INDIAN JOURNAL OF LEGAL AFFAIRS AND RESEARCH

VOLUME 3 ISSUE 1

Peer-reviewed, open-access, refereed journal

IJLAR

+91 70421 48991
editor@ijlar.com
www.ijlar.com

DISCLAIMER

The views and opinions expressed in the articles published in the Indian Journal of Legal Affairs and Research are those of the respective authors and do not necessarily reflect the official policy or position of the IJLAR, its editorial board, or its affiliated institutions. The IJLAR assumes no responsibility for any errors or omissions in the content of the journal. The information provided in this journal is for general informational purposes only and should not be construed as legal advice. Readers are encouraged to seek professional legal counsel for specific legal issues. The IJLAR and its affiliates shall not be liable for any loss or damage arising from the use of the information contained in this journal.

Introduction

Welcome to the Indian Journal of Legal Affairs and Research (IJLAR), a distinguished platform dedicated to the dissemination of comprehensive legal scholarship and academic research. Our mission is to foster an environment where legal professionals, academics, and students can collaborate and contribute to the evolving discourse in the field of law. We strive to publish high-quality, peer-reviewed articles that provide insightful analysis, innovative perspectives, and practical solutions to contemporary legal challenges. The IJLAR is committed to advancing legal knowledge and practice by bridging the gap between theory and practice.

Preface

The Indian Journal of Legal Affairs and Research is a testament to our unwavering commitment to excellence in legal scholarship. This volume presents a curated selection of articles that reflect the diverse and dynamic nature of legal studies today. Our contributors, ranging from esteemed legal scholars to emerging academics, bring forward a rich tapestry of insights that address critical legal issues and offer novel contributions to the field. We are grateful to our editorial board, reviewers, and authors for their dedication and hard work, which have made this publication possible. It is our hope that this journal will serve as a valuable resource for researchers, practitioners, and policymakers, and will inspire further inquiry and debate within the legal community.

Description

The Indian Journal of Legal Affairs and Research is an academic journal that publishes peer-reviewed articles on a wide range of legal topics. Each issue is designed to provide a platform for legal scholars, practitioners, and students to share their research findings, theoretical explorations, and practical insights. Our journal covers various branches of law, including but not limited to constitutional law, international law, criminal law, commercial law, human rights, and environmental law. We are dedicated to ensuring that the articles published in our journal adhere to the highest standards of academic rigor and contribute meaningfully to the understanding and development of legal theories and practices.

CASTE AND REPRODUCTIVE CONTROL: WHY LEGAL RECOGNITION OF AUTONOMY FAILS DALIT RURAL WOMEN

AUTHORED BY - ANUKRITI SRIVASTAVA

Abstract

Medical Termination of Pregnancy Act 2022 amendment is a step forward towards recognising reproductive autonomy and safeguarding individual choice. However, this framework overlooks the uncomfortable reality faced by Dalit rural women who withstand coercion which is instrumentalised specifically targeted towards this segment of women through, sterilisation campaigns, differential treatment by healthcare workers and states ignorance towards caste based sexual violence.

At one hand, the amendment makes an attempt to tackle to the issue of potential barriers faced by women by integrating individual choice and bodily integrity in its framework. These barriers exist due to the patriarchal control, which usually resides in the husband or in-laws. However, it does not address the more deep-rooted issue of structural inequalities, which constraint real autonomy. The framework turns a blind eye to the tools by which caste hierarchy is exercised upon reproductive autonomy, resulting in the idea of autonomy being out of bounds for such rural Dalit women.

Although post Emergency, legal prohibition has been placed, sterilisation regime is still persistent. Especially in rural areas majorly populated by Dalit communities. This is done through economic coercion and state incentive policies which is worsened by the high illiteracy rates. Additionally, healthcare workers often avoid or even refuse to treat Dalit women and also face comparatively disproportionate degree of sexual violence. These further intensify the existing inequalities. This caste-based oppression exists irrespective of family control. A Dalit rural women may have the

reproductive autonomy even if her family is not in agreement of the same but at the same time, she may be a victim of state coercion and lack of assistance from healthcare workers.

