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Consent and Autonomy: Redefining Reproductive Rights

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ABSTRACT

The right to consent and autonomy over one's body is covered under Article 21 of the Indian Constitution, within the ambit of the right to privacy, dignity, and liberty of an individual. Pioneering cases, such as Suchita Srivastava v. Chandigarh Administration (2010) and K.S. Puttaswamy v. Union of India (2017), reiterates the importance of bodily autonomy and dignity as basic rights that inform policies addressing emerging societal norms. The judicial and legislative even widened the scope of reproductive health care through inclusion of maternal health, sterilization, and by interpreting and amending the abortion laws in the country. Informed consent plays a vital role in the protection of body autonomy, especially on medical assistance and treatments like sterilization, abortion, and surrogacy. The recent amendment of the MTP ACT 2021 amendment of the MTP ACT 1971 is seen as a step towards inclusivity. It took around 50 years to accept such inclusivity in India by allowing unmarried women access to safe abortion care and addressing post-reproductive rights. Personal laws and societal norms stand in the way of exercising the bodily autonomy and reproductive rights of an individual, especially the vulnerable sections of society such as marginalized women and sex workers. This paper study espouses strong frameworks that affirm reproductive rights as central to dignity, gender equality, and autonomy. It highlights judicial activism, legislative specificity, and public consciousness as central in revolutionizing reproductive healthcare. Through this study, policymakers, legal professionals, and healthcare professionals can harmonize their activities to provide equal access to reproductive options for everyone.

Keywords: Consent, Bodily Autonomy, Reproductive Healthcare, Judicial Analysis, Article 21, Fundamental Rights, Informed Consent, Surrogacy, Sterilization, Evolution of Abortion Laws, Privacy.

INTRODUCTION

The consent and body autonomy are interrelated with each other . And these both are enshrined in the fundamental rights of the constitution under article 21 , which protects and ensures that individuals have the freedom to make choices about their bodies and control on them . consent refers to voluntary, informed consent

While autonomy refers to right to make decesions about one’s own body including about the reproductive choices to healthcare and sexual activity.The elaboration of reproductive rights justice in India reflects a complex interplay between legal reform, judicial interpretation, and shifting societal values. At the heart of this converse lies the principle of fleshly autonomy, which underscores a woman's right to make informed opinions about her reproductive health without compulsion, demarcation, or

overdue hindrance. The corner Medical Termination of Gestation(MTP) Act of 1971, and its significant 2021 correction, mark vital moments in India's legal approach to revocation, expanding the compass of safe access and correcting long- standing gender and connubial status- grounded rejections. The correction specially extended the gravid limit to 24 weeks and included unattached women under its defensive dimension that gestured a move toward lesser inclusivity and recognition of reproductive autonomy. Judicial developments have further advanced this line. In particular, the Supreme Court's decision in X v. star Secretary, Health and Family Welfare Department(2022), fortified the foundation of reproductive rights by emphasizing that revocation is a naturally defended right under Composition 21 of the Indian Constitution. This ruling went beyond statutory interpretation by feting connubial rape within the frame of revocation access and declaring that denial grounded on connubial status is discriminative[1], thereby buttressing the indigenous values of equivalency, sequestration, and quality. Completing these legal mileposts, scholarly analyses similar as Anish Padhye's examination of revocation laws, and the work of Arijeet Ghosh and Nitika Khaitan in" A Womb of One's Own"[2], interpret the counter accusations of the Supreme Court's 2017 sequestration judgment Justice K.S. Puttaswamy v. Union of India[3] in relation to reproductive autonomy. They argue for a legal geography that recognizes revocation on request, challenges being statutory restrictions, and broadens the compass of reproductive rights to include all individualities anyhow of gender identity or connubial status. Still, legal reform alone is n't sufficient. The issue of informed concurrence, as stressed by the Network Medical Women's Center, points to patient gaps in patient autonomy and ethical medical practice. In authorities like California, the emphasis on clear, unprejudiced communication and safeguards against compulsion or conflict of interest serve as models for perfecting case- provider dynamics and esteeming individual agency. Further, M.B. Kapp's notice[4] of localized informed

