The Indian Journal for Research in Law and Management

Open Access Law Journal – Copyright © 2026

Editor-in-Chief – Dr. Muktai Deb Chavan; Publisher – Alden Vas; ISSN: 2583-9896

THE ANATOMY OF AUTONOMY

Feminist Jurisprudential Analysis of Constitutional Progress and Contemporary Realities of Reproductive Rights in India

- *Priyanshu Shishodia*

ABSTRACT

Reproductive freedom in India is locked in a heartbreakingly ironic paradox. As the Supreme Court gets more protective of bodily autonomy, actual laws in states become even more controlling and punitive. This paper examines the stark contrast between progressive judicial decisions concerning Article 21, including the landmark AIIMS Curative Petition [2026], and inviolable, rigid, nineteenth-century penal logic that continues to govern real-life medical treatment. The courts may assert that the pregnant body belongs wholly to the person. Still, India's legislative machinery insists on treating bodily autonomy as a conditional favour bestowed by the state and not an immutable human right.

This paper exposes the legal apparatus of India that it claims will protect its people, through a case analysis of the BNS, MTP Act, Code on Social Security and PCPNDT Act. The research shows, using an intersectional lens applied to data from the NFHS-5 and the e-Shram registry, that poverty and social vulnerability make metropolitan Medical Boards barriers to care. Whether it is disorganised female labourers affected by an unseen economic "child penalty" or rural health practitioners frozen in fear of criminalisation, the law functions to entrench a basic freedom behind gilded gates. Dismantling this medical paternalism and pro-choice agenda is a critical step towards gender equality, but true gender equality will require an overhaul of not just our institutional data ecosystem, but our entire health infrastructure, one that democratises healthcare and explicitly codifies reproductive justice into Indian statutory law.

Keywords: Reproductive Justice, Bodily Sovereignty, Feminist Jurisprudence, Medical Gatekeeping, Substantive Equality, Judicial Progressive, Right to Privacy, Medical Boards, Medical Paternalism; Foetal Viability

I. INTRODUCTION

Not only do reproductive rights occupy a highly contentious place within contemporary feminist jurisprudence because they implicate the biological capacity of a woman's body, but they constitute the very theatre in which competing visions of personhood, liberty and the scope of governmental authority are played out. Reproductive choices are really nothing less than the most fundamental property right she will ever have, the fundamental right to her own life and its direction.

Acknowledging that the right to reproductive choice is a constitutionally enforceable right, therefore, accepts a particular model of the human person—not merely as a biological vessel; not simply as a demographic/quotidian unit, but rather as one with full rights-bearing capacity—one who has the autonomy to self-define.

Grounded in the architecture of the *ICPD (Cairo, 1994)) Programme of Action*[1], human dignity reframes reproductive health from a narrow biomedical definition not only as the mere lack of disease, but as a complete state of physical, mental and social well-being across the entire ecosystem of reproduction. This framework empowers individuals and couples to plan their own lives with informed access to safe, affordable and acceptable family planning methods. Building on this bare minimum, it enshrines these rights into general human rights principles declaring that reproductive autonomy is based on core liberty: the right of everyone to make decisions about the spacing, timing and numbers of children they have without interference from discrimination, coercion or violence along with access to sexual and reproductive health services striving for an optimal standard.

India's strange legal challenge is that, over the last two-and-a-half decades, its constitutional courts have adopted this broad vision with near-cheering progressivism

[1]International Conference on Population and Development, Programme of Action, para. 7.2–7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1994); Convention on the Elimination of All Forms of Discrimination Against Women arts. 12, 16(1)(e), Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].

while its statutory architecture remains stuck in a pre-independence criminal prohibition framework. Reflective of these international standards, Article 16(1)(e) of the *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*[2] ties gender equality to bodily autonomy by guaranteeing women the same rights as men in determining the timing and size of their families. It creates a positive obligation on states, to provide women with the information, education and resources necessary to make these family planning rights real.

The provision is an undergirding pillar of reproductive autonomy from the perspective of international law and serves as a shield against large systemic abuses, prohibiting atrocities such as forced sterilization or coerced contraception or other forms of violence wielded by restricting access to comprehensive reproductive healthcare. It requires signatories to take tangible steps towards uprooting long-standing legal, cultural, and logistical frameworks that have traditionally limited a woman's ability to make choices concerning her reproductive future. India's position with regard to these instruments is further complicated by its exemptions, creating a dichotomy between an international obligation and deference to domestic personal law. The constitutionalisation of reproductive rights in the country has been achieved more through judicial interpretation than legislative action. The first explicit recognition of reproductive choice as part of the right to personal liberty under Article 21 by the Supreme Court can be found in *Suchita Shrivastava v. Chandigarh Administration (2009)*[3]*,* which stated that a woman's right to make reproductive choices is a direct consequence of her rights to personal liberty, privacy and bodily integrity. This established the groundwork, which was further strengthened by a nine-judge bench in *Justice K.S. Puttaswamy v. Union of India (2017)* [4] ,where it recognises that privacy is an integral facet of fundamental rights and clarifies that it includes personal autonomy over basic life choices, such as whether to procreate or not.

