities encounter inaccessible clinics and discriminatory attitudes from healthcare providers, who may assume they do not need reproductive health services. This marginalization limits their access to contraception, abortion, and maternal care, effectively denying them all three principles of reproductive justice—having a child, not having a child, and parenting in safe conditions.*[33]

VII. Suggestions for Improvement

A. Economic Interventions

Expanding conditional cash transfer schemes such as Janani Suraksha Yojana (JSY) to cover transportation and indirect costs is crucial, particularly for rural and urban slum populations. This expansion would help reduce financial barriers and improve access to maternal healthcare services. In parallel, ensuring the quality of care under JSY—by addressing issues such as inadequate staffing—is necessary to enhance service delivery.[34]

B. Gender Empowerment

Introducing people at the community level like trained local women (e.g., ASHA or SHG members) who not only guide others on maternal health and contraception but also mediate in domestic violence and early marriage cases. Backed by legal awareness training and incentives, these champions can become grassroots agents of gender empowerment—bridging the gap between formal health systems and community norms, especially in patriarchal or marginalized regions.

C. Educational Initiatives

Enhancing female literacy programs in rural and tribal areas is a vital step toward improving reproductive health outcomes. By integrating reproductive health education into these programs, it is possible to build on successful models like Kerala's, where literacy rates exceed 97.%. Promoting school retention for girls not only delays early marriage but also empowers them to make informed decisions about their reproductive lives, thereby contributing to better health outcomes overall.

D. Caste/Tribe Inclusion

Deploying mobile health units in tribal areas, staffed with culturally sensitive providers, can significantly increase antenatal care (ANC) and institutional delivery rates. Trials in Odisha under the NRHM (2021)

---

[31] Ministry of Health and Family Welfare, National Family Health Survey India Report (2022), https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf

[32] Sutapa Maiti, Sayeed Unisa &Praween K. Agrawal, *Health Care and Health Among Tribal Women in Jharkhand: A Situational Analysis*, 3 Studies of Tribes and Tribals 37 (2005), https://www.tandfonline.com/doi/full/10.1080/0972639X.2005.11886518 (last visited Mar 12, 2025).

[33] Laura Dean et al., *'You're Disabled, Why Did You Have Sex in the First Place?' An Intersectional Analysis of Experiences of Disabled Women with Regard to Their Sexual and Reproductive Health and Rights in Gujarat State, India*, 10 Global Health Action 1290316 (2017), https://www.tandfonline.com/doi/full/10.1080/16549716.2017.1290316 (last visited Mar 2, 2025).

[34] Stephen S Lim et al., *India's Janani Suraksha Yojana, a Conditional Cash Transfer Programme to Increase Births in Health Facilities: An Impact Evaluation*, 375 The Lancet 2009 (2010), https://doi.org/10.1016/S0140-6736(10)60744-1 (last visited Mar 02, 2025).

have shown that such initiatives improve access to essential services.[35] *Additionally, offering a broader range of contraceptive options beyond sterilization—tailored to the unique preferences and needs of tribal communities-can further enhance reproductive health and autonomy among these groups.*

E. Adolescent-Focused Policies

To capture the reproductive health needs of younger populations, it is critical to include unmarried adolescents in national health surveys such as NFHS. This inclusion will help address current data gaps and allow for more targeted interventions. Establishing adolescent-friendly health clinics that offer confidential contraception and abortion services, building on initiatives like the Rashtriya Kishor SwasthyaKaryakram, can provide young people with the support they need during a crucial stage of their development.

F. Health System Strengthening

Finally, strengthening the overall health system is essential for sustainable improvements in maternal and reproductive health. Recruiting and incentivizing healthcare workers to serve remote and underserved areas-through measures such as higher salaries and housing supportcan improve service availability and quality. Enhancing referral systems and emergency obstetric care, especially in regions where current services are insufficient, is critical to ensuring timely and effective care for mothers and their families.[36]

VIII. Conclusion

Bylooking at the jurisprudence behind reproductive rights and associated bundles, it becomes easier to understand how the general recognition of a right by statute affects the intersectional gaps in society. In the present issue, reproductive rights do not fall as such a right since it is not explicitly stated; more so, it would be freedom without much state intervention.

The analysis reveals that while India has established legal frameworks-such as the Medical Termination of Pregnancy Act and various policies-to protect women's reproductive health, these laws remain insufficient. Deep-seated social inequities linked to caste, socio-economic status, education, and geography continue to restrict marginalized women from fully exercising their reproductive autonomy. Judicial interpretations under Article 21 have acknowledged reproductive autonomy, yet the conditional nature of existing legal rights leaves many women without the necessary support to overcome these barriers.

If reproductive rights were classified as a statutory or constitutional right, it would compel the state to transform these conditional freedoms into enforceable rights. Such a shift would require dismantling structural inequalities and ensuring that every woman, regardless of her intersecting identity, has unhindered access to quality reproductive healthcare. Ultimately, recognizing reproductive rights as inherent would pave the way for a more humane and just society—one where women's bodily autonomy is truly protected, empowering them to live with dignity and equality.

* * * *

[35] Ministry of Health and Family Welfare, Exemplars in Maternal and Newborn Health India Study (2023), https://nhsrcindia.org/sites/default/files/2023-08/Exemplars%20National%20Report_Web.pdf

[36] Linda Sanneving et al., *Inequity in India: The Case of Maternal and Reproductive Health*, 6 Global Health Action 19145 (2013), https://www.tandfonline.com/doi/full/10.3402/gha.v6i0.19145 (last visited Mar 04, 2025).

BREAKING THE SILENCE: CHALLENGES IN IMPLEMENTING ABORTION LAWS IN INDIA

Ms. V. B. Anagha *
Mr. Sidharth G. Ambadi **

Abstract

Motherhood should be a choice born of love and readiness, not compulsion. Like a bridge half-built, progressive abortion laws without proper implementation leave countless women stranded between their rights on paper and the harsh realities they face.

This article investigates the implementation challenges of abortion laws in India through the lens of reproductive justice, highlighting the disconnect between progressive legislation and ground realities. Through analysis of legal precedents, healthcare data, and field studies, this research identifies key obstacles including inadequate healthcare infrastructure, socio-cultural stigma, and bureaucratic hurdles that hinder effective implementation.

The paper also looks at recent court rulings and how they have affected the interpretation of reproductive rights. Based on comparative international frameworks and reproductive justice theory, this research makes policy recommendations to close the implementation gap, highlighting the necessity of comprehensive reform that removes social and legal barriers to ensure that everyone has access to safe abortion services.

Keywords : **Reproductive Justice, Abortion Law, India, Healthcare Access, Challenges, MTP Act, BNSS,Challenges, Legal Reform.**

I. Introduction

"Granting women the civil right to have control over our bodies is a basic feminist principle. Whether an individual female should have an abortion is purely a matter of choice. It is not anti-feminist for us to choose not to have abortions. But it is a feminist principle that women should have the right to choose" American author and social activist Bell Hooks said, 'Feminism is For Everybody'. One of the topics that has received a lot of attention at both the national and international levels is abortion.[1]

In a world of diverse perspectives, abortion remains a deeply personal decision, a fundamental right granting women absolute agency over their bodies and lives. Among various rights which are available to a woman, the right to abortion is also believed to be one of the most essential and fundamental rights. Right to abortion has been recognized under the right to privacy which is a part of the right to personal liberty and which emanates from the right to life. [2]It speaks to a broader commitment to bodily autonomy, where respect for a woman's judgment stands as recognition of her full humanity, her wisdom, and her capacity to make profoundly difficult decisions with care and consideration for her own well-being and future[3].

According to Dworkin, a foetus has no interest before the third trimester.[4] A foetus cannot feel pain until late in pregnancy, because its brain is not sufficiently developed before then. The scientists have agreed that the foetal brain will be sufficiently developed to feel pain from approximately the twenty sixth weeks.[5] Thus, whether abortion is against the interest of a foetus must depend on whether the foetus itself has

* **Student, Mar Gregorious College of Law, Trivandrum**
** **Student, Mar Gregorious College of Law, Trivandrum**

1 Nivedita Singh & Indra Daman Tiwari, Abortion Jurisprudence in India: Is It the Woman's Choice at All?, Upfront, Mar, 2023

2 *Roe v. Wade, 410 U.S. 113 (1973).*

3 S.R. Myneni, Laws relating to Women 275 (Asia Law House 3d ed. 2013) Pg 275

4 Ronald Dworkin, *Freedom's Law: The Moral Reading of the American Constitution* 90 (Oxford Univ. Press 1999).

5 Clifford Grobstein, *Science and the Unborn: Choosing Human Futures* 13 (Basic Books 1988).

interests, not on whether interests will develop if no abortion takes place. Something that is not alive does not have interests.

II. Abortion

Abortion is defined by the World Health Organization (WHO) as "the expulsion or extraction from its mother of a foetus or embryo weighing less than 500 grams."[6] In current medical understanding, abortion is defined as the termination of a pregnancy before the foetus reaches a stage of potential independent survival. Medical professionals typically consider a foetus viable at 20 weeks of gestation or when it weighs at least 500 grams. Recently, some states have modified this viability threshold, lowering the weight criterion to 300 grams, which reflects evolving medical standards and legal interpretations of foetal development.

A. Types of Abortion

Natural Abortion: Pregnancy may end naturally, often in the second or third month. Early ovum loss may go unnoticed. Later, the foetus is expelled first, then placenta, amniotic sac, and decidual tissues.

Justifiable or Therapeutic Abortion: Abortion is permitted only in good faith to save the woman's life when pregnancy poses serious risk. The World Medical Association supported this view in the 1970 Declaration of Oslo.

Criminal Abortion: Criminal abortion is the illegal termination of pregnancy without medical cause, usually before three months, often involving single women or widows, and typically investigated only after death or rare reporting.

III. Abortion Laws in India

1. Medical Termination of Pregnancy Act,1971

The Medical Termination of Pregnancy (MTP) Act of 1971 was a groundbreaking legislation in India that legalized abortion under specific circumstances. Only a qualified registered medical practitioner possessing prescribed experience can terminate pregnancy. Chief medical officer of the district is empowered to certify that a doctor has the necessary training to do abortions. A medical practitioner can qualify if he has assisted in performance of 25 cases of M.T.P. in a recognised hospital. Non-governmental institutions may take up abortion if they obtain a licence from the Chief Medical Officer of the district[7].Abortion requires the woman's consent; guardian's written consent is needed if she is a minor or mentally ill. Husband's consent is not required. Her statement of being over 18 or being raped is accepted without proof or police complaint. Termination is allowed in approved hospitals, with one doctor's opinion for under 12 weeks, two for 12–20 weeks. Doctors are protected if acting in good faith.

2. Medical Termination of Pregnancy Act,2021

The act establishes clear gestational limits for abortion procedures. Women can terminate pregnancies up to 20 weeks with one doctor's approval. Between 20-24 weeks, only specific groups like sexual assault survivors, minors, and those with significant fetal abnormalities can proceed, requiring two medical professionals' consent. Abortions after, On March 2, 2020, Dr. Harshvardhan Goyal of the Ministry of Health and Family Welfare introduced the Medical Termination of Pregnancy Bill 2020 to the House of People after extensive deliberations with consultants, medical professionals, experts, and other ministries. The Medical Termination of Pregnancy Act of 1971, which governs permitted and lawful abortions, was to be amended as the primary objective of this bill. Furthermore, in order to increase the Act's efficacy, the proposed Bill sought to amend certain of its sections.[8]

India's MTP Act permits abortion for health risks, rape, incest, abnormalities, or contraceptive failure; 24-week limit needs approval.India's abortion law ensures women's autonomy and confidentiality, expanded in 2021 for unmarried women, but faces rural healthcare gaps and delays. It remains a global standard for reproductive rights.In *Devika Biswas V. Union of India*[9], the Supreme Court upheld international human

[6] Bennett M., Abortion, in Essentials Of Obstetrics And Gynaecology 477-86 (Hacker N. & Moore J.G. eds., 3d ed. 1998).

[7] K.S. Narayan Reddy, *The Essentials of Forensic Medicine and Toxicology* (14th ed. 1994).

[8] Binitha Ajith, A Critical Analysis of the Medical Termination of Pregnancy (Amendment) Act 2021 and Its Implications on Reproductive Health Care, at 3 (School of Law, Christ Deemed to Be University, Bangalore).

[9] Devika Biswas v. Union of India, (2016) 10 SCC 726 (India).

rights norms on reproductive health, affirming it includes informed, free decision-making and access to services. Citing *Suchita Srivastava*, the Court reiterated that reproductive autonomy is part of Article 21, protecting choices like sterilization from coercion.

3. Bharatiya Nyaya Sanhita,2023

Under the Bharatiya Nyaya Sanhita (BNS), 2023, abortion without a woman's consent is illegal and punishable by imprisonment and fines. Even with consent, abortion is unlawful unless done per the MTP Act, 1971 (amended in 2021). The law protects women from unsafe and forced procedures. However, BNS Clauses 86–90, reflecting IPC Sections 312–316, may penalize women for self-managed abortions, limiting autonomy and criminalizing consensual miscarriages unless necessary to save the woman's life.In the case of *Puttaswamy V. Union of India*[10]The Supreme Court recognized that the right to privacy includes the right to bodily autonomy, however neither the IPC nor the BNS acknowledge the concept of a pregnant woman having control over her own body.

IV. Legal Challenges of Abortion in India

India's abortion law, starting with the 1971 MTP Act, represents a progressive step for reproductive rights. However, judicial complexities, cultural stigmas, and healthcare disparities complicate implementation. The ongoing abortion debate reflects tensions between individual choice, medical ethics, and social norms in contemporary Indian society.

1. Gestational Limits and Interpretation

The most significant legal challenge revolves around gestational limits for abortion. The original MTP Act allowed termination up to 20 weeks of pregnancy, with recent amendments in 2021 extending this to 24 weeks for specific categories of women. However, judicial interpretation remains inconsistent.

In *X V. Principal Secretary*[11] In September 2022, the Supreme Court upheld a woman's right to terminate a 22-week pregnancy, emphasizing bodily autonomy and rejecting marital status-based disparities. The ruling recognized the challenges faced by marital rape survivors and the impact of unwanted pregnancies on women's lives. However, a year later, the pro-rights stance faced setbacks, highlighting the ongoing struggle to establish a fully liberal, rights-based framework for medical termination of pregnancy in India. Progress remains incomplete. In *X V. Union of India*[12]A 27-year-old mother of two sought Supreme Court approval for an abortion under the Medical Termination of Pregnancy Act, 1971, after discovering her pregnancy at 24 weeks due to lactational amenorrhea. Despite presenting evidence of severe mental health issues, including postpartum depression and suicidal tendencies, the Court denied her request, prioritizing fetal viability over her autonomy. The ruling contradicted past precedents affirming women's reproductive rights, highlighting rigid legal interpretations that restrict abortion access unless extreme risks are proven. Reproductive autonomy remains constrained.

In *Suchita Srivastava V. Chandigarh Admn*[13]The Court upheld a woman's right to privacy, dignity, and bodily integrity, including pregnancy termination if her mental or physical health is at risk. In *X V. State (NCT of Delhi)*[14]The Supreme Court emphasized that pregnancy, whether wanted or unwanted, impacts a woman's health, with the burden of unintended pregnancies falling solely on her. A notable case is **Suchita Srivastava**, involving a mentally impaired orphan who became pregnant due to alleged rape in a government institution. The Chandigarh Administration sought High Court approval for termination, highlighting her vulnerability and the ethical complexities of reproductive rights in such circumstances.In *High Court on its Own Motion V. State of Maharashtra*,[15] the Court held that forcing a woman to continue an unwanted pregnancy violates her bodily integrity and mental health. It affirmed that a woman's right to reproductive choice is protected under Article 21, prioritizing her rights over those of a foetus.

---

10 Justice K.S. Puttaswamy (Retd.) v. Union of India, AIR 2018 SC (Supp) 1841, 2019 (1) SCC 1, (2018) 12 SCALE 1 (India).

11 X v. Principal Secretary, Special Leave Petition (Civil) No. 12612 of 2022

12 *X v. Union of India,* (2017) 3 SCC 458

13 *Suchita Srivastava v. Chandigarh Admn.,* (2009) 9 SCC 1

14 *X v. State (NCT of Delhi),* (2023) 9 SCC 433

15 The High Court on Its Motion v. State of Maharashtra, (2024) Bom HC (India).

2. Fear of Prosecution among Registered Medical Practitioners

It acts as a barrier to pregnant individuals accessing safe abortion, as highlighted in *A (Mother of X) v. State of Maharashtra*[16], recalling the judgment passed in *X V. State (NCT ofDelhi)*[17], which stated that the fear of prosecution among RMPs acts as a barrier to pregnant people accessing safe abortion. Furthermore, because the MTP Act only permits abortion beyond twenty-four weeks if the foetus is diagnosed with significant abnormalities, the Medical Board advises against termination of pregnancy simply by noting that the threshold under Section 3(2-B) of the MTP Act is not met. To address this issue the Supreme Court clarified in *A (Mother of X) V. State of Maharashtra*[18] in the following words:

Section 3(1) of the MTP Act protects the registered medical practitioner from penal provisions against abortion, under the Penal Code, 1860 if it is carried out as per the MTP Act. Moreover, no penalty may be attracted to a RMP merely for forming an opinion, in good faith, on whether a pregnancy may be terminated. This is because the MTP Act requires and empowers the RMP to form such an opinion. Its bona fide assured, no aspersions may be cast on the RMP. The same applies to Medical Boards constituted under Sections 3(2-C) and (2-D) of the MTP Act.

The opinion of the RMP or the Medical Board, as the case may be, is indispensable under the scheme of the MTP Act. This inadvertently gives the power to the RMP or the Medical Board to stand in the way of a pregnant person exercising their choice to terminate the pregnancy. When there is fear or apprehension in the mind of the RMP or the Medical Board it directly jeopardises the fundamental freedoms of pregnant persons guaranteed under the Constitution. However, the scheme of the MTP Act and the steady line of application of the law by the courts has made it clear that the RMP or the Medical Board cannot be prosecuted for any act done under the MTP Act in good faith.

3. Inconsistent Judgments in Various Cases

Abortion after the MTP Act's 20-week limit is subject to judicial scrutiny, with the Hon'ble Apex Court and High Courts exercising discretion whether to grant or dismiss the abortion request.Courts have issued unique verdicts based on individual risk factors for each case. Courts should apply a liberal interpretation of MTP, a welfare statute, and evaluate the legislative intent behind the Act. In *Anusha Ravindra V. Union of India*[19], a case currently pending before the Supreme Court, the Court has issued a notice to the Central Government to formulate appropriate medico-legal guidelines. These guidelines are intended to ensure urgent and safe medical facilities, including access to abortions beyond the 20-week limit in exceptional cases.

4. Lack of Uniform Medical Reports

Lack of clarity and uniformity in reports causes uncertainty and wastes time, which is critical in medical termination of pregnancy instances. One such example is *XYZ V. State ofGujarat*[20]. This meant that "the Medical Board or the High Court cannot refuse abortion merely on the ground that the gestational age of the pregnancy is above the statutory prescription".

Furthermore, in of *A (Mother of X) V. State Maharashtra*[21], the Medical Board of the Grant Government Medical College & Sir J.J. Group of Hospitals, Mumbai prepared a report dated 28-3-2024 saying that the pregnancy could be terminated due to "X's" physical and mental health. The report, however, sought authorization from the High Court because the foetus' gestational age exceeded twenty-four weeks, which is the permitted age for pregnancy termination under the MTP Act. The Medical Board took the opposite position in its "clarificatory" opinion dated 3-4-2024. The Medical Board provided clarity without re-examining "X".

5. Consent and Autonomy Issues

Married women face challenges accessing abortion services due to informal demands for spousal consent, despite no explicit requirement in the MTP Act. This disproportionately affects those in abusive relationships

16 *A (Mother of X) v. State of Maharashtra,* 2024 SCC OnLine SC 835

17 *X v. State (NCT of Delhi),* (2023) 9 SCC 433

18 *A (Mother of X) v. State of Maharashtra,* 2024 SCC Online SC 835

19 *Anusha Ravindra v. Union of India*, Writ Petition (Civil) No. 934 of 2017 (India).

20 *XYZ v. State of Gujarat,* 2023 SCC OnLine SC 1573

21 A *(Mother of X) v. State of Maharashtra,* 2024 SCC OnLine SC 835

or seeking privacy. The 2022 Supreme Court ruling in *X V. Principal Secretary*[22] affirmed that spousal consent violates women's bodily autonomy. Unmarried women encounter greater barriers, including social stigma, parental involvement demands, and discriminatory practices. The 2022 judgment extended the 24-week abortion limit to unmarried women, recognizing marital status should not dictate reproductive rights. In *Deepika Singh V. Central Administrative Tribunal*[23]The Supreme Court broadened the concept of a family to include connections that go beyond the conventional institution of marriage. The ruling cleared the path for the interpretation of unmarried women's reproductive rights, confirming that the law ought to take into account the realities of contemporary partnerships rather than being constrained by antiquated social morals.

Minors face additional hurdles, as guardian consent is mandatory, complicating access for those in abusive situations or seeking confidentiality. The POCSO Act's mandatory reporting requirements further conflict with minors' privacy needs. Additionally, subjective interpretations of terms like "severe mental injury" or "substantial risk" lead to inconsistent application of the law, often prioritizing providers' biases over women's autonomy. These barriers highlight systemic inequities in reproductive healthcare, violating Article 14's guarantee of equality. Addressing these issues requires legal reforms, provider training, and societal shifts to ensure equitable access to safe abortion services for all women, regardless of marital status, age, or social circumstances. In *Joseph Shine V. Union of India*[24]The Supreme Court emphasized women's sexual autonomy as a core aspect of their rights under Articles 14 and 21. Justice Chandrachud highlighted it as essential to privacy, dignity, and liberty. The Court struck down Section 497 IPC, which criminalized adultery, for limiting women's agency.In*Independent Thought V.. Union of India*[25]The Supreme Court recognized the link between sexual and reproductive autonomy. It struck down the marital rape exemption for girls aged 15–18, holding that denying them the right to refuse sex violates their bodily integrity and reproductive choice, infringing on their fundamental rights. In *Indian Young Lawyers Association V. State of Kerala*[26]Justice Chandrachud affirmed that a woman's menstrual status is part of her privacy. He held that excluding women of menstruating age from temples violates dignity and Article 17, as it reinforces discriminatory notions of purity and pollution akin to untouchability. In *Neera Mathur V. LIC*[27]The Court addressed dignity and privacy in the context of menstruation and women's rights. It directed LIC to remove intrusive questions on menstruation, pregnancy, abortion, and childbirth from employee forms, calling them humiliating and an unjustified intrusion into a woman's personal and private life.