[1] Books, C. (2016) Rape is rape: How denial, distortion and victim blaming is fueling a hidden acquaintance rape crisis, Criminal Law and Criminal Justice Book Reviews. (Accessed: 09 April 2025).
[2] Nitika Khaitan and Arijeet Ghosh (2017) A womb of one's own: Privacy and reproductive rights, Economic and PoliticalWeekly. (Accessed: 09 April 2025).
[3] Justice K.S.Puttaswamy(retd) and ANR. Vs Union of India and Ors. on 24 August, 2017. Available at: https://indiankanoon.org/doc/91938676/ (Accessed: 09 April 2025).
[4] Kapp, M.B. (1982) 'Abortion and informed consent requirements', American Journal of Obstetrics and Gynecology, 144(1), pp. 1–4. doi:10.1016/0002-9378(82)90384-2.

concurrence laws in the United States exposes how legal authorizations, while presumably defensive, can become tools of political hindrance, undermining both croaker autonomy and women's rights. This pressure between judicial liberalization and nonsupervisory overreach is inversely applicable in the Indian environment, where state- led restrictions continue to hamper full consummation of reproductive freedoms. This paper aims to revise reproductive rights justice in India by exploring the corners of indigenous guarantees, judicial activism, medical ethics, and social equity[5]. Drawing on a wide range of legal analyses and relative fabrics, it seeks to answer a critical question how can India insure comprehensive, inclusive, and staid access to reproductive healthcare for all, in line with its indigenous morality and transnational mortal rights scores[6]

1. Informed Consent and Forced Sterilization

1.1 Informed Consent: The Pillar of Reproductive Autonomy

With existing legal protections in place, informed consent is disregarded in reproductive health. In Mexico, despite the fact that sterilization demands written consent under law, most women were not aware of its permanence or of their choices; some hadn't even been offered consent forms to sign. In Indonesia too, coercive family planning has included documented military coercion, with gruesome accounts of IUDs having been inserted at gunpoint in order to achieve fertility quotas.Informed consent is not a technical ritual rather, it is a corner-stone aspect of ethical health care and a vital part of reproductive rights. It guarantees individuals have control over their bodies and choices[7]. Despite this, in far too many nations, and especially in reproductive health, there is a troubling disconnect between what is promised by the law and what women actually receive, recording a stubborn failure to preserve autonomy and dignity.

1.2 Indian and global Historical and Contemporary Forced Sterilization and family planning

India has had a blemished past of coercive sterilization, especially in 1975 under Emergency rule by Prime Minister Indira Gandhi. Mass sterilization campaigns, led by Sanjay Gandhi, used police and administrative personnel to force people to be sterilized. Widespread violence and brutal crackdowns ensued, uncovering heinous violations of reproductive autonomy.

Even in the recent past, such violations persist. In 2012, in Bihar, more than 50 women were sterilized in unhygienic conditions on school desks, under the light of torches without gloves or running water. Some had severe postoperative complications. Investigations brushed aside concerns, even as expired medicines were being used.

A similar tragedy occurred in 2014 in Bilaspur, Chhattisgarh, where 13 out of 83 sterilized women died due to poor post-operative care and unsanitary conditions. These camps violated Supreme Court guidelines, including

[5] C;, M.S.M. (no date) On reproductive justice: 'domestic violence', rights and the law in India, Culture, health & sexuality. (Accessed: 10 April 2025).

[6] Indigenous peoples (no date) United Nations. (Accessed: 09 April 2025)

[7] Shalev, C. (2000) 'Rights to sexual and Reproductive Health: The ICPD and the convention on the elimination of All Forms of Discrimination Against Women', Health and Human Rights, 4(2), p. 38. doi:10.2307/4065196.

the directive that one doctor should not operate on more than 30 women in a day. The Supreme Court, in Devika Biswas v. Union of India[8], emphasized that coercive sterilization violates Article 21 of the Constitution, which guarantees the right to life and personal liberty. The judgment reaffirmed that reproductive rights include the right to informed and voluntary sterilization[9]. Not only India the problem is faced by women globally, for example In Mexico, although the Constitution guarantees reproductive rights and defines family planning as essential healthcare, implementation is flawed. Contraceptive options are limited mainly to IUDs and sterilization. Alarmingly, nearly 40% of women undergoing sterilization did not recall signing consent forms. One egregious case involved a woman who had her ovaries removed without her knowledge. Most complaints to Mexico's Medical Arbitration Board involved gynecological care[10], exposing systemic violations of consent and reproductive rights[11]. Women from economically and socially marginalized groups remain disproportionately impacted. Due to restricted access to quality healthcare, they are compelled to rely on government camps, frequently

without information or consent

These global examples underscore the urgent need for rights-based reproductive health policies grounded in informed consent, dignity, and bodily autonomy.

