

The Right to Health and Women's Empowerment: An Analysis of India's Constitutional and Legislative Frameworks

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Abstract

Women's right to health in India occupies a dynamic and contested terrain shaped by constitutional interpretation, legislative design, and socio-cultural realities. While the Indian Constitution does not explicitly enumerate a right to health, judicial interpretation, particularly of Article 21, has affirmed it as integral to life, dignity, and personal liberty. This paper examines how the evolving constitutional jurisprudence, statutory interventions such as the Maternity Benefit Act, the Medical Termination of Pregnancy Act and the PCPNDT Act, and policy frameworks including the National Health Policy 2017 and India's SDG commitments, collectively construct the normative and institutional foundations of women's Right to Health. By using doctrinal approach, the paper argues that despite significant normative advances, structural inequalities, embedded in gender norms, labour precarity, social determinants of health and implementation gaps, which continue to hinder the realisation of these rights. It concludes that a holistic and intersectional approach integrating constitutional guarantees, effective governance, and societal transformation is necessary to meaningfully empower women and secure their substantive right to health.

Keywords: Women's Empowerment, Right to Health, Article 21, Reproductive Rights, Gender Justice, SDGs

I. INTRODUCTION

The idea of health as a legal entitlement has acquired a central place in contemporary discussions of rights in India. The healthcare provision traditionally has been treated as a matter of state policy or medical professionalism. However, developments over the past several decades reveal that the right to health is not limited only access to clinical treatment alone. Its scope rather extends to the broader social and environmental conditions such as nutrition,

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sanitation, safe housing, environmental quality, and protection from hazardous labour, that collectively shape the dignity and well-being of all⁴. Therefore, World Health Organization conceives health as the highest attainable standard of physical, mental, and social well-being⁵. This definition grounded in the principles of dignity, equality, and non-discrimination. Further, this conception avoids narrow or paternalistic interpretations and recognizes that ideas of what it means to be healthy may vary across cultural and generational contexts. However, despite being conceptually rich, public discourse and administrative practice have often continued to treat healthcare as an individual or technical concern. This results in obscuring its deeply social and constitutional character.

In the Indian context, the right to health has evolved through a layered interaction between constitutional norms, judicial interpretation, and legislative initiatives. Although the Constitution does not expressly enumerate this right as fundamental, Indian Judiciary has repeatedly affirmed that the right to life under Article 21 necessarily incorporates conditions that allow an individual to live with dignity, including access to healthcare⁶. This doctrinal evolution has been complemented by a range of statutory protections addressing the needs of some specific vulnerable groups like women, children, workers, prisoners, and persons living with HIV/AIDS, alongside policy commitments such as the National Health Policy 2017 and India's obligations under the Sustainable Development Goals (SDGs)⁷.

Within this broad framework, women's health occupies an important and complex position. The legal system has attempted to safeguard women's reproductive and maternal health through instruments such as the Maternity Benefit Act, the Medical Termination of Pregnancy Act and the PCPNDT Act. At the same time, India's international commitments under CEDAW and the ICPD Programme of Action reinforce the understanding that gender equality cannot be realised without ensuring women's autonomy, bodily integrity, and access to reproductive healthcare. Yet despite this normative framework, women's actual experience of healthcare

⁴ Ravi Duggal, "Operationalizing Right to Healthcare in India" *The ICFAI journal of Healthcare Law* 13-42 (2004).

⁵ Daniel Callahan, "The WHO Definition of 'Health,'" 1(3) *The Hastings Center Studies* (1973), pp. 77-87, JSTOR, <https://doi.org/10.2307/3527467>.

⁶ J. K. Das, "Right to Health, Consumer Justice and Deficiency in Medical Services in India," 49(1-4) *Journal of Constitutional and Parliamentary Studies* pp. 8-30 (2015).

⁷ Goal 3 of Sustainable Development Goals. Also see, United Nations, "Health - Sustainable Development Goals," UN Sustainable Development, available at <https://www.un.org/sustainabledevelopment/health/>, last accessed on 2 Dec. 2025.

continues to be shaped by structural inequalities, socio-cultural norms and persistent implementation gaps in both law and policy.