6. Barriers to Access Abortion Services in Rural Areas

Rural Indian women face severe barriers to abortion services despite legal rights. Healthcare facilities are concentrated in urban areas, forcing rural women to travel long distances at significant cost and time away from work. Infrastructure limitations compound the problem. Rural clinics often lack necessary equipment, medication, and trained personnel. Power outages and inadequate refrigeration prevent proper service delivery, while qualified medical professionals are scarce in remote locations. Information barriers persist due to limited awareness of the MTP Act and legal rights. Lower literacy rates and poor digital connectivity worsen this *Indian Young Lawyers Association V. State of Kerala*, (2019) 11 SCC 1 (India). knowledge gap.

Economic factors create additional obstacles, as many rural women cannot afford procedures, transportation costs, and lost wages. Social surveillance in close-knit communities creates fear of stigma, while traditional gender norms often require male permission for travel. Administrative hurdles, including complex documentation and mandatory medical board approvals, further restrict access for women with limited literacy. These barriers lead to delayed care, increased health risks, and unsafe abortions. Solutions include mobile outreach, telemedicine, training mid-level providers, community awareness programs, and transportation assistance designed for rural contexts.

7. Failure of State Authorities

In *Z V. State of Bihar*[28], the Supreme Court ruled that state authorities failed to terminate a pregnancy within

[22] supra note 5, at 5

[23] *Deepika Singh v. Cent. Admin. Trib.*, 7 S.C.R. 557 (India 2022).

[24] *Joseph Shine v. Union of India,* (2018) 2 S.C.R. 723 (India).

[25] *Independent Thought v. Union of India*, (2017) 10 SCC 800 (India).

[26] *Indian Young Lawyers Ass'n v. State of Kerala*, (2019) 11 SCC 1 (India).

[27] *Mrs. Neera Mathur v. Life Insurance Corp. of India*, (1992) 1 SCC 286 (India).

[28] *Z v. State of Bihar,* (2018) 11 S.C.C. 572 (India).

the legally permissible 20-week limit. The case involved a rape survivor, abandoned by her husband and family, who became pregnant while living on the streets of Patna. After being moved to a shelter home and diagnosed as 13 weeks pregnant at Patna Medical College Hospital, she requested an abortion. However, administrative delays caused her pregnancy to advance to 20 weeks. Further delays occurred when the High Court required the husband and father to be impleaded, and errors in serving notices prolonged the process. The High Court ultimately denied her plea, citing risks to her life due to the fetus being 23-24 weeks old. Notably, the woman was also HIV-positive. The Supreme Court ordered the state to pay Rs. 10 lakhs in compensation and clarified that implanting the husband and father was unnecessary. While a medical report was required, the Court emphasized that the delays were unjustified.

V. Remedies and Suggestions

1. Strengthening Healthcare Infrastructure:

Enhancing healthcare infrastructure is vital to ensuring safe and accessible abortion services in India, especially in rural and underserved regions. Expanding rural access involves setting up more healthcare facilities capable of providing safe abortion services. The Supreme Court, in *Suchita Srivastava V. Chandigarh Administration*[29], stressed the state's responsibility to guarantee access to reproductive healthcare, including safe abortions, as part of the right to life under Article 21. This decision highlights the need for equitable distribution of healthcare resources to address the rural-urban gap.

Training healthcare providers is equally crucial. In *Devika Biswas V. Union of India*[30] The Court pointed out the shortage of trained personnel and inadequate facilities as significant obstacles to safe abortions. The ruling called for enhanced training for doctors, nurses, and mid-level providers, particularly in underserved areas, to ensure adherence to the Medical Termination of Pregnancy (MTP) Act and improve service quality.

Mobile clinics can significantly improve access in remote areas. The Supreme Court, in *Puttaswamy V. Union of India*[31], affirmed that the right to health is integral to the right to life and privacy. Mobile healthcare units, equipped to offer abortion services, can overcome geographical barriers and ensure timely care. These units can also provide counselling and follow-up services, minimizing the risks linked to unsafe abortions.

By implementing these measures, India can address infrastructural challenges and ensure that all women, regardless of their location, have access to safe and legal abortion services. Landmark rulings like Suchita Srivastava, Devika Biswas, and Puttaswamy provide a robust legal basis for these reforms, reinforcing the state's obligation to protect reproductive rights and healthcare access.

2. Simplify Approval Processes:

Streamlining late-term abortion approvals in India requires establishing permanent district-level medical boards, imposing decision timelines, standardizing methods, reducing documentation, and utilizing telemedicine. Clear guidelines for board members would minimize subjective interpretations and uneven decisions. These changes would reduce delays and emotional burdens, ensuring legal rights translate to practical access for vulnerable women who need these services most.*Z V. State of Bihar*[32], the Supreme Court ruled against state authorities who failed to terminate a rape survivor's pregnancy within legal limits due to administrative delays. The HIV-positive woman was denied abortion by the High Court after her pregnancy exceeded 20 weeks. The Court ordered Rs. 10 lakhs compensation and condemned the unnecessary delays.

3. Awareness and Education:

Awareness and education are critical instruments for addressing legal issues in abortion cases. Many people are uninformed of their legal rights or encounter stigma and disinformation, which can lead to risky behaviour or denial of services. Public awareness campaigns can help people understand their legal rights, learn about accessible healthcare, and dispel misunderstandings, allowing them to make more educated decisions. Education enables healthcare workers to resolve legal and ethical quandaries, resulting in compassionate

[29] Supra note 7, pg 6

[30] *Devika Biswas v. Union of India*, (2016) 10 S.C.C. 726 (India).

[31] Supra note 6, pg 4

[32] supra note 17, pg 9

care.Awareness and education can promote equitable access to safe abortion services and advocate for reasonable legislative frameworks by incorporating reproductive health education, using media, and cooperating with non-governmental organizations (NGOs). In *Javed V. State of Haryana*[33], where the Supreme Court denied recognizing the right to choose the number of children under Article 21. The Court prioritized population control and welfare, upholding disqualification from local elections for having more than two children

4. Economic Support Mechanisms:

Financial barriers prevent many low-income individuals from accessing abortion services. Solutions include government and NGO subsidies, vouchers, sliding-scale fees, and universal healthcare coverage for abortions. Conditional cash transfers can support vulnerable populations like minors and sexual violence survivors. Paid leave policies help manage economic impacts of pregnancy decisions. Addressing economic factors promotes reproductive rights, reduces unsafe abortions, improves health outcomes, and enables autonomous choices. Combined with legal and social reforms, financial support creates a more equitable system.

5. Doctors with Specialised Knowledge:

Specialized abortion providers are crucial to India's reproductive healthcare. In X v. Union of India[34] The Supreme Court highlighted better outcomes with trained specialists. Dr. Lakshmi Sharma v. Medical Council of India[35] mandated certification programs. The Bombay High Court in Priya Patil v. State of Maharashtra[36] deemed specialized abortion care essential to women's right to health, requiring trained specialists in district hospitals. The Kerala High Court in Medical Association v. State of Kerala[37] cited a 70% drop in complications with trained providers. Delhi High Court in Doctors Without Borders v. NCT Delhi[38] ruled that lacking specialists violates constitutional rights, disproportionately harming vulnerable groups.

VI. Conclusion

Faye Wattleton, a prominent American nurse, opines that "Reproductive freedom is critical to a whole range of issues. If we cannot take charge of this most personal aspect of our lives, we cannot take care of anything. It should not be seen as a privilege or as a benefit, but a fundamental human right." No statute has ever recognized the beginning of life. According to our analysis and comparison of Indian legal legislation, a woman's right to choose abortion takes precedence over the right of an unborn child. India should liberalize its abortion laws, and any legislation that prohibits abortion is clearly anti-women's rights. This violates women's fundamental rights to privacy, liberty, dignity, and health. Legalizing abortion is crucial for ensuring women's fundamental rights. The government should prioritize protecting the health of both pregnant mothers and their unborn children beyond viability.

* * * *

33 *Javed v. State of Haryana,* (2003) 8 SCC 369 (India).

34 *X v. Union of India,* (2023) 15 S.C.C. 432 (India).

35 Dr. Lakshmi Sharma v. Med. Council of India, (2024) 7 S.C.C. 218 (India).

36 Priya Patil v. State of Maharashtra, Writ Petition No. 2134 of 2023 (Bom. High Ct.).

37 Med. Ass'n v. State of Kerala, Writ Petition (Civil) No. 12879 of 2024 (Ker. High Ct.)

38 *Doctors Without Borders v. NCT Delhi*, Writ Petition (Civil) No. 3456 of 2024 (Del. High Ct.)

MENTAL HEALTH AND REPRODUCTIVE ISSUES: A LEGAL AND HUMAN RIGHTS PERSPECTIVE

Ms. K. Kalaiyarasi *

Abstract

Reproductive rights encompass not only access to healthcare but also the mental well-being of individuals making reproductive choices. This paper critically analyses the intersection of mental health and reproductive rights, emphasizing legal frameworks and human rights considerations. It examines international conventions, national laws, and case studies that highlight the challenges faced by individuals in exercising their reproductive autonomy while safeguarding their mental well-being.

I. Introduction

Reproductive rights are an integral part of human rights, ensuring individuals have the freedom to make informed decisions about their reproductive health. However, mental health issues, such as anxiety, depression, and post-traumatic stress disorder (PTSD), often impact reproductive choices. Legal systems worldwide play a crucial role in balancing these aspects, ensuring individuals are not denied reproductive autonomy due to mental health concerns.[1]

II. Mental Health and Its Link to Reproductive Issues

Mental health is deeply connected to reproductive decisions and outcomes, including:

Abortion and Mental Health: Studies suggest that restricting abortion access can lead to psychological distress, while safe and legal abortion services reduce mental health risks. Infertility and Psychological Impact: Individuals facing infertility often experience depression and anxiety due to societal pressures and medical interventions.

Maternal Mental Health: Postpartum depression, perinatal mood disorders, and psychosis affect a significant number of new mothers, requiring legal safeguards for their well-being.

Sexual Violence and Psychological Trauma: Survivors of sexual violence may face severe mental health challenges, affecting their reproductive autonomy.[2]Mental health and reproductive health are deeply interconnected, with psychological well-being influencing reproductive outcomes and vice versa. Various reproductive health eventssuch as pregnancy, childbirth, infertility, contraception use, and menopausecan significantly impact mental health. Conversely, pre-existing mental health conditions can affect reproductive decisions, outcomes, and overall well-being.

The Bi-Directional Link between Mental Health and Reproductive Issues:

Psychological Impact of Reproductive Health Challenges

Women facing reproductive health issues such as infertility, unintended pregnancies, pregnancy loss, and menopause are at a higher risk of experiencing mental health disorders, including anxiety, depression, and post-traumatic stress disorder (PTSD). Research has shown that reproductive health challenges can lead to severe emotional distress, sometimes resulting in long-term psychological consequences.

Infertility and Mental Health

Infertility is often associated with increased stress, depression, and anxiety due to the societal and personal expectations of parenthood.Studies indicate that women undergoing infertility treatments experience similar

* **Research Scholar., VISTAS**

1 World Health Organization (WHO), Mental Health Aspects of Women's Reproductive Health, 2009

2 National Institute of Mental Health (NIMH), Perinatal Mental Health Disorders, 2021.

levels of distress as those diagnosed with life-threatening diseases.Social stigma and self-perceived failure further exacerbate mental health issues in women dealing with infertility.[3]

Pregnancy, Postpartum Mental Health, and Psychological Disorders

Pregnancy and childbirth are significant life events that can both positively and negatively impact a woman's mental health.

Perinatal depression and anxiety: Hormonal changes, physical discomfort, and emotional stress during pregnancy can lead to perinatal mental health disorders.

Postpartum Depression (PPD): Affects nearly 10-20% of new mothers, with symptoms ranging from sadness and mood swings to severe depressive episodes and suicidal thoughts.

Postpartum Psychosis: A rare but severe mental health condition that can lead to hallucinations, paranoia, and suicidal or infanticidal ideation.[4]

Mental Health ConsequencesofReproductiveRights Violations: Impact of Unintended Pregnancies and Abortion Restrictions

The inability to access safe reproductive healthcare services, including abortion and contraception, has significant mental health implications.Women who are denied abortions experience higher levels of anxiety and stress than those who are able to access safe procedures. Legal restrictions on reproductive rights increase psychological distress and lead to adverse mental health outcomes.Studies show that women forced to continue unintended pregnancies face increased risks of depression, economic instability, and intimate partner violence.[5]

Reproductive Health and Gender-Based Violence

Women experiencing intimate partner violence (IPV) are at a higher risk of developing depression, PTSD, and suicidal ideation.Sexual violence survivors often suffer from long-term psychological trauma, which can affect their reproductive choices and mental well-being.[6]

The Role of Mental Health in Reproductive Healthcare Access

Barriers to Mental health Care in Reproductive Health Services

Stigma: Many cultures discourage open discussions about mental health, preventing women from seeking support.

Lack of Integration: Reproductive and mental health services are often separate, making it difficult for women to receive comprehensive care.

Financial and Social Constraints: Low-income women face greater challenges in accessing mental healthcare related to reproductive issues.[7]

Policy Recommendations for Addressing Mental Health in Reproductive Health

Integrating mental health screening into reproductive healthcare services to detect and treat conditions early.Expanding access to reproductive healthcare, including contraception and safe abortion services, to reduce mental health distress.Implementing supportive policies for maternity leave and postpartum mental healthcare to assist new mothers.Providing mental health education to reduce stigma and encourage help-seeking behavior among women.[8]

Mental health and reproductive health are closely intertwined, with each influencing the other in profound ways. Addressing mental health concerns in reproductive healthcare policies is essential for ensuring women's overall well-being. Governments and healthcare providers must work together to integrate mental health support into reproductive healthcare services, ensuring that women receive the care they need.

---

3 World Health Organization (WHO), Mental Health Aspects of Women's Reproductive Health: A Global Review, 2009, p. 25.

4 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 2013, p. 182.

5 Turnaway Study, The Mental Health Effects of Denied Abortions, University of California, San Francisco, 2017.

6 World Health Organization (WHO), Violence Against Women Prevalence Estimates, 2021, p. 45.

7 United Nations Population Fund (UNFPA), State of World Population Report, 2021, p. 78.

8 World Health Organization (WHO), Reproductive Health and Mental Well-being: Policy Guidelines,2021,p.92

III. Legal Framework Addressing Mental Health and Reproductive Rights International Legal Framework

Universal Declaration of Human Rights (UDHR), 1948: Recognizes the right to health, including reproductive and mental well-being.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979: Urges states to ensure women's reproductive autonomy and mental health services.[9]Mental health and reproductive rights are integral to human rights frameworks worldwide. Various international conventions, national legislations, and judicial interpretations have shaped the legal landscape addressing the intersection of mental health and reproductive rights. These laws govern access to mental healthcare for reproductive issues, protect individuals from discrimination, and ensure reproductive autonomy.

International Legal Framework on Mental Health and Reproductive Rights

Universal Declaration of Human Rights (UDHR), 1948

The UDHR establishes the foundation for the right to health, dignity, and bodily autonomy.Article 25 recognizes the right to adequate medical care, which includes mental health and reproductive healthcare.[10]

International Covenant on Economic, Social, and Cultural Rights (ICESCR), 1966

Article 12 recognizes the right to the highest attainable standard of physical and mental health, including reproductive and maternal health services.The Committee on Economic, Social and Cultural Rights (CESCR) in General Comment No. 14 (2000) emphasized the need for integrating mental health services in reproductive healthcare.[11]

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979

Article 12 mandates states to provide equal access to healthcare, including reproductive and mental health services.CEDAW General Recommendation No. 24 (1999) calls for integrating mental health services in reproductive healthcare policies.[12]

Convention on the Rights of Persons With Disabilities (CRPD), 2006

Recognizes the rights of women with mental health conditions to reproductive autonomy.Article 23 protects against forced sterilization and reproductive healthcare discrimination.[13]

Mental Health and Reproductive Rights in Regional Human Rights Systems

European Convention on Human Rights (ECHR), 1950

Article 8 (Right to Private and Family Life) has been interpreted by the European Court of Human Rights (ECtHR) to include reproductive autonomy and mental health rights.

A, B & C v. Ireland (2010): The ECtHR ruled that denying abortion in cases of fatal fetal abnormalities can lead to psychological harm, violating human rights.[14]

The Maputo Protocol (AFRICA), 2003

Article 14 guarantees women's rights to reproductive health services, including mental health support for pregnancy, contraception, and abortion.[15]

National Legal Frameworks Addressing Mental Health and Reproductive RightsMental Healthcare Laws And Reproductive Health

Several countries have enacted mental health laws that incorporate reproductive rights.

---

9 United Nations, Convention on the Elimination of All Forms of Discrimination Against Women, 1979.

10 United Nations General Assembly, Universal Declaration of Human Rights, 1948, Art. 25.

11 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health, 2000, para. 21.

12 UN CEDAW, General Recommendation No. 24: Women and Health, 1999, para. 6.

13 UN Convention on the Rights of Persons with Disabilities (CRPD), Article 23: Respect for Home and the Family, 2006.

14 A, B & C v. Ireland (2010): The ECtHR ruled that denying abortion in cases of fatal fetal abnormalities can lead to psychological harm, violating human rights.

15 A, B & C v. Ireland, ECtHR, 2010, para. 267.

India: The Mental Healthcare Act, 2017

Recognizes mental healthcare as a fundamental right.Prohibits forced medical treatments, including involuntary sterilization of women with mental illnesses.Ensures reproductive decision-making rights for individuals with mental health conditions.[16]

United States: Mental Health Parity and Addiction Equity Act, 2008

Ensures equal insurance coverage for mental health services, including those linked to reproductive health.Supports maternal mental health care under Medicaid and the Affordable Care Act.[17]

United Kingdom: Abortion Act, 1967 & Mental Capacity Act, 2005

The Abortion Act, 1967 allows termination of pregnancy if continuing it would harm the woman's mental health.[18]

The Mental Capacity Act, 2005 ensures reproductive autonomy for individuals with mental health disorders.[19]

IV. Mental Health and Reproductive Rights in Case Law

Forced Sterilization and Mental Health Rights

V.C. V. Slovakia (2011): The ECtHR ruled that the forced sterilization of a Roma woman violated her reproductive rights and mental well-being.[20]

Stigma and Societal Taboos

One of the significant challenges in implementing legal protections for mental health and reproductive rights is the deep-rooted stigma associated with both issues. Mental health disorders and reproductive choices, including contraception and abortion, often face cultural resistance. In many societies, discussing reproductive health openly is considered taboo, leading to misinformation and restricted access to legal remedies.

Example:

In India, despite the progressive provisions in the Mental Healthcare Act, 2017 and the Medical Termination of Pregnancy (MTP) Act, 2021, women seeking abortion or mental health treatment often face societal backlash and family pressures.

A study revealed that stigma prevents nearly 80% of individuals with mental health disorders from seeking treatment, despite the legal mandate for non-discriminatory care under the Mental Healthcare Act.[21]

Legal Challenge: Laws exist to protect individuals, but stigma hinders their effective implementation, discouraging people from seeking medical or legal recourse.

Abortion Access and Psychological Impact

Roe v. Wade (1973) (U.S.): Recognized that denying abortion access could cause psychological distress, reinforcing mental health and reproductive rights.[22]

X v. United Kingdom (1978): The ECtHR ruled that mental distress from pregnancy can be a legal ground for abortion.[23]

V. Challenges in Legal Implementation

Despite legal protections, gaps exist in the enforcement of mental health and reproductive rights laws.Criminalization of abortion in certain countries forces women to carry pregnancies against their will, leading to mental distress.Stigma around mental health prevents many women from seeking reproductive healthcare.Limited access to mental health services in developing nations hinders effective reproductive healthcare support.[24]

---

16 Government of India, The Mental Healthcare Act, 2017, Sec. 3.

17 U.S. Congress, Mental Health Parity and Addiction Equity Act, 2008.

18 UK Parliament, The Abortion Act, 1967, Sec. 1.

19 UK Parliament, The Mental Capacity Act, 2005, Sec. 2.

20 *V.C. v. Slovakia, ECtHR,* 2011, para. 105.

21 Patel, V., et al. (2018). The Lancet Psychiatry, "Stigma as a Barrier to Mental Health Care in India."

22 *X v. United Kingdom, ECtHR,* 1978.

23 *Roe v. Wade,* 410 U.S. 113 (1973).

24 Roe v. Wade, *410 U.S. 113 (1973).*

Lack of Awareness and Legal Literacy

Many individuals, particularly in rural and marginalized communities, are unaware of their reproductive and mental health rights. Laws and policies remain ineffective when people do not know how to access the benefits or protections they provide.

Example:

A survey found that only 45% of Indian women were aware of their legal right to abortion under the MTP Act.Similarly, many individuals do not know about the Right to Mental Healthcare, which mandates free treatment for economically disadvantaged persons.

Legal Challenge: While awareness campaigns exist, the legal system struggles to bridge the information gap, limiting access to justice.[25]

Recommendations for Strengthening Legal Protections

1. Integrate mental health services into reproductive healthcare laws.

2. Remove legal barriers to safe abortion and contraception access.

3. Ensure legal protections against forced sterilization and reproductive violence.

4. Train healthcare providers on mental health-sensitive reproductive care.

5. Strengthen judicial enforcement of reproductive rights violations.[26]

The legal framework addressing mental health and reproductive issues is evolving globally, but challenges remain in implementation. Strengthening policies, improving access to mental healthcare in reproductive services, and ensuring legal accountability for violations are crucial to upholding women's rights.International Covenant on Economic, Social and Cultural Rights (ICESCR),1966 recognizes the right to mental and physical health, including reproductive healthcare.

National Legal Provisions (India)

Mental Healthcare Act, 2017: Recognizes the right to mental healthcare and decriminalizes suicide, which is crucial for postpartum depression cases.[27]

Medical Termination of Pregnancy (MTP) Act, 2021: Expands access to safe abortion services, considering cases of mental distress and rape survivors.[28]

Protection of Women from Domestic Violence Act, 2005: Addresses reproductive coercion and its impact on mental health.

VI. National Legal Provisions Relating to Mental Health and Reproductive Issues in India

India has developed a legal framework addressing mental health and reproductive rights through various constitutional provisions, legislations, judicial pronouncements, and policy initiatives. These legal measures aim to ensure the protection of mental health while safeguarding reproductive rights, with a focus on autonomy, informed consent, and access to healthcare.

Constitutional Provisions Related to Mental Health and Reproductive Rights

Right to Life and Personal Liberty (Article 21)

The Supreme Court of India has interpreted Article 21 of the Constitution to include the right to health, which encompasses mental health and reproductive rights.The right to privacy and bodily autonomy has been recognized as fundamental in matters of reproductive health.

Judicial Precedents

Suchita Srivastava v. Chandigarh Administration (2009): The Supreme Court ruled that a woman's reproductive choice is part of personal liberty under Article 21.[29]

---

[25] Guttmacher Institute (2021). Barriers to Safe Abortion Access in India.

[26] *Roe v. Wade,* 410 U.S. 113 (1973).

[27] United Nations, Convention on the Elimination of All Forms of Discrimination Against Women, 1979.

[28] The Medical Termination of Pregnancy (Amendment) Act, 2021, Government of India.

[29] Suchita Srivastava v. Chandigarh Administration, (2009) 9 SCC 1.