My research paper analyses whether the Indian framework merely grants individual reproductive autonomy and bodily integrating and whether it address the issues at grassroot level. The only way to accord reproductive agency in its true sense would be by demolishing the underlying issues. Further, my paper argues whether reproductive autonomy is strained by differentiations generated by Brahmanical patriarchy, moral policing and caste-based endogamy and demands intervention.

Introduction

India's framework of reproductive rights underwent a considerable shift by the amendment of the Medical Termination of Pregnancy (MTP) Act, 1971 in order to recognise as well as safeguard the bodily integrity and reproductive autonomy of women. The above-mentioned Act changed the gestational limit from 20 weeks to 24 weeks and included unmarried women under its scope. It further widened the grounds for unmarried women on which abortion can be pursued by including contraceptive failure in addition to the already existing grounds. This step was accompanied by Supreme Court's judgement appreciating the Act for its contribution towards granting reproductive autonomy and bodily integrity. Establishing it as foundational to dignity of women and a step forward towards equality[1].

Although this recognition of bodily integrity and autonomy is a positive stride towards a progressive landscape, this change does not devoid it of the paradox which is more than apparent. The continued existence of sterilisation camps in rural areas, discrimination by state health workers, cash incentives and the impact of quota system in Family Planning Schemes. Thus, although formal legal autonomy is conferred, autonomy in it's true essence is not present. It has been stained by caste based institutional structures. My paper explores the ground reality of India's reproductive landscape from the lens of Dalit women and what could be no less than atrocities faced by them. Thereby, arguing that the 2022 Amendment fails to address some of the most

[1] X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi & AnrCivil Appeal No 5802 of 2022

pressing issues majorly the state driven coercion and the impact of Brahmanical patriarchy, moral policing and caste-based endogamy on the overall course of events.

Research Objectives and Aims:

Primary objective:

To document and examine issues that are unaddressed in the present framework including the state driven reproductive coercion faced by Dalit women through sterilisation camps, discrimination by health care workers and the caste hierarchy which perpetuates caste-based violence in addition to patriarchal control at family level.

Secondary objectives:

1. To establish that reproductive autonomy in Dalit women is more often than not constrained by institutional machinery and not by individual choice.
2. To establish despite the fact that progressive formal recognition is recognised, the institutional mechanisms is still overlooked.
3. To establish that this formal recognition is insufficient. Autonomy in its fullest sense of the term can be achieved only by institutional structural transformation.

Aim:

1. To refute the narrative that India's progressive reproductive scenario provides protection to all women equally.
2. To demonstrate such autonomy is illusionary from the lens of rural Dalit women.
3. To argue for institutional accountability against reproductive coercion in Dalit women.

Research Questions

Primary research question: why do legal frameworks which recognise reproductive autonomy of individuals do not address state reproductive coercion?

Sub questions:

1. What forms of empirical study documents uncover the intersection between caste, gender and the power of the state with reference to sterilisation programmes that, under the disguise of public health policy target rural women from Dalit communities.

1. The manner in which healthcare workers discriminate against women from these communities, although they have legally recognised entitlement?
2. How does sexual violence against these women lead to indirect reproductive control?
3. What are the reforms required to confer genuine autonomy and not just formal?

Research Methodology

This paper employs qualitative analysis on the basis of **doctrinal research** along with legal documents, statistics and various articles in order to come up with a comprehensive analysis of caste-focused reproductive coercion. This is strengthened by examination of academic research databases including JSTOR, numbers cited from Human Rights Watch and Hart UK. Additionally, supplemented by data from Indian Governments. Thus, the quantitative analysis incorporates empirical evidences from secondary sources in which Bilaspur Deaths are the primary focus.

Scope of my research: My analysis is majorly focused on **North and Central India** contexts where caste hierarchies are institutionally strong and sterilization targeting is documented. Thus, it is essential to highlight that this is not pan-India analysis as caste based hierarchical systems operates differently across regions as well as financial brackets. My study's scope is further narrowed down to include only **rural Dalit** women from these communities.

Literature Review:

1. **HUMAN RIGHTS WATCH, India: Target-Driven Sterilization Harming Women (2012)**

   This article examines the quota systems which are imposed upon health care workers on the basis of empirical evidence. It demonstrates how healthcare workers are threatened to meet state-imposed quotas for sterilisation by cuts in salary and loss of job. It incorporates field interviews of about 40+ health care providers and women. The text highlights how women are systematically pressurised from visits by these workers sometimes goes up to ten in a week[2].