This paper presents a doctrinal analysis of India's legal framework on the right to health, highlighting its implications for women's health and reproductive rights. It Draws on constitutional interpretation, statutory frameworks, and judicial decisions. It further examines how the legal system conceptualises health as a right and how effectively it addresses the specific vulnerabilities of women. While doing so, the paper situates its analysis within the theme of gender justice and argues that women's empowerment requires moving beyond formal legal protections toward a more substantive and accountability-oriented understanding of health rights. The paper concludes by identifying key areas where the law must evolve to bridge the gap between normative commitments and lived realities.

II. CONCEPTUAL FOUNDATIONS OF THE RIGHT TO HEALTH

Any inquiry into the legal status of health as a right in India must begin with a clear understanding of what "health" entails within contemporary constitutional and human-rights discourse. Historically, health was narrowly conceptualised as the availability of medical treatment or curative services—a view that positioned healthcare as a matter of professional ethics and institutional capacity rather than a broader social commitment. This individualised framing, while significant, obscured the deeper structural and environmental determinants that condition human well-being.

Over the past decades, both national and international developments have pushed jurisprudence and policy beyond this limited conception. Health is now widely understood as a composite of interrelated social goods, including adequate nutrition, safe drinking water, proper housing, hygienic surroundings, clean air, secure employment conditions and access to social security mechanisms. In this expanded sense, health functions not merely as a medical concern but as an integral element of human development and social justice. It reflects a shift from viewing health as an optional welfare objective to recognising it as a positive entitlement that forms part of the dignity of the individual.

India's engagement with international human rights treaties, Such as ICCPR, CEDAW etc., has reinforced this evolution. International instruments increasingly frame health not only as an obligation resting on states but as a substantive right held by individuals⁸. This move from

⁸ Susan Marks & Andrew Clapham, *International Human Rights Lexicon*, (New York: Oxford University Press, 2005), pp.200-201.

responsibility to entitlement signals a deeper normative transformation i.e., health is no longer something that the state provides benevolently, but something the individual may claim as of right. India's ratification of various treaties underscores its commitment to this conception and signals that domestic legal framework must be interpreted in that light.

Understanding health as a legal right has three important implications. First, it emphasises that the state's duty extends beyond providing hospitals or medicines; it requires the state to create environments in which people can lead healthy lives. Second, it aligns the right to health with other socio-economic rights i.e., strengthening the broader constitutional vision of substantive equality and social welfare. Third, it creates a strong normative foundation for interpreting the health-related needs of vulnerable groups, particularly women, as matters of justice rather than charity or administrative convenience.

Thus, Women's health cannot be separated from broader structures of gender inequality. The conceptualisation of health as a right, invites us to examine how law responds to the social, cultural, and economic conditions that shape women's access to healthcare and reproductive autonomy. This further requires moving beyond formal guarantees to interrogate the substantive conditions under which women navigate pregnancy, childbirth, reproductive decision-making, and the pervasive burdens of gender bias.

Therefore, the subsequent sections will highlight, India's constitutional jurisprudence, legislative design and policy frameworks have attempted, though often unevenly, to give effect to this expanded understanding. The right to health, as recognised through Article 21 and other constitutional provisions, now forms the backbone of judicial and legislative interventions aimed at protecting public health, ensuring environmental safety and responding to the specific vulnerabilities of women and other marginalized groups.

III. CONSTITUTIONAL FRAMEWORK OF THE RIGHT TO HEALTH IN INDIA

The constitutional foundation of the right to health in India is neither confined to a single provision nor rooted in explicit textual guarantees. Instead, it emerges from a constellation of principles, judicial interpretations and structural arrangements that together elevate health from a matter of governmental benevolence to a substantive entitlement. Over the last few decades,

this framework has developed into a coherent, though still evolving, architecture capable of grounding a broad range of health-related rights, including those central to women's well-being and empowerment.

