

ENGENDERING JUSTICE

LEGAL RESPONSES TO
WOMEN'S RIGHTS
IN INDIA

Prof. (Dr.) Geetanjali Chandra | Khushboo Israni



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Engendering Justice:

Legal Responses to Women's Rights in India

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Edited by

Prof. (Dr.) Geetanjali Chandra
Khushboo Israni



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About the

Engendering Justice to Women's Rights is a timely and insightful book that critically examines the response to gender violations of women's rights, statutes and landmark cases, highlights implementation, why constitutional provisions often remain unrealized. The volume covers nine personal laws, constitutional workplace sexual harassment, violence, property and international human rights participation, employment in the criminal justice system, legal analysis, case law and practical recommendations connect legal principles to challenges. Drawing on workplace POSH experience, perspectives, the book provides insights for law students, judicial aspirants, law policymakers, HR practitioners, rights advocates. More Engendering Justice sets an intellectual roadmap for institutions, advancing promoting meaningful change in India.

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Reproductive Rights and Bodily Autonomy: Law, Ethics, and Women's Health Governance

Aakansha Verma*, Prof. (Dr.) Naseem Ahmed**

1. Introduction

Reproductive rights encompass the right to decide whether, when, and with whom to have children; access to safe and legal abortion, reproductive healthcare, and contraception; and freedom from coerced reproductive intervention. They are integral to women's bodily autonomy and central to gender equality.¹ The legal governance of reproduction is, accordingly, a site of intense normative contest: between women's claims to self-determination and State interests in population policy and public health; between secular human rights frameworks and religious or cultural norms; and between the formal recognition of reproductive rights and the conditions of their practical realization.²

The law of reproductive rights in India is complex and multi-layered. It comprises the "Medical Termination of Pregnancy Act,

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1 Nivedita Menon, *Recovering Subversion: Feminist Politics Beyond the Law* 102 (Permanent Black, New Delhi, 2004).

2 Vrinda Narain, "Reproductive Rights and the Constitution in India" 23 *Feminist Legal Studies* 221 (2015).

1971",³ as substantially amended in 2021,⁴ the "Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994",⁵ the "Surrogacy (Regulation) Act, 2021",⁶ and a body of constitutional case law recognizing reproductive rights as a facet of the right to life and personal liberty under Article 21.⁷ This legislative and constitutional architecture reflects the multiple, and sometimes competing, concerns that have shaped reproductive governance in India.⁸

The chapter proceeds as follows. Section II examines the constitutional basis of reproductive rights. Section III analyses the framework of the MTP Act, including the 2021 amendments. Section IV addresses the PCPNDT Act and the challenge of sex-selective abortion. Section V examines the regulation of surrogacy and assisted reproduction. Section VI considers the intersectional dimensions of reproductive governance, including coercive sterilization. Section VII surveys the international human rights framework. Section VIII concludes.

2. The Constitutional Foundation: Article 21 and Reproductive Autonomy

The right to reproductive autonomy in India has been progressively elaborated from the right to life and personal liberty under Article 21.⁹ In *"Maneka Gandhi v. Union of India"*,¹⁰ the Supreme Court held that the right to life is the right to live with dignity and encompasses all that gives life its meaning. Subsequent decisions established that reproductive choice is an element of personal liberty: the right to decide whether to bear a child, the choice of partner, and the conditions necessary for a healthy pregnancy and delivery fall within the protection of Article 21.¹¹

3 The Medical Termination of Pregnancy Act, 1971 (Act 34 of 1971).

4 The Medical Termination of Pregnancy (Amendment) Act, 2021 (Act 8 of 2021).

5 The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (Act 57 of 1994).

6 The Surrogacy (Regulation) Act, 2021 (Act 47 of 2021).

7 The Constitution of India, art. 21.

8 Indira Jaising, "Women's Health and Rights in the Indian Legal System" 45 *Economic and Political Weekly* 62 (2010).

9 K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

10 Maneka Gandhi v. Union of India, AIR 1978 SC 597.

11 Francis Coralie Mullin v. Administrator, Union Territory of Delhi, AIR 1981 SC 746; B.K. Parthasarathi v. Government of Andhra Pradesh, AIR 2000 AP 156.

The most authoritative statement of reproductive rights as constitutional rights came in "*Suchita Srivastava v. Chandigarh Administration*",¹² which arose from the question whether a woman with intellectual disability, in State care and pregnant as a result of rape, could be compelled to undergo termination. The Supreme Court held that the exercise of reproductive choice whether to continue or to terminate a pregnancy; is a facet of personal liberty and dignity under Article 21, and that any interference with that choice demands compelling justification. The decision anchored reproductive autonomy in the constitutional structure itself, marking a paradigm shift from the earlier, welfare-oriented understanding.¹³

Subsequent decisions have given further content to the constitutional dimension of reproductive rights. In "*X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi*",¹⁴ the Supreme Court held that unmarried women are entitled to the same rights under the MTP Act as married women; that conditioning access to safe abortion on marital status offends Articles 14 and 21; and that the right to bodily autonomy includes the right to choose to terminate an unwanted pregnancy. The decision marked a significant movement towards a rights-based, rather than policy-based, understanding of abortion access in India.¹⁵

3. The Medical Termination of Pregnancy Act: Framework and Reform

"The Medical Termination of Pregnancy Act, 1971" was enacted primarily as a public health and population policy measure rather than as recognition of women's reproductive autonomy. The Act permits termination of pregnancy up to twenty weeks where one or, depending on gestational age, two registered medical practitioners are of the opinion, formed in good faith, that continuance of the pregnancy would risk the life of the woman or grave injury to her physical or mental health, or that there is a substantial risk of serious foetal abnormality.¹⁶ The pivotal role

¹² *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

¹³ *Ibid.*

¹⁴ *X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi*, 2022 SCC OnLine SC 1321.

