

**Autonomy on Paper, Autonomy in Practice: Examining the
Enablers and Barriers to Reproductive Choice in India**

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Abstract

The paper examines the evolution of reproductive autonomy in India and evaluates whether legal and judicial recognition has translated into meaningful access to abortion. It discusses various aspects like theoretical, judicial, legal, socio-economic, and international comparisons, that are needed to evaluate whether India has in fact transitioned towards reproductive autonomy or not. For this analysis, it uses the qualitative method with secondary data evidence. Through this analysis, the paper finds that India has moved towards recognizing reproductive autonomy as an integral implicit component of constitutional rights as interpreted through judicial and legislative reforms. However, this recognition is incomplete in practice. Since a persistent lack of harmony between constitutional principles- *articles 14, 15, 21*, judicial interpretations- *X v. Principal Secretary* (2022) and legal frameworks, MTP Act 1971 and its 2021 amendment, POCSO Act, 2012, in India has made it difficult to achieve the objective of reproductive autonomy. Moreover, the paper also finds that the provisions governing abortion of adolescent girls are not in line with the realities of the day and the health systems are also not equipped properly to provide abortion services and sexual and reproductive health (SRH) and contraception information. Thus, all these factors together push women and girls towards unsafe options showing that legal recognition must be accompanied by socio-economic realities.

Keywords: Reproductive Autonomy, Pro Choice and Pro Life, Abortion Law Liberalization, Sexual and Reproductive Health (SRH), MTP Act, 2021, NFHS-5

Introduction

The debate between 'pro-choice' and pro-life' lies at the heart of discussions on abortion and reproductive autonomy. The pro-choice perspective emphasizes a woman's right to decide whether to continue or terminate a pregnancy, while the pro-life perspective prioritizes the protection of fetal life (Bhattacharjya, 2025). This ethical and legal debate raises a fundamental question: are we moving towards a progressive world where women have the autonomy to make decisions concerning their own bodies and pregnancies? Central to this question is the concept of reproductive autonomy, which refers to the ability of women and girls to make free

and informed decisions concerning their bodies, reproductive health, contraception and family planning, including the decision to continue or terminate a pregnancy (Gupta, 2026).

In India, reproductive rights have evolved through a combination of statutory reform and judicial interpretation. The Medical Termination of Pregnancy (MTP) Act, 1971, and its 2021 amendment provide the principal legal framework for abortion, while constitutional jurisprudence under Article 21 has increasingly recognized reproductive decision-making as part of personal liberty. Yet this progress remains uneven. Gestational limits, questions of fetal viability, adolescent sexuality, and the interaction between the MTP Act and other laws such as the POCSO Act continue to shape and often constrain access to safe abortion.

This paper examines reproductive autonomy in India through legal, judicial, socio-economic and institutional lenses, with reference to international comparisons. It moves beyond the question of whether abortion is legally permitted to ask whether women can actually exercise reproductive choice freely and safely. By analyzing the gap between formal legal recognition and lived reality, the study seeks to understand how law, governance and inequality together shape women's ability to make informed reproductive decisions in contemporary India.

Literature Review

Kumar et al. (2022) examined the **Medical Termination of Pregnancy (Amendment) Act, 2021** to understand its impact on reproductive healthcare and women's access to safe abortion services in India. The study discusses the major amendments introduced in the Act, including the extension of the gestational limit for abortion from 20 to 24 weeks for specified categories of women, protection of confidentiality, and permission for termination beyond 24 weeks in cases of substantial fetal abnormalities. The authors argue that these changes represent a progressive step towards strengthening reproductive rights. However, they also note that differences in implementation across states and the functioning of Medical Boards may create barriers to equal access. The study concludes that while the amendment improves the legal framework, effective implementation is essential to ensure reproductive justice for all women.

Shendge et al. (2024) examined the **Medical Termination of Pregnancy (Amendment) Act, 2021** from the perspective of the LGBTQIA+ community to assess whether the law ensures

inclusive reproductive rights. The study argues that although the amendment expanded access to safe abortion services, it continues to use gender-specific language, limiting its applicability to transgender men and non-binary individuals who may also require abortion care. The authors highlight those legal and social barriers, discrimination in healthcare settings, and the absence of explicit recognition of gender-diverse individuals to restrict equal access to reproductive healthcare. The study concludes that achieving true reproductive justice requires gender-inclusive laws, non-discriminatory healthcare services, and policies that recognize the reproductive rights of all individuals capable of pregnancy.