A cornerstone of this architecture is the expansion of Article 21, which protects life and personal liberty. Though originally interpreted narrowly, the Supreme Court has steadily transformed Article 21 into a vehicle for substantive rights, including the right to health. Court's decisions in *Vincent Panikurlangara*⁹, *Parmanand Katara*¹⁰, and *Paschim Banga Khet Mazdoor Samity*¹¹ established that medical care, emergency treatment and access to adequate health facilities are essential components of the right to life. By emphasising that life cannot be reduced to mere physical survival, the Court has reinforced the idea that dignity, central to Article 21, requires a functioning healthcare system capable of addressing both general and acute medical needs.

This interpretive evolution is significant not only for its doctrinal implications, because it also repositions health as a justiciable claim rather than a discretionary policy choice. In doing so, The Courts facilitates constitutional jurisprudence, which creates a normative basis for holding the state accountable when it fails to provide essential medical services. For women, whose access to healthcare is frequently shaped by social norms, economic dependence and structural inequality, the constitutionalisation of health offers an important avenue for asserting rights that may otherwise remain unaddressed.

Further, the Directive Principles of State Policy, though formally unenforceable, articulate a comprehensive social vision that has shaped judicial interpretation of health-related rights. Articles 38, 39, 42 and 47 collectively underscore the state's duty to promote welfare, ensure humane working conditions, improve nutritional levels and advance public health. The Supreme Court has routinely relied on these provisions to reinforce the meaning of Article 21, recognising that socio-economic conditions are inseparable from the right to health¹².

Environmental protection, too, is intimately tied to public health. Article 51A(g), which places on citizens a duty to protect the environment, has been interpreted alongside Article 21 to establish a right to live in a pollution-free environment. In *M.C. Mehta*¹³, the Court made this

⁹ *Vincent Panikurlangara v. Union of India*, (1987) 2 SCC 165.

¹⁰ *Parmanand Katara v. Union of India*, AIR 1989 SC 2039.

¹¹ *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, AIR 1996 SC 2426.

¹² Asdaque, S.S., and Hasan, A., "Ensuring the Right to Health of Vulnerable Groups: An Analysis of India's Constitutional Framework", (2023) 12(2) Nat'l J. Med. & Allied Sci. 3–9, last accessed on 2 Dec. 2025.

¹³ *M.C. Mehta v. Union of India*, (1987) 1 SCC 395.

connection explicit, underscoring that ecological degradation directly jeopardizes life and health. This environmental dimension has specific implications for women, who often bear disproportionate burdens arising from pollution, inadequate sanitation and unsafe living conditions.

Similarly, the decentralized governance structure incorporated by the 73rd and 74th Constitutional Amendments further embeds health responsibilities within local institutions. For examples, Panchayats and municipalities are constitutionally empowered to manage sectors such as drinking water, sanitation, family welfare and women's and child development. In *Javed v. State of Haryana*¹⁴, the Supreme Court specifically acknowledged that local bodies are expected to participate in implementing schemes related to health and family welfare. This decentralization potentially brings decision-making closer to women, especially in rural areas, though its success depends mainly on the availability of resources, administrative capacity and gender-sensitive governance.

Furthermore, the distribution of legislative powers under the Seventh Schedule provides the structural foundation for India's health governance¹⁵. Public health, hospitals and sanitation fall primarily under the State List (Entry 6), enabling states to enact their own regulatory measures. Supreme Court decisions such as *Madhyabharat Phosphate*¹⁶ and *K.M. Vijayan*¹⁷ have reaffirmed that states possess broad authority to legislate on matters affecting public health, including pollution control and regulation of hazardous industries.

At the same time, several areas in the Union List, such as quarantine, maritime health, insurance and the regulation of labour safety, affect health outcomes indirectly but significantly. The Concurrent List provides another layer of flexibility, enabling both the Union and the states to legislate on issues like food adulteration, labour welfare, medical professions, family planning and the control of infectious diseases. The Court's interpretation in *State of Bihar v. Shree Baidyanath Ayurved Bhawan Ltd.*¹⁸ and *State of A.P. v. McDowell & Co.*¹⁹ makes clear that the state's regulatory authority is wide-ranging but must be exercised within the broader framework of constitutional objectives.

