Jus Corpus Law Journal

Open Access Law Journal – Copyright © 2026 – ISSN 2582-7820

Editor-in-Chief – Prof. (Dr.) Rhishikesh Dave; Publisher – Ayush Pandey

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Maternal Health Governance and Tribal Women's Reproductive Rights under Article 21

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Received 22 August 2026; *Accepted* 22 September 2026; *Published* 26 September 2026

Maternal health in many tribal regions continues to fall behind national averages not because government schemes are missing, but because existing governance structures often fail to recognise the lived realities of tribal women. This study examines how autonomy, dignity and informed decision-making operate within the maternal health system in tribal areas, and why state interventions remain ineffective despite a strong policy framework. The research question guiding this study is: how the maternal health systems operating in tribal areas affect women's everyday experience of autonomy and dignity, and what changes could make this care truly centred on women's autonomy. Based on doctrinal analysis and field insights gathered during my postdoctoral research, including a review of governance models such as PHCs, SHCs and PMCs, the paper explores the gap between constitutional guarantees under Article 21 and the everyday healthcare experiences of tribal women. Although reproductive autonomy and dignity are increasingly acknowledged in legal discourse, these principles rarely shape service delivery on the ground. In several tribal areas of Udaipur, persistent communication barriers, pressure for institutional deliveries, and weak transport and referral systems restrict women's real agency. Digital health initiatives and monitoring tools, while well-intended, often overlook issues of access, literacy and cultural compatibility. Consequently, governance becomes compliance-driven rather than autonomy-centred.

Keywords: *tribal women's health, reproductive rights, article 21, maternal health governance, public health policy.*

INTRODUCTION

Maternal health occupies an important place within the constitutional promise of life with dignity under the Indian Constitution. A significant proportion of India's population lives in tribal areas. For tribal women in India, however, pregnancy and childbirth continue to be shaped by structural marginalisation, limited access to healthcare, and governance arrangements that often fail to translate constitutional guarantees into lived realities. Despite the State's formal commitment to improving maternal health outcomes, persistent disparities affecting Scheduled Tribe women raise deeper questions about the effectiveness of maternal health governance in securing reproductive autonomy and dignity.[1]

Despite the presence of several national maternal health initiatives, the situation in tribal regions suggests that policy expansion has not translated into meaningful access for women on the ground. Disparities in these contexts emerge not only through poorer health indicators but also through structural barriers such as distance, infrastructural gaps, and administrative procedures that influence reproductive decision-making. Viewed from a constitutional perspective, this gap between programme design and lived reality raises the question of whether maternal health governance in tribal areas genuinely satisfies the substantive protections associated with Article 21.[2]

The evolution of Article 21 jurisprudence demonstrates a clear shift from a survival-based conception of life to one grounded in dignity and autonomy. Courts have consistently recognised that life under the Constitution includes health, privacy, and reproductive choice, recognising that personal liberty has substantive as well as procedural dimensions. In this context, maternal healthcare cannot be treated merely as a welfare concern; it becomes part of the constitutional promise of dignified existence and the effective protection of the right to life.[3]

Constitutional obligations relating to maternal health are further shaped by provisions that acknowledge structural inequality. Article 15(3) enables the State to introduce protective

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[1] The Constitution of India 1950; *Maneka Gandhi v Union of India* (1978) 1 SCC 248; *Francis Coralie Mullin v Administrator U T of Delhi & Ors* (1981) 1 SCC 608

[2] *Janani Suraksha Yojana (JSY): Guidelines for Implementation* (Ministry of Health and Family Welfare)

[3] *Bandhua Mukti Morcha v Union of India & Ors* (1984) 3 SCC 161; *Consumer Education and Research Centre & Ors v Union of India & Ors* (1995) 3 SCC 42; *Suchita Srivastava & Anr v Chandigarh Administration* (2009) 9 SCC 1; *Justice K S Puttaswamy (Retd) & Anr v Union of India & Ors* (2017) 10 SCC 1

measures for women, recognising that gender disadvantage often requires targeted intervention rather than formally neutral policies. In tribal contexts, this is especially important because maternal healthcare needs are influenced by social, cultural, and geographic factors that cannot be addressed through uniform programme design. Article 46, which directs the State to promote the welfare of Scheduled Tribes and protect them from injustice, strengthens this constitutional expectation. Although directive in nature, it offers a normative lens through which governance practices affecting tribal communities can be assessed.[4]