---

[2]CEDAW art. 16(1)(e). India ratified CEDAW on July 9, 1993, entering a reservation to Article 16(1) to the extent it conflicts with personal laws.

[3]Suchita Shrivastava v. Chandigarh Administration, (2009) 14 SCC 989 (holding reproductive choice flows directly from Article 21 personal liberty, privacy, and bodily integrity).

[4]Justice K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1, paras. 300–305 (Kaul J., concurring) (recognising privacy as an intrinsic fundamental right under Article 21 encompassing autonomy over core life decisions including the right to bear or not to bear a child).

But a deep and structurally ingrained tension remains. Its law often relegates the pregnant woman to the status of a mere beholder of medical examination and state protection instead of treating her as an active full-blooded right-holding subject entitled to sovereign decisions over her body and life.[5] This article explores that tension across four key domains of law - the BNS, the MTP Act, the CoSS and the PCPNDT Act, through an empirical lens, purposively engaging with recent trends in case law. The primary contention is that the feminist promise of reproductive autonomy cannot be achieved with judicial reform alone, and requires comprehensive statutory change.

II. THE GATEKEPT REPRODUCTIVE REGIME: A DOCTRINE AND STATUTORY CRITIQUE OF THE ILLUSION OF REFORM IN INDIA

A. THE CRIMINALIZED BASELINE AND THE ILLUSION OF LEGAL MODERNIZATION

When the *Bharatiya Nyaya Sanhita (BNS), 2023* [6] was introduced to Parliament, it was heralded as a modernising overhaul of India, s colonial criminal justice system flowing from the Indian Penal Code (IPC), 1860. However, a critical statutory deconstruction reveals that regarding reproductive bodily sovereignty, the state has merely repackaged 19th-century patriarchal control into 21st-century syntax. Sections 88 to 92 of the BNS preserve the foundational criminalisation of pregnancy termination in terms virtually identical to their colonial predecessors.

The retention of these punitive provisions establishes a hostile legal baseline: abortion remains fundamentally a crime in India, and the pregnant individual is positioned not as a rights-bearing subject, but as an object to be policed or protected by the state. Section 88 of the BNS expressly includes the pregnant individual within its penal dragnet, criminalizing anyone who causes their own miscarriage. In an era where medical abortion pills (mifepristone and misoprostol) constitute the vast majority of

[5]Dipika Jain & Payal K. Shah, Reimagining Reproductive Rights Jurisprudence in India: Reflections on the Recent Decisions on Privacy and Gender Equality from the Supreme Court of India, 39 COLUM. J. GENDER & L. 1, 14–17 (2020); see also Dipika Jain, Supreme Court of India Judgement on Abortion as a Fundamental Right: Breaking New Ground, 31 SEXUAL & REPROD. HEALTH MATTERS 1, 3 (2023).

[6]Bharatiya Nyaya Sanhita, 2023, ss. 88–92 (India) [hereinafter BNS]. The BNS replaced the Indian Penal Code, 1860, ss. 312–316.

early-stage terminations globally and domestically, the penal code effectively criminalizes the baseline reality of modern reproductive choices.

The statutory framework adheres to the outdated common-law concept of a woman being "quick with child," a nineteenth-century benchmark based on the subjective perception of foetal movement. This reliance reveals a significant disconnect between the penal code and modern reproductive medicine. By keeping abortion codified within a penal framework, the state retains ultimate control over the womb. Access to abortion is structured not as the exercise of an inalienable constitutional right to bodily integrity under Article 21, but as a revocable exemption granted under strict, state-supervised conditions.

B. THE PATERNALISTIC EXCEPTIONS: GATEKEEPING UNDER THE MTP ACT

If the BNS supplies the penal lock then the MTP Act 1971 as amended in 2021 is the one and only key tightly regulated. However, the core weakness of the MTP Act lies in its historical and structural basis. It was introduced mainly as a public health measure to reduce maternal deaths from unsafe abortions and control population growth, not as a philosophical commitment to reproductive rights. Therefore, the law is still overwhelmingly geared towards doctors and paternalistic.

Under the present framework of laws, an individual does not possess a direct, enforceable right to terminate a pregnancy. Instead, they possess a right to *request a medical evaluation*[7]. The law is based on a rigid gestational tier system that moves the locus of decision-making completely away from the pregnant person.

- Up to 20 weeks (section 3(2)(a)): requires the opinion of a single Registered Medical Practitioner.
- 20 to 24 Weeks (Section 3(2)(b)): Only available for rape victims, minors, disabled, or those with changed marital status, and requires the opinion of two RMPs.

[7] Medical Termination of Pregnancy Act, 1971, ss. 3(2)(a), 3(2)(b), 3(2B), 4, 5 (India) [hereinafter MTP Act]; Medical Termination of Pregnancy (Amendment) Act, 2021; Medical Termination of Pregnancy Rules, 2003, Rule 3B (India).