1.3 Family planning

Reproductive choice is a fundamental aspect of women's autonomy and essential to achieving gender equality. It encompasses the freedom to decide if and when to have children, access to safe abortion and contraception, and the right to sexual and reproductive health education. Beyond personal preference, it reflects dignity, bodily integrity, and empowerment. Yet, this right is frequently undermined, especially where patriarchal norms, economic barriers, and systemic biases converge. In such contexts, family planning services become crucial, particularly in countries where abortion is illegal or restricted. In the Dominican Republic, where abortion is entirely criminalized, the government has failed to provide adequate contraceptive services, shifting the burden to underfunded NGOs. This neglect violates obligations under international law, including CEDAW, and disproportionately affects women's health and autonomy. In Indonesia, coercive state-led family planning policies have been reported. Women were denied information about contraceptive risks or alternatives, and some were forcibly fitted with IUDs under threat—often by military personnel. These practices constitute reproductive violence and violate international standards under CEDAW and the ICESCR.

[8] Devika Biswas vs Union of India on 14 September, 2016. (Accessed: 09 April 2025).

[9] Consent for sterilization: Form HHS-687. (Accessed: 09 April 2025).

[10] Consent for sterilization: Form HHS-687. (Accessed: 09 April 2025).

[11] Shalev, C. (2000) 'Rights to sexual and Reproductive Health: The ICPD and the convention on the elimination of All Forms of Discrimination Against Women', Health and Human Rights, 4(2), p. 38. doi:10.2307/4065196.

2. Medical Termination of Pregnancy (MTP) in India

2.1 Legal Framework

Abortion was, before 1971, prohibited in Sections 312-314 of the IPC. The MTP Act of 1971 was passed to reduce maternal mortality due to unsafe abortion. The Supreme Court, in Jacob George v. State of Kerala[12], decided that the MTP Act prevails over the IPC in abortion. The Rajasthan High Court, in Nand Kishore Sharma v. Union of India[13], declared the Act constitutional, deciding that it was in line with Article 21.

In Suchita Srivastava v. Chandigarh Administration[14], the Supreme Court recognized reproductive autonomy as a part of personal liberty under Article 21. The Bombay High Court also reaffirmed the same, reiterating that forcing a woman to continue a pregnancy is an intrusion into her bodily autonomy and mental peace.

2.2 Judicial Authorization and Access Issues

While judicial approval of abortion under 20 weeks is not mandatory by the MTP Act, the process is invoked by most women on account of social stigma or bureaucratic reasons. In X v. Govt. of NCT of Delhi[15], permission for aborting pregnancy due to prostitution was granted by the court for an HIV-infected rape survivor. In another case, Hallo Bi v. State of Madhya Pradesh[16], the court decided that if forced prostitution comes close to being as offensive as rape, a woman could seek termination under the MTP Act[17].

High courts have made it clear that approval by a woman or her guardian, if she is a minor and advice by competent medical professionals are enough for abortion according to the law. Yet, uneven implementation still hinders access in a timely manner.

3. Surrogacy in India

The Surrogacy (Regulation) Act, 2021 is a significant departure from Indian reproductive law by prohibiting commercial surrogacy and permitting altruistic surrogacy only. The Act restricts the ambit of eligibility to heterosexual, married, Indian, infertile couples and stringent requirements of age, health, and legal clearances. In November 2023, an unusual event unfolded when a 44-year-old unmarried lady filed a petition in the Delhi High Court, challenging the denial of unmarried and single women from the surrogacy process as envisioned by the Surrogacy (Regulation) Act, 2021. The petitioner argued that this denial was testing the provision under Section 2(1)(s) of the Act and the way the same was discriminatory in nature.discriminatory and offends her fundamental rights of equality and the right to lifeT he case of unmarried and single women is worthy of consideration, being aware of the constitutionally enshrined fundamental Right to Equality (Article 14) and

[12] Dr Jacob George vs state of Kerala on 13 April, 1994. (Accessed: 09 April 2025).
[13] Nand Kishore Sharma vs Union of India (UOI) and Ors. on 28 January, 1977. (Accessed: 09 April 2025).
[14] Suchita Srivastava & ANR vs Chandigarh Administration on 28 August, 2009.(Accessed: 09 April 2025).
[15] X vs. principal secretary, Health and Family Welfare Department, govt. of NCT of Delhi and another. (Accessed: 09 April 2025).
[16] 2013 (1) MPHT 451, 2013 (2) MPLJ 655, 2013 (1) RCR 770 (Civil), 2013 (1) RCR 834 (Cri), 2013 CriLJ 2868)
[17] Chandra, Aparna and Satish, Mrinal, "Securing Reproductive Justice in India: A Casebook" (2019).

