THE REPRODUCTIVE RIGHTS OF INTELLECTUALLY DISABLED WOMEN UNDER THE MEDICAL TERMINATION OF PREGNANCY ACT

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ABSTRACT

The reproductive autonomy of women with intellectual disabilities occupies a precarious position within Indian law, caught between a paternalistic tradition of substituted guardianship and a constitutional commitment to personal liberty and dignity. The Medical Termination of Pregnancy Act, 1971, as amended in 2002 and 2021, distinguishes a "mentally ill person", whose guardian may consent to termination on her behalf, from a person with "mental retardation", who retains the right to consent independently. This distinction, affirmed by the Supreme Court In Suchita Srivastava v. Chandigarh Administration, marks a departure from the "best Interests" and "substituted judgment" doctrines that had historically governed decisions concerning disabled persons. Yet the framework remains fragmented and often sits in tension with the Rights of Persons with Disabilities Act, 2016 and the Convention on the Rights of Persons with Disabilities, both of which mandate supported rather than substituted decision making. This article traces the legislative and judicial development of these rights, situates the doctrine within the wider disability rights framework and identifies definitional ambiguity, guardianship overreach and the absence of supported decision making as the principal deficiencies of the present regime, before proposing reforms to reconcile protective concern with the constitutional guarantee of reproductive autonomy.

Keywords: reproductive rights, intellectual disability, Medical Termination of Pregnancy Act, guardianship, supported decision making, bodily autonomy.

I. Introduction

The right to make reproductive choices has been read by the Supreme Court of India as an inseparable facet of personal liberty and dignity under Article 21 of the Constitution.[1] For most women this recognition translates into an unambiguous entitlement, but for women with intellectual disabilities the exercise of that entitlement has historically been mediated, curtailed or altogether displaced by guardians, medical practitioners and courts acting in what they describe as the woman's "best interests". The paternalism that pervades disability law finds one of its sharpest expressions in the regulation of abortion, where the very capacity of an intellectually disabled woman to consent, to refuse or to choose has repeatedly been treated as a question for others to answer on her behalf.

The Medical Termination of Pregnancy Act, 1971 ("MTP Act") is the principal legislation governing the legality of abortion in India.[2] Section 3(4) of the Act requires the written consent of a guardian before the pregnancy of a woman who has not attained the age of eighteen years, or who is a "mentally ill person", may be terminated.[3] Crucially, the Act defines a "mentally ill person" as one who requires treatment for a mental disorder "other than mental retardation".[4] The consequence of this definitional carve out is that a woman with an intellectual disability, described in the pre-2016 vocabulary of Indian law as a person of "mental retardation", falls outside the guardian consent regime and retains the right to consent to or refuse termination of her own pregnancy under Section 3(4)(b) of the Act.[5] This apparently technical distinction carries profound consequences. It is the fulcrum on which the Supreme Court balanced the competing claims of autonomy and protection in its landmark decision in Suchita Srivastava v. Chandigarh Administration, and it continues to structure the manner in which courts, medical boards and guardians approach the reproductive decisions of intellectually disabled women.[6]

This article examines the reproductive rights of intellectually disabled women under the MTP Act with three objectives. First, it traces the statutory architecture of consent under the Act, including the amendments of 2002 and 2021 and the accompanying Rules. Second, it analyses the judicial interpretation of this architecture, beginning with Suchita Srivastava and extending

[1]INDIA CONST. art. 21; Suchita Srivastava v. Chandigarh Admin., (2009) 9 S.C.C. 1, 14-15 (India).
[2]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code (1971).
[3]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code § 3(4)(a) (1971).
[4]Id. § 2(b).
[5]Id. § 3(4)(b).
[6]Suchita Srivastava, (2009) 9 S.C.C. 1.

to subsequent High Court and Supreme Court decisions that have refined, and at times strained, its logic. Third, it situates the MTP Act within the broader constitutional and statutory framework of disability rights, in particular the Rights of Persons with Disabilities Act, 2016 ("RPWD Act") and the Convention on the Rights of Persons with Disabilities ("CRPD"), to expose the doctrinal inconsistency between a reproductive law that still tolerates substituted consent for some disabled women and a disability law that mandates supported decision making for all. The article concludes that while Suchita Srivastava was a genuine advance for the reproductive autonomy of intellectually disabled women, the surrounding legal architecture remains incomplete, and it proposes specific reforms to close that gap.