¹⁵ *Ibid.*

¹⁶ *Supra* note 3, s. 3(2).

assigned to medical opinion, rather than to the woman's own decision, reflects the Act's original orientation towards medical gate keeping rather than reproductive self-determination.¹⁷

"The Medical Termination of Pregnancy (Amendment) Act, 2021" introduced significant reforms.¹⁸ The gestational limit was extended from twenty to twenty-four weeks for specified categories of vulnerable women; including survivors of rape and sexual assault, minors, women with disabilities, and women in humanitarian settings; whose access to timely services had repeatedly been obstructed by the need to seek judicial authorization.¹⁹ Equally significant, the amendment substituted the words "any woman or her partner" for "any married woman or her husband" in the Explanation concerning contraceptive failure,²⁰ thereby extending that ground for termination to unmarried women and decoupling lawful access to abortion from marital status.²¹

The judicial enforcement of abortion rights has been marked by a series of cases in which women in desperate circumstances; survivors of rape, women whose foetal abnormalities were detected after twenty weeks, women with life-threatening conditions; sought judicial authorization for termination beyond the statutory limits. The Supreme Court and the High Courts have generally responded with a liberal and rights-oriented approach, granting permission and directing public hospitals to provide services.^{22,23} These cases expose the inadequacy of a gestational-limit framework for protecting the rights of all women, and the need for a more principled approach grounded in bodily autonomy.

4. Sex-Selective Abortion and the PCPNDT Act

India's deeply rooted preference for sons; the product of patriarchal social structures, the perceived economic burden

¹⁷ Supra note 3, s. 3(4).

¹⁸ Supra note 4.

¹⁹ Supra note 4, s. 3(2)(b) read with r. 3B of the Medical Termination of Pregnancy Rules, 2003 (as amended in 2021).

²⁰ Supra note 4, s. 3(2), Explanation 1.

²¹ Ibid.

²² Meera Santosh Pal v. Union of India, (2017) 3 SCC 462.

²³ Z v. State of Bihar, (2018) 11 SCC 572.

of daughters, and the cultural assignment of religious rites to male offspring; has found expression in the widespread practice of sex-selective abortion. The deterioration of the sex ratio in several States, documented by successive censuses and surveys, reflects the elimination of female foetuses through pre-natal sex determination followed by selective termination.²⁴

"The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994" was enacted to address this crisis. The Act prohibits the use of pre-natal diagnostic techniques for sex determination, requires the registration of all facilities offering such services, and criminalizes the conduct and advertisement of sex determination tests.²⁵ In "*CEHAT v. Union of India*",²⁷ the Supreme Court exercised continuing supervision over the Act's implementation, reviewing State compliance and issuing enforcement directions across successive hearings. In "*Voluntary Health Association of Punjab v. Union of India*",²⁸ the Court again underscored the government's obligation to strengthen the Act's enforcement machinery, characterizing the declining sex ratio as a grave social, public health, and human rights emergency.

The PCPNDT Act has also drawn feminist critique. The Act's restrictions may affect women's reproductive decision-making more generally by limiting the information available to them about foetal health, and its enforcement has occasionally been directed against legitimate medical procedures. More fundamentally, the underlying pathology; the social devaluation of girls and women; is not one that criminal law alone can cure: it demands long-term investment in education, economic empowerment, and the transformation of gender norms.²⁹

5. Surrogacy, Assisted Reproduction, and Women's Rights

Commercial surrogacy in India expanded rapidly from the early 2000s, generating regulatory questions that first reached the

²⁴ Ministry of Health and Family Welfare, National Family Health Survey-5 (2019–21): India Report (Government of India, 2022).

²⁵ Supra note 5, ss. 4, 6 and 18.

²⁶ Ibid., ss. 22 and 23.

²⁷ Centre for Enquiry into Health and Allied Themes (CEHAT) v. Union of India, (2003) 8 SCC 398.

²⁸ Voluntary Health Association of Punjab v. Union of India, (2013) 4 SCC 1.

²⁹ Supra note 1.