Right to Life (Article 21). violation of a single women's right to surrogacy has taken the highest importance in view of the recent Supreme Court (Hereinafter "SC") ruling in the case of Arun Muthuvel v. UOI, where the court held that single women do not have the right to take advantage of surrogacy benefits., a crucial element which was not brought to one's mind by the court while pronouncing the decision was that the provision and their reasons in the present judgement, offended the rights enshrined under Article 21. As a method of reproduction, surrogacy squarely falls under the privacy rights relating to reproductive autonomy, and surrogacy falls within the privacy rights relating to reproductive autonomy, vested under Article 21 of the Indian Constitution[18].

This exclusion is illogical, referring to the need for an integrated legal framework that secures reproductive autonomy and equality. A two-judge bench of the SC held that "the right of every woman to make reproductive choices without excessive intrusion from the state is crucial to the purpose of human dignity." Once again, X v. The Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi and Ors, was another case which expressly legitimized this dimension of woman's fundamental right and categorically supports the argument that a woman can opt to become pregnant regardless of her marital statusThe Supreme Court's argument in denying single women reproductive autonomy is gravely constitutional. Firstly, the right to form a family through assisted reproduction is

integrally linked to bodily autonomy and mental well-being under Article 21. Even though Article 8(1) of the European Convention on Human Rights explicitly protects family life, and Article 51(c) commits India to respect international law, the Court overruled these provisions by alleging the petitioner "preferred to remain single" – an argument which mixes marital status with reproductive rights.
Second, Indian law acknowledges motherhood as a core element of identity, the Himachal High Court labeling it "the most natural thing for a woman" and the SC in Hema Vijay Menon v. Union of India (2021) reiterating reproductive choice as an autonomous private choice not subject to state intervention. The current ruling, however, hypocritically gives precedence to "social norms" over science, disregarding the Francis Coralie precedent calling for dynamic interpretation of core rights to keep up with changing values in society.. By equating the capacity for parenthood and marital status, the decision inscribes negative stereotypes linking women's worth to marriage. Such an argument undermines constitutional protections for personal dignity and inscribes systemic barriers to women's exercise of bodily autonomy

4. Forcible Pregnancy and Abortion

Recent Indian case law regarding abortion also indicates progressive development in the judiciary's formulation of reproductive rights[19]. While a 2004 Supreme Court decision eroded women's reproductive autonomy by holding that a woman's choice to acquire abortion or sterilization without the husband's consent constituted a

[18] Kabra, T. (2024) Inclusive futures: Surrogacy, single women and constitutional dynamics, THE CONTEMPORARY LAW FORUM. Available at: https://tclf.in/2024/07/15/inclusive-futures-surrogacy-single-women-and-constitutional-dynamics (Accessed: 09 April 2025).
[19] Dewangan, S. (2024) Reproductive rights under Indian Constitution, TSCLD. (Accessed: 09 April 2025).

case of mental cruelty, more recent judicial pronouncements have been directed towards increased constitutional protection of this right. In 2009, the Supreme Court re-emphasized women's reproductive autonomy as a fundamental right by holding that "There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21[20]." In 2011, the Punjab and Haryana High Court reaffirmed women's rights to reproductive autonomy by dismissing a suit by a husband against a doctor who had carried out an abortion without the husband's consent on the grounds that "[i]t is a personal right of a woman to give birth to a child…No body [sic] can interfere in the personal decision of the wife to carry on or abort her pregnancy…unwanted pregnancy would naturally affect the mental health of the pregnant women [sic].".
Also, in the case of Hallo Bi v. State of Madhya Pradesh and Others in 2013, the High Court of Madhya Pradesh held that the requirement to provide victims of rape opportunities for access to abortion without judicial permission, stating "we cannot compel a victim of violent rape/forced sex to bear a child of a rapist. The anguish and the humiliation which the petitioner is enduring daily, will surely inflict a serious injury on her mental health.".
Since 2008, petitions have been made throughout the country for interpretation of Section 5 of the MTP Act, which expressly allows abortion to preserve the life of a pregnant woman, to also allow abortion after 20 weeks on health grounds in case of rape or fetal disability. Although the Supreme Court still has

two cases pending for a ruling that the Constitution requires access to abortion after 20 weeks on broader grounds, since 2015 the Supreme Court has directed three times to permit abortion in specific cases after 20 weeks where medical boards advised that making the women go through the pregnancy would cause physical and mental harm to them. In 2017, the Supreme Court clarified that abortion at the 24th week is permissible in the case of anencephaly, a fatal fetal disability which also endangers the life of the pregnant woman, holding that her rights over her body and reproductive autonomy enable her to "save her own life against the avoidable risk to it."