II. Conceptualising Intellectual Disability, Consent and Reproductive Rights

A. Intellectual Disability Distinguished from Mental Illness

Indian law has long conflated intellectual disability with mental illness, a conflation with serious consequences for the legal treatment of consent. Intellectual disability, previously termed "mental retardation" in Indian statutes, refers to a condition of incomplete or arrested development of the mind, characterised by impairment of skills that contribute to overall intelligence, such as cognition, language and motor abilities, which manifests before adulthood.[7] Mental illness, by contrast, is typically an acquired and often episodic condition affecting mood, thought or behaviour, which may be amenable to treatment and may fluctuate in severity over time. The Mental Healthcare Act, 2017 defines "mental illness" as a substantial disorder of mood, thought, perception, orientation or memory, expressly excluding mental retardation, which is defined as a condition of arrested or incomplete development of mind specially characterised by sub-normality of intelligence.[8] The MTP Act, drafted decades before the Mental Healthcare Act, borrows this same distinction without adopting its vocabulary, and continues to speak of "mental retardation" as the residual category excluded from the definition of "mentally ill person" under Section 2(b).[9]

The significance of this distinction for reproductive rights lies in the differential consent regime it triggers. Because the guardian consent requirement in Section 3(4)(a) is confined to minors and "mentally ill persons", a woman with an intellectual disability, however severe, does not

[7]Suchita Srivastava, (2009) 9 S.C.C. 1, 9-10 (recording the medical evidence on the distinction between mental retardation and mental illness).
[8]Mental Healthcare Act, No. 10 of 2017, India Code § 2(s), (r) (2017).
[9]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code § 2(b) (1971).

fall within its terms on a plain reading of the statute. Her consent, and hers alone, is what the Act requires under Section 3(4)(b), subject only to the general conditions for termination set out in Section 3(2).[10] Whether this consequence was a deliberate legislative choice to protect the autonomy of intellectually disabled women, or an inadvertent gap arising from imprecise drafting, remains debated, but the Supreme Court has treated it as the former.

B. Reproductive Rights as an Incident of Personal Liberty

The constitutional foundation for reproductive rights in India rests on an expansive reading of Article 21. In Suchita Srivastava, the Supreme Court held that a woman's right to make reproductive choices is itself a dimension of personal liberty and observed that this right includes a woman's entitlement to carry a pregnancy to its full term, to give birth and to raise children.[11] The Court subsequently deepened this reasoning in Justice K.S. Puttaswamy v. Union of India, where privacy, dignity and decisional autonomy over one's own body were recognised as facets of the fundamental right to life.[12] Read together, these decisions establish that reproductive autonomy is not a privilege conferred by statute but a constitutional entitlement that legislation such as the MTP Act must operate to protect rather than displace. This has a direct bearing on intellectually disabled women, because any statutory provision that permits a third party to consent to the termination of a woman's pregnancy without her participation necessarily operates as a restriction on this constitutional right, and must therefore satisfy a correspondingly high threshold of justification.

