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# **WOMEN'S REPRODUCTIVE RIGHTS IN INDIA: A SOCIO-LEGAL ANALYSIS**

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## **I. INTRODUCTION**

Every woman has an inherent right to choose how she will use her body and therefore she has the right to make decisions regarding her reproductive health and reproductive rights free from external pressure or influence. The principle of autonomy applies to all aspects of a women's reproductive rights and subsequently affects her reproductive health. The basis for women's reproductive health is dependent upon both their right to privacy (right to make decisions concerning their reproductive health) as well as subsequently having the right to children (to be able to choose when to have children). The basis for an individual's right of privacy related to reproductive health and the ability to have children is contained in several different articles of the Constitution of India - primarily Article 14<sup>1</sup> (the right to equal treatment before the law) and Article 15<sup>2</sup> (the prohibition against discrimination against women).

This document's purpose is two-fold: to evaluate women's reproductive law in India and to put it in relation to the larger legal framework of India (constitution/legal provisions); to examine the women's reproductive rights' corresponding global obligations; and to illustrate through court decisions the chasm between the written letter of the law on women's reproductive rights versus how those laws have been followed in real life. Reproductive rights are often thought of as a basic human right; however, in this country, reproductive rights are restricted by the social and cultural constructs that deny the right to a woman.

## **II. CONSTITUTIONAL FRAMEWORK**

India's Constitution provides reproductive rights with solid foundation through Liberty, Equality and Dignity.

Article 21<sup>3</sup> -Right to Life and Personal Liberty-Supreme Court has Expanding Article 21 over

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<sup>1</sup> INDIA CONST. art. 14

<sup>2</sup> INDIA CONST. art. 15

<sup>3</sup>INDIA CONST. art 21

time includes Rakish to reside with dignity, privacy and self determination. In *Suchita Srivastava vs Chandigarh Admin* (2009)<sup>4</sup>, SC observes right of Woman to make Reproductive Choices form component of her personal liberty. The court held that Autonomy in relation to Reproductive matters was an integral part of a Women's Dignity.

Article 14<sup>5</sup>-Equality before Law-Reproductive Rights are also interconnected to Gender Equality, Denial of access to safe Abortion or Contraception impacts disproportionate Women; continues perpetuation Gender Inequality.

Article 15<sup>6</sup>-Non-Discrimination on grounds of Sex-This section support the Case that Reproductive Rights need to be safeguarded from Patriarchal authorities; an extension of Section, Again, male Dominion/Control over Women's Reproductive Rights will be challenged by Gender Based Discrimination.

Right to Privacy-**Justice K S Puttaswamy vs Union of India** (2017)<sup>7</sup>-established privacy as fundamental right under Article 21. This ruling also supports Reproductive Autonomy; the decision of an Individual as to whether/when to Procreate falls into private sphere/ belief.

Overall, these provisions create the legal foundation for Reproductive Rights. However, these rights require legislative and policy changes. Currently much of legal framework for these rights continues to restrict women's reproductive rights.

### III. LEGISLATION FRAMEWORK

#### 1. Medical Termination of Pregnancy (MTP)(Amendment) Bill, 1971<sup>8</sup>

The law governing abortion in India is under the MTP 1971. The Amendment 2021 to the MTP Act expanded the gestation limit for specific categories of women to 24 weeks and set up medical board(s) to determine if a case falls outside of 24 weeks. The law is progressive due to the increased access it has provided women regarding abortion(s) compared to before the amendment; however, it is still doctor-oriented rather than based

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<sup>4</sup> (2009) 9 SCC 1

<sup>5</sup> Supra 1

<sup>6</sup> Supra 2

<sup>7</sup> (2017) 10 SCC 1

<sup>8</sup> The Medical Termination of Pregnancy Act, 1971, No. 34, Acts of Parliament, 1971 (India)

on women's rights to make a decision about their pregnancy, as Women are Prthat they have met one or more of the category of conditions specified in the law, therefore taking away the right of women to make that ultimate decision about their pregnancy(s).

## 2. PCPNDT ACT<sup>9</sup>

The purpose behind the PCPNDT Act is to prevent sex selection abortions by regulating the use of diagnostic techniques. This law is significant for addressing the issue of sex selection, but its implementation has had an adverse impact on women vs. physicians. Many instances have occurred where women seeking legitimate diagnostic procedures have been denied because of the fear that physicians may face legal consequences.

## 3. FAMILY PLANNING POLICY AND NFHS-5

India's Family Planning Policies have ultimately focused on the use of sterilization as a form of contraceptive method, with females absorbing the most significant portion of the burden (37% of all contraception. Women restricting their ability to reproduce (have a baby) is often seen to meet population targets (demographically speaking). One example of gendered methods of controlling family-planning through the population goals of nations is sterilisation of women.