Even though state high courts have had varying judgments, two recent cases from Gujarat and Chhattisgarh have also gone further to interpret the MTP Act to permit abortions beyond 20 weeks in sexual violence cases. Significantly, these judgments acknowledge the importance of access to second trimester abortions for women's physical and mental health.

In the 2016 High Court on its Own Motion v. State of Maharashtra case, the Bombay High Court[21] directed to increase women prisoners' access to abortion and strongly reaffirmed women's rights over abortion under the right to live with dignity under Article 21. The judgment recognizes that unwanted pregnancy mostly impacts women and holds that compelling a woman to carry a pregnancy "represents a violation of the woman's bodily integrity and aggravates her mental trauma[22] which would be deleterious to her mental health." The judgment

[20] Maniyar,Z. (2022) Bodily Autonomy & Safe Abortion, a right under Article 21, CJP. (Accessed: 09 April 2025).

[21] MS, S. (no date) Bombay High Court seeks state's reply on compliance with Supreme Court's two-finger Test Ban, Bar and Bench - Indian Legal news. (Accessed: 09 April 2025).

[22] First, P. (2019) How courts uphold women's right to bodily autonomy and integrity, SheThePeople. (Accessed: 09 April 2025).

boldly recognizes that an unborn fetus is not a human rights entity. The pregnancy is within the body of a woman and has profound implications on her health, mental health and life. Thus, how she wishes to tackle this pregnancy should be a choice that she and she alone should be able to make. The choice of controlling their own body and fertility and motherhood decisions should be left to the women alone. Let us not forget women's basic right: the right to autonomy and to choose what to do with their own bodies, including whether or not to get pregnant and stay pregnant.

4.1 Legalization of Abortion and Child Marriage: A Rights-Based Approach

Indian courts have increasingly recognized child marriage as a violation of both human and constitutional rights, particularly in the rulings of the Delhi and Madras High Courts. These judgments emphasize the disproportionate harm child marriage causes to young girls depriving them of education, bodily autonomy, and the ability to make informed decisions about their health and reproductive lives.

In landmark decisions from 2010 and 2012, the Delhi High Court highlighted the gendered harms of child marriage, including domestic violence, sexual abuse, and forced motherhood, declaring such practices a violation of a girl's "right to live a life of freedom and dignity." The court noted that denial of education and silence around reproductive health further strips child brides of agency.

In this context, denying girls in child marriage access to legal and safe abortion only works to increase gender inequality and violates their inherent rights, such as:

Article 14: Equality before the law,

Article 15: Prohibition of discrimination,
Article 21: Protection of life and liberty.
The 2015 Madras High Court judgment in M. Mohamed Abbas v. The Chief Secretary reinforces the above opinion by affirming that the Prohibition of Child Marriage Act (PCMA) is superior to religious or personal law, in accordance with CEDAW[23] obligations and Indian constitutional guarantees. The decision reaffirms the state's responsibility to promote education, empowerment, and equality for girls.
If child marriage is prohibited and a violation of constitutional rights, then pregnancies that occur as a result of such marriages usually non-consensual or forced need to be addressed with utmost regard for the health, autonomy, and well-being of the girl. Legal abortion access is not just a medical requirement but a constitutional requirement to: Re-establish the girl's autonomy of body, prevent further psychological trauma, and let her take back control of her life and future.
Denying a child bride access to safe abortion services merely compounds the violence of an illegitimate institution that is already violating rights to begin with. Indian constitutional law, human rights norms, and High

[23] Goldberg, J. (2021) Reproductive rights in Indian courts, Center for Reproductive Rights. (Accessed: 09 April 2025).

Court jurisprudence give us a robust platform upon which to make the argument that abortion needs to be legal and available to girls subjected to child marriage, not merely a health issue, but an issue of justice.