III. The Statutory Architecture of the Medical Termination of Pregnancy Act

A. The Consent Requirement Under Section 3(4)

Section 3 of the MTP Act permits a registered medical practitioner to terminate a pregnancy within prescribed gestational limits where continuation would involve a risk to the life of the pregnant woman, grave injury to her physical or mental health, or a substantial risk of serious physical or mental abnormality in the child, among other grounds.[13] Section 3(4)(a) then carves out an exception to the ordinary rule of personal consent: no pregnancy of a woman below

[10]Id. § 3(2), (4)(b).
[11]Suchita Srivastava, (2009) 9 S.C.C. 1, 15.
[12]Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 S.C.C. 1 (India).
[13]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code § 3(2) (as amended by Act No. 8 of 2021).

eighteen years of age, or of a woman who, having attained majority, is a "mentally ill person", may be terminated except with the written consent of her guardian.[14] Section 3(4)(b) provides that, save as provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman herself.[15] The statute defines "guardian" as a person having the care of a minor or of a mentally ill person, thereby confining the very concept of guardianship under the Act to these two categories and excluding, at least textually, any guardianship over the reproductive decisions of an intellectually disabled woman.[16]

B. The 2002 Amendment

The MTP Act as originally enacted in 1971 used the term "lunatic", defined by reference to the Indian Lunacy Act, 1912, to describe the class of persons requiring guardian consent.[17] The Medical Termination of Pregnancy (Amendment) Act, 2002 replaced this archaic and stigmatising terminology with "mentally ill person" and introduced the definition that excludes mental retardation, thereby formalising the distinction on which Suchita Srivastava would later turn.[18] The 2002 amendment also decentralised the process for approving private facilities to perform abortions, but its most consequential change for the purposes of this article was definitional rather than administrative.

C. The 2021 Amendment

The Medical Termination of Pregnancy (Amendment) Act, 2021 introduced several structural changes. It raised the gestational limit for termination from twenty to twenty-four weeks for certain categories of women to be prescribed by rules, required the constitution of Medical Boards in every state to opine on pregnancies exceeding twenty-four weeks involving substantial foetal abnormality, and inserted Section 5A to protect the privacy of a woman whose pregnancy has been terminated.[19] The amendment also replaced the words "married woman or her husband" with "any woman or her partner" in the explanation to Section 3, a change of language that the Supreme Court would later read as reflecting a deliberate

[14]Id. § 3(4)(a).
[15]Id. § 3(4)(b).
[16]Id. § 2(a).
[17]The Medical Termination of Pregnancy (Amendment) Act, No. 64 of 2002, § 2 (replacing "lunatic" with "mentally ill person").
[18]Id.
[19]The Medical Termination of Pregnancy (Amendment) Act, No. 8 of 2021, §§ 3-6 (2021).

legislative intent to extend the benefit of the Act to all women irrespective of marital status.[20] The 2021 amendment left the guardian consent regime under Section 3(4) and the definitional exclusion of mental retardation in Section 2(b) untouched, so that the core distinction between "mentally ill" and intellectually disabled women that has governed consent since 2002 continues to operate under the amended Act.

D. The MTP Rules, 2003 and Rule 3B

The Medical Termination of Pregnancy Rules, 2003, as amended in 2021, prescribe the categories of women eligible to seek termination of pregnancy between twenty and twenty-four weeks under Section 3(2)(b) of the Act. Rule 3B lists survivors of sexual assault or rape, minors, women whose marital status changes during the pregnancy through widowhood or divorce, women with physical disabilities meeting a prescribed threshold of benchmark disability, mentally ill women including survivors of mental illness, women with foetal malformation carrying a substantial risk of the foetus being incompatible with life, and women in humanitarian settings or disaster situations as declared by the government.[21] The explicit inclusion of "mentally ill women" within Rule 3B, without a corresponding express reference to women with intellectual disability, mirrors the drafting pattern of the parent Act and again places the burden of interpretation on courts to determine how far the extended gestational limit applies to an intellectually disabled woman seeking a later termination.