- Beyond 24 Weeks (Section 3(2B): Strips local medical providers of all authority, requiring individuals to go before a State-level, multi-disciplinary Medical Board to diagnose significant foetal abnormalities

  This tiered gatekeeping produces a sharp structural rights gap: if medical practitioners will not certify a claim, whether due to moral conservatism, institutional bigotry or fear of criminal liability under the residual BNS, the individual is denied access to safety.

  Furthermore, the structure of the Section 3(2B) Medical Boards perpetuates geographic and economic discrimination. These boards are almost exclusively confined to metropolitan tertiary hospitals, and as a result this statutory remedy is impractically inaccessible to rural, working-class, and poor The MTP Act leaves a gaping legal hole regarding self-managed medical abortions. Available remedies through pharmaceuticals notwithstanding, the statute does not provide any self-administration protocol, and such self-avowed 'voluntary' persons are therefore extremely vulnerable to prosecution under the BNS.

SUBSTANTIVE EQUALITY VS. DOCTRINAL FRAILTY

Indian constitutional courts have often intervened to correct these statutory flaws, creating a progressive jurisprudence that seeks to shift toward an activist approach. However, examining these landmark cases shows a stark gap between the advanced constitutional theory at the top, and the reality on the ground.

The pinnacle of Indian abortion jurisprudence is the Supreme Court's judgment in *X v. Principal Secretary, Health & Family Welfare Dept. (2022)*[8]. Here, the Court adopted a purposive rights-based interpretation to declare that no one, irrespective of marital status, has a right to safe and legal abortion up to 24 weeks, by invalidating the discriminatory exclusions under Rule 3B of Article 14. Crucially, the Court made two major doctrinal breakthroughs, read marital rape into the MTP Act's definition of rape (directly challenging the penal immunity of the old text), and held that doctors are not bound to reveal the identity of a minor in POCSO reports when she seeks an abortion. By saying that the *law should not choose beneficiaries of a social welfare statute*

[8] X v. Principal Secretary, Health & Family Welfare Dept., Govt. of NCT of Delhi, (2022) 14 SCC 1, paras. 45, 68, 82 (Chandrachud J.) (holding that distinctions between married and unmarried women in Rule 3B violate Art. 14; holding that 'rape' under the MTP Act includes marital rape; holding doctors not obligated to report a minor seeking abortion to police under POCSO).

according to narrow principles of permissible sex, the Court briefly severed reproduction from patriarchy.

This progression found its most dramatic validation in the emergency proceedings of the *AIIMS Curative Petition (2026)*[9]. In this case, a coordinate bench had allowed a 15-year-old rape victim to abort her 29-week pregnancy due to trauma. AIIMS filed a curative petition to stop the process, claiming the foetus was viable, and that the termination at 30 weeks was a preterm delivery and should have forced the minor to carry the pregnancy for four more weeks. The hospital's move was rejected by the Supreme Court with Chief Justice Surya Kant remarking that Unwanted pregnancy cannot be forced upon a person. Imagine! She is a child... But we want her to be a mother. The Court characterised it as a foetus versus child fight, ruling that a living survivor cannot be compelled to sacrifice her own life to sustain a potential life, and that the final decision must be left to the survivor and her family.

THE ACCESS GAP

Although the *X v. Principal Secretary* and *AIIMS Curative Case* progressive rhetoric did not stop India's reproductive rights regime from having a severe execution failure. Doctrinal triumphs at the Supreme Court are often not followed by grassroots healthcare.

This gaping disparity is starkly evident from the Bombay High Court's judgment in *ABC v. State of Maharashtra (2026).* A 26-year-old unmarried woman, impregnated by contraceptive failure, was forced to litigate at 22 weeks when public hospital doctors refused to perform a legal abortion. These frontline doctors cited moral objection and fear of criminal prosecution under the BNS, ignoring the fact that the Supreme Court had established her legality four years earlier. Although the High Court granted immediate relief and undertook Article 144 to direct the statewide dissemination of reproductive law to public health workers, the case highlights the systemic last mile problem. Constitutional rights are merely a dream when frontline healthcare providers are ignorant of or ideologically hostile to the law. The state's

[9] AIIMS Curative Petition, Bench of CJI Surya Kant & Justice Joymalya Bagchi (S.C. India Apr. 30, 2026) (dismissing curative petition against coordinate bench order of Justices B.V. Nagarathna & Ujjal Bhuyan dated Apr. 24, 2026 permitting 15-year-old rape survivor to terminate 29-week pregnancy; CJI calling for removal of gestational time limits for rape survivors); 'Unwanted Pregnancy Cannot Be Thrust Upon a Person,' THE TRIBUNE (India), Apr. 30, 2026; 'Doctors Cannot Decide for Patients,' LIVE LAW, Apr. 30, 2026.

inability to match its medical bureaucracy with its constitutional jurisprudence makes its progressive judgments an empty promise for the women who need them most.