¹⁴ AIR 2003 SC 3057.

¹⁵ Poonam Sonwani, "Distribution of Legislative Powers under the Indian Constitution," 7(1) *Research Journal of Humanities and Social Sciences* pp. 39-46 (2016).

¹⁶ *Madhyabharat Phosphate Pvt. Ltd. v. State of Rajasthan*, 2012 (1) ILR (Raj) 355.

¹⁷ *K. M. Vijayan v. State of Tamil Nadu*, AIR 2005 Mad 408.

¹⁸ (2005) 2 SCC 762.

¹⁹ (1996) 3 SCC 709.

Although, this federal structure allows for context-specific interventions, it also results in substantial variation in health services across states. Women, especially those from rural or Socio-economic disadvantaged communities, are often the most affected by these disparities. A health system fragmented by geography risks reproducing inequalities that the constitutional vision seeks to eliminate, underscoring the need for coordinated approaches that balance state autonomy with national standards.

Taken together, these constitutional provisions and judicial interpretations create a strong normative foundation for protecting women's health. Article 21 jurisprudence affirms their entitlement to dignified living conditions, emergency medical care and reproductive autonomy; DPSPs articulate the state's obligation to ensure humane working conditions and maternal welfare; decentralized governance structures bring health administration closer to women's everyday lives. Yet the lived realities of women often diverge sharply from these constitutional ideals. Gender discrimination, socio-economic constraints, cultural norms and institutional shortcomings continue to limit women's access to healthcare. The constitutional framework provides the conceptual tools for addressing these challenges, but realizing its potential requires sustained legislative action, administrative commitment and a deeper social shift towards recognizing women's autonomy and rights.

IV. RIGHT TO HEALTH, REPRODUCTIVE RIGHTS AND WOMEN'S HEALTH IN INDIA

The recognition of women's right to health in India occupies a complex space at the intersection of constitutional guarantees, obligations under international human rights, and entrenched socio-cultural inequalities. While the legal system has progressively acknowledged health as an inseparable component of the right to life under Article 21, women's experiences of health and healthcare continue to be mediated by gendered structures of power. This section examines how Indian law conceptualizes and protects women's right to health, drawing from constitutional interpretation, statutory developments, and broader judicial approaches to gender equality.

At the core of this discourse lies the understanding that health is not confined to the availability of medical treatment. As elaborated earlier, it includes the conditions necessary for physical, mental and social well-being. For women, these determinants are profoundly shaped by family roles, economic dependence, mobility restrictions, and persistent social norms that privilege

male health needs over female bodily autonomy. Judicial engagement with women's health has therefore had to move beyond traditional medical frameworks and address questions of choice, dignity and structural discrimination.

International commitments have played a significant role in shaping this expanded view. India's ratification of CEDAW positions women's health squarely within the domain of equality jurisprudence. CEDAW obliges States to eliminate discrimination in healthcare access, ensure maternity protection, and guarantee reproductive autonomy. Judicial reasoning in India has frequently drawn on these principles, especially when interpreting Article 21 in conjunction with Articles 14 and 15. Courts have increasingly recognized that women's right to health encompasses not merely safe motherhood or reproductive choice but also the substantive conditions necessary to exercise those rights meaningfully.

The debate on reproductive rights illustrates this evolution clearly. The legislative framework on pregnancy, abortion and pre-natal technologies reflects attempts to balance women's autonomy with concerns relating to public health, social morality and demographic anxieties. The Medical Termination of Pregnancy Act, for instance, was enacted primarily to address unsafe abortions, but it simultaneously acknowledges the profound impact of unwanted pregnancies on women's mental and social well-being. Judicial decisions interpreting this Act have gradually strengthened the understanding that reproductive decisions belong primarily to the woman, and that the State's role is to facilitate safe and dignified access rather than impose paternalistic restrictions.²⁰

Similarly, the Pre-Conception and Pre-Natal Diagnostic Techniques Act was framed in response to structural gender discrimination that manifests in sex-selective practices. While the statute focuses on regulating technology, the deeper problem lies in social attitudes that devalue girls and impose disproportionate reproductive pressures on women. Courts have recognised that preventing sex selection is not merely a matter of policing clinics but requires attention to women's social status, access to healthcare, and protection from coercive familial practices. This insight aligns closely with emerging scholarly perspectives that caution against viewing gender justice through narrow legal prohibitions without addressing underlying inequalities²¹.