5. Non-Discrimination in the Distribution of Health Resources: The Case for Equitable Abortion Access

The issue of distributive justice in healthcare, especially in reproductive services, has become increasingly urgent worldwide. With rising fiscal deficits and healthcare costs, public health systems are under pressure, often excluding services considered "non-essential" or politically sensitive. Disturbingly, women's reproductive health is often the first to be deprioritized, exposing deeply rooted gender bias in resource allocation.
Abortion services, in particular, are frequently withheld under the pretext of economic rationalization disproportionately harming poor, rural, and marginalized women. This reflects not just financial policy but systemic discrimination, undermining principles of equality, non-discrimination, and the right to health.
Examples from transitioning economies reveal this trend starkly. In Croatia, budget restructuring led to the removal of abortion and contraception from state-funded healthcare. This shift dealt a severe blow to women's autonomy, especially for those unable to afford private care, reinforcing the notion that reproductive rights are conditional and economically negotiable. Similarly, Bulgaria[24] responded to high abortion rates not with improved reproductive services but by cutting family planning programs, framing it as an austerity measure. This reveals how women's health becomes expendable in broader fiscal reforms. These policy decisions have real consequences. Discrimination in healthcare contributes significantly to preventable maternal deaths and complications during pregnancy and childbirth. Essential services like contraception, safe abortion, and emergency obstetric care can reduce these risks, yet many governments continue to neglect them.

In Indonesia, the government blamed high maternal mortality on traditional birth attendants—responsible for nearly 64% of births without acknowledging that women often choose home births due to affordability and familiarity. Similarly, in Azerbaijan and the Dominican Republic, maternal deaths have risen due to the poor quality and affordability of care. In the Dominican Republic, NGOs cite the government's failure to prioritize reproductive health as the root cause.

These examples underscore that economic policy cannot come at the cost of women's lives and rights.

5.1 The Right to Abortion as an Issue of Equality and Justice

These are not isolated incidents but part of a global pattern of neglect and discrimination in women's reproductive healthcare, particularly during times of crisis. Under international human rights law, especially the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), states are obligated to ensure equal access to healthcare, including abortion and family planning, without economic discrimination.

[24] Shalev, C. (2000) 'Rights to sexual and Reproductive Health: The ICPD and the convention on the elimination of All Forms of Discrimination Against Women', Health and Human Rights, 4(2), p. 38. doi:10.2307/4065196.

However, in many regions, financial barriers limit abortion access, creating a two-tiered system—where the privileged can access private care, and economically disadvantaged women are left to suffer unwanted pregnancies, unsafe procedures, or long-term health issues. This violates the principles of equity, non-discrimination, and reproductive justice.

Framing abortion denial as economic necessity ignores the broader social and economic costs of forced pregnancy, maternal mortality, and poor health outcomes. Abortion is not a luxury it is a public health essential and a human right that states must uphold regardless of fiscal pressures[25].

6. Reproductive Choice - Abortion

Unsafe abortion also contributes to high maternal mortality and morbidity. Reports presented by States Parties to the Committee often omit official data regarding this issue because abortion is still illegal in many countries; nevertheless, these reports invariably point to unsafe abortion correlating with high maternal mortality and morbidity rates due to hemorrhage and complications of pregnancy.

Incidentally, Zimbabwe indicated that hemorrhage and sepsis following abortion rank as leading causes of death, although the figures cannot be determined since abortion is illegal. The Dominican Republic has also classified "clandestine abortions" as the third cause of maternal mortality after toxemia and during childbirth, with the recognition that "heavy underreporting" was observed in this area. Most probably, such laws that criminalize health services to only women, either targeted at the persons who provide such services, or the women who receive them, may be considered discriminatory. Criminalizing abortion is most atrocious in that, it hinders women's reproductive choices to make free and responsible decisions concerning the most important matters to be controlled in their lives and exposes them to very serious health risks of unsafe abortion, thus violating their rights to bodily integrity and, in the most extreme cases, to life itself.

Most countries have exceptions to that criminal norm affording legal abortion, for instance, while the life of the mother (or indeed fetus) is endangered by the continuation of the pregnancy, or when pregnancy was caused by rape. However, for Indonesia, not even rape constitutes a ground for legalizing abortion;

hence, the state multiplied rape by the pregnancy carrying that she was forced to carry.