In many tribal areas, infrastructural constraints continue to shape women's experiences of pregnancy and childbirth in ways that differ significantly from policy expectations. Available national data suggest that Scheduled Tribe women often encounter lower access to institutional maternal healthcare and higher vulnerability compared to broader population averages. Development indices similarly reflect uneven health progress across regions, with tribal communities frequently remaining on the margins of improvement. Although national indicators point toward gradual advancement, disaggregated evidence highlights persistent inequalities that remain insufficiently addressed, indicating that governance mechanisms have not fully translated constitutional commitments into equitable outcomes.[5]

In this background, the paper argues that maternal health governance in tribal regions often focuses more on meeting administrative targets than on ensuring real reproductive autonomy and dignity for women, even though Article 21 recognises these as constitutional rights. The study examines whether current governance systems actually support women's choices or whether structural barriers continue to limit them in practice. To explore this issue, the paper uses doctrinal analysis of constitutional provisions and judicial decisions, along with an examination of maternal health programmes and insights drawn from field experiences in tribal areas.

[4] The Constitution of India 1950, arts 15(3) and 46

[5] *National Family Health Survey (NFHS-5), 2019–21* (International Institute for Population Sciences (IIPS) & ICF, 2022); *SDG India Index & Dashboard* (NITI Aayog)

ARTICLE 21 – HEALTH, DIGNITY AND REPRODUCTIVE AUTONOMY

The decision in *Maneka Gandhi v Union of India* (1978) marked an important shift in the interpretation of Article 21. The Supreme Court emphasised that the protection of life and personal liberty is not confined to procedure alone, but must satisfy standards of fairness and reasonableness[6]. It also clarified that Articles 14, 19, and 21 are interconnected. Most importantly, the Court recognised that life under the Constitution means a life with dignity and quality, not mere physical existence.

The Court further developed this position in *Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) by emphasising that the right to life under Article 21 includes the right to live with dignity.[7] According to the Court, dignity is closely linked with access to basic necessities such as health, nutrition, and humane living conditions. This interpretation strengthened the understanding that health forms a core part of constitutional protection under Article 21.

In *Bandhua Mukti Morcha v Union of India* (1984), the Supreme Court recognised that Article 21 places positive obligations on the State. The State is not only required to avoid violating rights but must also take active steps to protect human dignity.[8] Health under Article 21 is not optional. It becomes a duty of the State to protect human life and to ensure access to basic healthcare facilities. In this sense, failures in governance and implementation can amount to constitutional failures.

In *Consumer Education and Research Centre v Union of India* (1995), the Supreme Court recognised that the right to health forms an essential part of the guarantee of life under Article 21. The Court emphasised that good health is necessary for living with dignity and that the State has a duty to ensure conditions that protect the well-being of individuals[9]. This decision helped remove uncertainty about the constitutional position of the right to health, establishing it as a substantive element of the broader right to life.

In *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996), the Supreme Court held that failure of public healthcare infrastructure violates Article 21. The Court stated that lack

[6] *Maneka Gandhi v Union of India* (1978) 1 SCC 248
[7] *Francis Coralie Mullin v Administrator, Union Territory of Delhi & Ors* (1981) 1 SCC 608
[8] *Bandhua Mukti Morcha v Union of India & Ors* (1984) 3 SCC 161
[9] *Consumer Education and Research Centre & Ors v Union of India & Ors* (1995) 3 SCC 42

of funds or facilities cannot be used as a defence, particularly in cases involving emergency medical care.[10] Access to timely medical treatment was recognised as a constitutional obligation of the State. As a result, gaps in healthcare infrastructure, delivery failures, and institutional shortcomings become legally relevant under Article 21.