IV. Judicial Interpretation: From Parens Patriae to Autonomy

A. Suchita Srivastava v. Chandigarh Administration

The foundational decision on the reproductive rights of intellectually disabled women is Suchita Srivastava v. Chandigarh Administration.[22] The case concerned a woman in her early twenties, a resident of a government run welfare institution in Chandigarh, who had a mental age assessed at approximately nine years and who became pregnant as a result of rape committed by a staff member of the institution.[23] The Chandigarh Administration approached the Punjab and Haryana High Court seeking permission to terminate the pregnancy on the

[20]X v. Principal Secy., Health & Family Welfare Dep't, Govt. of NCT of Delhi, 2022 SCC OnLine SC 1321, ¶¶ 66-77 (India).
[21]Medical Termination of Pregnancy Rules, 2003, r. 3B (as amended by the Medical Termination of Pregnancy (Amendment) Rules, 2021), Gazette of India, pt. II, § 3(i) (Oct. 21, 2021).
[22]Suchita Srivastava, (2009) 9 S.C.C. 1.
[23]Id. at 7-8.

ground that the woman was incapable of understanding the consequences of pregnancy and motherhood. An expert body constituted by the High Court found that the woman had mild to moderate mental retardation but had clearly expressed her willingness to continue the pregnancy and to bear the child. Notwithstanding this finding, the High Court directed termination of the pregnancy, invoking the doctrine of parens patriae and its own assessment of what would serve the woman's best interests.[24]

On appeal, the Supreme Court reversed the High Court and held that the woman's reproductive choice had to be respected. The Court drew a sharp distinction between a "mentally ill person" as defined in Section 2(b) of the MTP Act and a person with mental retardation, holding that while a guardian may consent on behalf of the former under Section 3(4)(a), no such substituted consent is contemplated for the latter.[25] The Court reasoned that diluting the requirement of the woman's own consent would amount to an arbitrary and unreasonable restriction on her reproductive rights, and it expressly rejected the application of the "substituted judgment" test that the High Court had borrowed from common law parens patriae jurisdiction.[26] In support of its conclusion the Court invoked the United Nations Declaration on the Rights of Mentally Retarded Persons, 1971, which affirms that persons with intellectual disability have, to the maximum degree of feasibility, the same rights as other human beings, and it noted that India's ratification of the CRPD in 2007 bound the Indian legal system to respect the personal autonomy of persons with disabilities.[27] The Court directed that the pregnancy be allowed to continue, with the best available medical care to be provided to the woman during pregnancy and thereafter.

Suchita Srivastava is rightly regarded as a landmark because it displaced, in the specific context of intellectual disability and abortion, a paternalistic model of decision making with a rights based model grounded in personal autonomy. At the same time, the judgment has attracted criticism on the ground that it may have understated the practical difficulties of assessing the will and preferences of a woman with limited communicative capacity, and that a rigid insistence on express verbal consent, without an accompanying framework of supported decision making, risks leaving some intellectually disabled women without any meaningful

[24]Id. at 8-9.
[25]Id. at 13-14.
[26]Id. at 14-15.
[27]Id. at 15; United Nations Declaration on the Rights of Mentally Retarded Persons, G.A. Res. 2856 (XXVI), U.N. Doc. A/RES/2856 (Dec. 20, 1971).

mechanism through which to exercise the very autonomy the Court sought to protect.[28]

B. The Post-Suchita Jurisprudence

Subsequent decisions have applied and, in some instances, qualified the Suchita Srivastava framework. In Z v. State of Bihar, the Patna High Court considered a petition concerning the pregnancy of a young woman with intellectual disability and undertook a careful inquiry into the medical evidence and the social circumstances of the woman before determining the appropriate course of action, expressly relying on the reasoning in Suchita Srivastava regarding the limits of parens patriae jurisdiction.[29] Courts confronted with cases involving severe psychiatric illness, as distinct from intellectual disability, have reached different outcomes. In one instance the Gujarat High Court distinguished a woman diagnosed with schizophrenia from the woman in Suchita Srivastava, observing that schizophrenia is a severe mental illness within the meaning of the MTP Act, and that the woman was consequently found incapable of caring for a child or of taking an informed decision regarding the pregnancy, a finding that permitted the ordinary Section 3(4)(a) guardian consent regime to operate.[30] This line of cases illustrates that the mentally ill or mentally retarded classification is not always self-evident and that courts continue to rely heavily on medical board opinion to place a given woman on one side or the other of the Section 2(b) definitional line, with materially different legal consequences flowing from that classification.

