JUDICIAL PATERNALISM AND REPRODUCTIVE AUTONOMY: A CRITICAL ANALYSIS OF INDIAN JUDICIAL APPROACH TOWARDS WOMEN WITH INTELLECTUAL DISABILITIES

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ABSTRACT

The reproductive choices of women are protected as human rights, which refer to the autonomy of making decisions regarding their reproductive choices, such as whether to procreate or not, family planning, access to healthcare services, etc. The reproductive choices of women with intellectual disabilities (hereinafter referred to as WID) have lately gained momentum as acknowledged by the Indian Constitution under Article 21 and legislative enactments such as the Rights of Persons with Disabilities Act, 2016, and the Medical Termination of Pregnancy Act, 1971, as amended in 2021, yet are displaced by judicial paternalism coated in the "best interests" doctrine. The authors in this paper have critically examined the approach taken by the Indian Judiciary towards the reproductive autonomy of WID. The evolution of the judicial approach can be traced back to the landmark decision in *Suchita Srivastava v. Chandigarh Administration* (2009), and the jurisprudence of reproductive rights was expanded in *X v. Principal Secretary, Health and Family Welfare Department* (2022). From Z vs. State of Bihar (2017), where medical authorities went beyond the law and denied the termination of pregnancy to a 35-year-old mentally retarded rape survivor without the consent of her guardians, and recently, the Karnataka High Court's judgment permitted a hysterectomy on a 23-year-old woman with severe intellectual disability at her parents' request without even following the process of supported decision-making. The authors in this paper argue that despite progressive constitutional interpretation of reproductive autonomy under Article 21, the Indian judiciary continues to apply a paternalistic "best interests" principle which substitutes the will of WID, which is both constitutionally suspect and incompatible with India's obligations under Articles 12 and 23 of the United Nations Convention on the Rights of Persons with Disabilities, 2006. The paper further examines the legislative framework, the conflict between substituted and supported

decision-making models, and concludes with concrete recommendations for a rights-based judicial framework anchored in individual capacity assessment and supported decision-making.

Keywords: Reproductive Rights, Intellectual Disability, Judicial Paternalism, Article 21, Supported Decision-Making.

I. Introduction

Reproductive autonomy is core to a woman's dignity and personhood as it is protected as a human right. The ability to decide when to bear a child, continue or terminate a pregnancy, use contraception, or retain one's fertility is not a privilege extended by the grace of the State; it is a fundamental right available to every woman by virtue of her personhood and provided by the Constitution of India under Article 21. The Honorable Supreme Court of India has placed reproductive decision-making firmly within the constitutional guarantee of personal liberty under Article 21. Indian Judiciary, in a series of landmark judicial pronouncements, has recognized that decisions related to reproduction are "borne out of complicated life circumstances, which only the woman can choose on her own terms."[1]

Yet, after more than a decade of Suchita Shrivastava vs. Chandigarh Administration, the constitutional affirmation has not been converted into consistent legal protection for women with intellectual disabilities. Women with intellectual disabilities are still among the most vulnerable and legally underserved group of individuals whose most intimate decisions continue to be made by others as parents, guardians, courts, and medical professionals. Their right to make decisions is substituted for the woman's own will under the guise of acting in her "best interests." The result is a legal regime that speaks the language of rights but practices the logic of control.

India has a population of approximately 26.8 million persons with disabilities, out of which 11.9 million are women.[2] Among this population, women with intellectual disabilities face a double, distinctive and compounded vulnerability. They face dual discrimination against both as women in a patriarchal society and as persons with disabilities in a medical-legal framework that treats cognitive difference as incompatibility with autonomous personhood. Various

[1] X v. Principal Secretary, Health and Family Welfare Department, W.P. (C) No. 1241 of 2021 (S.C. India July 21, 2022).
[2] Office of the Registrar General and Census Commissioner, India, *Census 2011: Disabled Population* (Gov't of India 2011).

studies suggest that more than 93% of women with disabilities in India are denied their right to make reproductive decisions due to their disability.[3] There are various reports available in which it is shown that institutions have conducted forced hysterectomies, coerced sterilizations, and non-consensual abortions, which are often done with judicial approval. They are current realities, as highlighted by the Karnataka High Court's 2026 judgment, which starkly illustrates this.[4]

This paper undertakes a critical analysis of how the Indian judiciary has approached the reproductive rights of WID. The core argument of this paper is about how the Indian judiciary has articulated a constitutionally robust framework for reproductive autonomy that it has simultaneously failed to apply to women with intellectual disabilities. The "best interests" doctrine, which courts continue to apply for WID, is not merely paternalistic. But this approach is discriminatory and against constitutional values, as it treats WID as a group of individuals whose fundamental rights are qualified by their disability. This inconsistency cannot be justified by reference to the severity of intellectual disability. It requires to be taken into consideration and should be addressed by making changes in the legal framework, and the judiciary's approach should also move towards supported decision-making rather than substituted decision-making.