[2] Human Rights Watch, India: Target-Driven Sterilization Harming Women (last visited: Nov. 13 2025), https://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women, (last visited: Nov. 13 2025)

2. **HART UK, India's Inequality in Healthcare: The Caste Divide**

   This report examines discrimination on the basis of caste in India with regards to healthcare. The analysis is done on the basis of field research in Uttar Pradesh and other states. It establishes that Dalit women are discriminated against by healthcare workers, often giving birth without trained healthcare workers as midwives refuse to perform their duty due to the status of 'untouchables'. Further deliberate delays are made and sometimes doctors even refuse to touch patients. It reveals the systematic discrimination, which is inherent in the healthcare scenario of India[3].

3. **INDIAN JOURNAL OF MEDICAL ETHICS, Bilaspur Sterilisation Deaths: Evidence of Oppressive State Population Control Policies (2019)**

   This article examines in details, the 2014 state driven sterilisation camp in Bilaspur, Chhattisgarh where a significant number of Dalit and Tribal woman was sterilised. The examination also incorporates the details of the procedure, causes of deaths which occurred during the procedure, failure to follow protocols and incentives to the healthcare workers in return of performing such sterilisations[4].

Chapter 1: Reproductive Coercion at State-Level: Targeted Sterilisation of Dalit Women

1.1 Where does India stand in the growing numbers of sterilisations globally?

The magnitude of sterilisation carried out in India is overwhelming and deliberate. "India carries out 39% of the world's sterilizations, with 4.6 million women sterilized in 2012 alone[5]." Further, "India has the highest rate of female sterilization in the world at 39%, and more than 40% of those women are sterilized before age 25[6]." Thus, on the basis of the above data the disproportionality in opting for sterilisation as a mode of fertility control in India can be clearly established and Dalit rural women comprise a major chunk of these numbers.

[3] HART UK, India's Inequality in Healthcare: The Caste Divide (last visited: Nov. 13 2025).
[4] N. Sarojini et al., Bilaspur Sterilisation Deaths: Evidence of Oppressive Population Control Policy, 12 Indian J. Med. Ethics 1 (Jan.–Mar. 2015), https://ijme.in/wp-content/uploads/2016/11/2019-5.pdf, (last visited: Nov. 13 2025)
[5] Voelkerrechtsblog, Katharina, India's Forced Sterilization Practices Under International Law, 9 MARCH 2022, https://voelkerrechtsblog.org/., (last visited: Nov. 15 2025)
[6] OREGON ST. U., Domestic Violence in India Linked with Higher Rates of Forced Sterilization (June 25, 2020), https://oregonstate.edu/., (last visited: Nov. 15 2025)

1.2 The Bilaspur case study

The Bilaspur tragedy was one of the cruellest results of state driven coercion. Within the sterilisation camps of Bilaspur, Chhattisgarh 83 women which were majorly from Dalit, tribal or OBC communities, around 16 of whom lost their lives due to the extremely gross negligence of the healthcare providers. The cause of death could be attributed to shocking facts. All these women were operated upon a time span of few hours by just one surgeon[7]. The surgeon driven by the high state quota and possible incentive adopted the inhumane approach of prioritising quantity over quality. Further, no regard was given to create a sterile environment, it has been alleged that even gloves were not changed, the medical equipment's including the bowl and the needles were not sterilised in between the operations which deteriorated the susceptibility of such women towards diseases[8].Further, "Post mortem examinations of the first seven deaths had suggested septicaemia. These indicate death by infection during or after the operation[9]."

Even though, this eye-opening event led to some reformatory work on part of the judiciary wherein a ban was place on sterilization camps[10]. However, merely posing a ban and emphasis on informed consent is not sufficient. The reason why this attempt to reform failed has been discussed under **Section 4** of this research.

1.3 How incentive scheme may lead to economic coercion

The above incident indicates how poverty turns the reproductive autonomy of the women into a mere illusion. Women living under poverty where basic minimum wage ranges from ₹500 to ₹1000, an amount of ₹1000 is an incentive of a significantly greater amount. For instance, in the case of Chhattisgarh, incentive varying between ₹600 to ₹1400 is a choice structured to ensure acceptance[11]. The financial incentives in cases like this function as a mechanism for removal of genuine consent.