## IV. INTERNATIONAL HUMAN RIGHTS CONTEXT

The Indian reproductive rights framework cannot be fully appreciated without considering the greater international human rights law context into which it fits. As a party to a significant number of key international treaties, India is legally required to safeguard women's reproductive autonomy. At the same time, there exists a large gap between these obligations, as set out in international law, and actual practice here in India.

- **CEDAW** (the Convention on the Elimination of All Forms of Discrimination Against Women) was ratified by India in 1993 and is commonly referred to as the "international bill of rights for women". **Article 12 of CEDAW**<sup>10</sup> specifically requires States to eliminate discrimination in health care and to guarantee access to family planning services. The CEDAW Committee has consistently stated that reproductive rights are at the heart of women's equality, self-determination and dignity.

Previously, family planning programs in India have operated under a coercive model

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<sup>9</sup> Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, Act No. 57 of 1994, Acts of Parliament, 1994 (India)

<sup>10</sup> Convention on the Elimination of All Forms of Discrimination against Women art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13, 19 I.L.M. 33 (1980)

and have been heavily focused on sterilization of women. The countryside of India has faced a long history of not complying with CEDAW's requirement for women to access the full spectrum of contraceptive methods and for women to possess control over their bodies. The continuing prevalence of unsafe abortions indicates that India fails to provide women with the CEDAW-prescribed standard for safe reproductive health quality.

- **INTERNATIONAL COVENANTS ICCPR AND ICESCR**

The international covenants governing civil and political rights (ICCPR) and economic, social and cultural rights (ICESCR), in addition to CEDAW and judicial protection under **Article 17 of ICCPR**<sup>11</sup>, guarantee the right of every individual to enjoy a reasonable degree of health, protection of his/her personal privacy, and the conditions necessary to develop his/her family. **Article 12 of ICESCR**<sup>12</sup> identifies the right of everyone to enjoy the best level of health that can be reached, which includes all reproductive healthcare.

India's restrictive abortion laws — which require only doctors' approval and do not differentiate between women making choices about pregnancy termination compare — violate these obligations because they are centred on the physician. Thus, there is a violation of privacy and autonomy and thereby putting copies of reproductive decisions into the hands of others. Additionally, inadequate health care infrastructure, particularly in rural areas, prevents many women from reaching the level of "highest attainable standard of health" that the ICESCR intends.

- **INDICATIONS FROM THE UN HUMAN RIGHTS COMMITTEE**

The UN Human Rights Committee has called upon India, many times via various treaty monitoring bodies, to address the unsafe abortion practices that continue to exist in India and that there must be an increase in the availability of reproductive health care services throughout the country. The MTP Act has provisions for safe & legal abortion, but numerous unsafe abortions still occur in India due to: Stigmas related to abortion; A lack of knowledge regarding safe methods for obtaining an abortion; A lack of access to safe medical facilities. The difference between the provisions legally available &

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<sup>11</sup> International Covenant on Civil and Political Rights art. 17, Dec. 19, 1966, 999 U.N.T.S. 171.

<sup>12</sup> International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S.3.

their effective practical implementation shows that India systematically fails to comply with requirements under International Law.

## **V. THE GAP BETWEEN LAW AND PRACTICE**

India has signed many international agreements and treaties that affirm international reproductive health as a basic human right. Although India has agreed to the terms of these treaties and has affirmed its support for women's reproductive health, on the national level, the country's laws and policies do not support women's rights regarding their control over their reproductive health and their decisions about the use of reproduction. India's domestic laws present an example of a nation with restrictive practices. In India, sterilisation remains the predominant form of contraception available to Indian women; as such, there exists no lawful means for most women residing within India's territory to access quality abortion services and/or assistance. This creates a gap between the commitments undertaken by India on the international stage and the measures that it employs on the domestic stage to fulfil those commitments, thus highlighting the need for an alignment between these two, if women's reproductive health is to be adequately provided for in the context of both domestic and international law and policy.

For women to ensure that they are able to access the various rights and protections created by the numerous international treaties that have been established for the benefit of women, India is required to implement domestic laws that conform to the stipulations of these treaties; therefore, by utilising a rights-based approach to reproductive health, there will be developed a solid legal framework that complies with applicable global standards established to ensure the protection of the rights of women.