Singh et al. (2018) examine abortion incidence and unintended pregnancy in six Indian states. The study highlights a significant gap between the legal availability of abortion and women's actual access to safe reproductive healthcare. It finds that most abortions occur outside formal health facilities, mainly through medical abortion pills bought from chemists or provided by informal sellers. While medical abortion has reduced reliance on more dangerous methods, inadequate counselling and misinformation remain common. The authors argue that reproductive autonomy in India is constrained not only by legal frameworks but also by barriers in healthcare access, service quality and information availability, particularly for safe abortion services.

The work on Sexual and Reproductive Health by **K. Mayall et al. (2025)** highlights the global perspective in abortion law reform through a legal analysis. The study maps 199 countries across the past 3 decades to show the progression and regression of abortion laws across jurisdictions. The study concludes that most countries have progressed towards the recognition of abortion rights rooted in the culmination of civil society coalitions actively advocating for the abortion law reform and reproductive rights. However, this liberalization and its positive effects have not been uniform and women across the world are yet to attain the basic human right of reproductive autonomy. Hence, legal reforms do not automatically ensure reproductive autonomy or access to abortion; a holistic approach is essential to address the concern.

Dr. Datar (2021) examined **The MTP Act of 2021**, which allows Termination of Pregnancy (TOP) for rape survivors till 24 weeks; beyond 24 weeks, court (writ petition) is the only recourse. For substantial foetal anomalies, TOP beyond 24 weeks requires a state level medical

board's permission. Termination after 24 weeks for "failure of contraception" or a rape survivor can expose doctors to criminal liability under Section 88 and 89 of BNS. For normal cases, the limit is 20 weeks which the **Shantilal Shah Committee** did not suggest and calls arbitrary as late-stage TOP risks are the same for childbirth and prostaglandins have made abortions much safer. The paper also highlights how judiciary has carved a system for legal permission beyond the limits set by law.

Tyagi & Tiwari (2023) analyse the **Judiciary's role** in expanding the interpretation of the disputed terms, rules and access to safe abortions. In **K S Puttaswamy vs UOI**, court recognized women's choice to bear or abort a child fall within the right to privacy under Article 21. The court noted the extra-legal conditions imposed by Registered Medical Practitioners (RMPs) and the chilling effect (Article 19) cast by IPC, while acknowledging harms of delayed termination, allowed unmarried women abortion from 20 to 24 weeks, included marital rape within the term 'Rape', grave injury to mental health' as a condition for abortion within MTP Act, expanded the term 'women' to be all inclusive of gender identities, exempted RMPs from mandatory reporting under section 19 of the POCSO Act. The paper also highlighted how intersectionality causes women to seek unsafe abortions.

Reproductive rights have become a significant area of legal, ethical and public health discussion in India over the past few decades. Earlier, abortion was mainly viewed as a public health issue aimed at reducing maternal deaths caused by unsafe abortions. However, with changing social attitudes, legal reforms, and with the Supreme Court's evolving interpretation of reproductive autonomy under article 21 of constitution, the discussion has gradually shifted towards recognizing reproductive autonomy as a fundamental right (**Ganatra et al., 2014; Rao, 2021**).

Existing literature reveals that India is moving towards a more rights-based approach, although the law continues to place certain restrictions on reproductive choices. There has been a gradual transition from viewing abortion as a public health intervention to recognizing it as a matter of privacy and gender equality.

Many scholars have discussed the Medical Termination of Pregnancy (MTP) Act, 1971 as a prominent legislation act that legalized abortion under specific conditions. According to

researchers, the primary objective of the Act was to protect women's health and maternal mortality, by reducing unsafe and illegal abortions. While the Act was progressive for its time, several authors point out that it did not give women complete decision-making power; rather the final decision largely depended on the opinions of registered medical professionals. As a result, the Act is often described as a medical regulatory framework rather than a law that fully recognizes women's reproductive rights **(Iyengar & Iyengar, 2002; Government of India, 1971)**.

