

Right to Reproductive Choice and the Doctrine of Personal Liberty: A Critical Study of Judicial Trends.

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ABSTRACT

Reproductive rights constitute a vital aspect of human rights, encompassing the freedom to make informed decisions about reproduction, family planning, and access to quality healthcare services. Within the Indian constitutional framework, these rights are deeply rooted in Article 21 of the Constitution, which guarantees the *Right to Life and Personal Liberty*. This provision has been interpreted to include the right to health, privacy, dignity, and bodily autonomy, making reproductive rights a central element of individual freedom and gender equality.

This paper examines the intersection of reproductive rights and access to healthcare through a Constitutional and Doctrine of Personal Liberty. It traces the evolution of these rights at both national and international levels, highlighting their recognition in global instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The study emphasizes that reproductive autonomy is inseparable from the broader goals of social justice and sustainable development.

Further, the paper analyzes key legislative frameworks such as the Medical Termination of Pregnancy Act, 1971 (amended 2021) and the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, which collectively aim to safeguard reproductive health and prevent discrimination. It argues that effective implementation, awareness, and accessibility remain critical challenges that demand attention from policymakers and institutions.

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The paper concludes that ensuring reproductive rights and access to healthcare is not merely a health policy issue but a constitutional and ethical imperative. Strengthening legal safeguards, promoting gender-sensitive healthcare policies and enhancing public awareness are essential to uphold the principles of equality, dignity, and justice enshrined in the Constitution.

1.INTRODUCTION

Reproductive choice has become one of the most significant constitutional questions of the 21st century, representing a deeper struggle for bodily autonomy, gender equality, and human dignity. Decisions relating to contraception, abortion, pregnancy, and family planning are central to an individual's identity and personal life. Therefore, reproductive choice is no longer viewed merely as a medical or demographic issue but as a core aspect of personal liberty and freedom of self-determination. The ability to exercise control over one's reproductive functions is essential for leading a dignified and fulfilling life.

Traditionally, reproductive decisions were shaped by patriarchal beliefs and moral restrictions. For decades, legal systems across the world upheld state interests, religious morality, and social norms over individual autonomy, especially over women's bodies. However, shifting constitutional and human rights discourses have progressively questioned such state interference. Courts have increasingly recognised that personal liberty is incomplete without the freedom to make reproductive choices. Within contemporary jurisprudence, liberty is interpreted not only as freedom from physical restraint but as the freedom to make meaningful personal decisions without unwarranted state intrusion and patriarchal society interference .

In recent decades, the global trend has increasingly leaned toward a rights-based recognition of reproductive autonomy. Courts have highlighted the need to ensure that reproductive decisions remain voluntary, informed, and free from discrimination. Yet, inconsistencies remain across jurisdictions, and resistance persists due to cultural, political, and religious pressures.

This study critically examines evolving judicial trends to understand how reproductive choice has been conceptualized within the expanding doctrine of personal liberty and how constitutional democracies continue to define and redefine bodily autonomy.

2. CONCEPTUAL FOUNDATION OF REPRODUCTIVE CHOICE & DOCTRINE OF PERSONAL LIBERTY

The conceptual foundation of reproductive choice is grounded in the belief that every individual must have the freedom to make independent decisions regarding reproduction, including access to contraception, continuation or termination of pregnancy, and maternity choices. These decisions influence a person's physical health, emotional well-being, social identity, and future opportunities, making reproductive autonomy essential for a dignified life. Core foundation of this topic is the **doctrine of personal liberty**, which recognises that individuals possess autonomy over their own bodies and intimate matters without undue state interference. Personal liberty is not confined to freedom from physical detention; it includes decisional freedom and bodily integrity as necessary elements of self-determination.² Restrictions on reproductive choices have been judicially acknowledged as violations of dignity and gender equality because they disproportionately burden women who primarily bear the consequences of pregnancy and childbirth.³ Modern jurisprudence therefore views reproductive rights as inseparable from constitutional guarantees of liberty, privacy, and equality.⁴ Recognising reproductive choice as a protected liberty ensures that motherhood is voluntary, informed and safe rather than coerced by customs. This rights-based understanding affirms that reproductive decisions must remain free, autonomous, and shielded from discrimination or coercion.