## **VI. SOCIO-LEGAL DIMENSIONS**

The legal right to reproductive freedom in India is a part of the struggle against, and at times in conflict with, the existing socio-cultural reality for women. Patriarchy is a modified, but still prevalent force in India today. The reproductive autonomy of women continues to be dictated and determined primarily by their husband's or mother-in-law's or community elders because women are often not allowed to make their own decisions regarding their reproductive choices, this reinforces other cultural beliefs that women exist only to reproduce and contributes to female inequality.

The impact of stigma and social control on women considering abortion is considerable; many times they perceive abortion as immoral or "wrong" and opt not to pursue safe options due to that stigma. Healthcare providers reinforce that stigma through their provision of services and the way they communicate about safe options to women and the way they make moral judgments regarding abortions. In addition to causing a woman who aborts to endure secrecy (and be at a greater risk for unsafe practices), stigma is enlarged because of the presence of intersectionality.

Women at the margins of society- Dalit, tribal, economically disadvantaged- are more greatly affected by stigma in that they experience multiple barriers (e.g., fewer opportunities to access contraception, discrimination in accessing healthcare services, and higher rates of unsafe abortion) than all of the other women in India. Their experiences with reproduction illustrate that reproductive rights are much more than legal entitlements but rather the ways in which one's experience of abortion is affected by social issues such as caste, class, and geographical location.

The socio-legal dimensions of reproductive rights reveal that reproductive rights in India are embedded within social structures. It is therefore impossible to have reproductive autonomy simply through the legal recognition of reproductive rights without addressing issues of patriarchy, stigma, and inequality.

## **VII. JUDICIAL TRENDS AND CASE STUDIES**

Women have been granted access to their reproductive rights through the help of India's judiciary. Judicial intervention has enabled the courts to declare that reproductive autonomy is a fundamental right protected by article 21<sup>13</sup> of the Indian Constitution.

In the case of *Suchita Srivastava v. Chandigarh Administration*<sup>14</sup>, it was held by the Supreme Court of India in 2009 that "A woman's right to make her own choice in respect of her reproductive choices is within the ambit of her personal liberty." By doing so, the Supreme Court recognized that reproductive autonomous choices are directly related to a woman's dignity and privacy. The Supreme Court also found that a woman who is forcibly sterilized or

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<sup>13</sup> Supra 3

<sup>14</sup> Supra 4

denied access to an abortion has been denied her constitutionally safeguarded rights and remedies.

In a landmark ruling, the Supreme Court ruled in 2017 that women wishing to terminate their pregnancies due to serious fetal defects are entitled to do so regardless of when the legal limit was previously established. In *Meera Santosh Pal v. Union of India*, the Court emphasized its commitment to the health and dignity of women rather than simply adhering to time constraints placed on seeking abortions.

In these cases, courts are trending toward treating reproductive health as fundamental to people's lives. The trend has been to expand the definition of autonomy, as well as to provide for privacy and dignity. However, laws do not yet reflect the evolution of the courts. Current federal legislation (the Medical Termination of Pregnancy Act) is still primarily focused on the physician delivering care; thus, it is ultimately the physician who will make the decision as to whether or not a woman has the right to make autonomous decisions regarding her pregnancy. In summary, while there has been significant court advancement in terms of understanding and enforcing reproductive rights as fundamental to the individual's autonomy, the continued necessity for legislative action is evident; too often the court has laid the groundwork for reproductive rights to be treated as fundamental but without corresponding legislative action, a woman's autonomy continues to be compromised.

### **VIII. CHALLENGES AND GAPS**

Several challenges are present that continue to create obstacles within India with regard to reproductive rights despite some judicial interest in these areas. A primary concern around reproductive rights is that abortion laws have become too medicalized. Under the Medical Termination of Pregnancy Act (MTPA), medical practitioners determine if there is an appropriate reason for abortion, where a woman's right to choose, in fact, lies with the physician; essentially, it gives physicians' authority over the body of a woman, as it does not afford her autonomy.

Another barrier exists because many women in rural and poor areas may not know that they can legally get an abortion. There are many women who qualify for abortion under the Indian law. However, because of a lack of knowledge about the law(s) surrounding abortion and the

stigma often attached to abortions, many women do not access safe services to have their abortions done. There has been little success with creating a level of awareness within communities so that women are aware of their legal right(e), relating to having an abortion.

The challenges faced in enforcing the PCPNDT Act are many. In aiming to reduce the number of sex-selection abortions, rather than acting against medical practitioners, the Act has primarily penalized women. This has resulted in limited access to legitimate diagnostic services for women because diagnostic service providers fear prosecution under the PCPNDT Act.