C. THE LIMITS OF LIBERTY

Even after so much debate on the absolute sovereignty one has over choices over decisions over one's own body, reproductive autonomy is not absolute; it is bounded by socio-legal realities. In *Vinod Soni v. Union of India (2005)*[10], the Bombay High Court rejected a challenge to the PCPNDT Act, 1994, holding that the right to reproductive choice includes no right to the sex of the child.[11]

This case represents an important conceptual turn highlighting that reproductive autonomy does not exist in a vacuum. In a society grotesquely distorted by son preference, systematic female foeticide, and dowry-related extortion, an uncontrolled "right to choose" is a weapon of demographic genocide. (Confirmed by Census data indicating that child sex ratio has plummeted to a post-independence low of 914 girls per 1000 boys in 2011, but only recovering to 933 in SRS Statistical Report 2023; restriction of diagnostic information is a state intervention in gender justice). The Supreme Court reinstated this stance in *Dr. Sabu Mathew George (2017)*[12] by ordering popular search engines to categorically filter out sex-selection advertisements, calibrating the stance that individual reproductive liberty must be limited when it threatens a vulnerable demographic class.

This has been strongly supported by judicial interpretation. In the recent *Dr. Ramesh v. State of Maharashtra (2026)*[13], the Court has clarified, that routine clinical administrative forms, particularly Form 'F', cannot be brushed aside as mere bureaucratic formalities. The judiciary codified an unassailable statutory presumption under Section 4(3) of the Act, holding that any omission, shortcoming, or even clerical error in these papers directly transfers the burden of evidence onto the

---

[10] Vinod Soni & Anr. v. Union of India, 2005 SCC OnLine Bom 1151.

[11] Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, ss. 3A, 3B, 4, 5(2), 6, 16, 22 (India) [hereinafter PCPNDT Act]. As per Census 2011, the child sex ratio stood at 914 girls per 1,000 boys (0–6 years), the lowest since independence. The SRS Statistical Report 2023 shows improvement to approximately 933. See Office of the Registrar General & Census Commissioner, Census of India 2011: Child Sex Ratio Data (Govt. of India 2011); Sheida Tabaie, Stopping Female Feticide in India: The Failure and Unintended Consequence of Ultrasound Restriction, 7(1) J. GLOB. HEALTH 010304 (2017).

[12] Dr. Sabu Mathew George v. Union of India & Ors., (2017) 9 SCC 1, paras. 22–27.

[13] Dr. Ramesh v. State of Maharashtra, Criminal Appeal No. 2451 of 2026, 2026 INSC 635, paras. 14–18 (Supreme Court of India, judgment dated June 11, 2026).

medical practitioner. It accepts that regulatory mechanisms may contribute to female foeticide. The legal establishment makes thorough documentarian surveillance the major weapon against India's imbalanced sex ratio at birth, transforming normal healthcare documentation into an evidential conflict.

D. BROKEN WELFARE SYSTEM, ONLY FOR A FEW

Aside from physical termination, the state also does not deliver a proactive, rights-based framework for basic reproductive health and care. On paper, the 2020 Social Security Code (CoSS) appears progressive, following the incorporation of the Maternity Benefit Act of 1961. Section 60 develops crèches for larger firms and extends paid maternity leave to 26 weeks.[14]

With the foundational case of *MCD vs. Female Workers (Muster Roll) (2001)*[15], the Supreme Court successfully incorporated CEDAW's obligation as customary international law for providing maternity leaves to all women workers irrespective of their employment status. Courts have actively worked in these years to expand these protections by purposive interpretation. In *Deepika Singh v. Central Administrative Tribunal (2022)*[16], the Supreme Court went a step further to expansively interpret the plural family structure, declaring a woman's biological pregnancy be granted full maternity leave regardless of her husband's children from a previous marriage. In doing so, the Court also critiqued the law's reliance on the *"idealised, traditional nuclear family"* and accommodated single-parent households, blended families, and queer relationships, that deserve equal entitlements for such care. This non-biological model of what constitutes parenthood was seen being further pushed in *Hamsaanandini Nanduri v. Union of India (2026)*[17], where the Constitutional Court struck down the CoSS's three-month age cap for adoptive mothers as unconstitutional

---

[14] Code on Social Security, 2020, s. 60 (India) [hereinafter CoSS]; Maternity Benefit Act, 1961, ss. 4, 5, 9, 9A, 11, 12 (India). As per the Periodic Labour Force Survey (PLFS) 2023–24, approximately 61% of women workers in the non-agriculture sector are employed in informal sector enterprises. MoSPI, Consultation on Informal Sector in GDP Estimation (Jan. 30, 2025). The e-Shram portal database registered over 30.68 crore unorganised workers as of March 2025, of whom 53.68% were women. Ministry of Labour & Employment, e-Shram Statistical Report (Mar. 2025).