These judgments clearly show that Article 21 is a dynamic provision. Health is closely linked to human dignity, and the Supreme Court has consistently adopted a rights-based approach while interpreting the right to life.[11] This constitutional framework forms the doctrinal foundation for examining health governance and reproductive autonomy.

REPRODUCTIVE RIGHTS AND TRIBAL WOMEN: INTERSECTIONAL CONSTITUTIONAL OBLIGATIONS

Courts have recognised that reproductive choice is closely linked with personal liberty and dignity under Article 21. In *Suchita Srivastava v Chandigarh Administration*, the Supreme Court held that a woman has the right to make decisions about reproduction, including whether to continue a pregnancy. These choices were described as part of bodily autonomy and personal freedom, which should remain primarily with the woman rather than the State.[12]

In later rulings, the Supreme Court has reiterated that a woman's decision regarding the continuation or termination of a pregnancy lies primarily with her, within the bounds of the constitutional scheme. When a woman does not wish to proceed with a pregnancy, the Court has recognised her right to make that choice independently. Overall, the Court's approach reflects the position that reproductive choice is not a matter of generosity or administrative discretion, but a right protected under Article 21.[13]

The constitutional protection of reproductive autonomy was further examined in *Devika Biswas v Union of India*, where the Hon'ble Supreme Court dealt with coercive sterilisation

[10] *Paschim Banga Khet Mazdoor Samity of Ors v State of West Bengal & Anr* (1996) 4 SCC 37
[11] Abhinav Viswanath, 'CRITICAL ANALYSIS OF THE VARIOUS FACETS OF RIGHT TO HEALTH UNDER ARTICLE 21 OF THE CONSTITUTION' (2023) 3(3) IJIRL <https://ijirl.com/wp-content/uploads/2023/06/CRITICAL-ANALYSIS-OF-THE-VARIOUS-FACETS-OF-RIGHT-TO-HEALTH-UNDER-ARTICLE-21-OF-THE-CONSTITUTION.pdf> accessed 10 August 2026
[12] *Suchita Srivastava & Anr v Chandigarh Administration* (2009) 9 SCC 1
[13] *X v The Principal Secretary, Health and Family Welfare Department, Govt of NCT of Delhi & Anr* (2022) Civ App No 5802/2022

practices carried out under State programmes. The Court held that such practices violate a woman's dignity, bodily integrity, and reproductive autonomy.[14] It clearly stated that procedural compliance with population control or health schemes cannot justify the violation of fundamental rights. This judgment is particularly important in understanding how reproductive rights can be undermined through governance practices, even when such practices are presented as welfare measures.

The constitutional foundation of reproductive choice is further strengthened by the decision in *Justice K.S. Puttaswamy v Union of India*, in which the Supreme Court recognised privacy as a fundamental right protected under Article 21.[15] The Court held that privacy includes bodily integrity and decisional autonomy, especially in matters relating to family life and reproductive choices. The judgment affirmed that reproductive decisions belong to individual women and must be free from coercion, surveillance, or undue State interference.

When examined in the context of tribal women, the obligations of the State become more pronounced. Tribal women often experience reproductive decision-making at the intersection of gender, social marginalisation, and historical disadvantage. Structural barriers such as limited access to healthcare facilities, language difficulties, lack of informed consent, transportation constraints, and dependence on State health machinery frequently restrict their ability to exercise reproductive choice in a meaningful manner. In such contexts, reproductive autonomy is compromised not through explicit denial, but through procedural exclusion and systematic neglect.

The statutory framework under the *Medical Termination of Pregnancy Act, 1971* (as amended in 2021) also reflects this autonomy-based approach by recognising a woman's right to make decisions relating to termination of pregnancy within a regulated framework.[16] While the statute itself is not the central focus of this analysis, it reinforces the constitutional understanding that reproductive decision-making lies primarily with the woman and must be respected as an aspect of her dignity and personal liberty.

Empirical and academic studies on maternal and reproductive health in India have highlighted persistent inequities faced by marginalised groups, including tribal women.