6.1 Employment-Based Pregnancy Discrimination: Violation of Choice

Reproductive choice violations at the workplace mainly manifest in . A non-governmental report stated that there were systematic and widespread cases of pregnancy discrimination against women working in the export-processing (maquiladora) sectors of Mexico. A fact-finding mission investigating these claims found that women applying for jobs had to undergo mandatory tests to determine if they were pregnant-an act obviously intended to make it difficult, if not impossible, for women to be hired on the pretext that they might

[25] (No date) Abortion is essential healthcare and women's health must be prioritized over politics | OHCHR. (Accessed: 09 April 2025).

get pregnant at some time in their lives. Even more egregious, those who became pregnant during their employment were forced to resign and punished for exercising that right.

6.2 Barriers by Health Professionals: A Zimbabwean Case Study

Only certain situations allow for abortion in Zimbabwe; however, the government subsidizes contraceptive use and does not restrict it by law in the case of minors. Still, some disconnect between the law and practice continues to jeopardize adolescent girls. On some occasions, health workers refuse sexually active teenage girls contraception based on their subjective judgment or personal cultural beliefs, arguing that they are too young or unmarried. These arbitrary refusals, particularly in face of the high teenage pregnancy incidence in Zimbabwe and HIV/AIDS burden on young girls, 84% of new infections in the 15 to 19 years old group being females, straight contravene their legal rights and jeopardize their health. Such practices create cycles of poverty, sickness, and inequity, demonstrating that healthcare systems can become platforms of moralistic judgment rather than empowerment and care.

7. Women's Abortion Rights and Consent in Vulnerable Circumstances

Over the past few decades, human rights debates have increasingly realized that justice cannot be realized without vindicating the distinctive needs of marginalized and vulnerable groups[26]. This change—grounded in the ascendance of economic and social rights—is based on the understanding that individuals do not suffer violations of their rights as solo actors, but as group members exposed to structural disadvantage and multiple forms of discrimination[27]. For women in vulnerable circumstances, these consist of the suppression of their reproductive and sexual rights, and access to abortion and informed consent are key among the most important, yet habitually overlooked, aspects.

A broad range of vulnerable populations, including rural and urban poor women, women in armed conflict, internally displaced women, and women in prostitution, typically do not have meaningful access to safe and legal abortion services, even though they suffer from the serious health and social repercussions of unwanted pregnancy, sexual violence, and loss of autonomy.

7.1 Rural and Marginalized Women: Geographic and Economic Barriers to Consent and Access

Rural women and poor urban residents in most countries are disproportionately disadvantaged in access to reproductive health care. According to Mexico, there is still high unmet demand for contraception among rural and poor urban women. In Zimbabwe, despite the government's advocacy for family planning services, rural areas are left with a fifth of their population without access to maternal and

reproductive health care. When

[26] Shalev, C. (2000) 'Rights to sexual and Reproductive Health: The ICPD and the convention on the elimination of All Forms of Discrimination Against Women', Health and Human Rights, 4(2), p. 38. doi:10.2307/4065196.
[27] . Prince, D.M., Rocha, A. and Nurius, P.S. (2018) Multiple disadvantage and discrimination: Implications for adolescent health and Education, Social work research. (Accessed: 09 April 2025).
[28]women are denied or do not have access to contraception, the risk of unwanted pregnancy jumps exponentially, and without available abortion services, they are compelled to bear pregnancies involuntarily.

Consent in these circumstances then becomes a matter of theory rather than practice. A woman is not able to give or refuse consent to pregnancy if she cannot access contraception, reproductive education, or abortion care. To impose childbirth in such circumstances is to infringe her right to autonomy, dignity, and bodily integrity.

7.2 Women in Armed Conflict and Displacement: Layers of Vulnerability

Women who are living in or displaced from armed conflict are among the most vulnerable groups to sexual violence, rape, and forced pregnancies. In East Timor, to name but one example, women were subjected to such sexual violence that it has left them with permanent psychological trauma, reproductive health consequences, and social exclusion. But most are too embarrassed or afraid to report these abuses. Stigma, fear of retaliation, and rejection by their communities further entrench their trauma and mute their demand for care.

They become pregnant due to rape, and without safe, legal, and stigma-free abortion, they must bear the physical and emotional consequences of violence. In these circumstances, abortion is not a question of choice but a necessary lifesaving and healing medical intervention. Refusal to provide abortion to sexual violence survivors is a failure of the healthcare system and the justice system as well, and constitutes reproductive coercion.

In internally displaced persons (IDP) settlements, like those in Azerbaijan, women cited family planning and contraception as primary health concerns. Despite this, bureaucratic hurdles prevented the distribution of even basic items like condoms. This lack of service provision underscores the systemic neglect of displaced women's reproductive rights, including their right to abortion, and fails to account for their unique needs as survivors of trauma and instability.