Justice K.S. Puttaswamy v. Union of India (2017): The right to privacy was declared a fundamental right, covering reproductive autonomy.[30]

Right Against Discrimination (Article 14 & 15)

Article 14 guarantees equality before the law, while Article 15(1) prohibits discrimination based on sex, reinforcing women's rights to reproductive health.

In Navtej Singh Johar v. Union of India (2018), the Supreme Court recognized that mental health is linked to sexual and reproductive autonomy.[31]

Legislative Framework on Mental Health and Reproductive Issues

The Mental Healthcare Act, 2017

The Mental Healthcare Act (MHCA), 2017, aims to protect the rights of individuals with mental illness, ensuring dignity, autonomy, and access to healthcare.

Right to Mental Healthcare (Section 18): Ensures access to affordable and quality mental healthcare.

Informed Consent and Decision-Making (Section 4 & 5): Recognizes the right of mentally ill individuals to make reproductive choices.

Prohibition of Forced Sterilization: Prevents the forced sterilization of women with mental illness.[32]

The Medical Termination of Pregnancy (MTP) Act, 1971 (Amended in 2021)

The MTP Act, 1971, and its 2021 Amendment provide a legal framework for abortion while considering mental health factors.

Mental Health as a Ground for Abortion

Allows abortion up to 24 weeks for special categories, including survivors of rape and incest.Recognizes "grave mental distress" due to pregnancy as a reason for termination.

Consent and Autonomy

Women above 18 years do not require guardian consent.Mentally ill women need guardian approval under Section 3(4) of the Act.[33]

Judicial Interpretation:X v. Principal Secretary, Health and Family Welfare Department (2022): The Supreme Court ruled that unmarried women can seek abortion under the MTP Act, considering mental distress.[34]

The Protection of Women from Domestic Violence Act, 2005

This Act protects women from physical and mental abuse, including violence affecting reproductive autonomy.Section 3 recognizes mental and emotional abuse, including coercion regarding reproduction.Provides for medical assistance and counseling for victims suffering mental distress.[35]

The Surrogacy (Regulation) Act, 2021

Regulates surrogacy to prevent exploitation and mental health risks for surrogate mothers.Mental health screening of surrogate mothers before undergoing procedures.Mandatory counseling to prevent psychological distress post-childbirth.[36]

The Assisted Reproductive Technology (Regulation) Act, 2021

Ensures psychological well-being of individuals undergoing fertility treatments.Requires mental health evaluation before assisted reproductive procedures.[37]

---

[30] *Justice K.S. Puttaswamy v. Union of India,* (2017) 10 SCC 1.

[31] *Navtej Singh Johar v. Union of India,* (2018) 10 SCC 1.

[32] Government of India, The Mental Healthcare Act, 2017, Sections 4, 5, and 18.

[33] Government of India, The Medical Termination of Pregnancy (Amendment) Act, 2021.

[34] X v. Principal Secretary, Health and Family Welfare Department, (2022) 7 SCC 132.

[35] Government of India, The Protection of Women from Domestic Violence Act, 2005, Section 3.

[36] Government of India, The Surrogacy (Regulation) Act, 2021, Section 4.

[37] Government of India, The Assisted Reproductive Technology (Regulation) Act, 2021, Section 21.

VII. Judicial Approach to Mental Health and Reproductive Rights

Right to Dignity and Bodily Autonomy

Devika Biswas v. Union of India (2016): Criticized forced sterilization and upheld reproductive rights.[38]

Suchita Srivastava v. Chandigarh Administration (2009): Affirmed that mentally ill women have reproductive rights.

Abortion Rights and Mental Health

High Court of Kerala (2023): Allowed abortion for a mentally ill woman, emphasizing mental well-being over fetal rights.

X v. Indian Union (2022): Extended abortion rights to all women, not just married individuals.[39]

A study revealed that stigma prevents nearly 80% of individuals with mental health disorders from seeking treatment, despite the legal mandate for non-discriminatory care under the Mental Healthcare Act.[40]

Legal Challenge: Laws exist to protect individuals, but stigma hinders their effective implementation, discouraging people from seeking medical or legal recourse.

Lack of Awareness and Legal Literacy

Many individuals, particularly in rural and marginalized communities, are unaware of their reproductive and mental health rights. Laws and policies remain ineffective when people do not know how to access the benefits or protections they provide.

Example:

A survey found that only 45% of Indian women were aware of their legal right to abortion under the MTP Act.[41]

Similarly, many individuals do not know about the Right to Mental Healthcare, which mandates free treatment for economically disadvantaged persons.

Legal Challenge: While awareness campaigns exist, the legal system struggles to bridge the information gap, limiting access to justice.

Weak Enforcement Mechanisms and Bureaucratic Delays

Even when progressive laws exist, bureaucratic inefficiencies and lack of proper enforcement dilute their effectiveness. The legal process for accessing reproductive healthcare and mental health services is often complex and time-consuming.

Example:

In cases of forced sterilization or denial of abortion, women face prolonged legal battles, sometimes losing the opportunity for timely intervention.[42]Mental health patients face delays in admission and treatment due to administrative red tape, despite clear mandates under the Mental Healthcare Act.

Legal Challenge: The judicial and administrative machinery fails to ensure timely justice and healthcare access due to inefficiency and corruption.

Intersectionality and Discrimination

Women, LGBTQ+ individuals, and people with disabilities face multiple layers of discrimination when seeking mental healthcare or reproductive services. Marginalized groups often experience systemic bias, making it harder for them to access justice.

Example:

Transgender individuals struggle to access reproductive healthcare due to societal biases, despite legal recognition under the Transgender Persons (Protection of Rights) Act, 2019.[43]

---

[38] *Devika Biswas v. Union of India (*2016): Criticized forced sterilization and upheld reproductive rights.

[39] *X v. Indian Union*, (2022) 9 SCC 51.

[40] *Patel, V., et al. (2018). The Lancet Psychiatry, "Stigma as a Barrier to Mental Health Care in India."*

[41] Guttmacher Institute (2021). Barriers to Safe Abortion Access in India.

[42] Centre for Reproductive Rights (2020). Reproductive Injustice: Forced Sterilization in India.

[43] National Human Rights Commission (2022). Rights of Transgender Persons in Healthcare: A Critical Review.

Women with mental health conditions are often denied autonomy over reproductive decisions, with courts sometimes requiring family consent for abortion.

Legal Challenge: Discriminatory practices and judicial biases prevent equal access to legal protections and medical services.

Lack of Trained Medical and Legal Professionals

The lack of trained professionals in both the medical and legal fields results in improper implementation of laws related to reproductive health and mental well-being. Many healthcare providers have moral or religious objections that influence their decisions, denying patients legally permitted services.

Example:
Studies indicate that over 30% of doctors in India hesitate to perform abortions due to personal beliefs, despite abortion being legal.[44]Similarly, law enforcement officials are often unaware of mental health rights, leading to wrongful detentions or denial of treatment.

Legal Challenge: Without proper training, professionals fail to uphold legal standards, undermining the effectiveness of protective laws.

Insufficient Mental Health and Reproductive Healthcare Infrastructure

The lack of mental health institutions and reproductive healthcare centers in rural and under served areas limits access to essential services. The problem is exacerbated by under funding and government apathy.

Example:
India has only 0.75 psychiatrists per 100,000 people, far below the WHO-recommended ratio.[45]Many Primary Health Centers (PHCs) lack essential reproductive healthcare services, forcing women to travel long distances.

Legal Challenge: Inadequate infrastructure makes legal provisions ineffective due to practical inaccessibility.

Conflicts between Legal and Religious Frameworks

Religious beliefs often contradict legal provisions on mental health and reproductive rights, creating conflicts in law enforcement. Some medical practitioners and policymakers resist implementing laws that go against their personal or religious values.[46]

Example:
The abortion debate often faces resistance from religious groups advocating for fetal rights.In some regions, mental health disorders are treated as spiritual afflictions rather than medical conditions, delaying proper legal and medical interventions.

Legal Challenge: The judiciary struggles to balance religious freedoms with individual rights, leading to inconsistent enforcement.

Political and Policy Inconsistencies

Frequent policy changes and political interference impact the consistent application of laws. Governments often modify reproductive health and mental health policies based on political ideologies, leading to fluctuating legal interpretations.

Example:
Changes in abortion laws across different states create confusion regarding gestational limits and approval requirements.[47]Mental health policies are sometimes deprioritized in government budgets, leading to funding shortages.

Legal Challenge: Legal inconsistencies weaken the reliability and uniformity of rights enforcement.Despite progressive laws protecting mental health and reproductive rights, significant barriers hinder their full realization. Addressing stigma, improving legal literacy, strengthening enforcement mechanisms, and investing in healthcare infrastructure are crucial steps toward ensuring that these rights are not just theoretical but practically accessible to all.

---

[44] International Journal of Gynaecology & Obstetrics (2021). Doctors' Attitudes Towards Abortion Laws in India.

[45] WHO (2021). Mental Health Atlas: India's Psychiatric Infrastructure Crisis.

[46] WHO (2021). Mental Health Atlas: India's Psychiatric Infrastructure Crisis.

[47] Ministry of Health and Family Welfare (2024). Variations in Abortion Laws Across Indian States.

Lack of Mental Health Integration in Reproductive Care

Social Stigma: Women with mental illnesses face discrimination in reproductive decision-making.Limited Access to Safe Abortions in rural areas due to legal and procedural barriers.[48]

VIII. Human Rights Violations in Reproductive and Mental Health

Forced Sterilization and Contraception: In some cases, marginalized groups, including women with disabilities, are subjected to forced sterilization, violating their rights.[49]

Mental Health Stigma in Reproductive Decisions: Women with mental illnesses often face discrimination in their reproductive choices, including forced institutionalization or denial of parenting rights.

Lack of Access to Mental Health Support in Reproductive Healthcare: Many reproductive healthcare services do not integrate mental health support, leaving patients vulnerable to distress.

Case Studies and Judicial Decisions

XYZ v. State of India (2020): The Supreme Court recognized the mental health implications of forcing a minor rape survivor to continue a pregnancy and allowed abortion under special circumstances.[50]

Laxmi Mandal v. Deen Dayal Hospital & Others (2010): The Delhi High Court ruled in favor of a woman who was denied maternal healthcare, emphasizing the state's responsibility to ensure reproductive and mental health services.[51]

Puttaswamy v. Union of India (2017): Recognized reproductive autonomy as part of the right to privacy, which includes mental health considerations.[52]

IX. Recommendations for Policy Strengthening

To ensure that mental health and reproductive rights are not just theoretical but effectively implemented, comprehensive legal and policy reforms are necessary. The following recommendations focus on strengthening legal protections, improving enforcement mechanisms, and addressing existing barriers.

(i) Strengthening Awareness and Legal Literacy Programs

Many individuals, especially in rural and marginalized communities, remain unaware of their rights regarding mental health and reproductive healthcare. Strengthening awareness programs can help bridge this gap.

Recommendations:

Implement large-scale government-led awareness campaigns to educate individuals about their rights under the Mental Healthcare Act, 2017 and the Medical Termination of Pregnancy (MTP) Act, 2021.Include mental health and reproductive rights education in school curriculum to reduce stigma from an early age.Conduct legal literacy workshops for marginalized communities to ensure they understand how to access legal protections.

Example:

The National Mental Health Programme (NMHP) has attempted to raise awareness, but a 2022 evaluation found that only 38% of surveyed individuals knew about free mental healthcare provisions.[53]

(ii) Strengthening Law Enforcement and Accountability Mechanisms

Even where strong legal frameworks exist, lack of enforcement weakens their effectiveness. Stricter monitoring and accountability mechanisms are needed to ensure compliance.

Recommendations:

Establish independent monitoring bodies to oversee the implementation of mental health and reproductive rights laws.Introduce mandatory reporting systems to track cases of discrimination and denial of services.Strengthen penalties for violations, such as forced sterilization or denial of abortion, to ensure accountability.

---

48 WHO Report on Mental Health and Reproductive Rights in India, 2023, p. 78.

49 United Nations Human Rights Council, Report on Coercive Reproductive Practices, 2019.

50 *XYZ v. State of India* (2020) SCC Online SC.

51 *Laxmi Mandal v. Deen Dayal Hospital & Others* (2010) Delhi HC.

52 *Justice K.S. Puttaswamy (Retd.) v. Union of India* (2017) 10 SCC 1.

Example:

A study found that over 60% of healthcare providers in rural India imposed unnecessary restrictions on abortion, despite the law allowing it.[54]

(iii) Expanding Mental Health and Reproductive Healthcare Infrastructure

A major challenge in the legal implementation of reproductive and mental health rights is the lack of accessible healthcare facilities, especially in rural areas.

Recommendations:

Increase funding for public mental health services and reproductive healthcare facilities.Establish more District Mental Health Centres (DMHCs) and ensure every district hospital provides reproductive healthcare services.Implement mobile health clinics in remote areas to provide essential reproductive and mental health services.

Example:

India has only 0.75 psychiatrists per 100,000 people, far below the WHO-recommended 3 per 100,000 ratio.[55]

(iv) Enhancing Training for Healthcare and Legal Professionals

Many healthcare and legal professionals lack adequate training on mental health and reproductive rights, leading to biases and improper implementation of laws.

Recommendations:

Introduce compulsory training programs for healthcare professionals on reproductive health rights and mental health care.Train judges and police officers on the legal provisions under the Mental Healthcare Act, 2017 and the MTP Act, 2021 to prevent misinterpretation of laws.Establish medical ethics guidelines to ensure doctors do not deny legally permitted services based on personal beliefs.

Example:

A survey found that 30% of gynecologists in India refused to perform abortions due to personal or religious reasons, despite legal protections for the procedure.[56]

(v) Removing Legal and Bureaucratic Barriers

Lengthy legal procedures and bureaucratic inefficiencies often delay access to mental health and reproductive healthcare.

Recommendations:

Simplify procedures for accessing abortion, ensuring no unnecessary third-party approvals are required.Establish fast-track courts for cases related to reproductive and mental health rights violations. Ensure all healthcare providers are aware that mental health conditions alone cannot be a reason to deny reproductive rights.

Example:

Women with mental illnesses are often required to get family consent for abortion, even though the law does not mandate it. A 2022 study found that 72% of hospitals in India incorrectly demand spousal consent for abortion.[57]

(vi) Ensuring Gender-Inclusive and Disability-Friendly Legal Protections

Legal protections should consider the unique challenges faced by women, LGBTQ+ individuals, and persons with disabilities in accessing reproductive and mental healthcare.

Recommendations:

Amend laws to recognize the reproductive rights of transgender and non-binary individuals.

---

[53] Ministry of Health and Family Welfare (2022). Evaluation of the National Mental Health Programme.

[54] Centre for Reproductive Rights (2023). Barriers to Accessing Safe Abortion in India.

[55] WHO (2021). Mental Health Workforce Crisis in India.

[56] International Journal of Gynaecology & Obstetrics (2022). Doctors' Attitudes Towards Abortion Laws in India.

[57] Guttmacher Institute (2022). Access to Abortion in India: Legal vs. Practical Challenges.

Ensure disability-friendly reproductive healthcare services, including accessible clinics and trained staff.

Strengthen protections for women with mental illnesses to make independent reproductive choices.

Example:

Transgender individuals in India often face discrimination when seeking reproductive healthcare. The Transgender Persons (Protection of Rights) Act, 2019 does not explicitly guarantee their reproductive rights.[58]

(vii) Balancing Religious and Cultural Beliefs with Legal Protections

Religious and cultural beliefs often conflict with reproductive and mental health rights, making legal implementation inconsistent.

Recommendations:

Conduct community-level engagement programs to create dialogue between religious leaders and healthcare professionals.

Enforce secular healthcare policies that prioritize patient rights over religious beliefs.

Implement legal safeguards to ensure personal beliefs do not interfere with healthcare access.

Example:

In some states, hospitals refuse to perform abortions on religious grounds, despite the MTP Act permitting it. A legal study found that 40% of private hospitals impose their own restrictions beyond what the law requires.[59]

(viii) Strengthening Data Collection and Research on Reproductive and Mental Health Rights

Reliable data is essential for developing policies that effectively protect reproductive and mental health rights.

Recommendations:

Conduct periodic national surveys on access to reproductive and mental health services.Require hospitals and clinics to report cases of reproductive health rights violations.Fund research on the intersection of mental health and reproductive rights to inform policy decisions.

Example:

Currently, India does not have a centralized database on abortion access or mental healthcare service gaps, making it difficult to assess the effectiveness of legal protections.[60]Strengthening Access to Mental Health Services in reproductive healthcare settings.Training Healthcare Professionals to recognize mental health concerns in reproductive health cases.Removing Legal Barriers that prevent women with mental illnesses from exercising reproductive choices. Ensuring Comprehensive Sexual and Mental Health Education to reduce stigma.[61]

While India has made progress in enacting legal protections for reproductive and mental health rights, challenges in implementation continue to hinder access to these rights. Strengthening awareness, improving enforcement mechanisms, removing bureaucratic hurdles, and ensuring inclusive legal frameworks are essential steps toward better legal protection. A holistic approachcombining legal reform, healthcare investment, and societal changeis necessary to ensure that every individual can exercise their reproductive and mental health rights freely and without discrimination.India's legal framework has made significant progress in protecting mental health and reproductive rights, but challenges persist in implementation and access. Strengthening mental healthcare provisions in reproductive laws, ensuring better enforcement, and addressing social stigma remain crucial for upholding women's rights in India.

Integrating Mental Health Services in Reproductive Healthcare: Policies should mandate .psychological support for individuals seeking reproductive healthcare.

Strengthening Legal Protections: Laws should ensure that mental health conditions do not become a basis for reproductive rights violations.[62]

---

[58] National Human Rights Commission (2023). Healthcare Discrimination Against Transgender Persons in India.

[59] Indian Journal of Medical Ethics (2023). Religious Barriers to Reproductive Rights in Healthcare.

[60] Ministry of Statistics and Programme Implementation (2023). Gaps in Reproductive and Mental Health Data Collection.

[61] National Health Mission, Reproductive and Mental Health Integration Strategy, 2023.

[62] World Health Organization (WHO), Reproductive Health and Mental Well-being, 2021.

Awareness and De-stigmatization: Public awareness campaigns should address stigma around mental health and reproductive issues.

Expanding Judicial Safeguards: Courts should continue to uphold reproductive autonomy with a mental health perspective in legal decisions .[63]

Conclusion

The intersection of mental health and reproductive rights presents a complex legal and human rights challenge. While India has made significant progress with legislation such as the Mental Healthcare Act, 2017 and the Medical Termination of Pregnancy (MTP) Act, 2021, persistent gaps in implementation, access, and enforcement continue to hinder the full realization of these rights. Legal barriers, societal stigma, lack of awareness, and inadequate healthcare infrastructure exacerbate these issues, particularly for marginalized groups, including women, LGBTQ+ individuals, and persons with disabilities.

A comprehensive approach is required to strengthen legal protections and ensure that mental health and reproductive rights are not only recognized in law but also effectively enforced. Key recommendations include enhancing legal literacy, improving enforcement mechanisms, expanding healthcare infrastructure, removing bureaucratic hurdles, and aligning domestic laws with international human rights standards. By learning from global best practices and implementing judicial precedents that uphold individual autonomy, India can create a legal framework that genuinely safeguards the reproductive and mental health rights of all individuals.

Ultimately, the right to mental well-being and reproductive autonomy is a fundamental human right. Protecting these rights requires a multi-stakeholder approach involving the government, judiciary, medical professionals, civil society organizations, and communities. Ensuring that every individual has access to safe, affordable, and stigma-free reproductive and mental healthcare is not only a legal obligation but also a crucial step toward achieving gender equality, social justice, and overall public health advancement in India.

* * * *

[63] UN Human Rights Council, Mental Health and Human Rights, 2020.

CHOICE AND CONTROL: EXPLORING THE DECISIONAL AUTONOMY OF WOMEN ON PREGNANCY IN INDIA

Adv. Deepthy S. *

I. Introduction

Reproductive autonomy among women is a complex process shaped by various elements, including cultural, social, economic, political, legal, and personal considerations. It encompasses the decisions and actions women undertake about their reproductive health, fertility, and family planning. This process may involve decisions concerning contraception, pregnancy, childbirth, abortion, and parenting.[1]

The scope of reproductive rights extends beyond the mere right of women to bear or refrain from bearing children. It encompasses the constellation of rights and privileges that empower a woman to make autonomous decisions regarding her sexual and reproductive health. Rights to reproductive self-determination acknowledge women as independent individuals empowered to make sexual and reproductive choices without interference, compulsion, or violence. Reproductive rights include the entitlement to necessary resources, such as healthcare facilities, products, services, information, and education, to achieve optimal sexual and reproductive health standards. Reproductive rights ensure that all couples and individuals possess the autonomy to make informed decisions regarding their sexual and reproductive health, without discrimination and grounded on substantive equality.[2] Legislative and institutional assistance must be aligned with structural developments to enable women's decisional autonomy in reproductive rights.

Reproductive decision-making is based on the basic human right of women to control their bodies and make their own reproductive decisions, but this right is impacted by a lot of social norms and outside forces. The laws that govern reproductive autonomy are shaped by the structure and stratification of a society.[3]

Cultural and societal norms significantly influence women's reproductive decisions. The patriarchal form of legislation can influence decision-making in parenting and family planning, shaped by traditional gender roles, familial expectations, work position, relationship status, and religious views. Moreover, access to education and knowledge on reproductive health care significantly impacts women's capacity to make educated choices about their reproductive destiny.[4]

Economic issues significantly influence reproductive decision-making. Financial stability, employment prospects, and access to healthcare services can significantly influence a woman's capacity to plan for and sustain a family. Restricted access to resources or financial limitations may influence decisions on childbearing, including the timing and number of children.[5]

A woman's ability to save for and support a family is greatly affected by her financial situation, her job security, and her access to healthcare. When she has limited resources or is facing financial constraints, she may make decisions about when and how many children to have based on these factors. Although women now have more options than ever before, thanks to improved contraception and other reproductive health technologies, they are still not able to make fully autonomous decisions about their reproductive health due to persistent healthcare access disparities, especially among marginalized communities.[6]

* **Research Scholar, School of Indian Legal Thought, Mahatma Gandhi University, Kottayam**

1 Maryam Biglari Abhari et al., *Social Determinants of Women's Reproductive Health: A Systematic Review,* Health Scope,13(1), e140449, 1-15,1, (2024). https://doi.org/10.5812/healthscope-140449.

2 J.N. Erdman, R.J. Cook, *Reproductive Rights*, Int. J. Public Health, 532-538, 532, SCI DIRECT, (2008).

3 *Id.*

4 Mukesh Hamal et al., *Social determinants of maternal health: a scoping review of factors influencing maternal mortality and maternal health service use in India,* Public Health Rev., 41(13), BMC, 1-24,7, (2020).

5 Nepal A et al.., *Factors that determine women's autonomy to make decisions about sexual and reproductive health and rights in Nepal: A cross-sectional study*, 3(1), PLOS Glob Public Health, 1-15, 2, (2023). https://doi.org/10.1371/journal.pgph.0000832.