The Medical Termination of Pregnancy (Amendment) Act, 2021 has received significant attention in recent literature. Most scholars have agreed that the amendment marked a major step towards expanding reproductive rights in India. It increased the gestational limit for certain categories of women, extended the benefit of contraceptive failure to unmarried women, and strengthened confidentiality provisions. These changes have been widely seen and appreciated for making abortion services. However, researchers also argue that requiring the opinion of multiple doctors and Medical Boards in certain cases may create delays, especially for women living in rural areas where healthcare facilities are limited. Therefore, although the amendment has expanded access to abortion, complete reproductive autonomy has still not been achieved as still there are barriers which need to be overcome **(Sama Resource Group for Women and Health, 2023)**.

The literature also identifies situations where the State places restrictions on reproductive choices. The PCPNDT Act, 1994 is frequently discussed in this context. Scholars acknowledge that the Act has played a significant role in preventing sex-selective abortions and addressing the problem of female foeticide in India. At the same time, some of them argue that strict regulations have increased the administrative burden on healthcare providers and, in certain cases, have affected access to legitimate prenatal diagnostic services **(George, 2006)**. This reflects the challenge of balancing individual reproductive freedom with the broader objective of promoting gender equality.

Recent studies have also focused on the Surrogacy (Regulation) Act, 2021 and the Assisted Reproductive Technology (Regulation) Act, 2021. According to researchers, these laws were introduced to prevent the exploitation of surrogate mothers and regulate fertility clinics. While these objectives are widely supported, some scholars argue that the strict eligibility criteria and

the ban on commercial surrogacy limit reproductive choices for many individuals and couples. This has led to an ongoing debate about whether such regulations adequately balance ethical concerns with the right to reproductive autonomy (**Pande, 2014; Deonandan et al., 2012**).

Public health researchers further highlight that legal reforms alone cannot ensure reproductive rights. Many women continue to face barriers such as lack of awareness, social stigma, inadequate healthcare facilities, financial difficulties, and unequal access to trained medical professionals, particularly in rural areas. These challenges often prevent women from exercising the rights that are legally available to them. Therefore, scholars emphasize that effective implementation, better healthcare infrastructure, and public awareness are equally important for ensuring reproductive justice. (**Ganatra et al., 2017; World Health Organization, 2022**).

Overall, the existing literature indicates that India has made significant progress in recognizing reproductive autonomy through legislative reforms and judicial interpretation. However, reproductive rights continue to operate within legal, medical, and social boundaries. While recent developments suggest a gradual shift towards a more pro-choice approach, the State continues to balance women's autonomy with concerns related to maternal health, fetal welfare, ethical regulation, and gender justice. These differing perspectives form the basis of the present study, which seeks to examine whether India is genuinely moving towards greater reproductive autonomy or whether important limitations still remain.

Research Gap

While there is considerable literature on the subject of abortion legislation and the constitutional rights of women to have an abortion, rights-based jurisprudence, gestational limits, the POCSO Act and the impact of socioeconomic inequalities on women's ability to have an abortion, much of this is written from a legal perspective. Another body of literature addresses inequity in healthcare access, reproductive health, and abortion practices, while also highlighting critical social, cultural, and contextual factors associated with abortion. At the same time, there is a need to better understand the interaction between legal access and women's capacity to exercise their reproductive rights within the broader social, healthcare, and socioeconomic context. The literature reviewed does not adequately address the ways in

which women's reproductive autonomy is influenced by legal access to abortion and its limitations posed by societal attitudes, healthcare accessibility, and related factors. Finally, while much has been written about the differences in education, healthcare access, contraception, and socioeconomic status, the literature lacks an in-depth analysis of the effects these factors have on reproductive rights and women's ability to exercise their reproductive autonomy in various contexts. Thus, the current study will address these gaps by evaluating the relationship between legal access to abortion and women's reproductive autonomy in India through an interdisciplinary approach that uses the literature review alongside selected socioeconomic indicators and international comparisons.