Further incentive schemes formulated by states also influence the health providers. The above-mentioned surgeon's drive to achieve such high numbers could have been inspired from

[7] INDIAN J. MED. ETHICS, Bilaspur Sterilisation Deaths: Evidence of Oppressive State Population Control Policies (2019) , (last visited: Nov. 15 2025)

[8] https://www.thehindu.com/news/national/other-states/sterilisation-deaths-in-chhattisgarh-doctor-freed/article17336215.ece, (last visited: Nov. 18 2025)

[9] Wikipedia, 2014 Chhattisgarh Sterilisation Deaths, https://en.wikipedia.org/

[10] Devika Biswas v. Union of India & Others is (2016) 10 SCC 726

[11] ibid

recognition he achieved earlier from chief minister of the state in 2014 as a reward for performing 50,000 sterilisations. [12]. Thus, the economic impact is not only limited to the victims of such schemes, but also the perpetrators. Interestingly enough, the surgeon was tried, however, he was released on the basis of technical grounds as sanction of the state was not taken.

1.4 The Quota System as a means to Institutional Coercion mechanism for coercion

Quota systems imposed on health workers operates as a mechanism for targeted sterilisation by state. Workers are often threatened with salary cuts or loss of jobs if the required numbers are not met. Thus, resulting in health care workers being aggressive in order to pursue the targets, pressurising women to go through the operation. Some healthcare providers in the desperate need to fulfil the goals visit 10 times weekly to persuade women[13].

As a result of the **Devika Biswas v. Union of India & Others[14]** an attempt has been made to change the target-based framework to quality-based framework. However, in ground reality neither the target driven approach has been transformed nor has the quality-based framework been achieved. The failure of the same has been discussed under **Section 4** of the research.

1.5 Analysing patterns: the disproportional effect of such policies on certain sections

The target of these sterilisation campaigns are women from lower financial brackets. Statistically, there is a high rate of illiteracy among Dalit community[15] and women who are less educated comparatively opt for sterilisation more frequently as an option for fertility control as compared to women who are more educated.[16] "Women with no formal education experience 43% sterilization by age 30; women with higher education 19.2%.[17]" Thus, it can be inferred that the rate at which less educated women predominantly Dalit rural poor women undergo such procedures is double the ones who are educated.

[12] Supra 7
[13] HUMAN RIGHTS WATCH, India: Target-Driven Sterilization Harming Women 10 (2012). Health workers become enforcement mechanisms: meet quotas or lose livelihood
[14] Supra 10
[15] https://timesofindia.indiatimes.com/india/in-india-5-out-of-6-multidimensionally-poor-are-from-lower-tribes-or-castes-un-report/articleshow/86843808.cms , (last visited: Nov. 18 2025)
[16] NAT'L INST. FOR FAM. HEALTH, Female Sterilisation in India: Prevalence, Informed Choice and Caste-Based Barriers (2024)
[17] Id