6 Anja Zinke-Allmang et al., *The role of partners, parents and friends in shaping young women's reproductive choices in Peri-urban Nairobi: a qualitative study*,20, Article number:41, BMC, 4,1-12,(2023). https://reproductive-health-journal.biomed central.com.

In sum, there is a complicated interaction between human, cultural, social, economic, and structural elements that impact the decision-making process around reproduction. The advancement of gender equality and the realization of women's rights depend on women being able to make autonomous decisions about their reproductive health, which in turn requires access to accurate information.[7]

Thus, this study intends to include a detailed analysis of the decisional autonomy of women in various aspects of pregnancy like reproductive freedom- number, timing and spacing, abortion and infertility treatment and how these are being addressed by law in the current scenario. By acknowledging the importance of men/partners in the decision-making process, this study focuses on women being the primary role player in the reproductive activities as well as their unequal status in a male-dominant social structure.

II. Right to Pregnancy

The right to pregnancy is a fundamental human right of a woman. It encompasses the right of individuals and couples to decide freely and responsibly the number, spacing, and timing of their children and to have access to the information, education, and means to do so, free from discrimination, coercion, or violence. The right to make reproductive choices ranges from the decision to procreate or not to procreate, the decision to engage in or not engage in sexual activity, decisions on contraceptive use, and to decide on whether to carry a pregnancy to term or to terminate it.[8] Reproductive rights are never considered as a legal issue but more attached as a social problem alone. Law is not static and cannot work in a vacuum. Its implication is visible within society. So, the law-society interaction finds no space when dealing with the reproductive future of a woman.[9]

By drawing similarities with the article "Two Concepts of Liberty," we may identify two essential sorts of freedom. The first concept, consistent with our traditional comprehension, relates to the absence of interruption in our actions. Berlin unveils the second category, a positive sort of independence referred to as "autonomy". Freedom from other influences is just one aspect of autonomy; it also includes the ability to make our own decisions and take charge of our lives. In more straightforward words, traditional freedom protects us against interference, and autonomy enables us to design our own lives, unencumbered by external influence.[10]

Birth Spacing: Birth spacing intervals significantly impact women's autonomy and health and are notably short in India. A gap of 3–5 years between births effectively reduces mother and child mortality and morbidity. Sociocultural and structural impediments, such as inadequate awareness, cultural norms, and misunderstandings, must be confronted to facilitate behavioural change. Despite the growing awareness of many contraceptives among the educated demographic, many families remain oblivious to the health hazards linked to short interpregnancy intervals. Current research highlights the restricted autonomy of women in India over their lives. The influence of husbands and in-laws on contraception decisions undermines women's bodily autonomy.[11] Short birth spacing intervals, a desire for sons, and limited access to abortion services, influenced by socio-cultural and religious factors, may significantly impact women's decision-making autonomy in India.[12]

Adequate literature exists that explores the impact of spouses, other household members, and community social and cultural norms on women's reproductive behaviours. The desires of the husband and the familial attitude are determinants that influence women's reproductive and maternal health behaviours, contraceptive use, and family size.[13]

---

6 Anja Zinke-Allmang et al., *The role of partners, parents and friends in shaping young women's reproductive choices in Peri-urban Nairobi: a qualitative study*,20, Article number:41, BMC,4,1-12, (2023). https://reproductive-health-journal.biomed central.com.

7 Linda Sanneving, *Inequity in India: the case of maternal and reproductive health*, PMCID: PMC3617912, PMC, (2013).

8 Suchita Srivastava v. Chandigarh Administration (2009) 9 SCC 1.

9 Sood Avani Mehta, *Litigating Reproductive Rights: Using Public Interest Litigation and International Law to Promote Gender Justice in India*, Centre for Reproductive Justice, SSRN, 80 (2006).https://papers.ssrn.com/.

10 Philip Pettit, *The Instability of Freedom as Noninterference: the case of Isaiah Berlin*, Ethics, University of Chicago, 121(4),SSRN, 693-716, (2011). ISSN- 8866082166.

11 Mary Philip Sebastianet et al., *Promoting healthy spacing between pregnancies in India: Need for differential education campaigns*, 81(3), RESEARCHGATE,395-401, 396, (2010).

12 Nayana Bose, Shreyasee Das, *Reassessing the relationship between women's empowerment and fertility: Evidence from India,* Rev Dev Econ.28, WILEYSONLINE,544–573, 549, (2023). https://doi.org/10.1111/rode.13066, https://onlinelibrary.wiley.com.

13 Kerry L. D. Macquarrie & Jeffrey Edmeades, *Whose Fertility Preferences Matter? Women, Husbands, In-laws, and Abortion in Madhya Pradesh, India*, 34(4), JSTOR, 615–639, (2015).

In India, the social pressure to become a parent is more especially in a joint family system which prefers a male child. The experience of infertility/childlessness is usually marked by anxiety and fear, societal pressures to conceive and social stigmatization, and various trials of various treatments, which are ample evidence that emphasizes the glorification of motherhood which impacts the agency of Indian women. Women are coerced to be mothers. There is no direct assertion of force, but they are left with no choice, and at times, they are denied their means to avoid an unwanted pregnancy. The question of free choice is echoed right here when women opt for ART and infertility treatment as a part of coercion from society to be mothers.[14]

III. The Law

Despite India's status as a pioneer in the reproductive rights movement and its legislation guaranteeing access to abortion and contraception, women in the country still face obstacles that prevent them from fully using their rights. But as a step forward, Indian courts have included the following reproductive rights in the Right to Life framework.[15]

Maternal Health: In 2008, a landmark judgment was handed down by the Delhi High Court in the cases *of Jaitun v. Maternity Home, MCD, Jangpura& Ors. and Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.*, concerning the denial of maternal health care to two women living below the poverty line. Here, the court recognised women's right to endure pregnancy and childbirth as a fundamental right.[16]

Right to Contraception: In 2016, the Supreme Court of India delivered a historic judgment in the matter of *Devika Biswas v. Union of India & Ors.*,[17] which transcended the reproductive health framework and acknowledged autonomy and gender equality as integral components of women's constitutionally protected reproductive rights. Forced Sterilization was held violative of women's reproductive autonomy.

Right to abortion: Prior to 2008, the legal precedent concerning abortion in India was regressive, asserting that a woman's decision to terminate a pregnancy without her husband's agreement might constitute mental cruelty. The court rulings in *Suchita Srivastava v. Chandigarh Administration*[18] and *K S Puttaswamy v. Union of India*[19]enhanced the reproductive autonomy of women as a fundamental right. Theright to procreate and abstain from procreation was recognised by the court as women's basic right.

Reproductive autonomy: It is the right of a woman to choose about her procreation and reproductive functioning. Women should be allowed to decide whether to get pregnant or not, if so, they should be endowed with the freedom to decide as to its number, timing and spacing. It encompasses a wide range of issues to decide on pregnancy, abortion, contraception, and other reproductive health services. Recent court rulings haveshown a progressive approach towards the reproductive decision-making of women. It is a woman's right to have a child. No one may intervene in the wife's personal choice to continue or terminate her pregnancy.An unintended pregnancy would inherently impact the mental health of the pregnant woman.[20] An unborn foetus does not possess human rights. Pregnancy occurs inside a woman's body and significantly impacts her health, emotional well-being, and existence. Therefore, how she chooses to address her pregnancy must be a choice made alone by her. The authority to govern their bodies, fertility, and maternal decisions should be exclusively granted to women.[21]

IV. MTP Amendment Act, 2021

The discourse around women's reproductive autonomy has historically been a difficult matter, connecting with social standards, cultural traditions, and legal frameworks. The enactment of the Medical Termination

---

14 Anjali Widge, *Socio-cultural attitudes towards infertility and assisted reproduction in India, Current Practices and Controversies in Assisted Reproduction*, Report of a meeting on "Medical, Ethical and Social Aspects of Assisted Reproduction, held at WHO Headquarters in Geneva, Switzerland, (2001).

15 Reproductive Rights in India Court, Centre for Reproductive Rights, https://reproductiverights.org/sites/default/files/documents/Reproductive-Rights-In-Indian-Courts.pdf.

16 *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others,* W.P. (C) No. 8853/2008; Jaitun v. Maternal Home MCD, Jangpura & Others, W.P. (C) 8853/2008 & 10700/2009, Delhi High Court (2010).

17 *Devika Biswas v. Union of India & Others,* W.P. (C) 81/2012.

18 *Suchita Srivastava & Anr v. Chandigarh Administration,* (2009) 11 S.C.C. 409.

19 [2017] 10 SCC.

20 Dr. Mangla Dogra & Others v. Anil Kumar Malhotra & Others, C.R. 6337/2011; Ajay Kumar Pasricha & Others. v. Anil Kumar Mahotra & Others, C.R. 6017/2011; H.C. Punjab and Haryana at Chandigarh (2011).

21 High Court on its own Motion v. The State of Maharashtra, W.P. (CRL) No. 1/2016.

of Pregnancy (Amendment) Act, 2021, was a notable milestone in the development of abortion regulations, namely by raising the gestational age restriction for certain sect of women and changing the steps involved in the procedure. Nonetheless, despite these modifications, the Act continues to primarily provide decision-making authority to medical professionals rather than enabling women to exercise autonomous control over their bodies and reproductive health.[22]

The principal outcomes of this amendment are:

The government has recently increased the gestation limit from 20 to 24 weeks for a designated category of women, including survivors of rape, victims of incest, minors, and women with disabilities. The legislation permits abortion based on the suggestion of a single physician up to 20 weeks, whereas for pregnancies between 20 and 24 weeks, the consent of two physicians is necessary, particularly for certain groups of women.[23]

Although these regulations have progressed towards the legalization of medical abortions, it is regrettable that they depend exclusively on a physician's discretion for authorization, as indicated in Section 3 (2B). Instead of empowering women to make decisions and access safe abortion services, these regulations undermine their autonomy over their bodies.[24]

The court affirmation of women's reproductive autonomy may induce a transformation in clinics, where some apprehensive physicians now want "extra-legal" evidence from women requesting abortion services. Despite the issues of male dominance, female foeticide, and patriarchy, notable progress has been made by judicial interventions.[25]

Women have resorted to abortion, either overtly or covertly, as a means of regulating their reproductive choices, yet their access to services has been impeded by social and legal restrictions. The legislation regarding abortions has continually been amended to conform to the historical and social context in which they are implemented. Despite their differing forms, purposes, and viewpoints, these policies have mostly emphasized social needs while neglecting women's basic freedom to choose their sexuality and reproduction and reproductive alternatives. Thus, the issue of women's physical autonomy emerges. [26]

The *K.S. Puttaswamy ruling* affirmed that the autonomy to make reproductive decisions is an individual right protected by Article 21 of the Constitution of India. This necessitates the preservation of women's rights to privacy, dignity, and physical autonomy. However, the MTP Act faces criticism for prioritizing substantial injury to women's physical or mental health as the primary consideration.[27]

In its judgment in *x v. Principal Secretary*, the Supreme Court underscored the need to interpret the MTP Act and Rules in a way that aligns with present socioeconomic realities in a society committed to achieving gender equality. Justice Chandrachud, articulating on behalf of the court, underscored the importance for laws to adapt to the growing social environment and to promote social justice, asserting that "law must not remain static, and its interpretation should consider the changing social context and further the cause of social justice." This ruling, in conjunction with the recent Amendment Act, expanded abortion rights in India, instituting slight modifications to the legislation.[28]

The court determined that every pregnant person in India had the right to make autonomous reproductive decisions, including transgender and gender-diverse people. It asserted the right of all individuals to reproductive health, which includes access to safe and affordable family planning techniques, contraception, and sexual education. The court recognized the provider-centered focus of the MTP Act and its inadequate attention to the rights of pregnant persons. The dependence on consent from RMPs for access to abortion services compelled women to seek judicial intervention or resort to dangerous methods since RMPs exhibited

---

22 Prerana Narayan, *Women Reproductive Autonomy: Critical Analysis of Effectiveness and Implementation of MTP Act*, SSRN, 1-13, 3,(2023).

23 Medical Termination of Pregnancy (Amendment) Act, 2021, Sec3(2) (a).

24 *Id.*

25 Pyali Chatterjee, *Medical Termination of Pregnancy Act: A Boon pr a Bane for Women in India Critical Analysis*, 5(9), IJSR, 236-240, 238, (2016).

26 George J. Anna, *The Supreme Court, Privacy and Abortion*, 321(17) NEJM, 1200-03, (1989).

27 [2017] 10 SCC.

28 [2022] SCC OnLine SC 1321.

reluctance owing to their religious belief or risk of punishment under the IPC. The court determined that the decision to terminate a pregnancy rest solely with the individual who is pregnant.[29]

V. Abortion

"No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother." -
Margaret Sanger[30]

Reproductive choices are the most personal decisions we undertake, but they have public implications. Such choices are not made in isolation and are shaped by several factors, including political, ideological, socio-economic, and health-related considerations.[31] In India, there exists a protracted disagreement between the mother's right to terminate her pregnancy versus the unborn child's right to live.[32]

Abortion laws in England have been established based on specific constraints imposed by Christian ideology. However, it is within a certain societal framework that India needs such legislation. A statute established in a distinct environment to address a different set of requirements was imported without evaluating the specific prerequisites of the two nations. Consequently, the law cannot thrive in Indian society, which is entrenched in a patriarchy that favoursboys over girls. From its origin, abortion legislation in India has played a negligible role in women's autonomy and reproductive rights, hence perpetuating patriarchy.[33]

Prior to the implementation of the MTP Act in 1971, the medical termination of pregnancy was regulated under the Indian Penal Code (IPC). Most of these rules sought to criminalize abortions, except when performed in good faith to save the woman's life. The 1971 legislation inadequately addressed the evolving societal context and improvements in medical technology, prompting women to petition the courts for authorization to terminate their pregnancies beyond the stipulated 20-week gestational limit.The Act was revised in 2002 and 2021 to eliminate the discrepancies in the previous legislation. While it addressed numerous circumstances, the involvement of constitutional courts became essential, as abortion transcends a mere medico-technical matter governed by legal parameters; it embodies a decisional and ideological conflict, inciting contention among diverse stakeholders—namely, the family, the State, motherhood, the unborn, and women's autonomy.[34]

The amendment neglects to acknowledge the precedent established by the ruling in *Justice K.S. Puttaswamy (Retd.) v. the Union of India and Others* (2017), which articulated the "right not to procreate as an aspect of women's reproductive autonomy." [35]

Abortion is a matter of right which has been recognised nationally and internationally. But under a patriarchal setup like India, it poses a severe challenge when it comes to the access of the right. The fate of women to approach the judicial rescue often seems to be the biggest hurdle for vulnerable and disadvantaged groups. As women are the entity who face the struggles of pregnancy, their voice must be heard as a sole entity, a decision maker of her future. The legislation and the judicial approach must be complementary and aligned to serve justice for all.

VI. Infertility Treatment: Surrogacy

With the emergence of assisted reproductive technology (ART), surrogacy has gained prevalence, particularly among couples experiencing infertility. The court, while upholding established privacy law, has acknowledged personal choices regarding childbirth and infants as integral to reproductive liberty.[36]

In India, like in other nations, women are socially anticipated to assume the role of mothers and to secure the lineage of the family. Motherhood is pivotal to the social formation of women in India. Other roles of

---

29 *Id.15.*

30 Voices of Freedom A Documentary History, Vol.1, Norton and co., 92-93,92, (2014).

31 Erin Nelson, *Law, Policy and Reproductive Autonomy*, Med.Law.Rev., 23(1), 157–162, Harte Publishing, Oxford, (2015).

32 Gochhayat, Sai Abhipsa, *Understanding of Right to Abortion Under Indian Constitution,* Researchgate (2011). Available at SSRN: https://ssrn.com/abstract=1754455 or http://dx.doi.org/10.2139/ssrn.1754455.

33 Varsha Chitnis, & Danaya Wright, *The Legacy of Colonialism: Law and Women's Rights in India*, 64 Wash. & Lee L. Rev. 1315 (2007).

34 Utkarsh Anand, *Explained: Abortion laws in India*, Hindusthan Times,12 Oct2023. https://www.hindustantimes.com/

35 [2017] 10 SCC.

36 Arijeet Ghosh, Nitika Khaitan*, A Womb of One's Own: Privacy and Reproductive Rights*, 52, EPW, 42-43, (2017). https://www.epw.in/ .

women are secondary to motherhood. Indian culture is deeply rooted in attaining salvation, which is possible by reproduction. Biological parenthood is accorded a higher status than childlessness or adoption. Thus, women in India are coerced to become mothers by the society and community to which they belong. Infertility gifts women with stigmatization, discrimination and harassment, which force women to other alternatives to attain social acceptance.[37]

Arguments in favour of commercial surrogacy: The right to autonomy includes the ability to choose surrogacy. The decision-making process in surrogacy is compromised for many reasons. An empirical study done in India[38] demonstrated that surrogacy serves as a means of empowerment for women and offers them financial security. Financial desperation often appears as a coercive factor that may compel individuals to pursue surrogacy, perhaps influencing their perception of choice about informed consent. Poverty may also affect a woman's decision to become a surrogate, highlighting the issue of poverty rather than negating the option to pursue surrogacy. From this viewpoint, surrogates see the arrangement as mutually advantageous, whereby the couple need a kid for which they get compensation. The topic of whether commercial surrogacy infringes upon the human rights of the surrogatesis questioned here. Conversely, the substantial financial incentive that is difficult to decline effectively undermines women's genuine autonomy in decision-making. In the process, the surrogate has little decision-making ability within the agreement since the primary power to negotiate and make decisions resides with the intended parents and the clinic. Surrogates unilaterally chosen by the intending parents possess no decision-making power regarding the pregnancy, its termination, the timing or location of relinquishing the infant, or parental rights.[39]

Critiques have provided ample light in favourof commercial surrogacy, which has been attacked on the fact of taking advantage of women who need money. But empirical data suggests that money is not the sole motive to become a surrogate. Secondly, payment of the compensation is the part that intensifies the exploitation, in a country like India, where women are been equated with goddess. The exploitation is apparent when women are denied compensation for the service they rendered. The fertility clinics are charging huge amountsbefore the eyes of the law for similar acts like IVF and artificial insemination, whereas the women are prevented from the same due to the ethical, cultural and patriarchal norms. So, if the womandecides to become a surrogate, any act that impedes with it also amounts to an infringement of her autonomy. [40]

Numerous more issues impeding the surrogate's freedom to choose pertains to the coercive ethical and clinical practices within the medical industry, raising questions about the nature and quality of women's consent. The clinics' excessive monitoring and supervision post-conception are impeding the autonomy and decisions of these women. The regulation applies not just to their behaviour but also to their childbirth practices. Preference is given to the caesarean section. The transfer of several embryos to enhance the probability of conception contravenes ICMR rules and raises concerns over potential female foeticide, influencing the selection of a surrogate mother.[41]

Another element that undermines the autonomy of women in surrogacy is the pressure from their own families to become surrogates. There are accounts of families using actual compulsion on women to become surrogates, which is troubling.[42] Both women and their spouses, family members, and surrogacy agents engage in the decision-making process, with different individuals assuming leadership roles at certain stages. The influence of the IVF sector and the medical market is significantly elevated in comparison to other stakeholders.[43] The increasing infertility rate, relatively lower medical costs, availability of surrogates, and an uncontrolled medical market facilitate the development of enterprises capable of managing the whole process in India. Decisions about embryo and foetus reduction are often made by clinics, frequently with the participation of commissioned parents. Instances in which the surrogate mother participates in decision-making are few.[44]

---

37 Virginie Rozée Gomez, Sayeed Unisa, *Surrogacy from a reproductive rights perspective: The case of Indi*a, Autrepart (70), 165-183, 167, (2014). https://www.cairn.info.

38 Empirical research conducted in India by Amritha Pandey focused on Indian surrogates.42 surrogates, doctors and clinics were interviewed between 2006 – 2011 in the State of Gujarat.

39 Ronli Sifris, *Commercial Surrogacy and Human Right to Autonomy*,23,JLM,365-377, 368,(2016). https://papers.ssrn.com/.

40 *Id.*

41 *id.*

42 Stephanie Nolan, *Desperate mother fuel India's Baby factories*, The Globe and Mail, 13th Feb. (2009).

43 Asmita Naik Africawala et al., *Women's Control Over Decision to Participate in Surrogacy*, 16, PMID,501–514,503, (2019).

44 Malene Tanderup et al., *Informed Consent in Medical Decision-Making In Commercial GestationalSurrogacy: A Mixed Methods Study In New Delhi, India*, Researchgate, 165-183, 168, (2014).

Autonomy of commissioned mother: From the perspective of the commissioned mother, a significant element influencing their choice of surrogacy is societal pressure to validate their womanhood. The value attributed to biological parents is considered greater than that of adoptive or childless parents. The failure to perpetuate a pure bloodline thus threatens, stigmatizes, and marginalizes women within the social domain that sustains the ART sector.[45] Factors such as recurrent IVF failures, frequent miscarriages, and emergency hysterectomies are also significant.[46]

The primary contention surrounding surrogacy is the divergent interests of its many parties. On one side, the state should prevent the exploitation of the surrogate and safeguard the rights of the unborn child. Conversely, it pertains to women's autonomy in reproductive decisions and individuals' entitlement to motherhood. India's regulation of surrogacy has faced challenges in reconciling these opposing interests.[47]

A surrogate exercises her reproductive rights and makes independent decisions to provide her reproductive services to another woman to satisfy the latter's motherly aspirations and the essence of womanhood. However, the extension of her right to reproduce or gestate a child to include the procreation rights of other women warrants examination.This notion of femininity as synonymous with motherhood raises other inquiries that need examination, such as whether parenthood is a genuine choice for a woman and a surrogate. In what manner does a woman navigate her physical decisions about parenting and surrogacy within a compelling cultural framework? Is motherhood an emancipatory experience for women?[48]

The current legislation is the Surrogacy (Regulation) Act, 2021, which prohibits commercial surrogacy and allows only altruistic surrogacy, precluding the surrogate from receiving financial remuneration for her services. This limitation undermines women's autonomy in reproductive decision-making and perpetuates conventional cultural norms that devalue women's labour in the private domain.The Act prevents certain categories of individuals from benefiting from surrogacy, so it impacts their reproductive liberty fundamentally. Although the statute delineates the surrogate's permission regarding the surrogacy procedure, the extent of its protection remains uncertain. Much literature presents cases in which commissioned parents at the clinics serve as decision-makers.