²⁰ Pai, S.N., and Chandra, K.S., "Medical Termination of Pregnancy Act of India: Treading the Path Between Practical and Ethical Reproductive Justice", (2023) 48 *Indian J. Community Med.* 510–513, available at https://doi.org/10.4103/ijcm.ijcm_540_22, last accessed on 2 Dec. 2025.

²¹ Bhaktwani, A., "The PC-PNDT Act in a Nutshell", (2012) 22 *Indian J. Radiol. Imaging* 133–134, available at <https://doi.org/10.4103/0971-3026.101114>, last accessed on 2 Dec. 2025.

Maternal health legislation further highlights the gender-specific dimensions of the right to health. The Maternity Benefit Act seeks to protect women during pregnancy and childbirth by emphasising dignity, rest, financial security, and freedom from workplace discrimination. Judicial interpretation of the Act has been sensitive to women's vulnerabilities in informal and precarious employment, stressing that maternity protection must be understood as an entitlement grounded in equality rather than as a concession. This approach resonates with broader judicial trends that view gender-based exclusions in employment, healthcare access, and social protection as constitutional violations requiring affirmative state action.

Yet, despite these legal advances, the lived reality of women's health in India reflects persistent gaps. Scholars have underscored that social norms, domestic violence, early marriage, economic dependency, and unequal labour burdens significantly undermine women's ability to access healthcare²². Judicial responses have increasingly acknowledged that discrimination may be subtle, systemic and cumulative, requiring a context-sensitive approach. Courts have thus begun to interpret health rights through the lens of substantive equality, recognizing that formal guarantees are insufficient in the face of entrenched patriarchal practices.

It is pertinent to highlight an important dimension of this development i.e., the judiciary's reliance on Article 21 to address situations where legislation is silent or inadequate²³. The expansion of the right to health to include mental well-being, reproductive choice, emergency care, and a safe environment provides a constitutional foundation for women to seek remedies for a wide range of violations. This broad reading of Article 21 aligns with international human-rights principles and with contemporary feminist legal scholarship, which views reproductive autonomy and bodily integrity as fundamental to women's citizenship.

Taken together, these developments reveal a framework in which women's right to health is both constitutionally grounded and socially contested. While legislative frameworks provide important safeguards, the transformative potential lies in judicial reasoning that foregrounds dignity, autonomy and equality. However, the challenge ahead is to strengthen institutional mechanisms, address structural barriers and ensure that the gains made in jurisprudence translate into tangible improvements in women's everyday lives.

²² Sanneving, L., Trygg, N., Saxena, D., Mavalankar, D., and Thomsen, S., "Inequity in India: The Case of Maternal and Reproductive Health", (2013) 6 *Global Health Action* 19145, available at <https://doi.org/10.3402/gha.v6i0.19145>, last accessed on 2 Dec. 2025

²³ Viswanath, A., "Critical Analysis of the Various Facets of Right to Health under Article 21 of the Constitution", (Vol. III, Issue III) *Indian J. Integrated Res. Law*.

V. LEGISLATIVE FRAMEWORK ON WOMEN'S HEALTH IN INDIA

The statutory protection of women's health in India reflects a layered attempt to reconcile constitutional commitments to equality with the lived realities of gendered disadvantage. While judicial interpretation of Article 21 has been instrumental in expanding the scope of women's health rights, but legislative interventions remain central to defining concrete entitlements, outlining institutional duties, and shaping the regulatory environment within which women negotiate their reproductive and maternal health needs. This section analyses three critical enactments, the Maternity Benefit Act 1961, the Medical Termination of Pregnancy Act 1971, and the Pre-Conception and Pre-Natal Diagnostic Techniques Act 1994, each addressing a different dimension of women's health and bodily autonomy.