Likewise, in Croatia, women refugees did not have legal access to the entire spectrum of health care, including reproductive care. The withholding of abortion care for refugee and displaced women as a state-paid benefit is symptomatic of the profound injustice faced by non-citizen or displaced populations in which health systems treat them without granting the legal recognition or institutional facilitation to act with bodily autonomy.

7.3 Women in Prostitution and Trafficking: Criminalization and Coercion

Prostitutes are among the most stigmatized and excluded people in any given society. They are extremely susceptible to rape, violence, and trafficking, and yet are regularly denied access to basic reproductive health care, including abortion. State messaging on HIV/AIDS prevention in Indonesia has also been directed to areas around brothels, again reinforcing stigma more than structural inequality or guaranteeing access to services.

More disturbing still are accounts of coerced vaginal exams under urban "cleansing" schemes, a serious transgression of bodily autonomy and consent. In these instances, state actions blur the distinction between healthcare and coercion, too often denying women in prostitution the capacity to make informed, voluntary choices regarding their reproductive health, including the right to end a pregnancy.
When the women in prostitution get pregnant repeatedly as a consequence of violence or force and are thus deprived of the right to safe abortion, it creates cycles of abuse, poverty, and marginalization and reinforces the idea that their bodies are not entirely their own.

7.4 The Role of Health Professionals: First Responders to Gender-Based Violence

Health workers frequently provide first-line witness and response to gender-based violence. In Bulgaria, though not officially recorded in government reports, health professionals themselves reported instances of sexual violence on their own initiative and emphasized the gravity of the issue. Through their reports, the pervasiveness of the abuse is reflected as well as the systemic inadequacy of response to its reproductive effects, such as access to abortion.
Health care systems, when properly resourced and sensitized, can empower women by restoring dignity and agency to them through ensuring abortion is accessible, available, and provided with informed consent without stigma, pressure, or fear.

8. Recommendations and conclusion

The current legislation framework , judicial interpretation and judgements unfairly excluded LGBTQ+ individuals,and non-traditional families from accessing surrogacy.There is pressing need to reform the restrictive laws and change towards inclusive and equitable reproductive rights. In the changing times the new change of the society should be accepted by giving the individuals the principal autonomy rather than notions of marital status or conventional family structures. The protocols and guidelines which mentions informed consent and reproductive rights should be adhered strictly .Which ensures ethical and legality grounds and closely monitored by independent bodies to safeguard the rights and dignity of those seeking care.
The abortion services should be universally available for 24 weeks without the need of judicial approval . The
abortions in some cases are necessary not optional example for rape victims,sexual abuse victims and women in vulnerable situation .Medical professionals must be trained to offer care that is non-judgmental, respectful, and aligned with the principles of reproductive justice. Improvisation of the healthcare accessibility ,also access to contraception services and education of reproductive health in rural and marginalized can help address the stark inequalities that persist in these areas. Regular judicial training helps to better judgements.
In India, there is a dynamic shift unfolding in the realm of reproductive rights, marked by a deep tension between societal norms and the judiciary's evolving interpretation of bodily autonomy. Landmark judgments such as Suchitra Srivastava, Puttaswamy, and X vs Principal Secretary have affirmed that bodily autonomy is a fundamental right protected under Article 21 of the Constitution. However, a significant gap remains between these progressive interpretations and the legislative frameworks in place, such as the MTP Act and surrogacy laws. The MTP Act, amended in 2021, has indeed evolved to include unmarried women, yet judicial delays continue to impede timely access to abortion services. Meanwhile, the surrogacy laws explicitly exclude unmarried individuals and members of the LGBTQ+ community, creating a legal framework that not only contravenes Articles 14 and 21 but also violates

India's international commitments under CEDAW. These laws fail to align with the evolving understanding of family, identity, and individual rights.

India also carries the dark legacy of forced sterilizations—a history that continues to cast a shadow today, as coercive sterilization practices are still reported, particularly among vulnerable and marginalized women. Internationally, similar patterns emerge: from coercive contraception in Indonesia to the denial of contraceptives to youth in Zimbabwe, these instances highlight how institutional and cultural biases can undermine autonomy under the guise of health or morality.

To really achieve reproductive justice, India needs to step beyond token legislation change and towards rights-based, empathetic, inclusive health systems that have regard for people's agency.

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