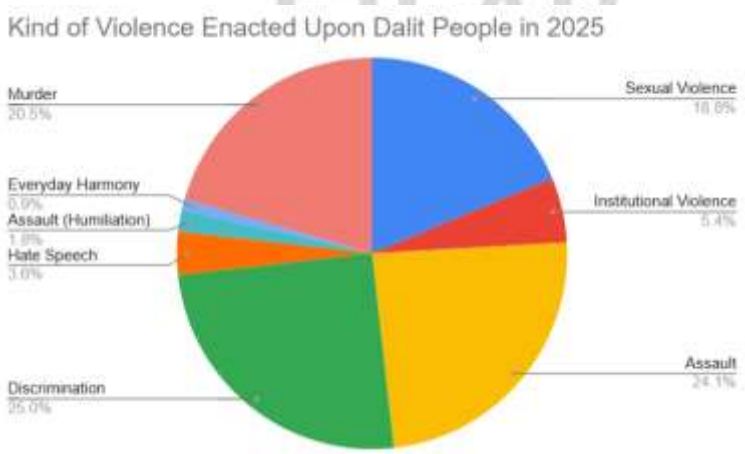
Chapter 2: Health care discrimination

2.1 Refusal by health care providers

The discrimination done by healthcare providers is not irregular rather it is **systematic** and **deliberate**. This can be observed from documented statistics which highlight the caste pollution theory, in a survey in Gujrat it has been found around a 66.2% of the times mid-wives refuse to assist delivery by Dalit women.[18] Similar patterns are noticed in other states one of them being Uttar Pradesh where Dalit women are left no choice but to deliver without medical assistance.[19] The 2022 Amendment overlooks this issue of systematic discrimination by health care workers. Though certain Acts including the "SC/ST Prevention of Atrocities Act" and "The Protection of Civil Rights Act, 1955" are in place, Dalits fail to invoke these laws due to varying reasons including lack of awareness and cooperation from officials which has been discussed in **Section 4**.

2.2 The trauma that follows:

Statistics highlight the lived reality of women facing caste based institutional gatekeeping. Instances where women have faced a spectrum of grave medical negligence including deliberate extension of time to refusal to cut the umbilical cord of Dalit women can be cited from testimonies of the victims of such institutional discrimination.[20] Leaving some families traumatised for life by



[18]https://www.ohchr.org/sites/default/files/Documents/HRBodies/CEDAW/RuralWomen/FEDONavsarjanTrustIDS.pdf, (last visited: Nov. 18 2025)
[19] Supra 3
[20] RE-SOLVEGLOBALHEALTH, How Caste is a Major Barrier to Health Equity in India (May 12, 2024), https://re-solveglobalhealth.com/, (last visited: Nov. 18 2025)

such instances and thereby avoiding future visits to hospitals. Thus, destroying the public trust in these institutions which are meant to assist/protect them.

Thus, even as recent as in 2025 instances of discrimination and sexual violence are still prevalent among 113 caste atrocities in months of January to July 2025.[21]

2.3 Tracing the reason behind inherent biases: systematic health provider discrimination

The philosophical reason behind such conduct can be attributed to the **Brahmanical Patriarchy** notion which combines caste as well as gender hierarchy and the concept of caste pollution. Instances where doctors even refused to touch their patients are prime examples of belief in these notions of pollution or untouchability still existing.[22] Dr B.R. Ambedkar defined caste as a system of control and asserted that caste power deepens the caste hierarchy and is thereby linked to controlling Dalit women and their sexuality which holds true even today.[23]

Brahmanical Patriarchy is a term coined by Uma Chakravarti, in her work "**Conceptualising Brahmanical Patriarchy in Early India: Gender, Caste, Class and State."[24]** She establishes this social order as distinct to India in which caste and gender are intertwined. In this order caste purity and **endogamy** (practice of restricting marriage to own caste) are enforced through exercising patriarchal control over women's sexual autonomy.

According to ancient Hindu texts there are four varanas namely the Brahmins (priests and teachers), below them the Kshatriyas (rulers and warriors), the Vaishyas (traders and merchants), and finally the Shudras (servants). However, as restated by Louis Dumont "There is in actual fact a fifth category, the untouchables, who are left outside the classification". They are called "Avarnas" or 'outcastes.'[25]They are also often referred to as Dalits or Harijans, this particular sect is the focus of my study.

[21] Everyday Atrocity: Mapping the normalisation of violence against Dalits and Adivasis in 2025 https://cjp.org.in/everyday-atrocity-mapping-the-normalisation-of-violence-against-dalits-and-adivasis-in-2025/, (last visited: Nov. 19 2025)

[22] (a 40-year-old Dalit woman with high fever at district hospital). ASIA TIMES, India's Dalit Women Lack Access to Healthcare and Die Young (Feb. 17, 2020), https://asiatimes.com/., (last visited: Nov. 19 2025)

[23] Ambedkar, B. R. Annihilation of Caste: The Annotated Critical Edition. Edited by S. Anand, Navayana, 2014.

[24] Uma Chakravarti, Economic and Political Weekly, Vol. 28, No. 14 (Apr. 3, 1993), pp. 579-585 (7 pages) https://www.jstor.org/stable/439955, (last visited: Nov. 19 2025)

[25] Louis Dumont (1911-1998) was a French anthropologist and an associate professor at Oxford University during the 1950s

These notions are so deeply ingrained that even in one of India's leading medical institute, discrimination by examiners and lectures to the extent of deliberately failing Dalit students in order to stop them from becoming doctors are reflected in reported instances.[26] By doing so it is ensured that health-care institutions are solely controlled by non-Dalit professionals.