A. The Maternity Benefit Act 1961: Protecting Dignity, Labour and Maternal Well-Being

The Maternity Benefit Act 1961, amended in 2017, represents one of the earliest and most comprehensive efforts to anchor women's reproductive capacities within a rights-based labour framework. The Act recognises that pregnancy and childbirth involve unique physical burdens and social vulnerabilities that can expose women to discrimination, wage loss and job insecurity. It affirms the constitutional mandate under Articles 14, 15(3) and 21 to safeguard women's dignity during maternity by mandating paid maternity leave, restricting employment immediately before and after childbirth, and ensuring job protection.

Judicial interpretation has reinforced this rights-based reading. In *Municipal Corporation of Delhi v Female Workers (Muster Roll)*²⁴, the Supreme Court held that maternity protection extends even to casual and temporary workers, underscoring that motherhood cannot be contingent upon the nature of employment. The judgment reflects a broader judicial trend of using constitutional equality guarantees to expand legislative protections beyond their formal text. It also aligns with scholarly critiques that stress the structural vulnerability of women in

²⁴ (2000) 3 SCC 224.

informal sectors, where precarious employment amplifies the health risks associated with pregnancy and childcare.

However, despite the Act's progressive spirit, practical implementation remains uneven. Women in informal labour markets, domestic work and unregulated service sectors continue to face barriers in accessing maternity benefits. Employers' reluctance, limited awareness and infrastructural deficits often restrict the Act's reach²⁵. These gaps reveal the persistent tension between statutory design and socio-economic realities, a theme repeatedly highlighted in gender-justice scholarship. The challenge is not merely legal enforcement but addressing the broader inequities that shape women's labour and health outcomes.

B. Medical Termination of Pregnancy Act 1971: Reproductive Autonomy and Access to Safe Abortion

The Medical Termination of Pregnancy Act 1971, amended in 2021, emerged from the urgent need to address unsafe abortions, which was a leading cause of maternal mortality in post-independence India. Although originally the act was framed as a public health measure, but it implicitly recognises a woman's right to make decisions concerning her reproductive life, acknowledging that unwanted pregnancies can have profound implications for a woman's physical and mental well-being.

The Act's framework requires medical certification for termination, distinguishing between early and later stages of pregnancy. While this reflects an attempt to balance medical safety with reproductive choice, it also positions physicians as gatekeepers of women's autonomy. Judicial decisions have nonetheless pushed the law toward a more expansive understanding of women's rights. Courts have permitted termination beyond statutory limits in cases involving foetal abnormalities, sexual violence and risks to the woman's health, grounding these decisions in Article 21's guarantees of dignity, autonomy and bodily integrity.

At the same time, academic critiques caution that access barriers, such as geographic, financial, cultural and institutional, continue to limit the Act's transformative potential²⁶. Further, timely access to abortion services often impedes due to regulatory inconsistencies across states,

²⁵ Bala, Shashi, "Implementation of Maternity Benefit Act", (2012) NLI Research Studies Series 99, last accessed on 2 Dec. 2025.

²⁶ Chatterjee, P., "Medical Termination of Pregnancy Act: A Boon or a Bane for a Woman in India – A Critical Analysis", (2016) 5(9) IJSR 236–240, last accessed on 2 Dec. 2025.

administrative delays and restrictive interpretations by medical boards. These systemic obstacles, when combined with social stigma, disproportionately burden women from marginalised communities. Thus, while the legal framework is comparatively liberal, meaningful reproductive autonomy requires addressing the intersectional inequalities that shape women's access to safe abortion care.

C. The Pre-Conception and Pre-Natal Diagnostic Techniques Act 1994: Regulating Technology and Confronting Gender Bias

The widespread misuse of diagnostic technologies to determine the sex of the foetus and facilitate sex-selective abortions lead to the legislative response in the form of PCPNDT Act 1994. Female foeticide, driven by entrenched patriarchal norms and the socio-economic disadvantages associated with raising girls, contributed to a sharp decline in sex ratios across several regions. The Act seeks to prohibit sex selection, regulate diagnostic facilities and criminalise practices that enable gender-biased abortions.