II. Constitutional Framework — Reproductive Rights as Fundamental Rights

A. Article 21 and the Right to Reproductive Autonomy

The basis of reproductive rights is firmly rooted in the Constitution under Article 21, which guarantees to every person the right to life and personal liberty. The Supreme Court of India, through its purposive constitutional interpretation, has progressively expanded this provision to provide rights essential to live a human life with dignity, including the "right to make decisions" regarding one's own body and reproductive choices.

The foundational evolution of reproductive rights was *Suchita Srivastava & Anr. v.*

[3] Arundhati Katju, *Forced Sterilization of Disabled Women in India: A Tale of Lost Autonomy*, LSE HUM. RTS. BLOG (Mar. 20, 2023), https://blogs.lse.ac.uk/humanrights/2023/03/20/forced-sterilization-of-disabled-women-in-india

[4] In re Petition for Hysterectomy of a Woman with Intellectual Disability, Karnataka High Court (June 2026), *reported in Karnataka HC Permits Total Abdominal Hysterectomy of 23-Year-Old Woman with Intellectual Disability*, SCC ONLINE BLOG (June 24, 2026).

Chandigarh Administration (2009).[5] The Apex Court held 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 of the Constitution of India and affirmed the reproductive autonomy of a woman with intellectual disability."[6] This statement was made expressly for women with intellectual disability and established that the constitutional guarantee of personal liberty extends to WID without qualification and their reproductive rights cannot be taken from them on the basis of their disability.

In *Justice K.S. Puttaswamy (Retd.) v. Union of India* (2017)[7], the nine-judge bench recognized decisional autonomy, defined it as the individual's authority to make choices about matters integral to their personhood and designated it as a core dimension of the constitutional right to privacy. The court held that reproductive decisions fall squarely within this protected zone and the choice whether or not to bear a child is among the most intimate expressions of personal autonomy, entitled to the highest constitutional protection from external interference.[8]

The latest articulation of the Supreme Court of India came in *X v. Principal Secretary, Health and Family Welfare Department* (2022)[9], in which the court held that "it is the woman alone who has the right over her body". The Court further added that the law must recognize "reproductive autonomy as an inseparable part of the bodily integrity and right to privacy guaranteed under Article 21."[10] The Court emphasized that barriers to reproductive autonomy constitute a form of gender discrimination which is inconsistent with Articles 14 and 15 of the Constitution.[11]

B. Articles 14 and 15 — Equality and Non-Discrimination

Articles 14 and 15 of the Indian Constitution guarantee equal protection and prohibit discrimination, which sets another constitutional foundation for reproductive rights of women with intellectual disabilities. The equal protection principle implies that like should be treated alike, and WID should also be given a chance to exercise reproductive autonomy. When courts

[5] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 9 SCC 1.
[6] *Id.* at ¶ 18.
[7] Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1.
[8] *Id.* (Chandrachud, J., concurring).
[9] X v. Principal Secretary, Health and Family Welfare Department, W.P. (C) No. 1241 of 2021 (S.C. India July 21, 2022).
[10] *Id.* at ¶ 34.
[11] *Id.* at ¶ 36.

and medical professionals apply "the best interest" standard to the reproductive choice of WID, they are applying different legal standards to the individuals who share the same constitutional rights, as it is not applicable to women without disabilities. This differential treatment on the basis of disability is a kind of arbitrary classification that Article 14 prohibits under the Constitution.

Article 15(1), while not expressly listing disability as a prohibited ground of discrimination, has been interpreted by the Court to encompass all characteristics essential to a person's identity.[12] The application of a diminished standard of legal recognition to WID in reproductive matters engages both the equality guarantee and the non-discrimination principle, reinforcing the constitutional imperative to extend reproductive rights uniformly.

C. The Positive Obligation of the State

The constitutional framework also generates positive obligations on the State. The Court in *Suchita* recognized the State's duty to "respect personal autonomy" and to take active steps to remove barriers that prevent WID from exercising their reproductive rights.[13] The Directive Principles under Articles 39, 42, and 47 further reinforce the State's obligation to promote reproductive health and dignity. The judicial framework, read comprehensively, demands not merely abstention from interference but active facilitation of WID's reproductive agency.