[14] *Devika Biswas v Union of India & Ors* (2016) 10 SCC 726
[15] *Justice K S Puttaswamy (Retd) & Anr v Union of India & Ors* (2017) 10 SCC 1
[16] Medical Termination of Pregnancy Act 1971

These studies point to reduced autonomy, inadequate consent processes, and limited participation of women in reproductive decision-making.[17] When examined alongside constitutional jurisprudence, such findings reveal that reproductive rights violations are not merely failures of the health system, but raise serious constitutional concerns under Article 21.

In light of this jurisprudence, the judicial recognition of reproductive autonomy, dignity, and privacy establishes that reproductive rights form an inseparable part of the right to life under Article 21. For tribal women, these rights acquire an intersectional dimension, requiring governance frameworks that are sensitive to both gender and tribal status. Maternal health governance that overlooks this intersection risks reducing reproductive rights to procedural compliance rather than ensuring their substantive realisation.

MATERNAL HEALTH GOVERNANCE IN TRIBAL AREAS

Maternal health governance in tribal areas can be understood through government data and policy documents. The National Family Health Survey 2019–21 (NFHS-5) shows that Scheduled Tribe women have lower access to institutional maternal healthcare, antenatal care, and skilled birth attendance compared to national averages. These differences are not isolated service failures. They reflect structural gaps in health governance. The data show unequal access to healthcare services, not only differences in outcomes.

Similar patterns appear in the NITI Aayog SDG India Index, which tracks progress on health-related Sustainable Development Goals. While national indicators show some improvement in maternal health, the Index shows uneven progress across States and population groups. Tribal and marginalised communities continue to remain behind. This suggests that national averages do not capture internal inequalities. The gap between official data and lived experience highlights limits in how maternal health governance is assessed.

[17] Sarojini Nadimpally and Keertana K Tella, 'Recalibrating Health Governance, Equity and Reproductive Rights in India: A Case Study from the Global South (2025) 8(4) CRISPR Journal <https://journals.sagepub.com/doi/10.1089/crispr.2025.0053> accessed 10 August 2026; Nadja Trygg et al., 'Inequity in India: the case of maternal and reproductive health' (2013) 6(1) Global Health Action <https://doi.org/10.3402/gha.v6i0.19145> accessed 10 August 2026

The National Tribal Health Action Plan 2019, issued by the Ministry of Health and Family Welfare, identifies barriers to maternal healthcare in tribal regions. The document points to geographical isolation, poor infrastructure, shortage of trained health workers, and cultural and language barriers. It recognises that maternal healthcare in tribal areas is affected not only by lack of services, but also by governance that does not adjust to local conditions.

Maternal health services in tribal areas are mainly delivered under the National Health Mission through Primary Health Centres, Community Health Centres, and frontline workers such as ASHAs and Auxiliary Nurse Midwives[18]. While this structure exists on paper, its functioning in tribal areas is often weak. Infrastructure is limited. Referral systems are fragile. Transport is difficult. Skilled personnel are often unavailable. Because of this, the presence of health facilities does not always result in actual access to maternal healthcare.

Schemes such as the Janani Suraksha Yojana were introduced to encourage institutional deliveries through cash incentives.[19] In tribal areas, this approach has shown limited success. Institutional delivery targets are often followed without proper attention to informed consent, women's choice, or local realities such as distance and family decision-making. This turns maternal health governance into a target-driven exercise rather than a rights-based one.

The Janani Shishu Suraksha Karyakram guarantees free maternal and newborn healthcare services.[20] However, in tribal areas, access to these services remains uneven. Services exist in policy, but delivery is inconsistent. These gaps show that maternal health governance in tribal regions often remains procedural and does not ensure meaningful access for tribal women.

JUDICIAL INTERPRETATION OF MATERNAL HEALTH AND REPRODUCTIVE RIGHTS UNDER ARTICLE 21

According to Article 21, the Supreme Court has acknowledged that the right to choose one's own reproductive path is a component of individual liberty and dignity. The court ruled in

[18] *Framework for Implementation National Health Mission 2012-2017* (Ministry of Health and Family Welfare, 2017)
[19] *Janani Suraksha Yojana Guidelines* (Ministry of Health and Family Welfare)
[20] *Janani Shishu Suraksha Karyakram Guidelines (*Ministry of Health and Family Welfare)

Suchita Srivastava v Chandigarh Administration that a woman's reproductive decisions are a component of her personal liberty.[12] The Court clarified that these rulings are independent of State policy and discretion and are guaranteed by the Constitution.