3. CONSTITUTIONAL JURISPRUDENCE IN INDIA

The Indian Constitution does not explicitly employ the term “reproductive rights.” However, through the interpretative role of the Supreme Court has progressively read reproductive autonomy into the framework of fundamental rights. This development is primarily rooted in

² *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1 — privacy recognised as intrinsic to personal liberty under Article 21 of the Indian Constitution.

³ *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1 — the Supreme Court held that reproductive choice is a dimension of personal liberty and dignity of women.

⁴ Cook, Rebecca J., et al., **Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law**, Oxford University Press (2003) — conceptualises reproductive autonomy as an intersection of liberty, privacy, and gender equality.

Article 21 of the Constitution, which guarantees not just physical existence but a life of dignity, autonomy, and personal liberty. Through evolving judicial interpretation, reproductive choice has been recognized as an indispensable component of bodily integrity and self-determination.

3.1 RIGHT TO HEALTH UNDER ARTICLE 21.

The Supreme Court's expansive reading of Article 21 has established that the right to life includes the right to health and access to adequate medical care. As a result, reproductive healthcare comprising prenatal and postnatal care, maternal health services, and access to safe abortion, forms part of constitutionally protected entitlements. The Court has repeatedly held that denial of maternal healthcare or unsafe reproductive services violates Article 21 because it compromises a woman's dignity, wellbeing, and survival.

3.2 RIGHT TO HEALTH AND PERSONAL AUTONOMY

The landmark Puttaswamy Judgment (2017)⁵ recognised privacy as a fundamental right inherent in personal liberty. The Court held that privacy encompasses autonomy over reproductive decisions, freedom to make choices regarding pregnancy and contraception, and confidentiality of reproductive health information.⁶ These landmark judgements transformed reproductive rights from a matter of medical discretion to a constitutional guarantee of self-governance.

4. INTERNATIONAL HUMAN RIGHTS PERSPECTIVE

Global human rights instruments have shaped the recognition of reproductive rights.

Instrument	Key Provisions on Reproductive Rights
CEDAW (1979)	Eliminates discrimination in healthcare; ensures access to reproductive healthcare and family planning.

⁵ *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1 — Supreme Court held that privacy is intrinsic to personal liberty and extends to decisional autonomy over intimate matters, including reproductive choices.

⁶ *Suchita Srivastava v. Chandigarh Administration* (2009) 9 SCC 1

ICESCR (1966)	Recognizes the right to the highest attainable standard of physical and mental health, including reproductive health.
ICCPR (1966)	Protects dignity, liberty and privacy in reproductive decisions.
Beijing Platform for Action (1995)	Calls for ending maternal mortality and improving access to reproductive services.
SDGs (2015)	Goal 3 and 5 focus on maternal health, gender equality and universal healthcare.

India is a signatory to these instruments, which imposes a global responsibility to protect reproductive autonomy.

5. LEGISLATIVE FRAMEWORK IN INDIA

India has taken several legal and policy initiatives to regulate reproductive rights and expand access to healthcare. Although reproductive autonomy has developed primarily through constitutional interpretation, statutory frameworks play a crucial role in ensuring safe, ethical, and accessible reproductive services.

5.1 MEDICAL TERMINATION OF PREGNANCY ACT 1971 (AMENDMENT 2021)

The MTP Act is the central legislation governing abortion in India. It legalizes termination of pregnancy under defined medical and humanitarian grounds and aims to balance reproductive autonomy with fetal protection. The 2021 Amendment broadened access by extending the permissible gestation limit to 24 weeks for survivors of rape, minors, and women with disabilities. It further permits termination beyond 24 weeks in cases of substantial fetal abnormalities based on the decision of a Medical Board. The Act also mandates confidentiality of the woman seeking abortion, ensuring non-disclosure of her identity. Although the MTP

framework advances safe reproductive healthcare, practical barriers persist due to medical hesitancy, lack of awareness, and unequal availability of services across regions.⁷