[15] Municipal Corporation of Delhi v. Female Workers (Muster Roll) & Anr., (2000) 3 SCC 224, at 236–38 (Ahmad J.) (citing Universal Declaration of Human Rights, G.A. Res. 217 (III) A, art. 25(2), U.N. Doc. A/RES/217(III) (Dec. 10, 1948); CEDAW art. 11(2)).

[16] Deepika Singh v. Central Administrative Tribunal, (2022) 11 SCC 1

[17] Hamsaanandini Nanduri v. Union of India & Ors., 2026 INSC 246 (S.C. India Mar. 17, 2026) (Pardiwala & Mahadevan JJ.) (striking down s. 60(4) of CoSS three-month age cap; calling for mandatory paternity leave legislation).

and having no rational nexus with any reasonable classification. The judgement effectively viewed maternity leave as something to do with emotional bonding and familial integration rather than just physical recovery.

However, despite these advancements in doctrines, the CoSS enforces a extremely unfair system of selective welfare as its current applicability relies entirely on a formal employer-employee relationships with an 80-day qualifying employment requirement of continuous service. This has thoroughly excluded the vast majority of Indian women workers. Data from the Ministry of Statistics and Programme Implementation (MoSPI) and the Periodic Labour Force Survey (PLFS) confirms that approximately 61% of women workers in the non-agriculture sector are employed informally. Moreover, the e-Shram portal registered over 30.68 crore unorganised workers, of whom 53.68% (approx. 151 million) are women.[18] These millions of women, working without any formal contracts, steady wages, or any social protections, are left invisible by the statute. Even though the court in *Hamsaanandini Nanduri* took a step forward by calling for mandatory paternity leave to challenge the inherent patriarchal assumption that caregiving is solely a female duty, the statutory text itself remains indifferent to the material realities of the informal sector women workforce in the first place.

III. BODILY SOVEREIGNTY ON TRIAL

A. SUBCONTRACTING CHOICE: THE LEGAL RELEGATION OF AUTONOMY TO THE 'EXPERT'

In India feminists are critical of how medical experts and women's rights clash. The Medical Termination of Pregnancy (MTP) Act does not give women rights. Instead, it allows doctors to decide if a woman can have an abortion. They are protected from punishment if they think the woman qualifies. This effectively means the doctor has the say, not the woman. This legal structure reduces female bodies to subjects of medical discretion, directly echoing the sentiment behind "no uterus, no opinion", a modern feminist slogan widely popularised by social media movements to protest the

[18]India Employment Report 2024, ILO & Institute for Human Development (2024) (finding 62.8% of employed women in agriculture in 2022 versus 38.1% of men, with women disproportionately concentrated in unpaid family labour and informal home-based work); World Economic Forum, Global Gender Gap Report 2024 (India ranked 129 out of 146 nations).

exclusion of women from decisions regarding their own reproductive health. By prioritizing clinical judgment over personal agency, the statutory framework supports what Carol Smart famously posited: “the law often ignores women’s experiences.[19]

Doctors often use their power to question a pregnant woman’s reasons for wanting an abortion. They might ask about her marriage, age or past pregnancies. This happens even though the law says women have the right to make this choice. Sometimes doctors and others involved in healthcare insist that a woman’s husband or family members must agree to her having an abortion. This is a reality on ground. It takes away a person’s power to decide about their own bodies.[20]

Another important observation is that such moral carceral policing does not only intimidate the seeker; it also incapacitates the provider too. Such fear transforms a medical intervention into a case of criminal liability. The state ends up creating this hostile ground where marginalized women are forced to navigate between being denied care, risking prosecution, or being pressured into having children they didn’t consent to carry.[21]

All of this isn’t just legal theory. It’s happening, right now, to real people. In rural India, studies show that public clinics regularly turn away women looking for legal abortions. The laws aren’t always the problem; it’s the people in charge. Doctors, driven by fear of legal trouble and shaped by patriarchal norms, use their power to just say “no.” Meanwhile, health workers like ASHAs get caught in their own bind: they’re supposed to help women but work inside deeply conservative communities where abortion is taboo. They risk being shunned or punished if they break from those community values, so they often mirror the same moral judgments. For them, enforcing the rules isn’t just about authority, it’s about protecting themselves, even if that means denying other women the right to choose.[22]

---

[19]CAROL SMART, FEMINISM AND THE POWER OF LAW 86 (Routledge 1989) (arguing that law systematically 'disqualifies' women's experiential knowledge from adjudicative inquiry).

[20] ANUBHA CHANDRA ET AL., LEGAL BARRIERS TO ACCESSING SAFE ABORTION SERVICES IN INDIA: A FACT FINDING STUDY 24-31 (Center for Reproductive Rights, National Law School of India University, & National Law University, Delhi, 2021).

[21] Dipika Jain, Beyond Bars, Coercion and Death: Rethinking Abortion Rights and Justice in India, 14 OÑATI SOCIO-LEGAL SERIES 99, 103-107 (2024).

[22] Victoria Boydell et al., Hostilities Faced by People on the Frontlines of Sexual and Reproductive Health and Rights: A Scoping Review, 8 BMJ GLOBAL HEALTH e012652, 3-6 (2023).