Chapter 3: Sexual Violence as a tool for Institutional control of autonomy

One of the instruments of control to establish caste hierarchy is caste-based violence. Caste based violence is often deployed by men of upper caste towards women of lower caste as a means of asserting dominance and as a manner of punishment.[27] Studies display the degraded moral compass of upper men who self-proclaim themselves as flag bearers of the caste system and place upon themselves the prerogative to reform the deemed impure castes.[28]

Further, rural Dalit women are mostly the targets of such violence as they are at the intersection of two oppressed class one based on gender and the other caste, the situation is further aggravated by poverty. There is an increased number of cases filed every year. The percentage being 159% between 2009 to 2019, even though most of these cases go under reported.[29]

Further, the sexual violence when results in pregnancy, infringes upon the reproductive autonomy of these women. They have to choose between going through unsafe abortions due to medical negligence faced by them or to carry pregnancies which are born out of such violence. Thus, resulting into the denial of reproductive autonomy to such women.

Chapter 4: Failure of legal reforms

1. **Combined effect of gender and caste bias on institutions:** Dalit women face two barriers at different levels. First is their caste accompanied by their gender and the situation is

[26] Supra note 3; Soutik Biswas, Why are India's Dalit students taking their lives? https://www.bbc.com/news/world-asia-india-35349979, (last visited: Nov. 19 2025)

[27] Pupul Lama, Sexual and Gender-Based Violence Against Dalit Women and Girls in India, COFEM Social Change , https://cofemsocialchange.org/sexual-gbv-dalit-women-girls-india/ , (last visited: Nov. 19 2025)

[28] *Justice Denied: Sexual Violence & Intersectional Discrimination: Barriers to Accessing Justice for Dalit Women and Girls in Haryana, India* **at** page x (Equality Now & Swabhiman Society, Nov. 25, 2020), https://equalitynow.org/wp-content/uploads/2020/11/EN-Haryana_Report-ENG-PDF-1.pdf :

[29] https://www.indiatoday.in/magazine/cover-story/story/20201019-price-of-prejudice-1729903-2020-10-10, (last visited: Nov. 19 2025): Prachi Patil, *Understanding Sexual Violence as a Form of Caste Violence*, 7 **J. Soc. Inclusion** 59 (2016), https://pdfs.semanticscholar.org/8655/6fc810e5743be8e81ba07dc0a92dcb0093c7.pdf

further aggravated by poverty. The caste of a women increases her vulnerability to mortality due to intersectional discrimination, poor sanitation and inadequate healthcare.[30] Though there are provisions in place against discrimination faced by this segment of women, in reality they are often denied their legal rights by deliberate mishandling of cases by officials and under reporting of cases due to various factors varying from fear of social stigma to gender-based violence and lack of awareness and financial resources to pursue legal battles.

2. **Medical Termination Act and its failure:** Though the Act makes a progressive step by recognising various legal rights of women including the right to have the choice of abortion irrespective of the decision of their family. However, the Act fails to include in its scope all segments of women. On bare reading of the Act, it may seem that women across all category are covered and in sense of formal recognition the same holds true. However, the Act fails to address the concern of my research i.e., Dalit rural women who are deprived of this autonomy on its true sense.

3. **Aftermath of the 2016 judgement: Did ground realities change?**

   Even after the court banned targeted sterilization based on quota the actual structure did not change. The judgement effectively only changed the nomenclature of the term to "Expected Levels of Achievement" continuing the same framework which encouraged pressurised health care workers to attain certain numbers with a lingering fear of job loss. [31] Further, the court banned sterilization camps which was again a step forward. However, this did not make much of a difference as the same activities are now carried out in fixed day facilities which often lack the same i.e. basic hygiene and essential medical

[30] Turning Promises into Action: Gender Equality in the 2030 Agenda for Sustainable Development 31 Box 1.2, UN Women (2018), https://www.unwomen.org/en/digital-library/publications/2018/2/gender-equality-in-the-2030-agenda-for-sustainable-development-2018, (last visited: Nov. 19 2025)

[31] Jashodhara Dasgupta, On the Ground, It's Business As Usual: Jashodhara Dasgupta On One Year Since the Supreme Court Banned Sterilisation Camps, Caravan Magazine (Nov. 19 2025) 2017), https://caravanmagazine.in/vantage/jashodhara-dasgupta-one-year-since-supreme-court-banned-sterilisation-camps. , (last visited: Nov. 20 2025)

instruments[32]. The judgment also emphasised on informed consent. However, since the reasons why such uninformed consent persisted remain unchanged.