5.2 THE PRE- CONCEPTIONS AND PRE NATAL DIAGNOSTIC TECHNIQUES ACT 1994

The PCPNDT Act was enacted to combat gender-discriminatory practices and eliminate female feticide. It prohibits sex-selection tests, regulates diagnostic techniques, and penalizes medical practitioners involved in prenatal sex determination. By addressing misuse of technology to uphold patriarchal norms, the Act strengthens gender justice. However, rigid implementation mechanisms have sometimes led diagnostic centers to limit legitimate prenatal services out of fear of prosecution, highlighting the need for stricter monitoring alongside supportive compliance measures.⁸

5.3 OTHER SUPPORTING FRAMEWORK

Policy-based measures complement the legal regime by promoting reproductive and maternal health. Initiatives such as the National Health Mission (NHM), Janani Suraksha Yojana (JSY), POSHAN Abhiyan, and the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (RMNCH+A) aim to enhance institutional deliveries, nutrition, financial support, and healthcare awareness. However, gaps remain due to infrastructure disparities between urban and

⁷ • *The Medical Termination of Pregnancy (Amendment) Act, 2021*, Act No. 8 of 2021 — amended Sections 3 and 5A, extending gestational limits and ensuring confidentiality of abortion seekers.

9.. *The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994*, Act No. 57 of 1994 — enacted to regulate diagnostic techniques and prevent sex-selective abortions to curb female feticide.

rural regions, uneven distribution of healthcare professionals, and limited reproductive health literacy in marginalised communities.⁹

6. BARRIERS TO REALIZING REPRODUCTIVE RIGHTS

Although constitutional guarantees and statutory protections recognise reproductive autonomy, the practical enjoyment of reproductive rights in India remains uneven. Deep-rooted social structures, economic inequality, healthcare limitations, and administrative barriers restrict individuals particularly women and gender-marginalised groups from exercising reproductive choice freely and safely.

6.1 SOCIO – CULTURAL BARRIERS

Persistent patriarchal values often restrict women from independently making reproductive decisions. Early marriage and pressures for early childbearing continue to normalise motherhood as a compulsory social role rather than a voluntary choice. Stigma surrounding abortion and contraception discourages individuals from seeking reproductive services. Religious and moral narratives further reinforce guilt and social condemnation, undermining autonomy over reproductive decisions.

6.2 ECONOMICS BARRIERS

Economic inequality remains a decisive factor in reproductive freedom. High healthcare costs, limited insurance coverage for reproductive procedures, and lack of financial independence among women reduce accessibility to safe services. Low-income women are disproportionately pushed toward unsafe or delayed reproductive care.

6.3 HEALTH CARE SYSTEMS LIMITATIONS

⁹ Ministry of Health and Family Welfare, Government of India — NHM, JSY, POSHAN Abhiyan and RMNCH+A initiatives targeting maternal and child health, nutrition, and institutional delivery outcomes.

Healthcare infrastructure gaps significantly hinder access to safe reproductive services. Rural regions face a chronic shortage of gynecologists and trained healthcare professionals, and emergency obstetric services remain inadequate. Many facilities lack basic infrastructure for safe abortions, resulting in delays and unsafe procedures.

6.4 LEGAL AND ADMINISTRATIVE CONSTRAINTS

Over-regulation and bureaucratic hurdles also contribute to denial of reproductive services. Medical professionals often fear prosecution under the PCPNDT Act, leading to reluctance to provide legitimate reproductive services. Delays in the constitution of Medical Boards for late-term abortions and persistent confusion between abortion rights under the MTP Act and restrictions under PCPNDT create ambiguity and hesitation in healthcare delivery.

6.5 VULNERABILITY AMONG MARGINALIZED GROUPS

Reproductive rights violations disproportionately affect groups positioned at the margins of society. Rural women face systemic discrimination and lack of accessible healthcare. Women with disabilities encounter medical prejudice and denial of informed reproductive choices. LGBTQ+ individuals are often excluded from reproductive services due to heteronormative assumptions embedded in law, policy, and healthcare practices.