While the Act is essential for addressing a structural form of gender discrimination, it also illustrates the complexity of legislating reproductive practices in a society marked by unequal gender relations. Scholars note that sex selection is not merely a technological problem but a symptom of broader socio-cultural biases, like dowry norms, son-preference, inheritance patterns, and the undervaluation of women's labour. Thus, although the PCPNDT Act targets supply-side actors such as clinics and diagnostic centres, the deeper challenge lies in transforming societal attitudes that frame daughters as economic liabilities and sons as bearers of lineage.

Judicial intervention has reinforced the normative aims of the Act, urging strict monitoring of diagnostic centres and directing state governments to strengthen implementation mechanisms. However, conviction rates remain low, reflecting administrative weaknesses, lack of awareness and difficulties in prosecuting offences occurring in private medical settings. Feminist scholars caution that while the Act is necessary, overemphasis on punitive enforcement risks ignoring the structural drivers of gender discrimination, including health inequalities, inadequate social support and gendered economic vulnerabilities²⁷.

²⁷ Dhar, M., Payal, Y.S., and Krishna, V., "The Pre-Conception and Pre-Natal Diagnostic Techniques Act and Its Implication on Advancement of Ultrasound in Anaesthesiology: Time to Change Mindsets Rather Than Laws", (2018) 62(12) Indian J. Anaesth. 930–933, last accessed on 2 Dec. 2025.

Collectively, these three legislative frameworks offer an illuminating overview of the State's attempts to protect women's health across different life stages, from pregnancy, childbirth, reproductive decision-making to protection from gender-biased practices. Yet they also expose the persistent gaps between statutory entitlement and lived experience. A consistent theme emerging from judicial interpretation, scholarly literature and empirical evidence is that women's health rights cannot be secured merely through legislative command; they require a supportive socio-economic environment, institutional accountability, and sustained efforts to dismantle structural gender inequalities. The cumulative effect of these statutes, when interpreted considering constitutional guarantees and international commitments, is to position women's health as a matter of substantive equality and human dignity. However, empowering women in the realm of health requires not only legal reform but also a deeper shift in societal values and state priorities. To achieve this goal, strengthening access to healthcare infrastructure, ensuring non-discriminatory treatment, addressing reproductive coercion, and expanding social support systems remain essential components.

VI. POLICY FRAMEWORKS, SDGs, AND INDIA'S COMMITMENT TO GENDERED HEALTH EQUITY

Translating constitutional commitments and legislative guarantees into actionable strategies, policy frameworks play an indispensable role. In the context of women's health, national policies function not only as administrative roadmaps but also as normative statements that shape how the State conceives and prioritises health-related rights. The National Health Policy (NHP) 2017, together with India's commitments under the Sustainable Development Goals (SDGs), particularly SDG 3 on health and SDG 5 on gender equality, provides an important backdrop for assessing the country's approach to women's right to health.

The National Health Policy 2017 marks a significant shift from earlier policy frameworks by situating health within a rights-sensitive discourse. While the policy falls short of explicitly recognising health as a fundamental right, it affirms the State's obligation to strengthen public healthcare, improve access to services and address social determinants of health. NHP 2017 emphasises preventive and promotive health, universal access to essential drugs and diagnostics, and financial protection through health insurance schemes. These commitments reflect the constitutional jurisprudence that views health as integral to Article 21 and linked to equality under Articles 14 and 15.

For women, the policy includes targeted measures relating to maternal health, reproductive services, anaemia control, adolescent health, and gender-sensitive healthcare system. It identifies gender-based violence as a public health concern and emphasises the need for integrated survivor support within healthcare settings²⁸. These provisions further underscore that women's health cannot be divorced from broader patterns of inequality, violence and socio-economic exclusion.