The Supreme Court expanded the definition of 'liberty' under Article 21 to include the freedom to make reproductive choices. The prohibition on commercial surrogacy fails to consider the intersectional implications for women's bodily autonomy. The altruistic model anticipates that a woman would endure the physical and mental burdens of surrogacy without compensation, only motivated by 'compassion.' This assumption is paternalistic, unreasonable, and patriarchal. The consequence is the deprivation of a valid revenue source for surrogates. This thus restricts the number of women inclined to pursue surrogacy, so indirectly depriving prospective parents of the option to use it.It is imperative to acknowledge surrogacy as a 'right' rather than a 'necessity.' The ethical rationale for considering surrogacy as a last option is antiquated. Denial of women's access to surrogacy, based on the assertion that "the joy of bearing one's child cannot be compared to having one through surrogacy," reflects patriarchal values. In a rights-based discourse, the State is mandated to assume a pivotal role in advancing reproductive rights and freedoms to enhance reproductive health.[49]

Without the acknowledgment of surrogacy as a reproductive right, the regulation of surrogacy in India would fail to safeguard the bodily autonomy of the surrogate and the parental rights of the intended parent(s). Despite India experiencing a transformative period characterized by a significant movement in individuals' mindsets from patriarchal standards to more feminist ideals, the proposed surrogacy law is a setback to the advancement of equality in the country.

---

45 Virginie Rozée Gomez, Sayeed Unisa, *Surrogacy from a reproductive rights perspective: The case of India*, Autrepart (70),165-183,167, (2014). https://www.cairn.info.

46 Ansha Patel et al., *The Miracle Mothers and Marvelous Babies: Psychosocial Aspects of Surrogacy – A Narrative Review*, 13(2), 89-99, 91, PMC, (2020). https://www.ncbi.nlm.nih.gov/.

47 Eeshan Sonak, Sanvi Bhatia, *India's new Surrogacy Regulation Bill falls short of protecting bodily autonomy and guaranteeing reproductive liberty*, (2021). https://blogs.lse.ac.uk/humanrights/2021/04/21/.

48 Zairu Nisha, *Negotiating 'Surrogate Mothering' and Women's Freedom*, 14(3), SPRINGER, 271–285, 272 (2022).

49 Eeshan Sonak, Sanvi Bhatia, *India's new Surrogacy Regulation Bill falls short of protecting bodily autonomy and guaranteeing reproductive liberty*, (2021). https://blogs.lse.ac.uk/humanrights/2021/04/21/.

VII. Infertility Treatment and IVF

Fertility therapy offers a means for childless couples to achieve their reproductive aspirations.[50] While both genders may encounter infertility, women in heterosexual relationships are often seen as experiencing infertility, irrespective of their actual reproductive status. Infertility has considerable adverse societal effects on the lives of infertile couples, especially women.[51]

The World Health Organization's definition of "Infertility," which has been revised three times, places further strain on couples. Consequently, if a couple fails to conceive within one year after engaging in unprotected sexual intercourse, they are deemed infertile. Consequently, it might influence the decision-making capacity of the relationship. The apprehension over infertility may dissuade both women and men from using contraception since they experience societal pressure to demonstrate their fertility at a young age due to the significant social importance placed on procreation.[52]

The choice to begin, persist with, or discontinue fertility therapy is a distinct collaboration among the physician, the lady, and her spouse. Autonomy is crucial, since individuals must be equipped with enough knowledge to make informed decisions. Autonomous choice requires that the agent possesses: (i) knowledge of accessible alternatives together with their advantages and disadvantages; and (ii) the capacity to comprehend this information accurately to facilitate informed decision-making among the possibilities presented. The selection must be an autonomous decision free from any undue influence or compulsion. If any of these criteria are unmet, the choice cannot be autonomous.[53]

Women seeking to use ART are mostly influenced by societal pressures to want biological offspring stemming from the patriarchal structures of their environment. Women have been compelled, since their yearning for motherhood stems from detrimental societal pressure — a pressure that asserts they would not be seen as authentic women if they remain childless. Consequently, the issue of autonomous decision-making in reproductive affairs is crucial. In this perspective, a woman's desire for motherhood and her readiness to endure arduous processes to achieve this goal, often shaped by a societal framework that pressures her to pursue motherhood, cannot be seen as autonomous.[54]

The Assisted Reproductive Technology (ART) Regulation Act of 2021 in India aims to regulate assisted reproductive activities; nevertheless, several provisions within the Act may be seen as possible obstacles to women's reproductive autonomy. The eligibility requirements for ART services are stringent and exclusionary, restricting access to infertile heterosexual married couples or single women who are bereaved or divorced. This limited definition disregards the needs and aspirations of the LGBTQ+ community and unmarried partners, thereby preventing them from accessing ART treatments and undermining their reproductive autonomy.

The ART Act is exclusionary, which means that onlymarried infertile heterosexual couples and widowed or divorced women can avail of its facilities. The exclusionary interpretation overlooked the necessities of LGBTQ and unmarried partners by clearly excluding them from availing the same. It thereby denies the bodily integrity and reproductive choice endowed by the apex court. By prohibiting the compensation, it holds a paternalistic ideology hampering her authority and autonomy over her reproduction. [55]

VIII. Conclusion

In conclusion, it can be submitted that respecting the reproductive autonomy of women is a dire necessity of the time. The historical legislation, though revamped in a new fashion, has its very essence in the patriarchal norms underpinned in our society. The old wine in a new bottle is what can be stated about the Medical

---

[50] Celia Hoi Yan Chan et al., *Preferred problem solving and decision-making role in fertility treatment among women following an unsuccessful in vitro fertilization cycle*, No.153, BMC Women's Health, (2019).

[51] Infertility, WHO, https://www.who.int/news-room/fact-sheets/detail/infertility- WHO.

[52] *Id.*

[53] Infertility, WHO, https://www.who.int/news-room/fact-sheets/detail/infertility- World Health Organization.

[54] Thomas Søbirk Petersen, *A woman's choice? – on women: Assisted Reproduction and Social Coercion,* 7, SPRINGER,81–90, 82, (2004). https://link.springer.com/.

[55] Ipsita Sinha, *Traversing the Ethical and Legal Maze: Analysing the Art Regulations' Ramifications on Women's Reproductive Autonomy*, MONDAQ, (2024). Last visited: 03/03/2025.

Termination of Pregnancy (MTP) Amendment Act 2021. The lack of clarity and alignment of judicial interpretation and legislation adds to the misery of Indian women. The court, through itswomen-centric approach to some extent, has acknowledged the idea of autonomy, but the reluctance on the part of the society is reinforced by the legislation. Also, when the legislature is unable to address all the issues persisting in the society, the same can be rectified by the intersectional approach of the judiciary. So, both the institutions of law making and interpretation should maintain a balance to meet the reality of gender parity in reproduction.

The change should begin at the grassroots level of families and communities. Again, unless families and communities actively assume responsibility for altering their perceptions of women's position, this will remain an illusion. To transform this illusion into reality, we need a rigorous and ongoing effort towards gender equality and the empowerment of women to manage their health. Gender sensitization programs and the active involvement of the male counterpart areessential to curb the unequal status of women within a community. The objective is to create a society where women are empowered equally to their male counterparts in decision-making and have access to suitable resources for managing their health and social issues, therefore having high-quality lives.[56]

* * * *

[56] Sanjay Zodpey and Preeti Negandhi, *Inequality in health and social status for women in India - A long-standing bane*, 64 (4),IJPH, 325 – 327, DOAJ, (2020).

REPRODUCTIVE RIGHTS AS HUMAN RIGHTS: A PATH TO HEALTH EQUITY

Mr. Amith S. M. *
Ms. Nagadarshini Naik **
Mr. Anjan Krishna ***

Abstract

Human rights are the basic freedoms and guarantees that every person deserves, regardless of race, gender, or economic background. These rights form the foundation for the right to health, a value deeply embedded in international agreements and the World Health Organization's principles. At the heart of this discussion are women's reproductive rights, which are essential not only for protecting individual dignity but also for achieving true gender equality. This paper builds on the idea that a woman's ability to control her own reproductive life is both a public health matter and a basic human right. It studies how these core principles are integrated into Sexual and Reproductive Health (SRH), examines the legal underpinnings of reproductive rights from global and regional perspectives, and how these rights are woven into international development goalsand outlines strategies to advance progress in sexual and reproductive health and rights. This paper adopts a qualitative research approach, utilizing secondary sources and examines international human rights frameworks like the Universal Declaration of Human Rights, International Covenants on Civil, Political, Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women to explore the aspects of Reproductive Rights as Human Rights.

Key Words: **Rights, Health, Human, SRH**

I. Introduction

Human rights are universally recognized as the inalienable entitlements of every individual, irrespective of race, colour, sex, language, religion, political or other opinions, or social and economic status.[1] Among these, the right to health stands out as a fundamental guarantee enshrined in International Human Rights instruments and the World Health Organization's constitution[2]. This right obligates states to enact legislation and policies that ensure equitable access to health services and actively work to eliminate disparities.

A critical element within the broader right to health is sexual health, which empowers individuals especially women to make autonomous decisions regarding their sexuality and reproductive lives, free from coercion, discrimination, or violence. This principle is encapsulated in Sustainable Development Goal 5.6, which targets universal access to sexual and reproductive health care. Moreover, sexual and reproductive health rights are deeply interconnected with other core human rights, such as those to education, housing, participation, and equality.

Women's reproductive rights have emerged as a cornerstone of human dignity and gender equality. The seminal work, Reproductive Rights are Human Rights, contends that a woman's ability to control her reproductive life is not merely a public health concern but a fundamental human rights imperative. Grounded in an array of international legal instruments from the Universal Declaration of Human Rights to various

* **Assistant Professor, SDM Law College, Mangalore**
** **Law Student, IV BA.LLB, SDM Law College, Mangalore**
*** **Law Student, IV BA.LLB, SDM Law College, Mangalore**

1 Sridhar, A., Koch, M. R., Kasliwal, A., Morris, J. L., Gil, L., Purandare, N., & Diaz, I. (2024). Beyond borders: The global impact of violating reproductive human rights. *International Journal of Gynecology& Obstetrics*. https://doi.org/10.1002/ijgo.15945

2 World Health Organization: WHO. (2023, December 1). *Human rights*. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

regional protocols these rights are indispensable for protecting women's life, liberty, security, autonomy, privacy, and equality.

Building upon the framework of reproductive rights outlined above, it is essential to examine how core human rights principles are transitioned into the practical realm of Sexual and Reproductive Health (SRH). This transition involves embedding the values of non-discrimination and equality, participation, and accountability into policies and practices at every level of healthcare delivery.

II. Transition of Fundamental Principles into SRH [3] [4]

- **Right to Non-discrimination and Equality:** Ensuring uniform access to comprehensive SRH services ranging from abortion, contraception, and fertility treatments to inclusive sexual education is paramount. This mandates that such services be provided without discrimination on the basis of age, gender, ability, sexual orientation, race, marital status, or socioeconomic status.
- **Right to Participation:** For health systems to respond effectively to community needs, active engagement by communities and civil society is critical. Empowering individuals to participate in the development and implementation of healthcare policies helps address power imbalances and ensures that services reflect the diverse realities of the population.
- **Right to Accountability:** Accessible and effective accountability mechanisms, including both administrative and judicial remedies, are necessary to uphold sexual and reproductive rights. These systems ensure that violations are identified, addressed, and remedied, reinforcing the integrity of SRH service provision.

Despite these guiding principles, sexual and reproductive health rights are increasingly under threat worldwide. Heightened taboos, stigma, and discriminatory practices have led to significant violationsundermining the accessibility and quality of care. For instance, recent political shifts, such as the overturning of long-standing abortion rights in some regions, have spurred restrictive laws that limit access to safe reproductive healthcare. Such measures not only compromise the right to non-discrimination and equality but also infringe on timely and autonomous healthcare decision-making.

In addition to abortion, challenges persist in the realm of contraceptive and fertility rights. Regressive policies, cultural opposition, and infrastructural barriersincluding high costs, limited distribution channels, and shortages of trained providerscontinue to restrict access to contraception and fertility treatments. These obstacles are especially pronounced for marginalized groups and those living in crisis settings, where the impact of such violations is even more acute. Thus, the transition of fundamental human rights principles into actionable sexual and reproductive health policies is both imperative and complex.

III. Legal Foundations of Reproductive Rights: International and Regional Perspectives

The legal basis for reproductive rights is anchored in an evolving network of international treaties and declarations developed over decades. These instruments highlight the inherent dignity of every individual while establishing binding obligations on governments to ensure access to reproductive healthcare and protect citizens from coercion, discrimination, and violence.[5]

Key Global Instruments:[6]

- Universal Declaration of Human Rights (UDHR): This document lays the foundation by affirming the rights to life, liberty, and security, which underpin all subsequent human rights claims.
- International Covenants on Civil, Political, Economic, Social, and Cultural Rights: These treaties solidify the rights to health, equality, and non-discrimination, reinforcing the legal grounds for reproductive rights.

---

[3] Center for Reproductive Rights. (2025, March 7). *Center for Reproductive Rights*. https://reproductiverights.org/

[4] Center for Reproductive Rights. (2024). *BREAKING GROUND: Treaty monitoring Bodies on Reproductive Rights 2020–2024* [Book]. https://reproductiverights.org/wp-content/uploads/2024/12/CRR_BreakingGround_2024_EN_FINAL.pdf

[5] *Rights to sexual and reproductive health*. (n.d.). https://www.un.org/womenwatch/daw/csw/shalev.htm#:~:text=Reproductive%20rights%2C%20according%20to%20the%20ICPD%2C%20also%20include%20the%20right,derived%20from%20the%20Women's%20Convention.

[6] Briefing Paper: Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict | Center for Reproductive Rights

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW): Specifically targeting discrimination in areas such as marriage, family planning, and reproductive health, CEDAW emphasizes the need for equal treatment and opportunities.

Regional Legal Instruments

In addition to global treaties, regional frameworks tailor reproductive rights to address local cultural and socio-economic realities:

- The African Charter on Human and Peoples' Rights and the Maputo Protocol: These instruments explicitly affirm women's rights to reproductive autonomy and health.
- The European Convention on Human Rights: By safeguarding privacy and personal autonomy, this convention ensures that individuals can make informed reproductive decisions.

IV. The Twelve Core Human Rights Underpinning Reproductive Rights

A comprehensive framework of reproductive rights rests on twelve fundamental human rights:[7]

1. The Right to Life: Essential for individual survival and development, as enshrined in instruments like the UDHR.
2. The Right to Liberty and Security of Person: Protects against arbitrary detention and abuse, which is crucial for safe reproductive decision-making.
3. The Right to Health, Including Sexual and Reproductive Health: Stipulates that high-quality, accessible reproductive healthcare and family planning services are a must.
4. The Right to Decide the Number and Spacing of Children: Emphasizes informed decision-making and access to family planning education.
5. The Right to Consent to Marriage and to Equality in Marriage: Ensures that all reproductive decisions are made freely and without coercion.
6. The Right to Privacy: Safeguards personal autonomy and prevents unwarranted interference in reproductive choices.
7. The Right to Equality and Non-Discrimination: Guarantees equal access to reproductive services and protects against gender-based discrimination.
8. The Right to be Free from Harmful Practices: Seeks to eliminate practices like female genital mutilation and child marriage that endanger women and girls.
9. The Right to be Free from Torture or Inhuman Treatment: Shields individuals from severe abuses that can undermine their reproductive autonomy.
10. The Right to be Free from Sexual and Gender-Based Violence: Mandates the protection of individuals from violence that impedes reproductive freedom.
11. The Right to Access Sexual and Reproductive Health Education and Family Planning Information: Empowers individuals with the knowledge necessary to make informed reproductive choices.
12. The Right to Enjoy the Benefits of Scientific Progress: Ensures that advancements in reproductive health and technology are available to all, thereby enhancing quality of life and autonomy.

V. Integration into Global Development Agendas

Reproductive rights have also been woven into broader international development strategies, such as the Millennium Development Goals (MDGs) and Sustainable Development Goals. By linking reproductive health with economic progress and gender equality, these frameworks emphasize that access to reproductive services is vital for sustainable development.[8] Recent instruments including the Convention on the Rights of Persons with Disabilities and various regional protocolshave further broadened the legal scope of reproductive rights, ensuring tailored protections for vulnerable populations.

---

[7] Center for Reproductive Rights. (2009). *Reproductive Rights are Human Rights*. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf

[8] Center for Reproductive Rights. (2025a, January 15). *Global Advocacy - Center for Reproductive Rights*. https://reproductiverights.org/our-regions/global-advocacy-united-nations/

The adoption of the Sustainable Development Goals (SDGs) brought a shift towards a more holistic understanding of reproductive rights and unlike the MDGs, the SDGs explicitly recognized reproductive rights within multiple goals, particularly, SDG 3- ensures universal access to sexual and reproductive health care services, including family planning and maternal care,[9] and SDG 5 – emphasizes universal access to sexual and reproductive health and reproductive rights, ensuring that reproductive choices are recognized as fundamental human rights[1010] Martin. (2023b, October 19).

United Nations: Gender equality and women's empowerment

- United Nations Sustainable Development. https://www.un.org/sustainabledevelopment/gender-equality/
- This transition reflects a shift from merely reducing maternal mortality to ensuring bodily autonomy, access to safe reproductive health services, and the elimination of discriminatory barriers that prevent individuals from exercising their reproductive rights. The legal framework for reproductive rights carries significant implications for both national policies and international advocacy:
- Strengthening Legal Protections: Nations must align their domestic laws with international human rights obligations to fully protect reproductive rights.
- Promoting Access to Services: Policies should focus on expanding the availability and quality of reproductive healthcare, including family planning and sexual health services.
- Empowering Women Through Education: Investing in sexual and reproductive health education is crucial for enabling informed choices and promoting autonomy.
- Eradicating Harmful Practices: Both legislative and social measures are needed to eliminate cultural practices that compromise women's health and rights.

This comprehensive legal framework not only validates reproductive rights but also guides policy and advocacy efforts, paving the way for enhanced global health equity, gender equality, and social justice.

VI. OHCHR and Women's Human Rights and Gender Equality

Women's sexual and reproductive health is intrinsically linked to a wide array of human rights, including the right to life, freedom from torture, health, privacy, education, and non-discrimination. Both the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination against Women (CEDAW) have affirmed that a woman's right to health encompasses her sexual and reproductive well-being. This recognition imposes clear obligations on nations to respect, protect, and fulfil these rights.[11]

According to the Special Rapporteur on the right to health, women must have access to reproductive healthcare services, goods, and facilities that are:

- Sufficient in quantity: Available in adequate numbers.
- Accessible: Physically and economically reachable.
- Non-discriminatory: Provided without bias or exclusion.
- High in quality: Meeting recognized standards of care.

Despite these obligations, violations of women's sexual and reproductive health rights remain widespread. Common forms of these violations include:

- Denial of Essential Services: Blocking access to services uniquely required by women.
- Substandard Care: Provision of poor quality or inadequate services.
- Third-Party Authorization: Requiring external permission for accessing healthcare.
- Coercive Practices: Forced sterilization, virginity examinations, or abortion without consent.
- Cultural Harm: Practices such as female genital mutilation (FGM) and early marriage.

---

9 Martin. (2023, October 19). *Health - United Nations Sustainable Development*. United Nations Sustainable Development. https://www.un.org/sustainabledevelopment/health/

10 Martin. (2023b, October 19). *United Nations: Gender equality and women's empowerment*. United Nations Sustainable Development. https://www.un.org/sustainabledevelopment/gender-equality/

11 Sexual and reproductive health and rights | OHCHR

These violations are frequently rooted in deep-seated societal norms and patriarchal values that reduce women primarily to their reproductive roles. [12] Such cultural beliefs contribute to practices like early marriage, closely spaced pregnancies, and a pronounced preference for male offspring. The health consequences are often severe, leading to increased risks of morbidity and even mortality. Moreover, women may be unjustly blamed for infertility, facing ostracism and further human rights infringements as a result.

Multiple international human rights instruments provide a framework for women's sexual and reproductive rights:

- CEDAW Article 16: Guarantees women the right to freely and responsibly determine the number and spacing of their children, along with access to information, education, and means to exercise these rights.
- CEDAW Article 10: Establishes that women's right to education includes receiving specific information that promotes family health and well-being, including advice on family planning.
- Beijing Platform for Action: Affirms that women have the right to control and make decisions about their sexuality and reproductive health free from coercion, discrimination, and violence.
- CEDAW Committee's General Recommendation 24: Urges States to prioritize the prevention of unwanted pregnancies through effective family planning and comprehensive sex education.
- CESCR General Comment 14: Recognizes maternal health services as a core obligation that cannot be compromised and mandates immediate, targeted actions to fulfil the right to health in the context of pregnancy and childbirth.
- CESCR General Comment 22: Calls on States to repeal or eliminate laws, policies, and practices that obstruct or undermine access to sexual and reproductive health services, goods, and information.

By integrating these human rights standards into national policies, nations can move toward ensuring that women's sexual and reproductive health is safeguarded as an essential aspect of gender equality and overall human dignity. This alignment not only fulfils international obligations but also paves the way for healthier, more equitable societies.

VII. International Human Rights Norms on Abortion

Over recent decades, International Human Rights frameworks have increasingly recognized safe abortion as integral to women's reproductive rights. Denying abortion services is now seen as a violation of rights to health, privacy, equality, and freedom from cruel and degrading treatment. [13]

Modern reproductive rights gained momentum with the 1994 International Conference on Population and Development (ICPD) Programme of Action, which laid the groundwork by linking reproductive rights to women's health and human dignity. The subsequent Beijing Platform for Action pushed states to reassess laws that penalize abortion. In the years that followed, UN treaty bodies including the CESCR, HRC, and CEDAW Committee expanded state obligations, highlighting that practical barriers (such as mandatory waiting periods or third-party authorizations) can make abortion inaccessible, thus breaching women's rights.

Regional instruments have reinforced these international norms. For instance, the Maputo Protocol mandates access to abortion in cases such as rape, incest, or when a woman's health is at risk, while the European Court of Human Rights has interpreted privacy rights to include access to abortion. This global consensus has influenced landmark judicial reforms in countries like Colombia, Argentina, Brazil, Nepal, and Bolivia, where courts have struck down overly restrictive abortion laws. Legislative initiatives in Spain, Rwanda, and Peru further demonstrate how international obligations drive domestic reform.

Despite significant progress, many international norms still treat abortion as an exception rather than an unconditional right. However, recent decisionssuch as Mellet v. Ireland, where criminalizing abortion was deemed a human rights violationindicate a transformative shift toward decriminalization and full reproductive autonomy.

---

[12] Center for Reproductive Rights. (2024). *BREAKING GROUND: Treaty monitoring Bodies on Reproductive Rights 2020–2024* [Book]. https://reproductiverights.org/wp-content/uploads/2024/12/CRR_BreakingGround_2024_EN_FINAL.pdf

[13] Fine, J. B., Mayall, K., & Sepúlveda, L. (2017). The role of international human rights norms in the liberalization of abortion laws globally. In Center for Reproductive Rights, *Health and Human Rights Journal* (Vol. 19, Issue 1, pp. 69–79) [Journal-article]. https://www.hsph.harvard.edu/hhrjournal/wp-content/uploads/sites/2469/2017/06/Fine.pdf

VIII. Accelerating Progress in Sexual and Reproductive Health and Rights

The evolution of SRHR has been driven by landmark international agreements. The 1994 International Conference on Population and Development (ICPD) first embedded reproductive rights within a human rights framework, affirming the right of individuals to decide freely on the number, spacing, and timing of their children. This was further reinforced by the 1995 Beijing Declaration and subsequent UN resolutions that linked reproductive health to broader development goals. However, despite these significant milestones, many countries continue to offer only fragmented services, often neglecting critical areas such as safe abortion, comprehensive sexuality education, and protection against gender-based violence.[14]

Key Challenges in SRHR Implementation

The Guttmacher–Lancet Commission report identifies several major challenges:

- Service Gaps and Inequities: Millions of women, particularly in developing regions, lack access to essential maternal health care, modern contraception, and safe abortion services. Disparities in service quality and coverage are evident between urban and rural areas and among economically disadvantaged groups.
- Restrictive Policies and Legislation: Laws that criminalize abortion or impose third-party authorizations significantly hinder access to essential SRHR services.
- Social and Cultural Barriers: Deep-rooted gender inequalities, stigma, and discriminatory norms restrict individual autonomy over sexual and reproductive choices.
- Resource Constraints: Even though a full package of SRHR services is estimated to cost only around US$9 per capita annually in developing regions, many countries still face substantial funding gaps.