Methodology

This study adopts a qualitative and descriptive method with secondary data analysis. It analyses the development of reproductive autonomy in India from legal, socio-economic and comparative perspectives. The legal analysis uses laws, constitutional provisions, court cases, and academic writings. Sources of this data include the Protection of Children from Sexual Offences (POCSO) Act, 2012, Medical Termination of Pregnancy (MTP) Act, 1971, and MTP Amendment Act, 2021, and key court rulings that have shaped reproductive rights, bodily autonomy and privacy in India. In addition, the study utilizes Abortion Care Guidelines, 2022 of WHO. From a socio-economic perspective, the study employs data from the National Family Health Survey-5, Sample Registration System 2022-24 report, and government documents. The regional and socio-economic disparities of reproductive autonomy are examined from the analysis of fertility rates, knowledge of contraceptives, maternal health, and access to reproductive health care. Finally, the comparative perspective adopts peer reviewed literature, governmental reports and international databases to study reproductive autonomy in countries such as Sweden and Poland. By uniting these aspects, the study examines the extent to which reforms have improved real choices and access to reproductive healthcare.

Analysis

Reproductive Autonomy and the “Pro Choice” vs “Pro Life” Debate

Reproductive Autonomy as a concept is of recent origin. Consequently, even though the term has been widely used in legal and policy discourse, the definition of reproductive autonomy remains absent from the literature. This paper thus attempts to fill the gap with a workable definition of the term. It can be defined as the right of women and girls to make free (absence of coercion or abuse) and informed reproductive choices, including choices regarding her own body, pregnancy, reproductive health, contraceptive methods, and family planning. This includes the right to privacy, dignity, bodily integrity, and most importantly the decision whether to continue or terminate a pregnancy. Reproductive Autonomy as opposed to the term ‘Reproductive Justice’ deals primarily with the ‘Choice’ of a woman or girl about her own body, whereas Reproductive Justice deals with determinants that are required to realize this freedom of choice (Gupta, 2026).

When we discuss about abortion, ethical debates emerge regarding whether a fetus can be considered a human and whether the sanctity of a fetus’s life can be equated to that of its mother. From this debate originated the “Pro Choice” and “Pro Life” labels which gained popularity in the United States in the 1970s. The “Pro Choice” proponents believe a mother’s right to abort her pregnancy takes precedence over the life of the fetus, whereas the “Pro Life” proponents say that the fetus has a right to life which is why the mother should not terminate her pregnancy (Bhattacharjya, 2025).

Judicial Shift

The judicial developments show the gradual but uneven progression towards reproductive autonomy. In *Suchita Srivastava v. Chandigarh Administration* (2009), the court upheld the importance of a woman’s consent by establishing that reproductive autonomy falls within the ambit of Article 21. Further, in the case of *X v. Principal Secretary* (2022), the court observed that an individual’s marital status cannot limit reproductive autonomy and acknowledged the mental and physical consequences of an unwanted pregnancy, reconciling MTP Act with POCSO regarding adolescent privacy. Nonetheless, *X v. Union of India* (2023) reflects the

limitations imposed on reproductive autonomy when court refused termination beyond 24 weeks citing statutory provisions and fetal viability. On the contrary, *A (Mother of X) v. State of Maharashtra* (2024) reflected dignity and autonomy even in extreme cases. Overall, the jurisprudence has shifted from recognizing reproductive choice to balancing autonomy against statutory limits, fetal viability, and State interests.

Constitutional and Legal Analysis

The Constitution provides for Reproductive autonomy through articles 14, 15, and 21. The Judiciary also through expansive reading of Article 21 has included the right to reproductive autonomy within it. But the legal landscape seems to present some challenges. The provisions like mandatory reporting and guardian consent in MTP Act, 1971, its 2021 amendment and POCSO Act, 2012 together make an environment which forces women and adolescent girls to seek unsafe and uninformed abortion options. India's MMR of 80 per 1,00,000 live births (SRS, 2022-24) still exceeds UN SDG 3.1 target of 70 per 1,00,000 live births by 2030, showing many women continue resorting to unsafe options. In India, the median age at first sexual intercourse is 18.9 years for women age 25-49. Ten percent of women age 25-49 had sex before age 15, and 39 percent before age 18. By age 20, 60 percent of women age 25-49 have had sexual intercourse. Keeping this data in mind, provisions assuming all sexual acts involving minors constitute abuse need relaxation, with clearer laws for adolescent girls too.