III. Statutory Framework — Provisions, Conflicts, and Gaps

A. The Rights of Persons with Disabilities Act, 2016

India enacted the Rights of Persons with Disabilities Act, 2016 (hereinafter referred to as the RPwD Act) and marked a significant milestone in advancing India's disability rights framework. This Act replaced the Persons with Disabilities Act, 1995, and expanded the recognized categories of disability from 7 to 21, explicitly including intellectual disability as a distinct category in Section 2(zc) as specified disability under the Schedule, and the definition is as follows-

[12] *See* Vikram Deo Singh Tomar v. State of Bihar, (1988) Supp. SCC 734.
[13] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 9 SCC 1, ¶ 22.

(zc) "specified disability" means the disabilities as specified in the Schedule;[14]

This reflects a legislative intent to treat intellectual disability distinctly from mental illness.

Further, the RPwD Act says that any medical procedure cannot be forced on any disabled person that can lead to infertility. Section 10(2) mandates that "no person with disability shall be subject to any medical procedure which leads to infertility without his or her free and informed consent."[15] The Act prohibits the arbitrary decision on reproductive choices of PwDs, and it applies to all disabled persons, including those with intellectual disabilities. This section does not provide any exception for guardian consent or judicial sanction. Section 92(f) creates a criminal offense for "performing any medical procedure which leads to termination of pregnancy without the consent of the woman with disability."[16]

Even though these provisions are progressive in their intent and reflect a formal legislative commitment to the reproductive autonomy of WID but they are critically incomplete in their design.

No provisions actually address the core question of how consent can be taken or assessed relating to women with intellectual disability. There is a mandate of consent under the Act, but no procedure has been provided for determining consent. There is no definition of "free and informed consent" in the context of intellectual disability. There is no framework for supported decision-making to assist WID in expressing their consent or will. This procedural silence renders the statutory guarantee hollow in practice.

B. The Medical Termination of Pregnancy Act, 1971 and Amendment, 2021

It is a landmark legislative framework that was enacted on the recommendation of the Shantilal Shah Committee (1964). The Act was framed and enacted to reduce the increased rate of maternal mortality caused by unsafe and illegal abortions. This legislation has legalized and regulated access to abortion services in India.

Section 3(4)(a) of the MTP Act, 1971, says that where a pregnant woman is a "mentally ill person," termination shall be permitted only with the written consent of her guardian.[17] The

[14] Rights of Persons with Disabilities Act, § 2(zc), No. 49, Acts of Parliament, 2016 (India).
[15] *Id.* § 10(2).
[16] *Id.* § 92(f).
[17] Medical Termination of Pregnancy Act, § 3(4)(a), No. 34, Acts of Parliament, 1971 (India).

section is read as – "No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian." Here, the consent of the guardian is a mandate for the termination of the pregnancy of a woman who is mentally ill.

The MTP (Amendment) Act, 2021, and the MTP Rules further expanded the scope of eligible categories. Rule 3B(e) permits termination up to 24 weeks for "mentally ill women including mental retardation."[18] By increasing the scope of termination of pregnancy for women, the legislature has shown its attempt at inclusion. But it is fatally compromised by a critical terminological error: it equates "mental retardation" with "mental illness," but it is a classification that the RPWD Act, 2016 had expressly repudiated by treating intellectual disability as a distinct category separate from mental illness.[19]

This terminological gap has a profound legal consequence. Section 3(4)(a) of the MTP Act applies to "mentally ill persons," and it says that there is a mandate of guardian consent. The RPWD Act distinguishes intellectual disability from mental illness, which means Section 3(4)(a) does not authorize a guardian to consent to termination on behalf of a woman with intellectual disability.[20] Simultaneously, the woman herself may be unable to provide the "written consent" required by the Act. There is one more situation, that arises due to this definitional gap, when a mildly mentally retarded woman wants to go for a termination of pregnancy, she is denied her right of reproductive choice, as she is being asked for a guardian's consent or judicial sanction. The result is a legal vacuum in which no one may lawfully consent to a termination on behalf of a WID under the current statutory framework. And at the ground level, WIDs are being denied their right to make a reproductive decision as mental retardation and mental illness are being equated under the MTP Act, 1971, as amended in 2021. Yet the law also does not provide a clear mechanism for the woman to exercise her own right. This is not a minor technical inconsistency. It is a structural failure that leaves WID without a viable legal pathway for one of the most fundamental reproductive decisions.