In *Devika Biswas v Union of India*, the Supreme Court examined coercive sterilisation practices under a state programme.[14] The Court held that such practices violated dignity, bodily integrity, and decisional autonomy. It rejected the argument that meeting programme targets or following procedures could justify violation of fundamental rights. The judgment shows how governance practices can become unconstitutional when they ignore consent.

The constitutional basis of reproductive autonomy was strengthened in *Justice K.S. Puttaswamy (Retd.) v Union of India*.[21] The Court affirmed that privacy is a fundamental aspect of the right to life under Article 21 and includes control over one's body and personal decision-making. This protection becomes especially significant in matters involving family relationships and reproductive decisions. The Court affirmed that reproductive decisions belong to the individual and should remain free from coercion or surveillance.

Courts have also addressed failures in maternal healthcare delivery. In *Laxmi Mandal v Deen Dayal Harinagar Hospital*, the Delhi High Court held that denial of timely maternal healthcare leading to death violated Article 21.[22] The Court treated maternal healthcare as an enforceable right and rejected administrative delay as a defence. In *Sandesh Bansal v Union of India*, the Madhya Pradesh High Court held that maternal health duties arise directly from Article 21 and cannot be diluted due to governance failure or poor coordination.[23]

When these principles are applied to tribal women, constitutional duties become stronger. Tribal women face reproductive decision-making under conditions of gender disadvantage, poverty, geographic isolation, and historical exclusion. Barriers such as lack of facilities, language gaps, absence of informed consent, and dependence on State systems restrict real

[21] *Justice K S Puttaswamy (Retd) & Anr v Union of India & Ors* (2017) 10 SCC 1
[22] *Laxmi Mandal v Deen Dayal Harinagar Hospital & Ors* (2010) W P (C) 8853/2008
[23] *Sandesh Bansal v Union of India & Ors* (2012) WP No 9061/2008

choice. In many cases, rights are affected not through direct denial, but through routine procedures that exclude women from decision-making.

Seen in this manner, judicial interpretation shows that reproductive autonomy, dignity, and maternal health are part of the right to life under Article 21. Governance models that focus only on targets and procedures risk violating these rights. For tribal women, these risks are greater because of intersectional disadvantage. This makes it necessary to examine maternal health governance as a constitutional responsibility, not only as a policy matter.

MATERNAL HEALTH GOVERNANCE FAILURES AS CONSTITUTIONAL VIOLATIONS UNDER ARTICLE 21

Maternal health governance in tribal areas, when seen beyond policy documents, shows that compliance with schemes often becomes more important than women's rights. Although health schemes and institutions exist on paper, their implementation in tribal regions often fails to protect reproductive autonomy, dignity, and informed choice, which are required under Article 21 of the Constitution.[10]

Government data and policy assessments show that maternal health governance focuses mainly on institutional delivery targets and service numbers. However, these indicators do not show whether women are actually able to make informed reproductive choices. In many tribal areas, institutional delivery is not experienced as a choice, but as a compulsion created by incentives, administrative pressure, and lack of alternatives. In such situations, compliance replaces consent, weakening the constitutional meaning of reproductive autonomy.

Incentive-based maternal health schemes highlight this problem clearly. Although these schemes are meant to improve maternal health, their design often ignores the realities of tribal areas. Distance from health facilities, lack of transport, language barriers, and limited decision-making power of women restrict meaningful choice. As a result, reproductive decisions are shaped by governance structures rather than by women themselves. This approach reduces maternal healthcare to numbers, instead of recognising it as a right based on dignity.