The stigma surrounding abortion and contraception within many societies is an additional barrier. Conceiving abortion and contraception as being inherently immoral, some women are discouraged from seeking services. Similarly, some healthcare providers may impose their own moral opinions onto women, further contributing to the cultural stigma surrounding the use of available reproductive healthcare services. This cultural stigma also forces many women to resort to secrecy and increases their risk of obtaining an unsafe abortion.

As the above problems suggest, there is a significant disparity between progressive judicial interpretations of laws and regulations, and the restrictive legislative mandates under which reproductive health care operates. There has been recognition from the courts that reproductive rights are a fundamental right, yet legislation and policy still carry out a paternalistic and/ or stigmatizing role with regard to reproductive rights, thus it is necessary to address this at all levels including legislation, social, and systemic. If all the above barriers are not resolved through comprehensive reform, there will continue to be a disparity between reproductive rights in India as an ideal, and reproductive rights as an attainable fact.

## **IX. RECOMMENDATIONS**

- To strengthen reproductive rights in India, a holistic approach is needed. To begin with, legislation relating to abortion should switch from being governed by a "doctor-centred" approach to being based upon the recognition of a woman's right to terminate her pregnancy—upon request—up to certain limits established by international human rights standards—which will enable women to exercise their reproductive rights in respect to their reproductive health care.

- Conversely, it is critical to strengthen the infrastructure supporting access to healthcare, particularly for women living in remote/rural communities across the country; the improvement of reproductive healthcare will require the allocation of resources in order that medical facilities can be expanded and trained professionals are available to deliver safe abortion services to all women across Canada.
- If there is inadequate infrastructure, then rights granted by law are rendered useless.
- Awareness campaigns play an important role in eliminating stigma associated with making reproductive choices. Education campaigns need to place greater emphasis on the fact that abortion and contraception are both legitimate forms of healthcare rather than being classified as immoral acts. Awareness campaigns should also be designed to reduce stigma and discrimination among women and healthcare providers.
- The reproductive rights guaranteed by Article 21 of the Constitution need to be more explicitly defined. The courts have already declared reproductive autonomy has been defined within judicial interpretation of Article 21, but the enactment of any laws which clarify this will further bolster enforcement and provide uniformity in enforcement across the board.
- To solve the problems encountered by largely excluded women, it is essential to implement intersectional-based approaches that include: (i) Assistance and support for those women from Dalit, tribal and very poor backgrounds within population groups that cannot access contraceptive, safe abortion, and health services due to the lack of financial resources; and (ii) Observation of women from all class (within hierarchical caste systems) as well as region to ensure that all women have access to the aforementioned services in an equally successful manner.

This series of recommendations seeks to connect the gap that exists between what's written law and what is experienced. India can establish a system of reproductive health care that focuses on the right to autonomy; lefties to build capacity; reduce stigma; and integrate an understanding of intersectionality (the ways in which different forms of discrimination intersect). Changes to the law are one means by which to align with the country's international obligations and ensure women are treated with dignity and access justice.

## X. CONCLUSION

The reproductive rights of women are the foundation of women's dignity, autonomy, and equality. In India, women's reproductive rights have been established through both the constitution and the judiciary as fundamental rights that form part of personal liberty and privacy, and both have expanded the definition of reproductive rights to emphasise women's equality and dignity.

Nevertheless, barriers continue to be faced, legislation creates barriers to accessing reproductive healthcare; for example, the Medical Termination of Pregnancy Act provides for restrictive abortion access by requiring a medical decision by a healthcare provider, as opposed to where the woman exercises the right herself to choose to have an abortion; poor quality of healthcare services and lack of facilities create unsafe and/or unregulated abortions, particularly in rural areas; and patriarchal values, social stigma, and multiple forms of intersecting discrimination further limit women's exercise of their reproductive rights and ability to make informed and accountable choices about their reproductive health and well-being.

There is a great need for comprehensive reform to help bridge the divide between law and real-world conditions. A shift to a rights-based approach in legal systems, fortified by health infrastructure, as well as counter-stigmatizing awareness-raising campaigns are necessary steps to take in bridging that divide—for that to happen, we need the development of intersectional policies to ensure all women (especially marginalised women) can exercise their rights in an equitable manner.

Reproductive rights in India are still very much an idealistic concept and therefore need to be moved from paper into practice for women to be free to make their own choices regarding their bodies and their futures. For women to obtain autonomy over their bodies from the government, there must be available, affordable and culturally sensitive healthcare; effective policies that support women in exercising their reproductive rights; and, lastly, there must be cultural change to support women being autonomous through reproductive rights. Reproductive rights are about much more than simply meeting the international community's obligations under human rights law; rather, they are about providing justice for all individuals equally and with dignity.