[18] Medical Termination of Pregnancy (Amendment) Rules, Rule 3B(e), 2021 (India).
[19] *Reproductive Agency Is Not a Courtesy, It's a Right of a Woman with Intellectual Disabilities in India*, OXFORD HUM. RTS. HUB (Mar. 8, 2026), https://ohrh.law.ox.ac.uk/reproductive-agency-is-not-a-courtesy [hereinafter *OHRH Article*].
[20] *Id.*

C. The Mental Healthcare Act, 2017 and the National Trust Act, 1999

Another legislative framework, which provides for consent and capacity for those who are suffering from mental illness, is the Mental Healthcare Act, 2017. It provides a mechanism for supported decision- making through nominated representatives. This Act is specifically applied to those who are suffering from mental illness and does not have any mention of the term "intellectual disability," which shows the fragmented disability legal framework in India.[21]

The National Trust Act, 1999, establishes a system of "limited guardianship" for persons with intellectual disabilities, autism, cerebral palsy, and multiple disabilities. Section 14 provides for the appointment of a local-level committee to act as guardian for persons with these conditions. However, the Act does not specify whether this guardianship authority extends to reproductive and medical decisions, nor does it provide any mechanism for ascertaining the person's will and preferences before a guardian acts.[22] Under section 15 of the Act, the duties of a guardian are provided, which say that every appointed guardian is supposed to take care of a person with disability and his property, or is required to look after him responsibly and maintain him. But this guardianship framework under the National Trust Act is, in essence, a substituted decision-making model, and it is inconsistent with the mandates of the CRPD.

The cumulative picture of India's statutory framework is one of fragmentation, terminological inconsistency, and procedural incompleteness. Multiple statutes address different facets of the issue without forming a coherent whole. The most critical gap is the absence of a procedure for obtaining or assessing consent from WID and a supported decision-making framework, which remains unaddressed across all statutes.

IV. Judicial Approach — A Critical Analysis

A. The Pre-2009 Landscape: Paternalism Unchallenged

Prior to the *Suchita Srivastava case*, the Indian judicial approach to reproductive decisions involving WID was characterized by unreflective paternalism. Courts treated intellectual disability as synonymous with legal incompetence and routinely authorized medical interventions, including sterilization procedures on WID without any interrogation of the

[21] Mental Healthcare Act, § 4, No. 10, Acts of Parliament, 2017 (India).
[22] National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, § 14, No. 44, Acts of Parliament, 1999 (India) [hereinafter National Trust Act].

woman's own will or preferences.[23]

The most important case related to women with psychosocial disabilities came to light when the Maharashtra government allowed the mass hysterectomy of women with psychosocial disabilities who lived in a shelter home named "Shirur home" in Pune. Out of 21 women, 11 already went through hysterectomy without their consent, and 10 escaped only after women's organizations intervened and exposed the forced hysterectomy.[24] This approach was rooted in the welfare model of disability, which understood disability as a personal tragedy requiring protection and management by capable others, rather than as a human condition entitled to full legal recognition and rights-based accommodation.

The absence of judicial scrutiny of forced sterilisation of WID during this period is particularly striking. While sterilisation camps targeting poor and marginalised women were well-documented phenomena in India, the specific vulnerability of WID within these settings received no judicial attention. The medical profession's paternalistic assumptions about WID's reproductive incapacity went unchallenged in the courts.

B. Suchita Srivastava & Anr. v. Chandigarh Administration (2009)

Suchita Srivastava case marked a turning point in India's jurisprudence on WID's reproductive rights. The case concerned a 19–20-year-old woman with intellectual disability (described at the time as "mentally retarded") who became pregnant following sexual assault while residing in a State-run institution. Medical assessments suggested that she had a mental age of about nine years. The Chandigarh Administration sought permission from the High Court to terminate the pregnancy, and the High Court granted the request after appointing a committee of medical experts and a judicial officer to investigate. The committee's report indicated that the woman expressed a desire to continue the pregnancy, but this preference was not given decisive weight; the High Court nevertheless ordered termination. On appeal, the Supreme Court set aside the High Court's order, holding that the pregnancy could not be terminated without the woman's consent.[25]

[23] Abha Singhal Joshi, *Reproductive Rights of Women with Intellectual Disability in India*, 20 INDIAN J. MED. ETHICS 87, 88 (2023).
[24] Murlidharan, *What the Karnataka Hysterectomy Case Reveals About Reproductive Rights of Disabled Women*, The Wire,(Jun.27,2026), https://thewire.in/law/what-the-karnataka-hysterectomy-case-reveals-about-reproductive-rights-of-disabled-women
[25] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 9 SCC 1.

The judgment relied on two foundational principles. First, reproductive choice is "an inseparable part of personal liberty" under Article 21, and this right extends to women with intellectual disabilities.[25] Second, the Judiciary's *parens patriae* jurisdiction and its authority to act as guardian of those who cannot protect themselves. The court held that this jurisdiction cannot be exercised to override the expressed will of a WID where she is capable of expressing her will and can give consent.[26] The Court directed that the woman be provided with appropriate support to make her own decision and that her expressed consent or willingness should be taken into consideration and be acted upon.