Socio-economic Analysis

In addition to legal entitlements, reproductive autonomy for women in India needs many other factors. The education level of a woman, healthcare facilities available in the place of residence, economic position of the individual, and various social factors play their part in choices made by women in terms of reproductive autonomy. In addition to the above-mentioned, individual awareness and family planning schemes also become highly significant. These variations are spread across Indian states. According to the National Family Health Survey-5 (NFHS-5, 2019–21), the institutional delivery rates in Kerala and Tamil Nadu are 99.8% and 99.6%, respectively, whereas those for Uttar Pradesh and Bihar are 83.4% and 76.2%, respectively. Moreover, the fertility rate is relatively lower in southern states as compared to that in Bihar and Uttar Pradesh. The variations in female literacy, awareness about contraceptives, and

maternal healthcare facilities give rise to social inequality. Women in rural and economically backward areas face barriers such as flawed healthcare facilities, limited reproductive health information, and social taboos. Therefore, the exercise of reproductive choice remains unequal across different socio-economic groups.

International Comparison

The comparative data suggests that abortion liberalization increases the space for reproductive freedom, although legal provision is not necessarily sufficient to guarantee real autonomy (Mayall et al., 2025). This is proven in Sweden, where almost 65% of abortions take place prior to seven weeks of pregnancy and 79% occur at home in 2025 (Socialstyrelsen, n.d.), proving that true autonomy can only be achieved through accessibility and decentralization of healthcare facilities, and not only legal provision. In addition, Poland highlights the effects of restrictive policies: the elimination of grounds of fetal abnormalities in 2020 resulted in a rapid reduction of legal abortions which continue to be below pre-2021 levels (Abort Report, n.d.). India serves as an example of a rights-based approach, as the ruling in 2026 of the Supreme Court allows abortion past 28 weeks in case minor rape survivor, recognizing dignity, vulnerability and reproductive autonomy as constitutional considerations (Srivastava, 2026).

Discussion

The paper has tried to fill the vacuum by providing a workable definition of the term Reproductive Autonomy. It discusses how lack of information regarding sexual and reproductive health (SRH), contraceptive methods, and pregnancy termination acts as a hinderance in making a free and informed consent, thus a barrier in realizing reproductive autonomy in practice. The evolution of judicial reasoning shows that legal recognition of reproductive autonomy does not automatically ensure uniform access. While *Suchita Srivastava* and *X v. Principal Secretary* strengthened autonomy and privacy, *X v. Union of India* revealed the continuing influence of gestational limits and provider-centered decision-making. The experience of adolescents further exposes the tension between abortion rights and mandatory reporting under POCSO. International developments, including abortion-rights jurisprudence in the United States and Poland, show that reproductive autonomy remains closely shaped by constitutional interpretation and legislative choices. The Indian experience

therefore reflects both judicial expansion and ongoing institutional and legal constraints.

Building on this distinction between legal recognition and its practical realization, the discussion section highlights the opportunities provided by the MTP Amendment Act, 2021 and the recognition of reproductive rights autonomy under the Indian Constitution. However, it points to the fact that without the necessary institutional support, women's exercise of their right to decide regarding their bodies remains limited. It argues that women's autonomy in pregnancy decision-making is dependent on their overall access to resources as well as the support from family and society. Therefore, women facing unwanted pregnancy, particularly the rape victims, should be encouraged to view abortion as a reasonable option.

The comparison shows that reproductive autonomy is closely connected with the wider social and economic environment. Within India, differences between selected southern and northern states point to the role of healthcare facilities, education and access to reproductive services. The international comparison also shows that countries with stronger healthcare systems have considerably lower maternal mortality. Therefore, legal reforms need to be supported by improvements in healthcare infrastructure, affordability, awareness, and women's socio-economic opportunities. This would help ensure that reproductive autonomy is accessible not only in law but also in practice.

These broader comparative findings reinforce the central argument that formal legal recognition must be accompanied by meaningful access to reproductive healthcare. The examples of Sweden and the Netherlands demonstrate how supportive healthcare systems can translate legal rights into practical autonomy, while Poland highlights the restrictive consequences of restricting legal grounds (Abort Report, n.d.). For India, the Supreme Court's evolving rights-based jurisprudence signals important progress; however, judicial recognition must be accompanied by legal reforms, accessible healthcare, information and institutional support to ensure that reproductive autonomy becomes a substantive right rather than merely a constitutional principle (Srivastava, 2026).