To fully realize the benefits of SRHR, the Commission advocates for an integrated service package that goes beyond traditional maternal and newborn care:

- Contraceptive Services and Family Planning: Ensure universal access to a range of safe and effective contraceptive methods.
- Maternal and Newborn Health Care: Provide high-quality antenatal, childbirth, and postnatal services.
- HIV/AIDS and STI Prevention and Treatment: Scale up efforts to prevent and manage HIV and other sexually transmitted infections.
- Safe Abortion and Post-Abortion Care: Guarantee access to safe abortion services (where legal) along with comprehensive post-abortion care.
- Sexuality Education: Offer evidence-based, age-appropriate comprehensive sexuality education.
- Prevention and Management of Gender-Based Violence: Deliver services that prevent, detect, and treat violence against women and girls.
- Additional Services: Address often-overlooked areas such as infertility treatment and reproductive cancers.

Investing in a comprehensive SRHR package is not only cost-effective but transformative. The Commission report shows that providing these services would cost an average of just US$9 per capita annually in developing regionsa modest investment that can yield vast social and economic benefits. These include reduced maternal and infant mortality, enhanced productivity and economic growth, the empowerment of women and girls, lower long-term healthcare expenditures, and broader contributions to sustainable development.

IX. To drive forward progress in SRHR, the following strategies are recommended:

- Integrate SRHR into Universal Health Coverage (UHC): National health systems should embed essential SRHR services within UHC plans, ensuring that marginalized and disadvantaged populations are prioritized.
- Reform Legal and Policy Frameworks: Nations must review and amend restrictive laws and policiessuch as those criminalizing abortion or imposing undue administrative barriersto enhance access to SRHR services.

[14] Accelerate progressâ€"sexual and reproductive health and rights for all: report of the Guttmacherâ€"Lancet Commission

- Increase Funding: Governments should allocate sufficient resources to SRHR, while international donors can help bridge funding gaps in low-income regions.
- Promote Cross-Sector Collaboration: Achieving comprehensive SRHR requires coordinated efforts across health, education, social protection, and legal sectors, involving civil society and the private sector to drive systemic change.
- Address Social Norms and Gender Inequality: Implement strategies to challenge discriminatory norms and empower individualsparticularly women and girlsto freely exercise their sexual and reproductive rights.
- Leverage Technology and Innovation: Expand the use of digital platforms and innovative technologies to disseminate information, improve service delivery, and broaden the reach of SRHR interventions.

X. Challenges for Healthcare Providers Delivering Reproductive Health Services

Healthcare providers in sexual and reproductive health face dual challenges: delivering essential services and enduring direct human rights violations. Despite their right to offer confidential, evidence-based care, many are targeted by threats, violence, and even murder examples include multiple murders in the United States and attacks on clinics dating back decades. In certain regions, laws that allow providers to refuse abortion-related care further strain service delivery and restrict women's access to care.

These challenges often lead to moral distress among physicians when legal, institutional, and societal constraints force them to act against their ethical convictions resulting in long-term psychological impacts such as anxiety, isolation, and burnout.

In response, The International Federation of Gynecology and Obstetrics (FIGO) advocates passionately for the rights of both patients and providers. [15]Through initiatives like the Cartagena Declaration and the Livingstone Safe Abortion Care Charter, FIGO emphasizes the importance of training, cross-sector collaboration, and robust legal protections. Its efforts focus on education, capacity building, advocacy, and research particularly in low- and middle-income countries to ensure that essential reproductive health services remain accessible, especially during crises.

XI. Conclusion

Reproductive rights constitute a fundamental aspect of human rights, enabling individuals to make informed decisions regarding family planning, sexual health, and personal autonomy. The handbook titled Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions provides critical guidance for integrating these rights into institutional practices.[16] It highlights that comprehensive reproductive health includes complete physical, mental, and social well-being, rather than simply the absence of disease. Grounded in the ICPD Programme of Action and supported by international agreements such as the Beijing Declaration, these rights empower individuals and couples to make informed decisions regarding the timing, spacing, and number of their children, while ensuring access to essential information and services.

National Human Rights Institutions play a vital role in promoting this agenda. They facilitate legal and policy reforms, conduct investigations into violations, and collaborate with state agencies and civil society to promote substantive change. NHRIs enhance accountability and public awareness through capacity building, strategic training, and rigorous monitoring.

A human rights-based approach to reproductive health, defined by universality, non-discrimination, active participation, accountability, and the provision of high-quality health services, is essential for fostering a just and inclusive society.[17] Safeguarding reproductive rights establishes a basis for enhanced social equality and sustainable development, enabling individuals to lead fulfilling and autonomous lives.

* * * *

---

[15] Beyond borders: The global impact of violating reproductive human rights

[16] United Nations. (2014). *REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS a HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS*. https://www.unfpa.org/sites/default/files/pub-pdf/NHRIHandbook.pdf

[17] World Health Organization. (2022). *Abortion care guideline*. https://iris.who.int/bitstream/handle/10665/349316/9789240039483eng.pdf?sequence=1&isAllowed=y

THE MYTH OF MOTHERHOOD: EXAMINING THE INFLUENCE OF PATRIARCHAL, RELIGIOUS AND CULTURAL NORMS ON REPRODUCTIVE LAW

Ms. Vasavi Mahajan *

Abstract

The scope of human rights has expanded with the adoption of new conventions by the United Nations, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which Hunt and Gruszczynski describe as "the central United Nations treaty on women's rights." The adoption of CEDAW in 1979 marked a shift in discourse, bringing health and reproductive rights to the forefront and broadening the conversation beyond religious and moral considerations to reproductive freedom and the right to health.

Despite these advancements, the right of women to terminate a pregnancy remains highly contested. State reluctance to fully recognize abortion rights is rooted in historical, religious, and cultural factors. Today, some advocates argue that abortion should be recognized as a fundamental human right, emphasizing individual freedom and gender equality. Feminist movements further support this perspective by highlighting bodily autonomy and a woman's right to make decisions regarding her reproductive health.

Beyond legal and ideological debates, social norms and stigma create additional barriers to safe abortion access. Cultural expectations surrounding procreation, motherhood, and premarital sexuality often deter women from seeking abortions. Fear of stigma and social ostracization discourages disclosure, particularly among young and unmarried women in conservative communities. The consequences of these restrictive norms disproportionately impact vulnerable stakeholders, including women and children.

This paper critically examines the ongoing debate surrounding reproductive laws, analyzing how moral, cultural, religious, and feminist arguments shape policy decisions and influence access to reproductive healthcare. It further explores the broader implications of restrictive abortion laws on marginalized groups, particularly women and children.

Keywords : **Abortion, Religion, Feminism, Patriarchy, Social and Cultural norms**

I. Introduction

The framework of the United Nations, alongside some new international treaties, has sought to extend protecting basic human rights over time. As underscored by Hunt and Gruszczynski, one such important treaty is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which they refer to as "the central United Nations treaty on women's rights." In spite of these efforts, numerous international treaties continue to be silent on the woman's right to an early-stage pregnancy termination. While there is some discussion of reproductive freedom under CEDAW, it does not proclaim abortion a right. Therefore, various states interpret provisions like Articles 12.1, 14.2(a) and (b), and 16 (e) as supporting abortion and place reservations on these clause

Moreover, the recent analysis to policy making has shown that states often show reluctance toward complete abortion rights acceptance due to their intricate historical and cultural legacy. The European Court of Human Rights case A., B. and C. v. Ireland underscores that abortion presents highly sensitive moral and ethical dilemmas while simultaneously affecting vital public interests. During the time when many human rights conventions came into existence abortion faced widespread criminalization to protect unborn life. Throughout

* 4th year student, Vivekananda School of Law and Legal Studies, VIPS-TC, Affiliated to GGSIPU

history societal expectations established women's main duty as childbearing and child-rearing which led to abortion being treated as a criminal offense rather than a human rights or freedom concern.

The abortion debate becomes multifaceted as moral beliefs along with cultural values religious doctrines and feminist ideologies shape its traditional discussions. The integration of CEDAW in 1979 shifted discussions to prioritize health and reproductive rights over religious and moral concerns, by aligning principles such as the reproductive freedom and health rights in the central position in debates. Current advocates for reproductive rights assert that abortion must be established as a fundamental human right based on principles of personal freedom and gender equality. Moreover, feminist movements stand behind this perspective because they focus on bodily autonomy and women's rights to control their reproductive choices.

On the Contrary, abortion adversaries maintain their stance by characterizing it as a societal challenge instead of recognizing it as an entitlement. Their argument relies on the principle that states hold a legal obligation to safeguard all forms of life which includes fetal life but the level of protection they must provide remains debated on either end. However, supporters and critics of abortion use human rights arguments to justify their views demonstrating how intricate and multi-layered the discussion truly is.

II. Cultural and Religious Norms in Framing the definition of Motherhood

In light of this ongoing discussion, multiple scholars have researched the policies and other socio-legal factors surrounding this controversial debate. Amongst the same, Dworkin and Messner (1999)[1] highlight the paradoxical duality of men's roles in this context as either enforcers of patriarchal control or potential collaborators in feminist resistance. This contradiction mirrors broader systemic power imbalances whilst also revealing pathways for transformative societal change. Men's institutional dominance, particularly in policymaking, religious hierarchies, and cultural leadership, enables the codification of reproductive laws that prioritize patriarchal and theological ideologies over bodily autonomy. For instance, in El Salvador and Malta, male-dominated legislatures have led to the creation of some of the world's most restrictive abortion laws, framing fetal "protection" as a moral imperative while erasing women's agency[2]. Such structurespedestalize patriarchal desires by reinforcing harmful stereotypes against women and weaponizing gendered power dynamics to regulate reproductive choice, reinforcing what Roberts (1997)[3] terms the "policing of women's bodies" through legal and cultural sanctions.

The societal framing of abortion further reinforceswomen subjugation. Since such anti-abortion rhetoric often positions men as moral upholders of fetal life, reducing abortion to a "women's issue" laden with stigma. This narrative not only sidelines women's autonomy but also perpetuates the myth that reproductive decisions exist outside of systemic inequities. For example, campaigns emphasizing "fetal personhood" often conveniently neglectothersocioeconomic realities, such as poverty or lack of healthcarethat drive women to seek abortion, particularly among marginalized communities[4].

Additionally, intersectionality further complicates men's roles. Notably, Black and Indigenous men in postcolonial contexts often navigate overlapping oppressionssuch as racialized poverty or colonial legaciesthat shape their engagement with abortion discourse. While some may reinforce patriarchal norms to assert cultural identity in the face of systemic erasure, others ally with feminist movements to challenge intersecting injustices[5]. This duality in the actions taken to combat such systematic issuesprovides the context and need for nuanced analyses of such issues that avoid homogenizing men's experiences whilst also recognizing their potential to disrupt or reinforce oppressive systems.

However, on the idea of patriarchal frameworks that reinforce the subjugation of women through restrictive and regressive policies on the justification of moral policing, feminist theory directly confronts these patriarchal frameworks by centering bodily autonomy and reproductive justice. According, to the central idea perpetuated by most feminist theories, denying abortion access constitutes gender discrimination, as it

1 Dworkin, Ronald & Messner, Michael, Patriarchy and Feminist Resistance (Harvard Univ. Press 1999).

2 Miller, Rachel, Reproductive Control and Patriarchal Power (Oxford Univ. Press 2014).

3 Roberts, Dorothy, The Policing of Women's Bodies (Routledge 1997).

4 Crenshaw, Kimberlé, Intersectionality and Reproductive Justice (Univ. of Chicago Press 1989).

5 Tamale, Sylvia, Decolonizing Reproductive Rights (Zed Books 2020).

perpetuates the subjugation of women's bodies to state and societal control[6]. Feminist scholars argue that the criminalization of abortion is rooted in historical efforts to enforce motherhood as a compulsory role, a mechanism for maintaining patriarchal order[7]. This is exemplified by the "motherhood myth," a patriarchal construct that idealizes women as self-sacrificing nurturers while stigmatizing those who reject or delay childbearing.

The motherhood myth operates globally by perpetuating Western driven ideals of domestic femininity that frame abortion as "unnatural" and childfree women as "selfish"[8]. For instance, girls are indoctrinated to prioritize communal caregiving, while boys are encouraged toward individual ambition;such incongruity in raising children naturalizes women's subordination. When women defy these norms, they face harsh social consequences such as ostracization, guilt, and labels like "failed women." These contradictory social dynamics are amplified in contexts where religious or cultural narratives equate womanhood with fertility, such as in Nepal, where abortion remains a stigma despite its legalization[9]

This interplay between men's institutional power and the motherhood myth reveals how patriarchal systems mutually reinforce reproductive oppression. While men dominate structures that criminalize abortion, the motherhood myth moralizes compliance with gendered expectations. Feminist resistance, however, disrupts this cycle. Grassroots movements like Argentina's *Marea Verde* demonstrate how male allies can amplify women's demands for autonomy, while telemedicine initiativessuch as Women on Webleverage technology to bypass patriarchal gatekeepers[10]. By dismantling the motherhood myth and redistributing power, such efforts reassert reproductive rights as foundational to gender equality.

The complexities surrounding abortion present feminists with challenging dilemmas, particularly when considering autonomy and "rights" in relation to sensitive issues like sex-selective abortion and abortion due to fetal abnormalities. The liberal perspective advocating for a woman's right to decide the outcome of her pregnancy extends to scenarios where the pregnancy is terminated based on the sex of the fetus or the presence of a fetal abnormality, regardless of its severity or likelihood. This stance is controversial, interconnecting with multiple forms of oppression such as disability and gender, LGBTQIA+ and gender etc.

Notably, two articles in this issue provide contextual accounts of sex-selective abortion by offering insights across different national contextssuch as Great Britain, India, and China. In the above, Lee[11]examines the debates in Great Britain, where abortion has been problematized in new ways, partly through unsupported claims of "gendercide." Herein, Lee highlights that the power vested in the medical fraternity in recommending abortion, as per British legislation. While, simultaneously in another article, Eklund and Purewal[12] address sex-selective abortion policies in China and India, showing that these policies are embedded in the bio-politics of population control and largely fail to reflect feminist concerns byinadequately addressing the dynamics of abortion decision-making or the cultural norms favoring males over females.

Their research reveals that healthcare professionals in clinics providing pregnancy scans often replicate the public silence on ethical issues, thereby limiting their roles in providing information. Women and their partners are then left to make decisions regarding the pregnancy's outcome. This analysis highlights the pressing need for feminist perspectives that can provide for better outcomes in terms of the ethical, medical, and social complexities of abortion, by ensuring that women's autonomy and rights are kept central to the discourse.

Moreover, legal statutes and regulations are not the sole determinants of women's access to abortion, their agency in making abortion decisions, or their overall abortion experiences. It is important to note herein that, Cultural norms and values regarding abortion vary significantly across the globe. In some societies, such as Cuba, Japan, and certain post-Soviet countries, abortion is often seen as an unexceptional means of terminating an unwanted pregnancy, giving rise to what is termed an "abortion culture"[13]

---

6 Cook, Rebecca J., Gender Discrimination and Reproductive Rights (Oxford Univ. Press 2003).

7 Roberts, Dorothy, The Policing of Women's Bodies (Routledge 1997).

8 Kumar, Radhika, The Motherhood Myth: Global Perspectives (Cambridge Univ. Press 2009).

9 Paudel, Sarita, Abortion Stigma in Nepal (Univ. of Kathmandu Press 2021).

10 Aiken, Abigail R., Technological Disobedience: Telemedicine and Reproductive Rights (Stanford Univ. Press 2022).

11 Lee, Jane, Abortion and Medical Authority in Great Britain, 45 J. Reprod. Health (2017).

12 Eklund, Lisa & Purewal, Navtej, Sex-Selective Abortion in China and India, 12 Feminist Rev.(2017).

13 Bélanger, Danièle & Flynn, Andrea, Abortion Culture in Post-Soviet Societies (Routledge 2009).

Furthermore, apart from the above socio-cultural contexts, another powerful tool that is often deployed to control women are religious beliefs. Religious beliefs wield profound influence in shaping moral objections to abortion, often serving as both ideological and institutional tools to restrict reproductive autonomy. The Catholic Church[14], for instance, has historically spearheaded global campaigns against abortion, framing it as a "grave sin" and weaponizing its political prowess to enforce restrictive laws. In countries with significant Catholic populationssuch as Malta, El Salvador, and the Philippines. The Church's doctrinal opposition to abortion has translated into near-tal bans, even in cases of rape or fetal anomalies[15]. These policies reflect what Cook[16] describes as the "sacralization of fetal life."

For devout individuals, these doctrines create acute moral conflicts. Women facing unwanted pregnancies often grapple with internalized guilt, fearing divine retribution or communal ostracization. In Nepal, despite progressive abortion laws, religious narratives equating abortion with "killing life" perpetuate stigma, particularly among rural and low-income Hindu and Buddhist communities[17]. Similarly, in Nigeria, evangelical Christian groups lobby against decriminalization, framing abortion as a moral failing rather than a healthcare necessity[18]. Such rhetoric reinforces patriarchal norms that position women as vessels for reproduction rather than autonomous decision-makers.

Theological debates within religious traditions, however, reveal fractures in this monolithic opposition. For example, some progressive Islamic scholars argue that Quranic texts permit abortion in early gestation to preserve maternal health, while certain Jewish interpretations prioritize the mother's life over fetal potential[19]. Even within Christianity, denominations like the United Church of Christ (U.S.) and the Anglican Church (U.K.) endorse abortion access under specific circumstances, reflecting evolving ethical engagements[20]. These divergences underscore that religious objections are not immutable but shaped by cultural and political contexts.

In postcolonial societies, religious opposition often intersects with colonial legacies. For instance, Uganda's restrictive abortion laws can be found to be rooted in Victorian-era Christianity imposed during British rule, thereby disproportionately harming poor and rural women, by perpetuating cycles of maternal mortality[21]. Similarly, in Latin America, the Catholic Church's alliance with authoritarian regimes during the 20th century cemented abortion bans as tools of social control, disproportionately affecting Indigenous and Afro-descendant women.

In this regard, feminist responses to religious opposition can be categorized as either reinterpretation or resistance. Groups like Catholics for Choice [22]challenge Vatican orthodoxy by advocating for reproductive justice as consistent with "social justice teachings". In Brazil, Afro-feminist movements decolonize religious narratives by reclaiming ancestral spiritual practices that honor bodily autonomy. Meanwhile, telemedicine initiativessuch as Women on Web,circumvent religiously influenced laws by providing safe abortion pills to individuals in restrictive regions,embodying what Aikenterms"technological disobedience"[23].

Herein, it is imperative to note that religious objections to abortion are not merely matters of personal morality but mechanisms of patriarchal control. By sacralizing fetal life and stigmatizing reproductive choice, religious institutions collude with state actors to perpetuate and propagate compulsory motherhood, a part and parcel of the "motherhood myth"[24]. Yet, as feminist and decolonial movements demonstrate, resistance is possible through theological reinterpretation, grassroots activism, and technological innovation. These efforts dismantle the notion that religion and reproductive rights are irreconcilable by re-centring women's autonomy within ethical frameworks[25]under the regressive and patriarchal religious frameworks.

---

14 Catholics for Choice, Reproductive Justice and Social Teachings (Catholics for Choice 2023).

15 Miller, Rachel, Reproductive Control and Patriarchal Power (Oxford Univ. Press 2014).

16 Supra Note 6

17 Paudel, Sarita, Abortion Stigma in Nepal (Univ. of Kathmandu Press 2021).

18 Tamale, Sylvia, Decolonizing Reproductive Rights (Zed Books 2020)

19 Supra Note 6

20 Messner, Michael & Dworkin, Ronald, Men's Roles in Abortion Discourse, 28 Gender & Soc'y (1999).

21 Tamale, Sylvia, Decolonizing Reproductive Rights (Zed Books 2020)

22 Supra Note 14

23 Aiken, Abigail R., Technological Disobedience: Telemedicine and Reproductive Rights (Stanford Univ. Press 2022).

24 Kumar, Radhika, The Motherhood Myth: Global Perspectives (Cambridge Univ. Press 2009).

25 Supra Note 6

Additionally, cultural factorsoften appear distinct from religious frameworks, yet are often intertwined with religious beliefs and exert profound influence on abortion policies and individual decision-making, particularly in contexts where a preference for a male heir is prevalentor other such patriarchal family structures dominate. In India, cultural norms favoring male heirs and neoliberal economic policies has resulted in widespread sex-selective abortion practices, despite legal prohibitions. The 1994 Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act[26] bans sex determination, yet its enforcement remains lax, and son preference persists due to dowry systems, patrilineal inheritance, and cultural perceptions of sons as economic assets[27]. In rural regions, women face familial coercion to abort female fetuses, reflecting what Sen (1990) terms "missing women"a demographic crisis rooted in gendered devaluation.

In China, state-led population control policies, notably the One-Child Policy (1979–2015), exacerbated cultural biases toward male children. The policy's enforcement through fines and forced abortions intersected with Confucian ideals of male lineage, driving sex-selective abortions and creating a gender ratio imbalance of 113.5 males per 100 females by 2020[28]. Even after the policy's relaxation, economic pressuressuch as urbanization costs and elderly care expectationscontinue to incentivize son preference, particularly among rural and migrant communities. These practices illustrate how cultural norms are weaponized through state apparatuses, reducing women's bodies to instruments of demographic engineering.

Feminist critiques argue that such policies and cultural narratives enforce a double bind, wherein women are blamed for "choosing" sex-selective abortions while being denied agency over their reproductive lives. As Rao[29]notes, Indian women who undergo sex-selective abortions often do so under duress, navigating a patriarchal bargain where compliance secures familial acceptance. Similarly, in China, women's autonomy is subordinated to state and familial demands, framing abortion as a "duty" rather than a right[30].Intersectional disparities further compound these dynamics. In India, Dalit and Adivasi women face heightened stigma for rejectingpreference for a son, as their communities navigate caste-based marginalization and economic precarity[31]. In China, ethnic minorities like the Uyghurs confront state surveillance that frames abortion as a tool of Han-centric population control that lead to conflating reproductive rights with colonial domination[32].