Suchita Shrivastava's case still remains the landmark judicial statement on the reproductive rights of WID in India. Through this judgment, the court repudiated the notion that intellectual disability deprives a woman of legal capacity in reproductive matters and limited the scope of paternalistic judicial intervention.

However, the judgment has several gaps and loopholes that subsequently have been exploited by various courts in India. First, the Court did not address the more difficult case where a WID is genuinely unable to express any preference in the situation of severe or profound intellectual disability. In the *Suchita Shrivastava case*, the woman had expressed a will, and the Court did not need to formulate a framework for cases where no preference could be expressed. This gap has been filled by subsequent courts through the "best interests" doctrine in a manner that contradicts reproductive rights of WIDs.[27] Second, the Court used the outdated terminology of "mental retardation" throughout, reflecting the linguistic limitations of pre-RPWD Act jurisprudence and inadvertently reinforcing the conflation of intellectual disability with mental illness that has since become a source of legal confusion.[28]

C. Devika Biswas v. Union of India (2016) — Sterilisation and Constitutional Rights

In *Devika Biswas v. Union of India*,[29] the Supreme Court took up the systemic practice of mass sterilisation camps across India — camps that had resulted in the deaths of women and in non-consensual sterilisations carried out in conditions endangering life. While not specifically

[26] *Id.* at ¶ 22.
[27] Ashpinder Kaur & Rimjim Singh, *Reproductive Rights of Women with Disabilities: A Commentary on Suchita Srivastava & Anr. v. Chandigarh Administration (2009)*, HPNLU L. REV. (2025), https://www.hpnlu.ac.in/PDF/71648234.pdf.
[28] *Id.*
[29] Devika Biswas v. Union of India, (2016) 10 SCC 726.

addressing WID, the Court's reasoning has direct implications for their reproductive rights. The Court held that the right to reproductive autonomy is a constitutionally protected fundamental right under Article 21, and that the State's obligation to protect women's bodily integrity extends to ensuring that sterilisation procedures are conducted only with free and informed consent, in safe conditions, and in compliance with prescribed medical standards.[30]

Devika Biswas established that the State cannot be absolved of constitutional responsibility for coercive or unsafe reproductive medical practices by delegating them to NGOs or private medical establishments.[31] For WID, this principle is particularly significant: the majority of forced sterilisations of WID occur in institutional settings — State-run homes, special schools, and care facilities — where the State's *parens patriae* authority is invoked to justify the procedure. After *Devika Biswas*, such practices cannot be insulated from constitutional scrutiny by the institutional setting in which they occur.

D. The K.S Puttaswamy Judgement Effect - Privacy, Autonomy, and Reproductive Decisions

The *Puttaswamy* judgment[32] transformed the constitutional landscape for reproductive rights by providing them with a privacy-based anchor. The nine-judge bench, in multiple opinions, recognised that the right to make decisions about one's own body — including reproductive decisions — falls within the innermost zone of personal autonomy that constitutional privacy protects. Chandrachud J.'s opinion is particularly significant: it articulates a concept of decisional autonomy that protects individual choices in "matters relating to the most intimate aspects of life," including "the right of every individual including... those with disabilities, to decide matters about their own life."[33]

The *K.S. Puttaswamy* judgment created the constitutional foundation for a rights-based approach to reproductive decision-making for WID. It is the one in which the woman's own decision is entitled to the same constitutional protection as that of any other woman, and in which State or third-party override requires the most compelling justification.

[30] *Id.* at ¶ 42.
[31] *Id.* at ¶ 48.
[32] Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1.
[33] *Id.* (Chandrachud, J., concurring) at para.127.

E. Z. vs. State of Bihar (2017)[34] – Denial of Reproductive Autonomy and unimaginable suffering

This judgment, **Ms. Z v. The State of Bihar and Others (2017)**, describes the suffering of a 35-year-old destitute woman whose reproductive choice was systematically denied through the negligence of state authorities and a fallacious judicial approach.

The appellant was a survivor of rape and was HIV positive, living in a shelter home when her pregnancy was discovered. She expressed her desire to terminate the pregnancy as early as she was in her 17th week of pregnancy. Despite being a major (35 years old) and providing her own consent, the Patna Medical College Hospital (PMCH) delayed her by demanding the signatures of her father and brother, as she was mildly mentally retarded. The Supreme Court noted that the hospital's failure to perform its duty under the Medical Termination of Pregnancy (MTP) Act was negligence and disobedience of law, which led to the long-term torment.