Supreme Court in *"Baby Manji Yamada v. Union of India"*³⁰ and the Gujarat High Court in *"Jan Balaz v. Anand Municipality"*,³¹ both of which exposed the absence of a legislative framework governing surrogacy arrangements and the citizenship and parentage of children born of them. "The Surrogacy (Regulation) Act, 2021" and the "Assisted Reproductive Technology (Regulation) Act, 2021" now supply a comprehensive statutory framework.^{32,33}

The Surrogacy Act prohibits commercial surrogacy; arrangements in which the surrogate receives payment beyond medical expenses and insurance; and permits only altruistic surrogacy, for specified medical indications and subject to eligibility conditions.³⁴ The legislation has been criticized by feminist scholars and surrogacy rights advocates as paternalistic and as denying poor women the economic agency to make reproductive decisions they regard as beneficial.³⁵ The prohibition, though aimed at preventing exploitation, removes a significant source of income from economically marginalized women who might freely choose surrogacy as a livelihood. The tension between preventing reproductive exploitation and respecting reproductive agency remains unresolved in the current framework.³⁶

6. Coercive Sterilisation and Intersectional Dimensions

The history of reproductive governance in India also includes the systematic violation of reproductive rights through coercive sterilization. The mass sterilization campaign of the Emergency (1975–1977), though directed largely at men, remains the most extreme instance of the State's appropriation of the body for population control; in its aftermath, the family planning programme shifted its focus overwhelmingly to the sterilization of women. The subsequent regime of incentive payments and provider targets operated as a form of structural coercion; formally

³⁰ *Baby Manji Yamada v. Union of India*, (2008) 13 SCC 518.

³¹ *Jan Balaz v. Anand Municipality*, AIR 2010 Guj 21.

³² *Supra* note 6.

³³ The Assisted Reproductive Technology (Regulation) Act, 2021 (Act 42 of 2021).

³⁴ *Supra* note 6, s. 4.

³⁵ Sama Resource Group for Women and Health, "Surrogacy and Women's Reproductive Rights in India" 47 *Economic and Political Weekly* 27 (2012).

³⁶ *Supra* note 2.

voluntary, but exerting economic pressure on the poorest women in ways never openly acknowledged.³⁷

The deaths of women in mass sterilization camps in Chhattisgarh; the result of unsafe procedures, contaminated supplies, and numerical targets; came before the Supreme Court in *Devika Biswas v. Union of India*.³⁸ The Court issued wide-ranging directions, including the discontinuation of sterilization targets, the prescription of quality standards for sterilization services, and compensation for the families of women who had died.³⁹ The earlier decision in *Ramakant Rai v. Union of India*⁴⁰ had already addressed the insanitary conditions of sterilization camps, directing that sterilization procedures conform to the standards of a properly equipped hospital. Coercive sterilization falls disproportionately on Dalit, Adivasi, and poor women; a pattern that mirrors the intersections of gender, caste, and class in the governance of reproduction.⁴¹

7. International Human Rights Framework

The international human rights framework for reproductive rights rests on multiple instruments and their authoritative interpretation. Article 12 of CEDAW requires States Parties to take all appropriate measures to eliminate discrimination against women in healthcare, including services relating to pregnancy, confinement, and the post-natal period.⁴² The Programme of Action of the "International Conference on Population and Development" (Cairo, 1994) articulated reproductive health as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system, and affirmed the right of individuals to decide freely and responsibly the number, spacing, and timing of their children.⁴³ The Beijing Platform for Action (1995) endorsed and extended these commitments.

³⁷ See *Devika Biswas v. Union of India*, (2016) 10 SCC 726 (tracing the history of target-driven sterilisation programmes).

³⁸ *Ibid.*

³⁹ *Ibid.*

⁴⁰ *Ramakant Rai v. Union of India*, (2009) 16 SCC 565.

⁴¹ Mohan Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic* (Sage Publications, New Delhi, 2004).

⁴² Convention on the Elimination of All Forms of Discrimination against Women, 1979, art. 12.

⁴³ Programme of Action of the International Conference on Population and Development (Cairo, 1994), paras. 7.2–7.3.

General Recommendation No. 24 of the CEDAW Committee, on women and health, specifically addresses the obligations to provide access to safe abortion and post-abortion care, to remove punitive measures against women who undergo abortion, and to protect women from coercive reproductive interventions. India's compliance with these obligations; in respect of unsafe abortion, the sex-selective elimination of female foetuses, and the coercive sterilization of marginalized women; has been evaluated and found wanting across successive review cycles.

8. Conclusion

The legal position of reproductive rights in India is layered and contested. The Constitution supplies a strong normative foundation for women's reproductive autonomy, developed over time through the interpretation of Article 21. The legislative framework; the MTP Act and its 2021 amendment, the PCPNDT Act, the Surrogacy Act, and the ART Act governs distinct aspects of reproduction with varying degrees of sensitivity to women's autonomy and agency.

The MTP framework continues to subordinate the woman's decision to medical authorization. The constitutional promise of *X v. Principal Secretary* awaits full legislative incorporation. The PCPNDT Act sits uneasily at the intersection of reproductive healthcare and the prevention of sex discrimination. Coercive sterilization continues to fall most heavily on the most deprived women. And the intersections of caste, class, and gender shape access to reproductive healthcare in ways that formal legal rights do not capture. A genuinely rights-based approach to reproductive governance attentive to structural inequalities of power, centered on women's bodily autonomy, and faithful to India's international obligations remains an aspiration whose realization will require sustained political effort and institutional commitment.

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