6.6 RECENT STATISTICAL DATA

India's recent reproductive-health indicators show a mixed landscape of progress and persistent gaps. The National Family Health Survey-5 reports that contraceptive prevalence has risen to **66.7%**, while unmet need for family planning has declined to **9.4%**.¹⁰ Yet, national estimates indicate approximately **15.6 million abortions** occur annually, with a majority taking place outside formal health facilities, highlighting barriers in safe access.¹¹ Maternal mortality has improved, with India recording an MMR of about **88 per 100,000 live births**, reflecting

¹⁰ International Institute for Population Sciences (IIPS), *National Family Health Survey (NFHS-5), 2019–21: India Fact Sheet*.

¹¹ Singh, Susheela, et al., "The Incidence of Abortion and Unintended Pregnancy in India, 2015," *The Lancet Global Health* (2018).

strengthened but uneven reproductive-health systems.¹² These data indicates the need for rights-based judicial and policy approaches.

7. REPRODUCTIVE RIGHTS AS A FOUNDATION OF GENDER EQUALITY AND SOCIAL JUSTICE

Reproductive rights forms a part of gender equality because the ability to exercise control over reproduction directly shapes an individual's life opportunities and social positioning. When women and gender-marginalised persons are empowered to make autonomous decisions about pregnancy, contraception, and childbirth, they gain greater control over their education, employment, financial security, and bodily integrity. Reproductive autonomy enables them to participate fully in public and private life without being constrained by involuntary pregnancies or societal expectations around motherhood.

Access to reproductive choice strengthens economic independence by allowing individuals to plan their careers, plan childbirth, and negotiate equal relationships within the family.

8. REPRODUCTIVE RIGHTS IN INDIA AND OTHER COUNTRIES

Reproductive rights are shaped not only by constitutional principles but also by specific statutes and rules. A brief comparative overview shows how different jurisdictions structure abortion access, conditions and limits.

8.1 INDIA

In India, abortion is primarily regulated by the **Medical Termination of Pregnancy (MTP) Act, 1971**, as amended in 2021.

¹² Registrar General of India, *Sample Registration System (SRS) Special Bulletin on Maternal Mortality*.

- **Section 3, MTP Act 1971** – permits termination of pregnancy by a registered medical practitioner where certain conditions are met (risk to life of the woman, grave injury to physical or mental health, substantial risk of serious fetal abnormalities). The 2021 amendment allows termination:
 - up to 20 weeks with the opinion of one registered medical practitioner, and
 - 20–24 weeks for specified categories of women (rape survivors, minors, women with disabilities, etc.) with opinion of two medical practitioners.
- For substantial fetal abnormalities, termination beyond 24 weeks is allowed based on the opinion of a Medical Board
- **Section 4** regulates the approved places where abortion may be carried out.
- **Section 5A** (inserted by the 2021 amendment) expressly protects the privacy of the woman, prohibiting disclosure of her identity except as authorised by law.

Alongside, the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 prohibits sex selection and regulates use of prenatal diagnostic techniques (e.g., ultrasound) to prevent their misuse for female feticide; sex-selection and related offences are criminalised, including through provisions such as Section 3A (prohibition of sex selection) and Sections 22–26 (offences and penalties)

Thus, India recognises abortion as lawful under specified indications and gestational limits, while separately prohibiting sex-selective practices.

8.2 UNITED STATES

Historically, *Roe v. Wade*¹³, recognised a constitutional right to choose abortion prior to fetal viability under the Fourteenth Amendment’s privacy doctrine, while *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) replaced strict scrutiny with the “undue burden” standard for state restrictions.

¹³ 410 U.S. 113 (1973)

However, in *Dobbs v. Jackson Women's Health Organization*¹⁴, 597 U.S. 215 (2022), the U.S. Supreme Court held that the Constitution does not confer a right to abortion, overruling *Roe* and *Casey* and returning regulatory authority to the states.

Post-Dobbs:

- Some states (e.g., New York and California) have enacted strong statutory protections:
 - New York Reproductive Health Act 2019 decriminalised abortion and allows it up to 24 weeks, and beyond that where the fetus is non-viable or the woman's life or health is at risk.
 - California's Reproductive Privacy Act, contained in California Health and Safety Code, Division 106, Part 2, Chapter 2, Article 2.5, protects a person's fundamental right to choose or refuse abortion and includes confidentiality safeguard.
- Other states have near-total bans or very narrow exceptions, relying on state criminal or health codes after Dobbs.