Courts have also confronted proposals for procedures more permanent than abortion. A High Court has, in recent years, permitted a hysterectomy for a young woman with severe intellectual and developmental disability, on a petition brought by her parents on grounds of unmanageable menstrual hygiene and recurring infection, after a multidisciplinary medical board opined that she lacked the capacity for informed consent.[31] Such decisions sit uneasily beside Suchita Srivastava, because they revive precisely the "best interests" reasoning that the Supreme Court declined to apply to a woman with intellectual disability in the abortion context, and they do so in relation to a procedure, sterilisation by hysterectomy, that carries irreversible

[28]See Malavika Parthasarathy, Integrating Mental Health Perspectives into the Legal Discourse on Reproductive Justice in India, 11 J. NAT'L L. UNIV. DELHI 45 (2019).
[29]Z v. State of Bihar, 2017 SCC OnLine Pat 786 (India).
[30]BehanBox, India's Laws Fail to Uphold Abortion Rights of Women with Disabilities (Nov. 11, 2021), https://behanbox.com/2021/11/11/indias-laws-fail-to-uphold-abortion-rights-of-women-with-disabilities/.
[31]See generally Reproductive Autonomy of Women with Intellectual Disabilities: Law, Consent and Court Decisions, Vajiram & Ravi (2026), https://vajiramandravi.com/current-affairs/reproductive-autonomy-of-women-with-intellectual-disabilities/.

consequences for fertility and that the RPWD Act treats with particular caution, as discussed in Part V below.

C. X v. Principal Secretary, Health and Family Welfare Department

In X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi, the Supreme Court considered whether an unmarried woman could seek termination of a pregnancy between twenty and twenty-four weeks under Rule 3B(c) of the MTP Rules on the ground of a change in her relationship status.[32] The Delhi High Court had refused relief on the ground that Rule 3B(c), which refers to a change of marital status through widowhood or divorce, did not extend to unmarried women. The Supreme Court reversed, holding that a narrow, literal interpretation of Rule 3B that excluded unmarried women would be discriminatory and inconsistent with the object of the 2021 amendment, which was intended to extend the benefit of the statute to all women regardless of marital status.[33] Although the case did not concern intellectual disability, its interpretive method is instructive for the present inquiry. The Court's insistence on a purposive rather than a categorical reading of eligibility criteria under the MTP Rules lends support to the argument, developed further in Part VII, that the categories in Rule 3B, including the category of "mentally ill women", should not be read so narrowly as to leave intellectually disabled women who require an extended gestational limit without a clear statutory pathway to access it.

V. The Interface with Disability Rights Law

A. The Rights of Persons with Disabilities Act, 2016

The RPWD Act was enacted to give domestic effect to India's obligations under the CRPD and replaced the earlier Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.[34] Section 3 guarantees persons with disabilities the right to equality, life with dignity and respect for bodily integrity, and expressly provides that no person shall be deprived of personal liberty only on the ground of disability.[35] Section 13 recognises the legal capacity of persons with disabilities on an equal basis with others in all aspects of life, including the right to own property and to make financial and personal decisions, and it

[32]X v. Principal Secy., 2022 SCC OnLine SC 1321, ¶¶ 1-10.
[33]Id. ¶¶ 66, 77.
[34]Rights of Persons with Disabilities Act, No. 49 of 2016, India Code, Preamble (2016).
[35]Id. § 3(1), (4).

contemplates a system of "limited guardianship" and supported decision making rather than plenary substitution of the disabled person's will, requiring that any person providing support act in accordance with the will and preferences of the person being supported.[36] Section 10 prohibits subjecting any person with disability to a medical procedure leading to infertility without her free and informed consent, a provision enacted precisely because women with intellectual disabilities have historically been vulnerable to non-consensual sterilisation.[37] Section 92(f) makes it a criminal offence to perform, conduct or direct a medical procedure on a woman with disability that leads to or is likely to lead to termination of pregnancy without her express consent, punishable with imprisonment of not less than six months extending up to five years, while carving out an exception for cases of "severe disability" where the procedure is permitted with the consent of a guardian obtained after the opinion of a medical practitioner.[38]