When she approached the Patna High Court for help, the court's approach aggravated her sufferings as the High Court single judge expressed doubt that the pregnancy caused "grave injury" to her mental health because she had not disclosed the rape for 13 weeks, an observation the Supreme Court found insensitive and erroneous given her destitute and mentally retarded state. The Supreme Court highlighted the vague approach of the High Court for being more concerned with the "future of the fetus" than the "life of the victim". The High Court erroneously required consent from her husband (who had deserted her) and her father, which was in contradiction with the Medical Termination of Pregnancy Act and the RPWD Act as well. The Supreme Court clarified that for a person with **"mild mental retardation,**" as opposed to "mental illness," her own personal autonomy and consent are legally sufficient for the Termination of pregnancy.

Because of the negligence of the hospital and the erroneous approach of the High Court, the pregnancy reached a stage where termination became a life-threatening risk.

By the time the case reached the Supreme Court, a Medical Board at AIIMS determined that termination was now too risky for her life. The Court characterized this forced continuation of pregnancy as **"mental torture**." The denial was described as a scuttling of her fundamental choice, corroding her self-respect and violating her right to **bodily integrity** and **personal**

[34] Ms. Z v. State of Bihar, 2017 SCC OnLine SC 943.

autonomy of reproductive choice.

F. X v. Principal Secretary, Health and Family Welfare Department (2022) — Reproductive Autonomy

The Supreme Court's 2022 decision in *X v. Principal Secretary*[35] extended reproductive autonomy to its fullest constitutional articulation to date. The Court held that the right to terminate a pregnancy vests solely with the pregnant person, that this right cannot be qualified by marital status, circumstances of conception, or personal characteristics, and that the MTP Act must be read purposively to uphold rather than restrict reproductive autonomy. The Court's reasoning grounded in equality, privacy, and dignity, admits no principled distinction based on disability.

Yet the decision did not address WID. The petitioner was an unmarried woman without disability. The Court's broad affirmation of reproductive autonomy was made in that context, and the question of whether — and how — it applies to WID whose decision-making capacity may be limited was left entirely open. This silence has had a troubling practical consequence: lower courts have continued to apply paternalistic reasoning to WID cases even after *X v. Principal Secretary*, drawing on the "best interests" doctrine as though the Supreme Court's expansive reproductive rights jurisprudence has no application to this class of women.

F. Karnataka High Court (2026) — Paternalism Reasserted

The Karnataka High Court's 2026 judgment[36] is the most recent and disturbing illustration of this judicial inconsistency. The case concerned a 23-year-old woman with severe intellectual and developmental disability, whose parents petitioned the Court for permission to proceed with a Total Abdominal Hysterectomy — an irreversible procedure permanently terminating fertility. The Court permitted the procedure on the basis of a medical board report concluding that the woman "lacked the cognitive and intellectual capacity to make an informed decision."[37]

Justice Suraj Govindaraj held that "medical evidence showed the procedure was in her best

[35] X v. Principal Secretary, Health and Family Welfare Department, W.P. (C) No. 1241 of 2021 (S.C. India July 21, 2022).
[36] In re Petition for Hysterectomy of a Woman with Intellectual Disability, Karnataka High Court (June 2026), *reported in* SCC ONLINE BLOG (June 24, 2026), https://www.scconline.com/blog/post/2026/06/24.
[37] *Best Interests of Patient: Karnataka High Court Allows Hysterectomy for Woman with Disabilities*, LAWCHAKRA (June 22, 2026), https://lawchakra.in/high-court/hysterectomy-woman-disabilities/.

interests, protecting her welfare, dignity and safety."[38] The Court simultaneously acknowledged that reproductive autonomy cannot be denied solely on the basis of disability — then proceeded to do exactly that. The judgment rests on three assumptions that are each independently problematic. First, it treats the medical board's assessment of incapacity as a sufficient basis for authorizing permanent sterilization — without examining whether the woman's will and preferences could be ascertained through supported communication or alternative methods. Second, it applies the "best interests" standard without examining whether a less drastic and reversible alternative was available. Third, it does not engage with India's obligations under CRPD Article 12, which requires that decisions involving persons with intellectual disabilities reflect their "will and preferences" rather than what others consider to be in their "best interests."[39]

The judgment has been widely criticized as a regression from the rights-based approach established in *Suchita* and as inconsistent with the constitutional framework articulated in *Puttaswamy* and *X v. Principal Secretary*.[40] Its primary defect is not that it authorized a difficult medical decision in extreme circumstances — it is that it did so without any framework for ensuring that the woman's voice, however expressed, was genuinely sought and given weight.