Frontline and community health workers do not just connect people to care they often bring their biases into the process. They pass along medical information make people wait too long and treat them with judgment or even hostility. This attitude is not a one-time problem. It builds up to the extent that women face unfair treatment in public health clinics. Even though the constitution says they have the right to end a pregnancy, clinics often tell them they can only get an abortion if they agree to birth control like sterilization. Instead of offering real care these clinics turn into places where women are forced to bargain with their own bodies.
This strips them of their rights and dignity.[23]

An insight into how things play out on the ground, *ABC v. State of Maharashtra (2026)* must be noted, in which an unmarried woman went to a government hospital hoping for the treatment the law promised. Despite the 2021 the MTP Act's amendment which replaces the word "husband" with "partner," expanding it's meaning to include consensual relationships, the on-ground reality was something which did not make a difference, the hospital still turned the request away.
The Supreme Court had already made it clear years ago. On paper the law is straightforward. In practice it all comes down to the people running the show. Doctors with their biases can basically ignore court orders and nobody stops them. Moreover, the rule also says a minor needs their guardian's consent under the MTP Act. Reading it with the Protection of Children from Sexual Offences Act (POCSO), it gets even more complicated. The law treats any sex involving a minor, as rape. So if a pregnant teenager needs an abortion, she cannot even get that easily if her parents force her to continue with the pregnancy.[24]

B. MAPPING THE MARGINS: INTERSECTIONALITY AND THE VARIED TOLL OF REPRODUCTIVE INJUSTICE

The struggle for reproductive autonomy looks vastly different depending on where a woman stands in society. Grounded in Professor Kimberlé Crenshaw's landmark theory of intersectionality, this section argues that reproductive oppression cannot be

[23] Bhuvaneswari Sunil, Running an Obstacle-Course: A Qualitative Study of Women's Experiences with Abortion-Seeking in Tamil Nadu, India, 29 SEXUAL & REPRODUCTIVE HEALTH MATTERS e1966218, 4-8 (2021).
[24] FACT SHEET, POCSO ACT & ADOLESCENTS' ACCESS TO ABORTION IN INDIA 2-4 (Center for Reproductive Rights, 2024).

understood through the lens of gender alone. Rather, it is an intricate web where gender bias meets and multiplies the burdens of caste, class background, financial hardship, and geographic remoteness. By moving past a one-size-fits-all view of women's experiences, we can better see how these colliding forces dictate who gets access to safe care and whose bodily autonomy is compromised.[25] In the Indian context, a wealthy, urban, upper-caste woman can navigate the MTP framework with relative ease through private healthcare networks. In sharp contrast, a poor, rural, Dalit woman confronts a matrix of exclusion: public health facilities are structurally under-resourced, caste prejudices permeate provider attitudes, and certified abortion facilities are concentrated in metropolitan hospitals under Section 4 of the MTP Act.[26] Empirical data from NFHS-5 (2019–21) corroborates this intersectional analysis. The survey found that among women who reported induced abortions, access to a qualified facility was strongly predicted by urban residence, education level, and economic positioning.[27] The formal legal entitlement to an abortion is thus, for vast segments of Indian women, entirely severed from the material capability to obtain one, rendering reproductive rights a promise in theory and an impossibility in practice. This is the structural violence of abstract rights-talk, the formal grant of liberty that the substantive denial of capability systematically negates.[28]

C. THE CARE-WORK ECONOMY AND THE CHILD PENALTY

The physical act of reproduction gives rise to an extensive, ongoing requirement for unpaid care work whose costs are overwhelmingly borne by women. The Supreme Court in *Deepika Singh (2022)* directly engaged with OECD data documenting that

---

[25]Kimberle Crenshaw, Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, 1989 U. CHI. LEGAL F. 139 (1989); Kimberle Crenshaw, Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color, 43 STAN. L. REV. 1241, 1242 (1991).

[26]Dipika Jain & Saptarshi Sengupta, Reproductive Rights and Disability Rights Through an Intersectional Analysis, 12 JINDAL GLOB. L. REV. 117, 122–25 (2021).

[27]National Family Health Survey-5 (NFHS-5) 2019–21, Ministry of Health & Family Welfare, Govt. of India (2022) [hereinafter NFHS-5]; Patterns and Predictors of Abortion Care-Seeking in India: Evidence From NFHS-5, 13(7) FRONTIERS PUB. HEALTH 1, 4 (2023) (finding 25.72% of pregnancy terminations among surveyed women were induced abortions and documenting a strong urban-rural care-access gradient). See also Registrar General of India, Sample Registration System: Special Bulletin on Maternal Mortality in India 2021–23 (2024) (reporting MMR of 88 per 100,000 live births nationally).

[28] Mansi Malik, Siaa Girotra, Mrunali Zode & Saurav Basu, *Patterns and Predictors of Abortion Care-Seeking Practices in India: Evidence From a Nationally Representative Cross-Sectional Survey (2019-2021)*, 15 Cureus, no. 7, 2023, at art. e41263.