The architecture of the RPWD Act is thus built around a presumption of capacity and a preference for supported rather than substituted decision making, tempered by a narrow exception for severe disability that itself requires both medical opinion and guardian consent rather than guardian consent alone. This structure is considerably more protective of individual autonomy than the blanket guardian consent regime that the MTP Act applies to every "mentally ill person" regardless of the severity of the illness, and it sits closer to the model that the Supreme Court articulated for intellectually disabled women in Suchita Srivastava.

B. The Convention on the Rights of Persons with Disabilities

India ratified the CRPD in 2007, and its provisions inform the interpretation of domestic law even where they have not been directly incorporated by statute.[39] Article 12 of the CRPD requires states parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life and to provide access to the support they may require in exercising that capacity, rather than displacing it through substitute decision making.[40] Article 23 obliges states to take effective measures to eliminate discrimination against persons with disabilities in matters relating to marriage, family and reproduction, and

[36]Id. § 13; see also id. § 14 (procedure for appointment of limited guardian).
[37]Id. § 10.
[38]Id. § 92(f); see also BehanBox, supra note 20.
[39]Suchita Srivastava, (2009) 9 S.C.C. 1, 15.
[40]Convention on the Rights of Persons with Disabilities art. 12, opened for signature Mar. 30, 2007, 2515 U.N.T.S. 3.

to ensure that persons with disabilities, including children, retain their fertility on an equal basis with others.[41] Article 25 requires states to provide persons with disabilities with the same range and quality of free or affordable health care, including sexual and reproductive health services, as is provided to others, and to ensure that health care is provided on the basis of free and informed consent.[42] The CRPD Committee's General Comment on women and girls with disabilities has further clarified that prohibited discrimination includes forced or involuntary sterilisation, contraception, abortion or hormonal intervention, and has called upon states to protect the right to legal capacity and to access to health care on the basis of free and informed consent.[43]

C. The Doctrinal Tension

Reading the MTP Act, the RPWD Act and the CRPD together exposes an unresolved tension in Indian law. The MTP Act, even after Suchita Srivastava, continues to authorise a guardian to consent to termination of pregnancy on behalf of any "mentally ill person" without regard to the severity of the illness or to that woman's own expressed wishes, so long as she does not fall within the narrower category of mental retardation.[44] The RPWD Act, by contrast, permits guardian consent for a procedure affecting fertility only in the narrower case of "severe disability", and even then requires a medical opinion in addition to guardian consent.[45] The two statutes therefore employ different thresholds, different terminology and different safeguards for what is, in substance, the same underlying question, namely when it is permissible for someone other than the pregnant woman to authorise the termination of her pregnancy. Because the RPWD Act is the later and more specific enactment on disability, and because it was enacted to fulfil India's CRPD obligations, a strong argument exists that its supported decision making model should inform, and eventually replace, the cruder guardian consent mechanism that the MTP Act retains for mentally ill women. As things stand, however, the MTP Act has not been harmonised with the RPWD Act, and the two statutes continue to operate on parallel and inconsistent tracks.

[41]Id. art. 23.
[42]Id. art. 25.
[43]U.N. Comm. on the Rights of Persons with Disabilities, General Comment No. 3 on Women and Girls with Disabilities, U.N. Doc. CRPD/C/GC/3 (2016).
[44]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code § 3(4)(a).
[45]Rights of Persons with Disabilities Act, No. 49 of 2016, India Code § 92(f).