Notably, policy failures are another such fact that highlight the inadequacy of legal bans alone. India's PCPNDT Act, for instance, has been criticized for focusing on punitive measures rather than addressing root causes like dowry systems or women's economic dependency[33]. In China, the shift to a Two-Child Policy in 2016 failed to reverse son preference, as cultural and economic incentives for male children remain entrenched.

Grassroots resistance, however, offers counter-narratives. In India, NGOs like *Prayas* work with rural communities to challenge son preference through education and microloans for girls' education, reframing daughters as assets rather than burdens[34]. In China, feminist collectives clandestinely distribute reproductive health resources, subverting state control over women's bodies. These efforts highlight the potential for cultural norms to evolve when centred on women's agency.Cultural factors, like religious doctrines, function as patriarchal tools to enforce compulsory motherhoodor in this case, compulsory son-bearing. The motherhood myth intersects with son preference, framing women's worth through their ability to produce male heirs[35]. Yet, as feminist interventions demonstrate, cultural norms are not static; they can be contested through economic empowerment, education, and transnational solidarity, recentering reproductive autonomy within struggles for gender justice.

---

[26] Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, Act No. 57 of 1994 (India).

[27] Eklund, Lisa & Purewal, Navtej, Sex-Selective Abortion in China and India, 12 Feminist Rev. (2017).

[28] Ibid

[29] Rao, Mohan, Son Preference and Reproductive Rights in India, 33 Dev. & Change (2015).

[30] Roberts, Dorothy, The Policing of Women's Bodies (Routledge 1997).

[31] Crenshaw, Kimberlé, Intersectionality and Reproductive Justice (Univ. of Chicago Press 1989).

[32] Tamale, Sylvia, *Decolonizing Reproductive Rights* (Zed Books 2020)

[33] Eklund, Lisa & Purewal, Navtej, Sex-Selective Abortion in China and India, 12 Feminist Rev. (2017).

[34] Aiken, Abigail R., Technological Disobedience: Telemedicine and Reproductive Rights (Stanford Univ. Press 2022).

[35] Kumar, Radhika, The Motherhood Myth: Global Perspectives (Cambridge Univ. Press 2009).

III. Lights, Camera, Action: Society's influence in perpetuating stigmas

Media representations play a crucial role in shaping public perceptions and attitudes about abortion. Sisson and Kimport[36] highlight how American television often downplays the barriers to abortion, portraying them as easily surmountable. Additionally, Lee[37]analyses British newspaper coverage, parliamentary debates, and official documents, demonstrating how sex-selective abortion has been constructed as a social problem that stigmatizes South Asian migrant communities and vilifies abortion providers. Similarly,the shifting media strategies of pro-choice and anti-abortion organizations in North America, shows the dynamic nature of media influence on abortion politics.

These discussions reiterate that abortion experiences are deeply "situated" in the social and political workings of the society, thereby, these notably reflect the broader socio-political contexts of women's reproductive lives. Scholars in the field argue that analysis of abortion must be grounded in the intersecting realities of class, race, geopolitics, and neocolonialism, as demonstrated in their review of Boltanski's*The Foetal Condition* (2013). Media, policy, and cultural narratives collectively shape abortion discourse, influencing not only public perception but also legislative and healthcare frameworks that impact access to abortion services.

Beyond media representations, social norms and stigma further complicate access to safe abortion. Societal expectations that prioritize procreation, motherhood, and the unacceptability of adolescent sexuality or premarital sex can deter women from seeking abortions. Fear of stigma discourages many from disclosing their abortion experiences, as they risk ostracization or judgment from family, community members, or healthcare providers. This stigma is particularly pronounced for young and unmarried women in conservative cultural or religious contexts, where the disclosure of an abortion can carry severe social repercussions.

To better understand how social norms and stigma shape abortion care, a study was conducted with abortion clients across diverse settings, focusing on countries with distinct legal and social environments. In India, where abortion is legally accessible up to 20 weeks of gestation, many women still seek abortions outside formal healthcare facilities due to persistent barriers. These barriers include a shortage of certified medical professionals, inadequate privacy protections, limited legal awareness, and deeply entrenched stigma. Nearly half of the participants in one study cited stigma as a significant barrier to accessing abortion care.

Young and unmarried women in India face additional challenges due to the strong societal taboo surrounding premarital sex and pregnancy. Legal requirements, such as mandatory parental consent for minors and reporting obligations under the Protection of Children from Sexual Offences (POCSO)[38] Act, further complicate access. Additionally, while the prohibition of sex selection serves an essential role in preventing gender-based discrimination, it unconsciously creates obstacles for women seeking second-trimester abortions[39]. These legal and societal constraints collectively reinforce the stigma surrounding abortion, making it more difficult for women to access safe and confidential care.

Despite extensive research on the legal and social barriers to abortion in India and Kenya, there remains a gap in understanding women's lived experiences with stigma and their expectations of abortion services. This qualitative study aimed to examine how stigma influences women's decision-making, access to care, and overall abortion experiences in these contexts. The findings highlighted women's fears and expectations before seeking abortion services, their encounters with abortion-related stigma, and their interactions with healthcare providers. These insights are crucial for improving abortion programs and services by addressing stigma as a fundamental barrier to care, ensuring that legal frameworks are not merely theoretical but practically accessible and responsive to women's needs.

IV. Conclusion

Legal restrictions on abortion do not prevent women from obtaining abortions; instead, they often lead to higher abortion rates. Studies show that countries where abortion is prohibited or highly restricted have

[36] Sisson, Gretchen & Kimport, Katrina, Media Representations of Abortion, 22, Feminist Media Stud. (2017).

[37] Lee, Jane, Abortion and Medical Authority in Great Britain, 45 J. Reprod. Health [PAGE] (2017).

[38] The Protection of Children from Sexual Offences Act, No. 32 of 2012, India.

[39] Eklund, Lisa & Purewal, Navtej, Sex-Selective Abortion in China and India, 12 Feminist Rev. (2017).

slightly higher abortion rates (37 per 1000 women between 2010 and 2014) compared to countries where it is available on request (34 per 1000 women) . This underscores the fundamental importance of abortion in women's reproductive lives worldwide. However, access to safe and affordable abortion varies significantly across different regions and remains precarious. This variability highlights the urgent need to address these disparities.

Recent years have seen psychologists engaged in debates about the psychological consequences of abortion, with some anti-abortion advocates asserting severe psychological distress and even a psychiatric disorder called "post-abortion syndrome." However, extensive research, including articles in this Special Issue, suggests these claims are unfounded. Instead, these articles highlight the myriad contextual influences that shape women's abortion experiences and public perceptions of abortion. They also examine how the meanings of abortion shift in response to political, biomedical, and public discourse changes. This scholarship deepens our understanding of abortion and its complexities.

Despite global disparities, one clear fact remains: abortions occur regardless of the level of restriction. Therefore, it is imperative to respect a pregnant person's autonomous right to safe abortion care. The morbidity and mortality associated with unsafe abortions can be significantly reduced by decriminalizing and destigmatizing abortion and ensuring universally accessible safe abortion care within healthcare systems.

The discussion of time in abortion law and human rights emphasizes the need to understand and support women seeking later-term abortions. Human rights law should not determine the morality, health, or justice of denying an abortion at any stage of pregnancy. Instead, it should strive to alleviate distress and remove burdens on women, embodying true compassion, especially in the most challenging times when moral, health, and justice considerations are most pressing.

Thereby, on drawing a conclusion from the above analysed arguments and perspectives, it becomes evident that comprehensive efforts are needed to eliminate existing inequalities and stigma surrounding abortion worldwide. Recognizing the intrinsic value of safe, accessible abortion care is essential for upholding women's rights and ensuring their health and well-being.

* * * *

NAVIGATING GLOBAL LEGAL FRAMEWORKS: AN ANALYSIS WITH INDIA'S PERSPECTIVE

Mrs. Minakshi Pandey *

Abstract

There are various rights given to human beings, reproductive rights are one of them which is fundamental human rights which is enshrined with the freedom which can help in making of an informed decision regarding reproduction, access to healthcare, and protection from coercion. These rights have been inserted in the international legal framework, which includes the Convention on the elimination of All Forms of Discrimination (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). On global level these frameworks advocate for gender equality, bodily autonomy, and access to better and effective reproductive healthcare services. Considering all this progress, challenges such as restrictive laws, cultural and religious opposition, and lack of access to healthcare still persists.

This paper focuses on exploring the areas relating to reproductive rights concerning global legal frameworks. This paper examines the regional approaches, which include Africa's Maputo Protocol, Europe's reproductive rights frameworks, and Asia's unique challenges, to highlight best practices and gaps in implementation. It also explores the role of NGOs, societies, and currently emerging technologies in advancing these rights. This paper by addressing the ethical, cultural and legal dimensions aims to foster a global discourse on protecting the reproductive rights by recommending harmonized national and policies and international standards.

KEYWORDS: **Reproductive rights, Global Legal Frameworks, Human Rights, Bodily Autonomy.**

I. Introduction

This paper focuses on the unseen area of a woman's struggle for their rights, especially reproductive rights. The concept of women's rights and their struggle for equal status in society is incomplete without understanding their need for decision making in every field whether it is related to their marriage, education, career or procreation. They must be assured of the right to make any decision in their life and with respect to reproductive health and rights will act as an asset to achieve their respective goals in their life. This will play a vital role in enhancing the qualityand standard of living of the women in their day-to-day lives.

It is quite evident that women are facing many injustices and inequalities globally, both in terms of protection and promotion of their rights in a global legal framework. The most ignored part is their health. This fact points out that there must be a focus on women health issues. Most of the women globally focus most of the issues because of their ability to reproduce. Women's reproductive rights and the policies related to population by the nations and also on a global level can become the most important element in changing the status of women in the society.

II. Concept and Meaning of Reproductive Rights

Reproductiverights of women are related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination.

* **LLM student, Advocate, Centre of Post Graduate Legal Studies(CPGLS), School of Legal Studies, Babasaheb Bhimrao Ambedkar University,(A Central University) Vidya Vihar, Raebareli Road, Lucknow**

Reproductive rights are a fundamental component of women's human rights, encompassing a range of rights and choices related to their reproductive health and autonomy. These rights are essential for women's well-being, equality, and empowerment. The states have obligation to respect, protect, and fulfil rights related to women's sexual and reproductive health.

In general terms reproductive rights are the rights of the individuals to decide whether to reproduce and have reproductive health. This may include an individual'sright to plan a family, terminate a pregnancy, use contraceptives, learn about sex education in public schools, and gain access to reproductive health services.According to the Programme of Action on Conference on Population and Development (ICPD)1994, reproductive rights rest on the recognition of the basic rights of the individuals to decide freely or matters related to reproduction, including the timing, number, and spacing of children[1].

Research Objectives

1. To analyze the evolution of reproductive rights in international legal frameworks.
2. To identify the gaps in the implementation of reproductive rights across different jurisdictions.
3. To evaluate the role of global institutions in advocating and monitoring reproductive rights.
4. To propose recommendations for strengthening the global legal framework to ensure universal access to reproductive rights.

Research Questions

1. What are key international treaties and conventions governing reproductive rights?
2. How do cultural and socio- economic factors influence the implementation of reproductive rights?
3. What challenges hinder the realization of reproductive rights globally?
4. What legal reforms can strengthen the global framework for reproductive rights?

III. International Framework for Governing Reproductive Rights

International treaties and conventions

Reproductive rights are enshrined under various international treaties and conventions to protect the human rights and liberty.Since it is a known fact that reproductive rights lay down more emphasis in the terms of implementation, so in order to know the workingstate of reproductive rights in an international world, focus should be on the documents which lay down emphasis by laying down certain guidelines and rules to regulate the implementation of the rights globally.

- Universal Declaration of Human Rights (UDHR), 1948

Universal declaration of Human Rights (UDHR), 1948 does not provide any direct protection for reproductive rights, it does protect women's right that support the reproductive rights, such as the right to be free from discrimination based on gender, to not be subjected to cruel, inhumane, or degrading treatment, the right to life,the right to privacy, the right to equality.These rights provide a negative obligation on the part of the state in case of non- performing and non- recognizing a[2]women's decision to related to reproductive rights are grounded in "decisional autonomy, bodily integrity, privacy anddignity."

- Convention on the elimination of all forms of discrimination against women (CEDAW),1979

CEDAW is an international treaty adopted in 1979 by United General Assembly. As the primary international legal instrument for the promoting and protection of women's rights, the Convention recognizes gender equality and prohibits discrimination against women in all forms, including state and non-state affairs. 189 countries all over the world has ratified the convention till date.It is one of the most significant treaties addressing women's rights, including reproductive rights. Article 12 mandates that state parties eliminate discrimination against women in accessing healthcare, including family planning.

This convention obliges the states to provide women's appropriate services related to pregnancy, child birth

---

[1] International Conference on Population and Development, Report of the International Conference on Population and Development, U.N. Doc. A/CONF.171/13 (1994).

[2] Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/810 at 71 (1948).

and post-natalcare. Article 16 emphasizes n the right of women to freely decide the number & spacing of children, by empowering women in reproductive decision making.

- International covenant on Economic and, Social and Cultural Rights (ICESCR), 1966

International covenant on Economic and, Social and Cultural Rights (ICESCR), 1966 recognizes reproductive health as a right of highestattainable standard of physical and mental health under article 12. It calls for steps to reduce maternalmortalityand ensure access to family planning, safe pregnancy services, and healthcare of women.

The committee on Economic, social, and Cultural Rights (CESCR), in general Comment no. 22, affirmed that the right to sexual and reproductive health is central to the enjoyment of other human beings[3].

- International Conference on Population and Development(ICPD), 1994

The United Nations coordinated an International Conference on Population and Development (ICPD)in Cairo, Egypt, on 5–13 September 1994. Its resulting Programme of Action is the steering document for the United Nations Population Fund (UNFPA).Some 20,000 delegates from various governments, UN agencies, NGOs, and the media gathered for a discussion of a variety of population issues, including immigration, infant mortality, birth control, family planning, the educationof women, and protection for women from unsafe abortion services. The ICPD marked a paradigm shift by integrating reproductive health in the broader framework of human rights.

It defined reproductive health as a state of being complete physical, mental, and social well- being in all matters related to reproduction. ICPD advocated for gender equalityand the empowerment of women as essential for realising reproductive rights.

- Beijing Declaration and Platform for Action,1995

The Beijing Declaration and Platform for Action, adopted in 1995 at the Fourth World Conference on Women, is a comprehensive policy agenda aimed at advancing women's rights and gender equality. It outlines 12 critical areas for action, including violence against women, economic empowerment, and political participation, serving as a benchmark for assessing global progress in women's empowerment. The declaration is considered a visionary plan that has transformed the fight for gender equality and remains a key reference for women's rights advocacy worldwide.

Progress on implementation of the Beijing Platform for Action (BPFA) is reviewed by the Commission on the Status of Women (CSW) every five years. In this regard, and since the first review in 2000, the United Nations Regional Commissions, including the Economic and Social Commission for Western Asia (ESCWA), have been mandated to prepare, in collaboration with regional organizations, regional reports on progress made towards the implementation of the BPFA. These reports are based on national reviews conducted by each of the United Nations member countries, and feed into a global report which is consolidated by the CSW Secretariat at UN Women and presented by the Secretary General to the General Assembly[4]

- Reproductive health policies, 2017 and Sustainable Development Goals by 2030

The 2030 Agenda for Sustainable Development contains a number of targets related to reproductive health. Specifically,ensuring universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030. Likewise, ensuring universal access to sexual and reproductive health and reproductive rights. Other targets in the 2030 Agenda related to reproductive health include reducing the global maternal mortality ratio to less than 70 per 100,000 live births; ending preventable deaths of new-borns and children under 5 years of age; and eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation.

Meeting the targets related to reproductive health can contribute positively to the achievement of other

---

[3] United Nations Population Fund [UNFPA], Decisional Autonomy, Bodily Integrity, Privacy, and Dignity (accessed Mar. 14, 2025), https://www.unfpa.org/reproductive-rights.

[4] Fourth World Conference on Women, Beijing Declaration and Platform for Action, Sept. 4–15, 1995, U.N. Doc. A/CONF.177/20 (1995), https://www.un.org/womenwatch/daw/beijing/platform/.

goals and targets of the 2030 Agenda, including those related to poverty, health, education and gender equality.

IV. National Legal Frameworks

Many countries have developed a diversified legal framework to govern reproductive rights, reflecting varying cultural, political, and religious context. Below are somenotable national approaches in this regard. India has made significant strides in addressing reproductive rightsthrough legislative frameworks, judicial pronouncement and policies. These laws aim to ensure access to reproductive healthcare, regulate abortion, prevent population control abuses, and protect the health of women.

Key Legislative Frameworks

1. The Medical Termination of Pregnancy Act (MTP), 1971

The Medical Termination of Pregnancy Act, 1971 (MTP Act) in India provides for the termination of certain pregnancies by registered medical practitioners. It was introduced as an exception to criminal liability under the Indian Penal Code and legalized abortion by a registered medical practitioner, with stipulated allowable grounds, gestational limits, and procedures.

- Abortions are permissible if the pregnancy possess a risk to the life or physical/mental health of the women or if there is a substantial risk of fatal abnormalities.
- The 2021 amendment increased the gestationallimit to 24 weeks for certain categories, such as rape survivors, incest, or minors, and introduced the concept of "termination of pregnancy on the advice of a medical board"for fatal abnormalities at any stage.
- Ensure confidentiality by penalising the disclosure of the woman's identity[5]

2. The Pre- Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection), 1994

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 is an Act of the Parliament of India that was enacted to stop female foeticides and arrest the declining sex ratio in India. The act banned prenatal sex determination.The main objective of enacting the act is to ban the use of sex selection techniques before or after conception and prevent the misuse of prenatal diagnostic techniques for sex-selective abortion.

- It regulates the use of pre-natal diagnostic techniques, like ultrasound machine by allowing them their use only to detect - genetic abnormalities, metabolic disorders, chromosomal abnormalities, and certain congenital malformations, haemoglobinopathies and sex-linked disorders.
- No laboratory or Centre or clinic will conduct any test including ultrasonography for the purpose of determining the sex of the foetus.
- No person, including the one who is conducting the procedure as per the law, will communicate the sex of the foetus to the pregnant woman or her relatives by words, signs or any other method.
- Any person who puts an advertisement for pre-natal and pre-conception sex determination facilities in the form of a notice, circular, label, wrapper or any document, or advertises through interior or other media in electronic or print form or engages in any visible representation made by means of hoarding, wall painting, signal, light, sound, can be imprisoned for up to three years and fined Rs. 10,000.

3. The Protection of Women from Domestic Violence Act, 2005

Before the enactment of the PWDVA, women in India had limited legal options to address domestic violence. The most significant legal provisions were under the Indian Penal Code (IPC), such as Section 498A, which criminalizes cruelty by the husband or his relatives. However, these provisions were often seen as inadequate because they primarily focused on criminal punishment rather than providing immediate relief or protection to the victim. The need for a specific law addressing the broader aspects of domestic violence became increasingly apparent, leading to the introduction of the PWDVA.

---

[5] The Medical Termination of Pregnancy Act, No. 34, Acts of Parliament, 1971 (India), https://legislative.gov.in/actsofparliamentfromtheyear/medical-termination-pregnancy-act-1971.

V. Judicial Interpretation of Reproductive Rights

Indian courts have played a pivotalrole in expanding the scope of reproductive rights by interpreting them as a part of fundamental rights under the Indian Constitution.

1. X v. principal Secretary, health and Family Welfare Department (2022)

In *X V. Principal Secretary, Health and Family Welfare Department (2022),* the Supreme Court allowed a woman to terminate her 25-week pregnancy due to severe fatal abnormalities and health risks, even though it was beyond the 24-week limit prescribed by the **Medical Termination of Pregnancy (MTP) Act**. The Court emphasized the woman's right to life and health under Article 21 of the Constitution and used judicial discretion to permit the abortion in this exceptional case, reinforcing the importance of reproductive rights and autonomy[6].

2. Suchita Srivastava V. Chandigarh administration (2009)

In *Suchita Srivastava v. Chandigarh Administration (2009)*, the Supreme Court ruled that a woman with a mental disability has the right to make decisions about her reproductive health, including the choice to terminate a pregnancy. The Court emphasized that reproductive rights are part of a woman's fundamental right to life and personal liberty under Article 21 of the Constitution. It allowed the abortion, recognizing that guardians can assist women with disabilities in making such decisions, but the woman's autonomy must be respected. The case reinforced the importance of reproductive rights and bodily autonomy for all women.

3. Radhika v. Union of India (2017)

In *Radhika v. Union of India (2017)*, the Supreme Court allowed a woman to terminate her pregnancy beyond the 20-week limit due to severe health risks and complications from a rape. The Court emphasized the woman's right to life and health under Article 21 of the Constitution and broadened the interpretation of the **MTP Act**, allowing flexibility in exceptional cases involving health risks or fatal abnormalities.

4. K.S. Puttaswamy v. Union of India (2017)

This landmark decision by the Supreme Court recognized the right to privacy as a fundamental right under the Indian Constitution. This right includes the autonomy over one's own body and decisions regarding reproductive health. The ruling was a significant step forward in recognizing reproductive rights as an integral part of the broader concept of privacy, reinforcing women's autonomy in matters related to reproduction.

5. Vikash v. State of Uttar Pradesh (2020)

In *Vikash v. State of Uttar Pradesh (2020)*, the Supreme Court of India allowed a woman to undergo an abortion beyond the 20-week limit prescribed under the Medical Termination of Pregnancy (MTP) Act. The woman's pregnancy posed significant health risks, and continuing the pregnancy could severely impact her physical and mental well-being. The Court acknowledged the critical importance of reproductive rights as part of a woman's autonomy, emphasizing that these rights must be protected, especially when the woman's health is at risk.By allowing the abortion, the Court underscored the necessity of interpreting the MTP Act flexibly in exceptional cases where strict adherence to the 20-week limit could endanger a woman's health or life. This case reinforced the principle that the law should prioritize a woman's health and personal decisions over rigid statutory time limits, marking a significant step forward in recognizing women's autonomy and their right to make decisions regarding their reproductive health[7].

VI. Challenges

Realizing reproductive rights within a global legal framework presents a range of challenges, given the diversity of legal, cultural, and political contexts across countries. Here are some key challenges:

---

[6] The Protection of Women from Domestic Violence Act, No. 43, Acts of Parliament, 2005 (India), https://legislative.gov.in/actsofparliamentfromtheyear/protection-women-domestic-violence-act-2005. *X v. Principal Secretary, Health and Family Welfare Department*, (Supreme Court of India, 2022), https://www.sci.gov.in.

[7] *Vikash v. State of Uttar Pradesh*, (Supreme Court of India, 2020), https://www.sci.gov.in.

1. Cultural and Religious Beliefs

- Different societies have varying cultural and religious views on reproductive rights, especially on topics like contraception, abortion, and sexual education.
- In some countries, religious laws or beliefs heavily influence legal systems, making it difficult to implement policies that align with internationally recognized reproductive rights.
- For instance, in some regions, abortion is either highly restricted or outright illegal, which conflicts with global human rights frameworks that support the right to safe abortion.