There is also a clear gap between what schemes promise and what women actually receive. Maternal health programmes guarantee free services and universal access, but in tribal regions these services are often not available in practice. Weak referral systems, shortage of health staff, and poor infrastructure affect women's experience of pregnancy and childbirth. These are not only administrative problems. When seen through Article 21, they raise constitutional concerns because the State has a duty to protect life with dignity.[24]

Experiences from field engagement in tribal areas during postdoctoral research further support this view. In many cases, women receive limited information and have little participation in decisions related to pregnancy and childbirth. Health interactions often focus on completing procedures rather than meaningful communication. This shows how governance practices can limit reproductive autonomy even when services formally exist.

When examined constitutionally, these governance failures become more serious. The Supreme Court has held that Article 21 places positive obligations on the State to protect health, dignity, and autonomy. Maternal health governance that focuses only on targets and procedures, without ensuring informed consent and sensitivity to local conditions, does not meet this constitutional standard. For tribal women, who already face social and economic disadvantage, these failures have a deeper impact.[25]

From this perspective, maternal health governance in tribal areas cannot be treated only as a policy or administrative issue. It must be assessed as a constitutional responsibility. Governance models that remain compliance-driven, without addressing women's lived realities, risk violating the right to life with dignity guaranteed under Article 21.

RECOMMENDATIONS AND CONCLUSION

The analysis undertaken in this paper indicates that maternal health governance in tribal areas requires a recalibration in order to align administrative practices with constitutional standards under Article 21. Maternal health programmes should be assessed not only on the basis of institutional delivery rates or service coverage, but also on whether governance

[24] Minal Madankar et al., 'Exploring Maternal and Child Health Among Tribal Communities in India: A Life Course Perspective' (2024) 16(2) Glob J Health Sci <https://doi.org/10.5539/gjhs.v16n2p31> accessed 10 August 2026

[25] *Devika Biswas v Union of India & Ors* (2016) 10 SCC 726; *Laxmi Mandal v Deen Dayal Harinagar Hospital & Ors* (2010) W P (C) 8853/2008

frameworks enable the exercise of reproductive autonomy, informed consent, and dignity. An exclusive reliance on outcome-based indicators risks overlooking the substantive content of the right to life as interpreted by constitutional jurisprudence.

An important aspect of constitutional compliance in maternal healthcare lies in the manner in which consent and decision-making are structured. Informed consent must be treated as a substantive requirement rather than a procedural formality. Communication relating to pregnancy and childbirth should be intelligible and context-appropriate, particularly in tribal areas where linguistic and cultural factors influence access to healthcare. Governance arrangements that operate primarily through incentives or administrative direction may constrain reproductive choice and therefore require closer constitutional scrutiny.

Maternal health governance also necessitates sensitivity to regional and social contexts. Uniform policy models, while administratively convenient, may not adequately address the structural constraints faced in tribal regions, including geographic isolation, infrastructural limitations, and availability of skilled healthcare personnel. Strengthening referral mechanisms and service delivery capacities is essential to ensure that formal entitlements translate into meaningful access, consistent with the State's positive obligations under Article 21.

The inclusion of tribal communities in health governance processes may further contribute to improved accountability and contextual responsiveness. Engagement with local institutions can facilitate better alignment between policy design and lived experience, thereby supporting the constitutional objective of substantive equality. Such participatory dimensions are consistent with the broader constitutional framework governing social justice and protection of Scheduled Tribes.

In conclusion, maternal health governance in tribal areas cannot be examined solely through the lens of policy effectiveness or administrative performance. It must be evaluated as a constitutional function subject to the requirements of Article 21. Judicial interpretation has established that health, dignity, privacy, and reproductive autonomy form integral components of the right to life. Where governance practices fail to secure these elements, particularly for tribal women, constitutional concerns arise.

This paper has demonstrated that persistent disparities in maternal health outcomes reflect deeper governance limitations rather than isolated policy failures. Assessing maternal health governance through constitutional standards of dignity and autonomy, rather than procedural compliance alone, provides a more accurate framework for understanding these disparities. For tribal women, whose reproductive experiences are shaped by intersecting social and structural disadvantages, the substantive realisation of Article 21 remains contingent upon governance models that are constitutionally informed and contextually responsive.