Thus, abortion rights in the U.S. are now highly state-dependent rather than uniform federal rights.

8.3 UNITED KINGDOM

In England, Wales and Scotland, abortion is governed primarily by the Abortion Act 1967 (c.87), as amended by the Human Fertilisation and Embryology Act 1990:

- Section 1, Abortion Act 1967 – provides that a person is not guilty of an offence relating to abortion when a pregnancy is terminated by a registered medical practitioner if two doctors form an opinion in good faith that certain statutory grounds are met (risk to the woman's life, injury to physical or mental health, substantial risk of serious fetal abnormality, etc.).
- Following 1990 amendments, the general time limit is 24 weeks for most grounds.

¹⁴ U.S. 215 (2022)

Historically, abortion outside these conditions was criminalised under Sections 58–59 of the Offences Against the Person Act 1861, but in June 2025, the UK Parliament approved an amendment decriminalising women themselves for ending a pregnancy in England and Wales, while retaining the regulatory medical framework.

8.4 FRANCE

In France, abortion is regulated under the French Public Health Code:

- Article L2212-1, Code de la santé publique allows any pregnant woman who does not wish to continue her pregnancy to request a termination by a doctor or midwife, and provides that abortion can be carried out up to the end of the 14th week of pregnancy (approximately 16 weeks amenorrhoea).
- French law also ensures information rights about abortion methods and provides that the costs are fully covered by health insurance, making access both legal and financially supported.

8.5 SOUTH AFRICA

- South Africa is often cited as having one of the more liberal statutory frameworks:
- The Choice on Termination of Pregnancy Act 92 of 1996 permits termination:
 - On request up to 12 weeks of pregnancy (Section 2),
 - Between 13–20 weeks where specified social, economic, health or fetal indications exist, and after 20 weeks only for serious medical reasons (risk to woman’s life, serious fetal malformation, or risk of severe fetal injury).
- The Act also stresses informed consent of the woman and allows trained nurses or midwives to perform early abortions in approved facilities, enhancing practical access.

8.6 IRELAND

Ireland moved from a near-total constitutional ban to a rights-based statutory framework:

- The Health (Regulation of Termination of Pregnancy) Act 2018 (Act 31 of 2018) provides for abortion:

- Section 12 – on request up to 12 weeks, subject to a three-day waiting period
- Section 9 – where there is a risk to the life or of serious harm to the health of the pregnant woman
- Section 10 – in emergencies with immediate risk to life or serious harm;
- Section 11 – where there is a condition likely to lead to the death of the fetus before or shortly after birth.

Although reproductive rights are constitutionally and statutorily recognised in India, the country still follows a conditional and medical-authorisation model, unlike several jurisdictions where abortion is treated primarily as a matter of personal choice. Nations such as France and South Africa adopt a more autonomy-driven framework, allowing abortion on request within a defined gestational period and ensuring strong state support for access. Ireland has recently shifted toward a rights-based model after decades of restrictive constitutional provisions, while the United Kingdom retains a regulated medical framework with relatively broad grounds. In contrast, the post-Dobbs landscape in the United States demonstrates a regression, where abortion rights vary drastically from state to state and creating unequal access. Against this global backdrop, India occupies a middle ground: it constitutionally acknowledges reproductive autonomy through Article 21 and judicial interpretation, yet the statutory regime continues to place women’s reproductive decisions under medical scrutiny rather than recognising abortion as a fundamental right. Strengthening access, reducing procedural burdens, and recognising abortion as a matter of individual choice, rather than conditional permission—would bring India closer to global best practices and realize the full promise of reproductive justice.

11. REPRODUCTIVE RIGHTS AND INTERSECTUALITY

Reproductive autonomy in India is shaped by intersecting identities such as caste, class, religion, disability, sexuality and geography. While upper-society, urban women often access contraception and abortion with relative ease, rural women face discrimination, stigma and infrastructural gaps. Persons with disabilities are frequently denied reproductive agency or coerced into sterilisation, and LGBTQ+ persons remain excluded from IVF, surrogacy and adoption frameworks designed for heterosexual married couples. These unequal experiences

show that reproductive justice requires dismantling structural oppression, not merely recognising legal rights.