G. The Constitutional critique of the “Best Interests” Doctrine

The courts have been applying the best interests doctrine in the cases related to reproductive decisions of the WID, and it is against the constitutional values for various reasons. First, it contradicts the Supreme Court’s own judgment in *Suchita Shrivastava’s* case, where it was held that the *parens patriae* jurisdiction cannot override the expressed will of WID.[41] Courts applying “best interests” reasoning in post-*Suchita* cases are departing from binding Supreme Court precedent without reasonable justification.

Second, the “best interests” standard is inherently paternalistic and discriminatory. It is applied to WID but not to other women in comparable situations such as women who make reproductive decisions under conditions of poverty, coercion, or limited information, who are

[38] *Id.*
[39] Committee on the Rights of Persons with Disabilities, *General Comment No. 1: Article 12: Equal Recognition Before the Law*, ¶ 27, U.N. Doc. CRPD/C/GC/1 (Apr. 11, 2014) [hereinafter CRPD General Comment No. 1].
[40] *What the Karnataka Hysterectomy Case Reveals About Reproductive Rights of Disabled Women*, THE WIRE (June 26, 2026), https://m.thewire.in/article/law/what-the-karnataka-hysterectomy-case-reveals.
[41] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 9 SCC 1, ¶ 22.

not subjected to judicial oversight of their "best interests." The application of a different and more burdensome standard to WID constitutes discrimination on the basis of disability which is prohibited under both Article 14 of the Constitution and Article 5 of the CRPD.[42]

Third, the "best interests" standard, as courts apply it, invariably substitutes the values and preferences of the decision-maker, typically a medical professional or a parent, for those of the woman herself. There is no established procedure in India for ensuring that a "best interests" determination reflects the woman's own will and preferences, even where these can be ascertained through supported communication. The standard operates, in practice, as an institutionalized mechanism for overriding the reproductive choices of WID.

V. India's International Obligations and the Demand for Supported Decision-Making

A. United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)- Articles 12 and 23

India ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2007.[43] The CRPD represents the most comprehensive international articulation of the rights of persons with disabilities, and its provisions on legal capacity and reproductive rights are directly applicable to the situation of WID in India.

Article 12 of the CRPD requires States to "recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[44] The CRPD Committee, in General Comment No. 1 (2014), clarified that Article 12 requires a paradigm shift from substituted decision-making — where a third party decides on behalf of a person with a disability — to supported decision-making — where the person is assisted in making their own decision.[45] The Committee was explicit that the "best interests" standard is incompatible with Article 12: "the 'best interests' standard is not a safeguard that complies with Article 12 in relation to adults."[46]

[42] United Nations Convention on the Rights of Persons with Disabilities, art. 5, Mar. 30, 2007, 2515 U.N.T.S. 3 [hereinafter CRPD].
[43] India ratified the CRPD on October 1, 2007. *See* U.N. TREATY COLLECTION, https://treaties.un.org (last visited July 16, 2026).
[44] CRPD, *supra* note 41, art. 12, ¶¶ 1–3.
[45] CRPD General Comment No. 1, *supra* note 38, at ¶ 26.
[46] *Id.* at ¶ 27.

Article 23 of the CRPD protects the right of persons with disabilities to "decide freely and responsibly on the number and spacing of their children," to "retain their fertility on an equal basis with others," and to found a family.[47] States are required to eliminate discrimination against persons with disabilities in matters relating to family planning, marriage, and parenthood.

B. India's Compliance Gap

India's domestic legal framework falls significantly short of CRPD compliance. The RPWD Act, while prohibiting forced sterilization and requiring free and informed consent, does not provide a supported decision-making mechanism, the core requirement of Article 12.[48] The National Trust Act's limited guardianship model is a substituted decision-making regime which says that a third party is appointed to make decisions on behalf of a person with intellectual disability, without any obligation to ascertain or give effect to the person's own will and preferences.[49]

The CRPD Committee, in its 2019 concluding observations on India's initial report, specifically flagged the normalization of violence against women and girls with intellectual disabilities in institutional settings and called for legislative reform.[50] The RPWD Amendment Rules of 2024 acknowledged the direction of travel towards supported decision-making but did not operationalize it with concrete mechanisms.[51] The Medical Termination of Pregnancy Act 1971, as amended in 2021 mandates the guardian's consent for termination of pregnancy of a minor, or a major who is mentally ill, but the RPWD Act bifurcates the mentally ill persons from intellectually disabled persons, and mental retardation is also not included in the definition of mentally ill persons, which creates a major gap in the Indian legislative framework.