Indian women spend approximately 577% more time on unpaid care work than men.[29] The groundbreaking research of Nobel laureate Claudia Goldin demonstrates that the 'child penalty', the precipitous drop in women's earnings and career progression following the birth of their first child is the single largest driver of the persistent gender pay gap in otherwise converging economies.[30]

Reproductive laws, maternity benefits, and childcare entitlements are therefore not welfare concessions. They are essential structural interventions designed to redistribute the costs of social reproduction and dismantle the systematic economic subordination of women. A state that grants women the right to bear children while simultaneously failing to redistribute the labour costs of that reproductive choice is engaged in a form of juridical hypocrisy: celebrating motherhood in constitutional rhetoric while subsidising its economic penalty through inaction.[31]

D. FOETAL VIABILITY VERSUS MATERNAL AUTONOMY: A CONSTITUTIONAL TENSION

As pregnancy moves forward, the debate about how the rights of the foetus can run headlong into a pregnant person's control over their own body starts. The *AIIMS Curative Petition, 2026* makes this painfully clear. In that case, a 15-year-old survivor of rape tried to end a pregnancy at 29 weeks, and everything came into stark relief. From a feminist angle, having a hard legal cut-off at 24 weeks just doesn't fit real life. It misses so much, unexpected health issues, times when people simply don't realize they're pregnant until late, and all the hurdles that stand in the way of getting help before the deadline. Setting these strict rules turns medical timelines into more ways to punish people. Feminists aren't arguing that the foetus doesn't matter, they're insisting that its rights can't erase a person's dignity and self-determination, especially after surviving something as traumatic as sexual violence.

---

[29]Deepika Singh v. Central Administrative Tribunal, (2022) 11 SCC 1, para. 22 (citing OECD, Dare to Share: Germany's Experience Promoting Equal Partnership in Families 18 (2017)); ILO, Care Work and Care Jobs for the Future of Decent Work 42 (2018) (documenting Indian women spend over 5.5 hours per day on unpaid care compared to approximately 52 minutes for men).

[30]Claudia Goldin, A Grand Gender Convergence: Its Last Chapter, 104 AM. ECON. REV. 1091, 1093–95 (2014). Goldin was awarded the 2023 Nobel Memorial Prize in Economic Sciences for this body of research.

[31]See Amartya Sen, Missing Women, 304 BRITISH MED. J. 587 (1992) (estimating 100 million missing women globally due to discriminatory practices including sex-selective abortion and differential care); see also UNFPA India, State of World Population: Seeing the Unseen 12 (2022) (reporting more than one in seven global unintended pregnancies occurs in India).

IV. TOWARD A RIGHTS-BASED REPRODUCTIVE JUSTICE REGIME

If one observes the journey from *MCD v. Female Workers (2000*) all the way to the *AIIMS Curative Petition (2026)*, a clear pattern is established that the constitutional courts in India are starting to treat reproductive freedom as something tied deeply to absolute human dignity under Article 21. The judges have knocked down the married-unmarried divide, recognised that families can look different ways, given equal rights to adoptive parents, brought in international human rights ideas, and pushed back against the old mindset that doctors or authorities always know best. Each of these steps marks a real win for feminist legal advocacy in India.[32]

However, three deep structural failures continue to undermine any claim that India has achieved a rights-based reproductive justice regime. The first is the criminalised baseline: as long as abortion remains a criminal offence under the BNS as long as the MTP Act functions as an exception to criminal liability rather than as the affirmative constitutional guarantee of a right, the State retains an unjustifiable degree of control over women's bodies. Women who self-administer medical abortion pills, which constitute the majority of early terminations in India, remain potentially exposed to criminal prosecution. This is not an abstract risk: it is a structural deterrent that drives millions of women away from the formal healthcare system and toward unsafe alternatives.[33]

The second structural failure is intersectional exclusion. Empirical data from NFHS-5 and the e-Shram portal demonstrate that access to reproductive healthcare — both abortion services and maternity benefits, tracks socioeconomic privilege with near-mathematical precision. The formal-sector bias of the CoSS, the geographic centralisation of certified abortion facilities, and the urban concentration of multi-disciplinary State Medical Boards collectively ensure that the most marginalised women in India, those for whom reproductive rights are most urgently necessary, are

---

[32]Jain & Shah, supra note 5, at 21–23 (arguing that India's doctrine treats abortion as a 'conditional right' contingent on medical approval rather than as an essential component of gender equality).

[33] Madhusudhan Mohanty et al., Trends in Maternal Mortality in India Over Two Decades in Nationally Representative Surveys, 129(6) BJOG 960 (2022) (documenting causes-specific distribution of maternal deaths and regional MMR disparities); Registrar General of India, SRS Special Bulletin on MMR 2021–23 (2024) (MMR of 88 nationally; Andhra Pradesh and Kerala lowest at 30; significant variation across EAG states).

the least equipped to exercise them. Formal equality of legal entitlement without substantive equality of access is not justice; it is a statistical fiction that masks ongoing structural oppression.