4. **Sate authorised coercion still exists but in the veil of guidelines**:

   The National Health Mission in its official guidelines provides general anaesthesia can be administered in case of "non-cooperation".[33]The term is often wrongly interpreted and misused to operate on women who refuse to undergo the operation, testimonials of which are present.[34]Thus using "non-cooperation and non-consensual interchangeably."

Chapter 5: Conclusion and Way forward

The reproductive autonomy of women is still out of bounds for Dalit rural women as it is restricted due to various mechanisms, including targeted sterilisation and quota systems along with economic incentives, which indirectly operate as a restriction. As well as discrimination by healthcare providers. These mechanisms are not addressed by the Act which merely provides relief from family control on the women's autonomy. Thus, although on paper, women have the legal entitlement, they are not able to pursue them in reality. Thus, in circumstances such as these the women are extremely vulnerable in pain, partially undressed, dependent on health professionals, and subjected to invasive procedures. It is essential to treat that person with dignity and among other things, it should be made sure that her vulnerability is not taken advantage of or increased by humiliating conditions or abusive behaviour.

There are certain requirements which need to be fulfilled in order to achieve autonomy in its genuine sense. These are:

1. **Quota system:** although passed the 2016 judgement state have formally dismantled the quota system. It still persisted. Only its nomenclature has been changed and still encourages sterilization under family planning as the only genuine choice. Thus, there is

[32] Id
[33]Standards for Female and Male Sterilization Services, Research Studies & Standards Division Ministry of Health and Family Welfare Government of India, https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/family-planning/std-for-sterilization-services.pdf, (last visited: Nov. 20 2025)
[34] ,https://slic.org.in/uploads/2018/10/Mistreatment-and-Coercion-Unethical-Sterilization-in-India-3.pdf, (last visited: Nov. 21 2025)

a need to change the quota-based approach in maintaining National Family Plans. A comparatively efficient way to do so would be by organising campaigns and by addressing the root causes such as the idea of necessity of a son to fulfil the life of parents, which can be done by granting more educational opportunities to girls. This will ensure two-fold benefit in context of my concern. First, an increased participation in decision making may come about as, financially independent women have comparatively more say. And additionally, the notion that only son can provide may reduce in some way solving the issue of women going through pregnancy until they receive a son.

2. **Accountability of healthcare providers**: a mechanism should be in place to impose accountability on healthcare providers who act in such discriminatory manner. Further, the provision under the National Health Mission's official guidelines allowing administration in case of non-cooperation should be reformed as it is often wrongly interpreted. Detailed conditions should be given to define what is exactly included in the term "non-cooperation" so that it cannot be interchanged with "non-consensual" as per convenience.
3. **Education on legal rights**: since most of the cases go under reported due to lack of awareness, there is a need to ensure that women suffering from such issues, know their legal rights and how to enforce them. Thus, it is essential that mass campaigns must be conducted in which women must be informed about various contraceptive methods along with the effects of sterilisation.
4. **Economic security**: one of the most prominent reasons why women undergo such operations is due to economic incentives. This is due to the fact that these women come from extremely poor financial brackets and consider these incentives as survival money.

These reforms require more than formal legal recognition having a generalised definition for all sectors of women. There is an urgent need to address these structural barriers. There is a necessity to establish a firm framework where a woman (whether married or unmarried) in addition to having the right to make the decision whether to continue a pregnancy and access to abortion within legally set time limits must also be able to accept or refuse sterilisation, while the State is obliged not to coerce, mislead or discriminate with reference to such decisions.

The 2022 Amendment is a move ahead yet the pathway towards genuine autonomy is still rocky.