Policy Recommendations

1. **Healthcare Infrastructure-** There is a need for a multi-sectoral approach for the development of healthcare infrastructure- hospitals, NGOs, and civil service advocacy, with mental health support to ensure grassroots level intervention and early access. A coordinated, multi-sectoral approach is essential to ensure that legal entitlements translate into accessible services.
2. **Socio-economic Interventions-** A digital portal to share experiences will be helpful as a reassuring factor for women and girls, also acting as a feedback mechanism for the government's evaluation. It will also help to improve general public awareness about the existing legal provisions, available abortion services and contraceptives practices. Women and girls often make decisions within a limited time window and lack of information can result in delays that make access more difficult. This would allow women to make informed decisions and seek appropriate care at an earlier stage of pregnancy.
3. **Legal Reforms-** Further, to ensure safe abortion access, we need relaxed provisions especially for adolescent girls that are specifically designed for them, like decriminalization of abortion, removing gestational limits and third-party authorizations (medical board paternalism), providing contraception and sexual and reproductive health (SRH) information (WHO Abortion care Guidelines, 2012) and improving awareness regarding existing laws and schemes.

Although the MTP Amendment Act introduced confidentiality protections, these protections need to be effectively implemented at the point of service. Healthcare institutions should establish clear procedures to protect patient information and limit unnecessary disclosure to family members or other third parties. Private counselling spaces and confidential record management systems should be available, particularly for adolescents, unmarried women and survivors of sexual violence.

Limitations

The limitations of the present research include the lack of primary data collection for proper analysis of socio-economic realities and implementation of laws, and its reliance on secondary sources. While the paper attempts to establish the reproductive autonomy framework at national and international levels, it does not adequately capture the perspectives of Indian women on reproductive autonomy and abortion rights. Nevertheless, the research holds significance in understanding the national framework through a comparative lens. This provides **scope for future theoretical and practical research** in this area, particularly by primary data collection and examining women's abortion rights through their own perspectives and understanding of autonomy.

Even though the paper has strived to create a reproductive autonomy paradigm at a national and international level, the perspective on the abortions and decision-making process of Indian women and young girls is not fully incorporated and explored in the paper. It does not consider their castes, religion, and the impact of living in urban or rural areas on their experience with pregnancy and miscarriage.

The analysis of legal and judicial aspects is also not exhaustive, as the paper only mentions a few cases (Suchita Srivastava, X v. Principal Secretary, X v. Union of India, A (Mother of X) v. State of Maharashtra) that highlight the issue, while there are many more cases in India that tackle various aspects of reproductive rights. Moreover, the judicial part of the paper is under constant pressure of new data, as the law surrounding abortions is actively changing – for example, the 2026 Supreme Court verdict mentioned in the paper already changed the landscape of the law.

Conclusion

Overall, the study demonstrates that the shift towards being Pro Choice in India is multidimensional. The analysis shows that legal and judicial developments have expanded the recognition of women's reproductive decision-making. But the socio-economic, institutional, and comparative analysis reveals that the exercise of this autonomy varies considerably in practice. The findings hence suggest that reproductive autonomy is shaped by the interaction

between legal recognition and the broader conditions in which reproductive decisions are made.

Therefore, all the dimensions when taken together indicate the transition towards a pro-choice framework which cannot be merely understood as a linear process of legal liberalization. It is rather a shift from interpreting abortion as a medical procedure towards recognizing reproductive, autonomy, dignity, privacy, and equality. However, the extent to which this shift becomes meaningful depends on whether women possess the necessary pre-requisite conditions to exercise that autonomy.

The distinction between autonomy on paper and autonomy in practice therefore emerges as the central insight of the study. Legal recognition establishes the formal choice for a woman, but the ability to make that decision is mediated by access to healthcare, awareness of reproductive rights, economic resources, social support and the institutional functioning of the legal framework. So, reproductive autonomy should be measured on the basis of the extent to which that right can be exercised freely, safely, and without coercion. The comparative evidence presented in the study further highlights that when India is placed within a broader global pattern, its realization ultimately depends upon the institutions and conditions through which those rights are delivered.

Thus, the study argues that a genuine autonomy-centered framework requires the law, healthcare institutions, and social environment to work together so that reproductive decisions are informed, accessible, and free from unnecessary constraints. The shift towards reproductive autonomy is therefore best understood not as a completed transition from pro-life to pro-choice, but as an ongoing process of transforming a formally recognized right into a substantive and equally accessible capability.

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