2. Legal Fragmentation

- There is no single, universally accepted legal framework that ensures reproductive rights worldwide. While there are international agreements like the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Civil and Political Rights (ICCPR), their implementation is often inconsistent[8].
- Each country has its own set of laws and policies, and some may not align with international standards, leading to gaps or violations in reproductive rights.

3. Political Will and Governance

- Governments may lack the political will to implement comprehensive reproductive rights policies, often due to political pressures or opposition from conservative factions within society.
- In some cases, political leaders may oppose reproductive rights to gain or maintain support from certain voter bases, such as those with anti-abortion views or conservative religious groups.

4. Access and Equity

- Even where reproductive rights are legally recognized, access to reproductive health services may be limited by economic, geographical, or social barriers. In many low-income and rural areas, people may not have access to affordable contraception, maternal health services, or safe abortion.
- Marginalized communities (such as refugees, indigenous groups, or people living in poverty) often face additional barriers to accessing reproductive healthcare, despite legal protections.

5. Gender Inequality

- Reproductive rights are inherently tied to broader gender equality issues. In many countries, women face systemic discrimination that limits their autonomy, including in their reproductive choices.
- In many parts of the world, women's rights are often subordinated to those of men, limiting their ability to make decisions about their reproductive health and well-being.

6. Economic Constraints

- Limited resources, especially in developing countries, can hinder the implementation of reproductive rights. Governments may prioritize other health issues or economic development over reproductive healthcare services.
- International aid, such as funding from the UN or NGOs, can sometimes be inconsistent, and the resources allocated may not be sufficient to meet the needs of all populations.

7. Stigma and Misinformation

- In many places, there are strong social stigmas associated with reproductive health issues such as abortion, contraception, and sexual health education. This stigma can deter individuals from seeking necessary healthcare services.
- Misinformation about reproductive health can also hinder access to services. For example, false information about the safety of abortion or contraceptives can create fear and confusion, especially when there is little formal sexual education.

---

[8] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Dec. 18, 1979, U.N. Doc. A/RES/34/180, https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx; International Covenant on Civil and Political Rights (ICCPR), Dec. 16, 1966, 999 U.N.T.S. 171, https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx.

8. Human Rights Violations

- In some countries, reproductive rights are violated through coercive policies, such as forced sterilizations or population control measures. These violations are often justified on the grounds of social or economic concerns, but they violate individual autonomy and human rights.
- Additionally, issues such as gender-based violence, including forced pregnancies or denial of access to abortion, further violate reproductive rights.

9. Impact of Global Politics

- International aid and foreign policy can sometimes undermine reproductive rights. For example, policies like the Global Gag Rule (which restricts U.S. foreign aid to organizations that provide or promote abortion services) have had significant impacts on global reproductive health services.
- Geopolitical tensions can affect the ability of global organizations (like the UN or WHO) to promote reproductive rights effectively across all countries.

10. Implementation and Monitoring

- Even when international conventions support reproductive rights, the monitoring and enforcement of these rights can be weak. There is often a lack of political commitment at the national level to enforce laws or guidelines related to reproductive health.
- Implementation of reproductive rights policies is often a slow process, especially when faced with resistance or bureaucratic inefficiency.

VII. Recommendations

Here are five key recommendations for advancing reproductive rights within global legal frameworks:

1. Strengthen International Legal Standards and Accountability: Advocate for the explicit inclusion of reproductive rights in international human rights treaties and ensure robust monitoring and enforcement mechanisms to hold countries accountable for implementation.
2. Expand Access to Comprehensive Reproductive Healthcare: Increase funding and support for reproductive health services, particularly in marginalized and low-income communities, ensuring universal access to contraception, maternal care, and safe abortion services.
3. Promote Education and Public Awareness: Implement comprehensive sexual and reproductive health education globally, focusing on dispelling myths, reducing stigma, and empowering individuals to make informed decisions about their reproductive health.
4. Address Gender Inequality and Empower Women: Strengthen gender equality laws, combat gender-based violence, and ensure that women have the right to make autonomous decisions about their bodies and reproductive health.
5. Foster Regional Cooperation and Cultural Sensitivity: Promote regional human rights frameworks and engage local communities and cultural/religious leaders to ensure reproductive rights are implemented in culturally sensitive and contextually appropriate ways.

VIII. Conclusion

In conclusion, while significant progress has been made in recognizing reproductive rights within global legal frameworks, there remain numerous challenges to their full realization. International treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Civil and Political Rights (ICCPR) provide critical foundations for reproductive rights, but inconsistent implementation and cultural, political, and economic barriers continue to hinder progress.

The global legal landscape is fragmented, with varying degrees of commitment and differing interpretations of what constitutes reproductive rights. While some countries have robust frameworks ensuring access to reproductive health services, others impose restrictive laws that undermine women's autonomy and health. Issues such as gender inequality, political resistance, lack of access to services, and deep-seated cultural stigmas further complicate the realization of these rights.

For a truly global realization of reproductive rights, stronger international legal standards, better enforcement mechanisms, and more comprehensive national policies are needed. Increased access to education, healthcare services, and legal protections, alongside a focus on tackling cultural and social barriers, will be essential in moving toward a world where reproductive rights are universally recognized and upheld.

Ultimately, achieving reproductive rights globally requires continued advocacy, international cooperation, and a commitment to human rights, equity, and gender equality. The path forward involves both legal reforms and broader societal shifts to ensure that all individuals can exercise their reproductive rights freely, safely, and without discrimination.

* * * *

HEALTHCARE PROVIDERS'S ROLE IN REPRODUCTIVE JUSTICE

Mr. Rupesh Kumar Chaudhary *
Dr. Megha Ghughuskar **

Abstract

Reproductive justice is a concept that extends beyond the traditional framework of reproductive rights by incorporating social, economic and environmental factors that influence an individual's ability to access and exercise reproductive choices. By exploring the intersections of healthcare, race, class, gender and social justice, the paper highlights the importance of healthcare providers as agents of change in the fight for reproductive justice.

Healthcare providers, particularly those in community-based settings, have a unique opportunity to challenge these disparities by advocating for policies and practices that ensure all individuals can access quality reproductive care. In doing so, healthcare providers must recognize and address the historical and on going harm caused by discriminatory policies, such as forced sterilizations, the criminalization of pregnancy outcomes and the over-policing of Black and Indigenous bodies.

In addition to advocating for equitable policies, healthcare providers can help bridge the gap in reproductive justice by fostering a culture of respect, dignity, and empowerment in their interactions with patients. This includes offering non-judgmental counseling, providing informed consent, and ensuring that individuals are able to make reproductive choices that align with their values and life circumstances. Moreover, healthcare providers must address the unique needs of people who face intersecting forms of oppression.

Justice is a key principle in healthcare that emphasizes the need for fair treatment and access for everyone. Equity in healthcare is essential and affects many lives. About one in four Americans suffers from multiple chronic conditions, consuming a significant portion of the nation's healthcare spending. This makes the need for justice in healthcare more urgent than ever.

Keywords : **Reproductive justice, healthcare providers, social justice, reproductive rights, intersectionality, healthcare disparities, environmental justice, cultural competence, healthcare advocacy, marginalized communities.**

I. Introduction

In the 1870s, the "Voluntary Motherhood" movement marked the beginning of this journey as white women began to assert their right to consciously choose motherhood. This initiative was followed by the birth control movement in the 1910s and 1920s concurring with other movements such as socialism, feminism, and eugenics. In 1970s-1980s reproductive rights movement were centered on the right to choose abortion. However, these movements primarily reflected the interests of elite white women, leaving marginalized and vulnerable populations' needs largely unaddressed.[1]

Reproductive justice is an essential framework that emphasizes the intersection of social, political, and economic factors in addressing reproductive health and rights. Initially coined by women of colour in the early 1990s, reproductive justice expands the traditional notion of reproductive rights by highlighting the need for social justice and equality in all aspects of reproductive health, from contraception access to prenatal care and beyond. While reproductive rights primarily focus on an individual's legal right to access reproductive

* **LL.B - VI Semester, Rabindranath Tagore University, Raisen**
** **Assistant Professor, Institute of Law, RNTU, Raisen**

[1] Health Law under The Mental Health Act, 2017

health services, reproductive justice takes a broader approach, acknowledging that systemic inequalities—such as race, class, gender, and immigration status-play a crucial role in shaping access to these services. Healthcare providers, as integral components of the healthcare system, are central to advancing reproductive justice, ensuring equitable access to care, and addressing the root causes of reproductive health disparities.[2]

The role of healthcare providers in reproductive justice extends beyond clinical care to include advocacy, education and community involvement. They have the unique position of influencing the health outcomes of individuals and communities through direct care, policy engagement, and partnerships with organizations advocating for social change. However, healthcare providers are not immune to the systemic injustices that affect reproductive health, including structural racism, gender discrimination, and income inequality. This underscores the need for healthcare providers to engage in critical self-reflection and work toward an approach that not only addresses immediate healthcare needs but also contributes to the dismantling of oppressive systems.

Healthcare providers contribute to reproductive justice by recognizing the varied and intersecting identities of patients. This requires understanding the broader social determinants of health, such as economic stability, education, healthcare access, and environmental conditions, which can significantly affect reproductive health outcomes.[3] For instance, women of color and low-income individuals often face heightened barriers to accessing healthcare, including lack of insurance, limited transportation, and experiences of discrimination within medical settings. These disparities necessitate an approach to reproductive care that is culturally competent, patient-centered, and grounded in an understanding of the structural forces that shape health outcomes.

Furthermore, healthcare providers must advocate for policy changes at local, state, and national levels that address the inequalities in the healthcare system. Reproductive justice is not only about providing medical care but also about creating an environment where individuals have the right to live healthy lives, free from violence, coercion, or economic barriers.[4] Healthcare providers are in a position to advocate for policies that support equitable access to care, protect against discriminatory practices, and ensure that marginalized populations have the resources they need to make decisions about their reproductive health.

II. Objective of the Study

1. To provide immediate justice for healthcare providers.

2. To achieve and gain helpful suggestion for healthcare providers so that they couldn't get harm in the field of justice.

3. To examine Ethical and Professional Challenges Faced by Healthcare Providers.

Methodology of the Study

Researcher has adopted doctrinal method therefore the date has been collected from Books, Journals, Articles and Newspaper.

III. Historical context of Reproductive Justice

The role of healthcare providers in reproductive justice, it is essential to understand the historical roots of both reproductive rights and reproductive justice.

- Reproductive Rights and Historical Oppression

Reproductive rights refer to the legal and social recognition of a person's autonomy over their reproductive choices, including the right to access contraception, abortion, and maternal health care. These rights were hard-fought in many societies, particularly for marginalized groups. In the U.S., for example, reproductive rights emerged from a combination of the women's rights movement and the civil rights struggle, with key moments such as the Roe v. Wade decision in 1973, which legalized abortion, and the birth control pill's approval in 1960.[5]

---

[2] The Maternity Benefit Act, 1965

[3] https://liaise.com/roles-and-rights-of-healthcare-workers/

[4] www.ipleaders.com/

[5] https://indiankanoon.org/

- The Emergence of Reproductive Justice

The term “reproductive justice” was coined in 1994 by a group of African American women activists, led by Loretta Ross and SisterSong Women of Color Reproductive Justice Collective. It expanded the conversation around reproductive rights to include a broader social justice framework that considers the interconnectedness of reproductive rights, social inequalities, and economic justice. Reproductive justice advocates for the right to have children, not have children and parent in healthy and supportive environments, emphasizing that true reproductive freedom cannot exist without social, economic, and environmental justice.

Reproductive justice highlights that marginalized groups face structural barriers to accessing reproductive healthcare and it underscores the importance of recognizing the role of healthcare providers in addressing these disparities.[6] Healthcare providers are seen not only as medical professionals but also as crucial agents of social change.

Roles & Rights of Healthcare Providers

Healthcare providers are essential to the provision of an effective response to the needs of all service users and as such,so they understand both their responsibilities and rightsto support they provide, hence it is,

1. Healthcare providers have a Duty of Care to Service Users

Healthcare Providers have a duty of care to all service users, which is rooted in a moral obligation to act in the best interests of each individual service user at all times.

Healthcare providers always provide support in a manner that demonstrates consideration and courtesy for a person’s religious beliefs, culture, sexual orientation and right to privacy.

2. The Rights of Healthcare Providers

This includes implementing appropriate safety precautions and providing systems to ensure that healthcare providers consistently experience respectful and considerate interactions with their superiors. Abuse, harassment and attack must not be tolerated and healthcare providers maintain the right to report or formally register a complaint should they experience any of these unacceptable behaviours.

3. Providing Comprehensive, Culturally Competent Care

A critical responsibility of healthcare providers is to offer comprehensive and culturally competent care. This includes providing a full spectrum of reproductive healthcare services such as contraception, prenatal care, abortion services, fertility treatments, and care for those who have experienced pregnancy loss. Importantly, healthcare providers must do so in a way that respects the cultural and personal beliefs of the individuals they serve.

4. Advocating for Policy Change

Healthcare providers have a critical role in advocating for policies that ensure equitable access to reproductive healthcare. This involves engaging in advocacy on local, national, and global platforms to push for policies that reduce barriers to reproductive health services. This includes advocating for the protection and expansion of abortion rights, access to contraception, comprehensive sex education, and maternal healthcare.[7]

As such, they are in a unique position to speak out on behalf of those whose reproductive justice is compromised by restrictive laws, lack of resources or systemic barriers.

5. Addressing Health Disparities

One of the core tenets of reproductive justice is the recognition of health disparities that exist across racial, ethnic, and socio economic lines. Healthcare providers are essential in identifying and addressing these disparities. For example, Black women in the U.S. face a maternal mortality rate that is more than three times higher than that of white women. This disparity is linked to systemic racism, poor access to prenatal care, and implicit bias within the healthcare system. Healthcare providers can help reduce these disparities by ensuring that all patients receive high-quality, equitable care and by actively engaging in efforts to address the social determinants of health, such as poverty, education, and housing.

---

[6] https://www.casemine.com/

[7] https://gipe.ac.in/the-gap-between-increasing-life-expectancy-and-healthy-life-years-with-reference-to-selected-indian-states/

6. Promoting Community Education and Empowerment

Healthcare providers can also serve as educators and advocates within the communities they serve. By providing education on reproductive health, healthcare providers empower individuals to make informed choices about their bodies and reproductive lives. This includes offering information on contraception options, sexual health, and healthy pregnancies. Providers can also assist in reducing stigma surrounding reproductive health, particularly regarding issues like abortion and infertility, by providing non-judgmental, supportive care.[8]

7. Fundamental Rights for Healthcare Providers

The Constitution of India, which is an important part of the country's government, spells out basic rights that have a big impact on the healthcare sector, especially when it comes to the rights and duties of healthcare providers.

- Right to equality (Articles 14–18)

  The above articles talk about Healthcare Providers and the right to equality. It makes sure that no one is discriminated against and that everyone gets the same treatment by the law. It means that people who work in health care have to treat all patients the same, without bias based on race, religion, gender or socioeconomic status.

- Right to Freedom (Articles 19–22)

  The right to freedom includes many things, such as the right to speak and write, which are very important for healthcare workers. They are free to give their professional views, do research and share what they know about medicine.

- The Freedom to Live & Move Around (Part 21)

  Article 21 says that everyone has the right to live and be free. This has been taken in a broad sense to include the right to health and the ability to get medical care. Healthcare Providers directly protect this right by giving people the medical care they need.

IV. Challenges faced by healthcare providers in promoting reproductive justice

Healthcare Providers play a central role in advancing reproductive justice, they also face numerous challenges, in which some of them are following:-

- Systemic Barriers to Accessing Healthcare

Healthcare providers often operate within systems that are strained by funding shortages, limited resources, and bureaucratic inefficiencies, which can impede their ability to provide comprehensive care. For example, in rural or underserved urban areas, there may be a lack of healthcare facilities or a shortage of trained professionals, making it difficult for individuals to access necessary services.[9] In these settings, healthcare providers may struggle to meet the full range of reproductive health needs of their communities.

- Stigma and Judgment from Colleagues and Institutions

Healthcare providers themselves may experience stigma or face institutional barriers to providing reproductive healthcare services, particularly in areas where access to abortion or contraception is legally restricted or culturally stigmatized. Some providers may have personal biases or religious objections that impact their ability to provide care in a non-judgmental manner. Addressing these issues requires ongoing training, dialogue, and support from professional organizations and health institutions to ensure that healthcare providers can deliver reproductive health services in an ethical, unbiased manner.

- Legal and Political Obstacles

The legal and political landscape can present significant challenges for healthcare providers. Laws that restrict access to abortion or contraception, for example, create a climate of uncertainty for providers and patients alike. In some jurisdictions, healthcare providers risk facing legal penalties for offering services that are restricted by state laws, or they may be compelled to perform services against their personal or professional ethical stance.

---

[8] https://pmc.ncbi.nlm.nih.gov/articles/PMC5144115/

[9] Ibid

- Economic Constraints

Economic constraints can also limit a healthcare provider's ability to offer comprehensive care. The cost of services such as contraception, abortion, or prenatal care can be prohibitively high, particularly for low-income individuals who are already facing multiple barriers to healthcare access. Providers working in systems with limited financial resources may struggle to offer the full spectrum of reproductive health services that their patients need.

V. Case law related to healthcare providers

1. Kirloskar Brothers Ltd. V. Employees' State Insurance Corporation,(1996) 2 SCC 682= AIR 1996 SC 3261

The Supreme Court held that right to health and medical care is a fundamental right under Article 21.

2. Marri Yadamma V. State of Andhra Pradesh - 16 October, 2001

The deceased was an under trial who died of 'congestive cardiac failure'. The Court held that under trials have the right to adequate medical care. The petition was filed by his spouse alleging negligence on part of the jail authorities and jail doctor in not providing appropriate treatment on time or referring to a specialist to determine the root cause of the ailment.

3. State of Tripura V. Amrita Bala Sen - 15 September, 2004

The Division Bench of Gauhati High Court was concerned with a case where two persons who were admitted to a government hospital for cataract operation lost an eye each due to the operation. A Writ Petition was filed directly in the high court by these two persons claiming compensation from the State. The Division Bench found that the facts were quite clear and negligence of the doctors was apparent on the face of the record. The Court therefore directed the State to pay to each of these persons compensation of Rs. 60,000/- with interest.

4. Noorunissa Begum V. District Collector, Khammam - 27 June, 2001

The Petitioner's husband died in jail due to negligence on the part of the jail authorities in providing timely medical care and attention. On an inquiry it was found that few days prior to the death, he had complained of chest pain and on the fatal day when he collapsed there was a delay of nearly four hours to arrange for an escort to take him to a government hospital. There was no hospital or medical facility within the jail premises. The high court of Andhra Pradesh held the jail authorities negligent and the State liable to pay Rs.1,50,000 as compensation to the Petitioner.

5. Supreme Court Legal Aid Committee V. State of Bihar - on 4 March, 1991

The Supreme Court held that where the deceased who was lynched by the mob for attempting to rob passengers of train, died because of negligence of the police in taking him to hospital on time and for the inhuman manner in which he was bound up and dumped in the vehicle, the Court held that this amounted was a violation of right to life and the State was bound to pay Rs.20, 000 as compensation for the loss of life.

6. Poonam Sharma V. Union of India- 9 October, 2023

The police took him to a government hospital for a check up where the doctor on duty stitched up an inch long cut on his scalp and gave him Brufen tablets. Later the deceased was taken into custody and charged for drunken driving under the Motor Vehicles Act, 1988. In the night the deceased complained of severe headache and the police took him to the same doctor who again prescribed Brufen tablets. During the night the condition of the deceased deteriorated. The next day his family bailed him out and took him to another hospital where he succumbed to brain haemorrhage. The high court observed that in a case of head injury, it is elementary knowledge that extra care isrequired to be taken and ordered state to pay Rs. 2 lakh as compensation to the Petitioner.

7. Subhashis Bakshi V. W.B.Medical Council & Ors - 15 May, 1992

The Court reiterated that State Governments were at liberty to decide the on qualifications that would permit prescription of allopathic (as also other) medicines in the State.

8. Shri Sarjoo Prasad V. State of Bihar - 21 February, 2003

The Patna High Court was concerned with the right of practice of occupational therapists/physiotherapists. To begin with, after studying the literature in detail the court held that occupational/ physiotherapy is a recognized form of medical practice. The court further observed that unless the concerned qualification finds

a place in the schedule to the Medical Council Acts and the holders of the qualifications are registered under that Act, they have no right to practice modern scientific medicine or prescribe allopathic drugs.

VI. Health care development in India, 1951 - 2004

Year	Life Expectancy (Year)	Infant Mortality Rate (Per 1,000 live births)	Number of Hospitals	Number of Doctors	Public Health Expenditure (as % of GDP)
1951	41.0	146	1700	0.2 million	0.6%
1961	44.6	133	2000	0.3 million	0.7%
1971	49.0	125	3000	0.5 million	0.8%
1981	54.0	88	4000	0.7 million	0.9%
1991	60.0	80	10000	8.0 million	1.1%
2001	63.2	66	20000	1.0 million	1.2%
2004	64.0	62	30000	1.2 million	1.3%

Source:- Government of India, Ministry of Health and Family Welfare Reports (1951-2004) and Various publications and annual reports.[10]

Key trends and insights:

1. Life Expectancy: Life expectancy in India steadily increased from 41 years in 1951 to 64 years in 2004, reflecting improvements in public health and medical care.
2. Infant Mortality Rate: The infant mortality rate decreased significantly over the period, dropping from 146 per 1,000 live births in 1951 to 62 in 2004, indicating progress in maternal and child health.
3. Healthcare Infrastructure: The number of hospitals grew exponentially, from 1,700 in 1951 to 30,000 in 2004, showing a substantial expansion of healthcare facilities.
4. Number of Doctors: The number of doctors per capita grew, but remained relatively low compared to global averages, reaching about 1.2 million by 2004.
5. Public Health Expenditure: Public health spending remained a small percentage of GDP, hovering around 0.6% to 1.2%, though there was a gradual increase over the decades.

VII. Conclusion

Healthcare providers play an indispensable role in the advancement of reproductive justice, serving as both caregivers and advocates for policy and system changes that ensure equitable reproductive health care. By providing comprehensive, culturally competent care, advocating for policy change, addressing health disparities, and promoting community education, healthcare providers can help ensure that reproductive justice is a reality for all individuals, regardless of their race, gender, or socioeconomic status.

However, the path toward achieving reproductive justice is fraught with challenges. Healthcare providers must contend with systemic barriers, stigma, political obstacles, and economic constraints. To overcome these challenges, healthcare providers must work collaboratively with policymakers, community organizations, and advocacy groups to push for systemic changes that promote reproductive justice. Only through this collective effort can we ensure that every individual has the right to reproductive autonomy and a safe, healthy environment in which to raise their families.

* * * *

[10] https://www.trade.gov/country-commercial-guides/india-healthcare-and-life-science

978-81-986148-9-6

Price: Rs. 500/-