VI. Sterilisation, Bodily Autonomy and State Practice

The reproductive rights of intellectually disabled women cannot be considered in isolation from the wider history of state and family practice concerning sterilisation. In Devika Biswas v. Union of India, the Supreme Court examined the conduct of mass sterilisation camps, including one in Bihar where fifty-three women were sterilised in a single day in unsanitary conditions without adequate counselling or informed consent.[46] The Court held that the right to health, including reproductive health, is an integral part of Article 21, and that the right to make a free and informed choice regarding sterilisation, without coercion, is constitutionally guaranteed.[47] The record before the Court disclosed that informal sterilisation targets set by state authorities had, in practice, led to the sterilisation of persons who were physically or mentally challenged and who were often illiterate, underscoring the heightened vulnerability of disabled women to coercive population control measures.[48]

This history is directly relevant to the interpretation of Section 92 of the RPWD Act and to judicial willingness to authorise procedures such as hysterectomy on the application of a guardian. The "severe disability" exception in Section 92(f) was intended as a narrow safety valve, not as a general license for guardians or institutions to seek fertility limiting procedures as a matter of administrative convenience.[49] Where courts permit such procedures without a rigorous and individualised inquiry into the necessity of the intervention, the availability of less restrictive alternatives and the actual will and preferences of the woman concerned, so far as they can be ascertained through supported communication, there is a real risk of reproducing the very pattern of non-consensual sterilisation that Devika Biswas condemned, now channelled through the language of medical necessity and family caregiving rather than population policy.

VII. Gaps and Contradictions in the Present Framework

A. Definitional Ambiguity

The entire consent architecture of the MTP Act for disabled women turns on the classification of a given woman as either "mentally ill" or intellectually disabled, yet the Act itself supplies

[46]Devika Biswas v. Union of India, (2016) 10 S.C.C. 726, 733-35 (India).
[47]Id. at 745-46.
[48]Id. at 741-42.
[49]See Rights of Persons with Disabilities Act, No. 49 of 2016, India Code § 92(f).

no criteria for making that classification beyond the residual definition in Section 2(b), and it makes no reference to gradations of severity within either category.[50] In practice, as the post-Suchita case law illustrates, this classification is performed by medical boards on a case by case basis, with the result that two women with broadly similar impairments in cognitive functioning may be treated differently depending on the diagnostic label attached to their condition and on the composition and disposition of the particular medical board that examines them. A statute that displaces or preserves a woman's right to consent to termination of her own pregnancy ought not to rest on so unstable a foundation.

B. The Persistence of Guardianship

Even where Suchita Srivastava correctly protects the autonomy of intellectually disabled women from guardian override, the judgment does not address the position of women whose intellectual disability is sufficiently severe that meaningful communication of will and preference is genuinely difficult. The binary structure of Section 3(4), which offers only full personal consent or full guardian substitution with nothing in between, leaves no statutory space for supported decision making, in which a trusted person assists the woman to understand her options and to communicate a decision that remains her own. The RPWD Act's model of limited guardianship and supported decision making under Section 13 offers exactly this intermediate mechanism, but it has not been imported into the MTP Act, leaving courts to improvise on a case by case basis, sometimes toward the Suchita Srivastava model of autonomy and sometimes, as in the hysterectomy cases, back toward an unstructured best interests inquiry.[51]

C. Institutional Vulnerability

The facts of Suchita Srivastava itself, in which the woman concerned was an orphan resident of a state run welfare institution and was impregnated by an employee of that very institution, illustrate a recurring pattern in which intellectually disabled women living in institutional settings, whether state run homes, residential care facilities or, in some instances, natal families acting as de facto custodians, face a compounded vulnerability.[52] They are more exposed to sexual violence, and the very authorities or family members responsible for their care are

[50]The Medical Termination of Pregnancy Act, No. 34 of 1971, India Code § 2(b).
[51]Rights of Persons with Disabilities Act, No. 49 of 2016, India Code § 13.
[52]Suchita Srivastava, (2009) 9 S.C.C. 1, 7-8.