In Parallel, India's commitment to SDG 3 further reinforces the normative expectation that health should be accessible, equitable and of adequate quality for all, including women. SDG 3 explicitly includes reducing maternal mortality, ensuring universal access to sexual and reproductive healthcare, combating communicable and non-communicable diseases and reducing preventable deaths²⁹. Further, SDG 5 situates women's health firmly within the broader framework of gender equality. It recognises that the ability to make decisions about one's body, reproductive life and health-seeking behaviour is essential to women's autonomy and agency. The SDG indicators on ending discrimination, eliminating violence, recognising unpaid care work and ensuring access to reproductive health services overlap substantially with constitutional equality mandates under Articles 14, 15 and 21.

The combined policy and SDG frameworks illuminate both the advances and the limitations of India's approach to women's health. On one hand, they articulate clear normative commitments, reinforce global standards and support the judiciary's expansive interpretation of health rights. On the other, they expose persistent structural gaps, resource limitations, uneven implementation, socio-cultural resistance and weak institutional accountability. From a constitutional perspective, the synergy between NHP 2017, SDG commitments and judicial interpretation suggests a movement toward recognising women's health as a matter of substantive equality. Statutory frameworks such as the Maternity Benefit Act, MTP Act and PCPNDT Act gain deeper normative coherence when read alongside these policy commitments, particularly when evaluated against the principles of dignity, autonomy and non-discrimination. Yet, the ultimate realisation of women's right to health requires an integrated approach. Legal reforms must be complemented by investments in public health infrastructure; policy commitments must be translated into enforceable entitlements; and health governance

²⁸ Pradhan, M.R. and De, P., "Women's healthcare access: assessing the household, logistic and facility-level barriers in India," 25 BMC Health Serv Res. 323 (2025).

²⁹ Sushma Sharma, "Reproductive Rights and Women's Health: A New Prospective," 4(4) International Journal of Humanities and Social Science Invention (2015) pp. 51-56 at p. 52

must adopt a gender-sensitive, rights-based framework capable of addressing both immediate needs and long-standing inequities.

VII. CONCLUSION

The examination of India's constitutional, legislative and policy frameworks reveal a complex but evolving landscape for the protection of women's right to health. At its normative core, the Indian Constitution, particularly Articles 14, 15 and 21, situates health within a broader vision of dignity, equality and substantive freedoms. Judicial interpretation has expanded this foundation by recognising that women's health cannot be confined to medical treatment alone; it encompasses the social, economic and cultural conditions that shape women's capacity to live autonomous and fulfilling lives. This jurisprudential evolution reflects a maturing understanding that the right to health is inseparable from reproductive choice, personal liberty and bodily integrity.

Legislative developments such as the Maternity Benefit Act, the MTP Act and the PCPNDT Act illustrate the State's continuing attempts to respond to women's distinct health needs across different life stages. Yet these statutes also expose the deep structural inequalities that impede their effective implementation. Women employed in informal sectors continue to experience barriers to maternity protection, access to safe abortion remains uneven despite a comparatively liberal legal framework, and the existence of sex-selective practices reveals how entrenched patriarchal attitudes can frustrate even the most stringent regulatory systems. These challenges underscore that formal legal equality, while indispensable, cannot by itself dismantle the gendered hierarchies that shape health outcomes for millions of women.

National policy commitments, particularly those encapsulated in the National Health Policy 2017 and the Sustainable Development Goals, reinforce the need for a holistic, equity-driven approach to women's health. Their emphasis on universal access, gender-sensitive services and the reduction of maternal mortality signals an important shift toward viewing health as a development imperative. However, a rights-based policy environment can succeed only if complemented by institutional accountability, adequate public investment and a sustained effort to confront the social determinants—nutrition, sanitation, early marriage, violence, labour burdens and economic dependency—that continue to constrain women's well-being.

Together, these developments suggest that the realisation of women's right to health in India depends on more than legislative reform or judicial innovation. It requires a deeper structural transformation that enables women to exercise autonomy over their bodies, access healthcare without discrimination, and navigate social spaces free from coercion and violence. Strengthening public health infrastructure, improving regulatory implementation, enhancing legal literacy, and fostering community-based awareness are all integral to this broader project. Thus, advancing women's right to health demands not only legal protections but a clear political and social commitment to dismantling the gendered inequities that shape everyday life of women. Only through such an integrated approach can India meaningfully honour its constitutional promise of dignity and equality for all women.