12. REPRODUCTIVE RIGHTS AND SUSTAINABLE DEVELOPMENT

Reproductive autonomy is central to SDG-3 and SDG-5. When women can plan childbirth, they participate in education, employment and career growth. This enhances family well-being and national economic growth. Safe abortion, family planning and maternal healthcare reduce mortality and contribute to intergenerational prosperity.

13. ROLE OF TECHNOLOGY AND DIGITAL HEALTH IN ADVANCING REPRODUCTIVE RIGHTS

Telemedicine, health apps, AI-based diagnostics and online counseling improve access to reproductive services for those facing geographical or social barriers. However, digital illiteracy, misinformation, gender gaps in mobile access and privacy concerns can limit their benefits.

14. IMPORTANT CASE LAWS ON REPRODUCTIVE RIGHTS

Indian jurisprudence on reproductive autonomy has evolved through a series of landmark judgments. The foundation was laid in *Suchita Srivastava v. Chandigarh Administration*, where the Supreme Court recognised that a woman's right to make reproductive decisions including abortion and this is part of personal liberty under Article 21 and inseparable from bodily integrity and dignity.¹⁵ The concept of privacy in *Justice K.S. Puttaswamy (Retd.) v. Union of India* further expanded reproductive rights by holding that intimate decisions relating to procreation, contraception and family planning fall within the core of decisional privacy.¹⁶

In *Devika Biswas v. Union of India*, the Court condemned coercive sterilisation practices and reinforced the State's duty to ensure safe reproductive services.¹⁷ In *XYZ v. State of Gujarat*, the Supreme Court permitted termination of pregnancy beyond the statutory limit in cases of severe fetal abnormalities, recognising the importance of mental and physical well-being of the

¹⁵ *Suchita Srivastava & Anr. v. Chandigarh Administration*, (2009) 9 SCC 1.

¹⁶ *Justice K.S. Puttaswamy (Retd.) & Anr. v. Union of India*, (2017) 10 SCC 1.

¹⁷ *Devika Biswas v. Union of India & Ors.*, (2016) 10 SCC 726.

pregnant person.¹⁸ Most recently, *X v. Principal Secretary, Health and Family Welfare Dept., Govt. of NCT of Delhi* extended abortion access under the MTP Act to unmarried women up to 24 weeks, affirming that marital status cannot determine reproductive choice.¹⁹

15. CONCLUSION AND SUGGESTIONS

Reproductive rights in India have evolved from a limited public-health concern to a recognised constitutional entitlement grounded in dignity, autonomy and personal liberty. Judicial interpretation has been instrumental in shaping this shift, affirming that decisions regarding contraception, pregnancy and abortion lie at the core of bodily integrity and decisional freedom. However, despite progressive judgments and statutory protections, reproductive autonomy is not experienced equally across society. Social stigma, medical reluctance, infrastructural gaps and discrimination continue to limit meaningful access. Legal guarantees become incomplete when individuals lack safe, affordable and stigma-free reproductive healthcare.

To transform jurisprudence into real empowerment, a multi-layered implementation approach is required. First, abortion and contraceptive services must be made widely available by strengthening public health infrastructure, especially in rural and marginalised regions. Second, regulatory ambiguity between abortion rights and sex-selection prohibitions should be clarified to reduce fear among medical practitioners. Third, reproductive healthcare should be integrated into insurance schemes and supported by trained personnel to minimise out-of-pocket expenditure. Fourth, public health campaigns must challenge patriarchal norms and abortion stigma while improving reproductive literacy. Finally, policies must prioritise intersectional groups, so that LGBTQ+ persons receive non-discriminatory and inclusive reproductive care. Only such comprehensive reform can ensure that reproductive choice becomes a lived reality rather than a conditional legal right.

¹⁸ *XYZ v. State of Gujarat*, (2022) 3 SCC 497.

¹⁹ *X v. Principal Secretary, Health and Family Welfare Dept., Govt. of NCT of Delhi*, (2022) 10 SCC 1.

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