frequently the parties who initiate proceedings for termination of pregnancy or for sterilisation, creating an inherent conflict of interest that the present statutory framework does not adequately address through independent representation or mandatory legal aid for the woman concerned.[53]

D. Absence of Legislative Harmonisation

Finally, the MTP Act and the RPWD Act remain legislatively unharmonised more than eight years after the RPWD Act came into force. Neither the 2021 amendment to the MTP Act nor the Rules framed thereunder cross-reference the RPWD Act's provisions on legal capacity or supported decision making, and Rule 3B's category of "mentally ill women" is not defined by reference to the Mental Healthcare Act, 2017, creating a further layer of definitional inconsistency across the three statutes that between them govern the reproductive rights of disabled women.[54] This fragmentation places an unfair burden on intellectually disabled women, their families and treating physicians, who must navigate overlapping and inconsistent regimes to determine the correct legal pathway for a time sensitive medical decision.

VIII. Towards Reform

Addressing the deficiencies identified above requires coordinated legislative and institutional reform rather than further piecemeal judicial correction. Four measures merit particular consideration.

First, Section 3(4) of the MTP Act should be amended to replace the binary of personal consent or guardian substitution with a graduated model of supported decision making modelled on Section 13 of the RPWD Act, under which a support person assists the woman to understand the decision and to communicate her will and preferences, with guardian substitution available only as a last resort, subject to independent medical board opinion and, where practicable, judicial oversight.[55]

Second, the definitional inconsistency across the MTP Act, the RPWD Act and the Mental Healthcare Act, 2017 should be resolved through a single, harmonised definition of mental illness and intellectual disability, adopted uniformly across all three statutes and the MTP

[53]See Devika Biswas, (2016) 10 S.C.C. 726, 741-42 (recording sterilisation of physically and mentally challenged persons to meet informal targets).
[54]Compare Medical Termination of Pregnancy Rules, 2003, r. 3B(d), with Mental Healthcare Act, No. 10 of 2017, India Code § 2(s).
[55]Rights of Persons with Disabilities Act, No. 49 of 2016, India Code § 13.

Rules, so that a woman's classification does not shift depending on which statute happens to be invoked in a given proceeding.

Third, wherever a guardian or institution seeks judicial or medical board approval for termination of pregnancy or for a fertility limiting procedure on behalf of an intellectually disabled woman, the woman should be entitled to independent legal representation and to an individualised assessment of her communicative capacity using accessible formats, rather than a generalised finding of incapacity based on diagnostic category alone.[56]

Fourth, the government should maintain and publish disaggregated data on applications for termination of pregnancy and for sterilisation involving women with intellectual disability, including the outcome of medical board and judicial review, so that patterns of institutional or familial pressure can be identified and addressed through policy rather than left to sporadic litigation.

IX. Conclusion

The Supreme Court's decision in Suchita Srivastava v. Chandigarh Administration remains, more than a decade and a half after it was decided, the single most important statement of the reproductive rights of intellectually disabled women under Indian law. By reading the consent requirement of Section 3(4)(b) of the MTP Act as an uncompromising protection of a woman's own will, and by declining to allow a paternalistic assessment of her best interests to override that will, the Court gave concrete legal content to the constitutional promise of reproductive autonomy under Article 21. Yet the decision, taken alone, cannot bear the full weight of protecting intellectually disabled women across the range of reproductive decisions they may face, from early termination to late gestation abortion to sterilisation. The subsequent enactment of the RPWD Act and India's continuing obligations under the CRPD have introduced a more sophisticated vocabulary of legal capacity and supported decision making that the MTP Act has yet to absorb. Until Parliament undertakes the harmonising reform outlined in this article, the reproductive rights of intellectually disabled women in India will continue to depend on the classification exercise performed by a medical board and on the willingness of individual courts to follow, rather than to distinguish away, the autonomy based reasoning of Suchita Srivastava.

[56]See Rights of Persons with Disabilities Act, No. 49 of 2016, India Code § 12 (right to access justice with support measures).