India's position in ratifying the CRPD, enacting legislation acknowledging reproductive rights of WID, but maintaining a judicial and guardianship framework that operates on substituted

[47] CRPD, *supra* note 41, art. 23, ¶ 1(b).
[48] *OHRH Article*, *supra* note 19.
[49] National Trust Act, *supra* note 22, § 14.
[50] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of India*, ¶ 38, U.N. Doc. CRPD/C/IND/CO/1 (Oct. 2019).
[51] *Sexual and Reproductive Health and Rights in India*, SOC. PROTECTION & HUM. RTS., https://socialprotection-humanrights.org/legaldep/sexual-reproductive-health-rights-india/ (last visited July 16, 2026).

decision-making represents a pattern of formal compliance without substantive implementation. The Karnataka HC 2026 judgment illustrates precisely what this gap costs in practice is an irreversible reproductive intervention on a young woman whose will was never genuinely sought, carried out under judicial sanction, in a legal landscape that formally prohibits exactly this outcome.

C. India Needs the Supported Decision-Making Framework

The CRPD's supported decision-making paradigm requires that persons with intellectual disabilities be provided with appropriate support to exercise their own legal capacity — rather than having their capacity displaced by guardians or courts. Support may take many forms: an advocate, a trusted person, an augmentative communication device, a series of consistent structured conversations over time. The key principle is that the decision ultimately made must reflect the will and preferences of the person with the disability, even if the decision-making process requires substantial support.

The United Kingdom's Mental Capacity Act, 2005 offers a workable model that India could adapt. The Act establishes a functional, decision-specific capacity assessment framework that presumes capacity and assesses it in relation to each specific decision rather than on the basis of diagnosis alone.[52] Any intervention in the affairs of a person who genuinely lacks capacity must reflect their "past and present wishes and feelings" as the primary consideration — not the views of family members or medical professionals about what is best.[53] India could adapt this model within its existing constitutional framework: the *Puttaswamy* case's right to privacy and *Suchita*'s case affirmation of reproductive autonomy provide all the constitutional authority needed.

VI. Conclusion and Recommendations

The Indian judiciary's approach to the reproductive rights of WID reflects a structural and persistent failure to apply constitutional principles uniformly. The Supreme Court has articulated an unambiguous framework for reproductive autonomy rooted in Article 21, enriched by *Puttaswamy*, and applied without distinction in *X v. Principal Secretary,* which it has simultaneously failed to enforce for WID. The "best interests" doctrine, as applied to WID,

[52] Mental Capacity Act 2005, c. 9, §§ 1–3 (Eng.).
[53] *Id.* § 4(6)(a).

is constitutionally discriminatory, CRPD-incompatible, and contrary to the Court's own precedent. The Karnataka HC 2026 judgment, permitting an irreversible hysterectomy on a young woman without any attempt to ascertain her will and preferences through supported means, represents the most recent and compelling demonstration of this failure.

The following reforms are proposed:

First, the Supreme Court should issue binding guidelines — ideally through suo motu or PIL proceedings — establishing that capacity for reproductive decision-making must be assessed individually, functionally, and decision-specifically, rather than inferred from the disability diagnosis. The presumption of capacity must apply to WID as to all other persons.

Second, any judicial authorisation of an irreversible reproductive procedure on a WID who cannot express consent must require: (i) a multi-disciplinary assessment that includes supported communication specialists; (ii) evidence that the woman's past and present will and preferences have been genuinely sought; (iii) independent review by a judicial or quasi-judicial body; and (iv) certification that no less restrictive alternative is available.

Third, Parliament must amend the RPWD Act, 2016 to introduce a statutory supported decision-making framework operationalising the consent requirement under Section 10(2). This framework should provide clear procedural guidance on how consent is to be sought, what support is to be provided, and what documentation is required before any reproductive medical procedure is carried out on a WID.

Fourth, the terminological inconsistency between the MTP Act (which uses "mental retardation" and "mentally ill women") and the RPWD Act (which uses "intellectual disability" as a distinct category) must be resolved by legislative amendment. The MTP Rules must be brought into conformity with the RPWD Act's classification framework, and a clear consent pathway must be established for pregnancy termination in cases involving WID.

Fifth, India must fulfil its obligations under CRPD Articles 12 and 23 by formally replacing substituted decision-making models in the National Trust Act and other guardianship legislation with supported decision-making frameworks that preserve the legal agency of persons with intellectual disabilities.

The reproductive rights of women with intellectual disabilities are not a special category of

diminished rights — they are the same fundamental rights that all women hold under the Constitution of India. The judiciary's continued failure to apply these rights uniformly is not a matter of judicial discretion. It is a constitutional failure that causes irreversible harm to real women in real cases. The time for reform is long overdue.

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