The third structural failure is the medical board bottleneck. The Section 3(2B) requirement that late-stage abortions based on foetal abnormality be approved by multi-disciplinary State Medical Boards introduces a bureaucratic barrier of Kafkaesque proportions for rural and economically marginalised women. These boards exist almost exclusively in metropolitan tertiary institutions; the rural poor encounter them not as an administrative procedure but as an insurmountable wall of institutional exclusion. The result is that the most medically vulnerable women, those carrying pregnancies with serious foetal abnormalities, those in rural areas, those without transport or resources are systematically denied access to the very remedy the statute purports to provide.

The AIIMS Curative Petition raises the broadest philosophical question that the existing framework is unequipped to answer: when, if ever, can the State's interest in potential life completely extinguish a child rape survivor's sovereignty over her own body? The Court's answer emphatically, never, must now be encoded directly in statute. The CJI's explicit call for the removal of gestational caps for rape survivors is not merely a policy recommendation; it is, this author submits, constitutionally compelled. A statute that forces a 15-year-old survivor to continue a pregnancy caused by sexual violence cannot survive rigorous scrutiny under Articles 14, 19(1)(a), and 21, read harmoniously, purposively, and in light of India's international obligations under CEDAW.[34]

The analysis by Jain and Shah shows that Indias courts see abortion as a 'conditional right' not a part of gender equality. [35] This gets to the heart of the problem. Changing this requires more than going to court; it needs a complete change in the law. The idea of 'Her Body, Her Choice' needs to be written into the law.

---

[34]Claudia Goldin, Career and Family: Women's Century-Long Journey Toward Equity (Princeton Univ. Press 2021); see also Caitlin Myers et al., Abortion Access and Infant Health, 63 J. HEALTH ECON. 122 (2019) (demonstrating strong causal link between abortion access and infant and maternal health outcomes in low- and middle-income contexts).

This research thus suggests that to make this change we need to do the following:

1. DECRIMINALISING PERSONAL CHOICES

The main problem with our system is in the criminal code. Under Sections 88–92 of the Bharatiya Nyaya Sanhita (BNS) abortion is still a crime with legal termination being an exception. We need to remove early-term abortions (up to 20 weeks) from the code and make self-managed medication abortions using certified medicines legal. By making this personal choice legal women get to make their decisions and the threat of being punished is removed, which mostly affects vulnerable people.

2. REMOVING TIMELINES FOR SURVIVORS

Trauma does not follow a fixed timeline. For survivors of rape, sexual assault and incest getting healthcare dealing with court delays and discovering trauma often means pregnancies go past the legal limits. We need to change Section 3 of the MTP Act to remove all time limits, for survivors as the Supreme Court has recently suggested. No one should be forced into parenthood by the state just because a certain amount of time has passed.

3. BRIDGING THE ECONOMIC DIVIDE: THE UNIVERSAL SECURITY FUND

Bodily autonomy is an empty promise if it is financially inaccessible. Today, the "child penalty"—the severe economic cost of childbirth identified by Nobel laureate Claudia Goldin—falls heaviest on India's informal sector. To fix this, we must decouple reproductive welfare from formal employment contracts. By establishing a State-funded Universal Reproductive Security Fund under the Code on Social Security (CoSS), 2020, we can extend vital maternity security to informal, casual, and seasonal workers. Crucially, this must include codified, equal paternity leave—as directed in *Hamsaanandini Nanduri* (2026 INSC 246)—finally normalising male caregiving and distributing the labor of care equitably.

4. DISMANTLING THE MEDICAL BOARD BOTTLENECK

For rural and marginalized women, the distance between a formal right and actual medical access is measured in miles and bureaucratic red tape. Section 3(2B) of the MTP Act, which mandates multi-disciplinary State Medical Boards for late-stage terminations, has created an urban-centric bottleneck. These boards must be repealed. In their place, we need standardized, expedited clinical guidelines that can be safely

administered by primary care physicians at district-level facilities. Healthcare must be localized if it is to be egalitarian.

5. ENFORCING ACCOUNTABILITY AT THE LAST MILE

The systemic failures exposed in *ABC v. Maharashtra* (2026) proved that progressive judgments mean nothing if a doctor at a rural clinic simply refuses care. To solve this "last-mile problem," the state must legislate a mandatory, time-bound reproductive rights training program for all registered medical practitioners and public health officials. This must be backed by enforceable accountability mechanisms, including professional sanctions for refusal-of-care violations.

CONCLUSION

These five interventions are not mere policy preferences; they are constitutional imperatives. They are compelled by Articles 14, 19(1)(a), and 21, read harmoniously and in light of India’s international obligations under CEDAW. Until these structural reforms are codified into statutory text, India's reproductive rights jurisprudence will remain an unfortunate contradiction: a brilliant monument to judicial progressivism, and a tragic testimony to legislative failure.