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Unnecessary Caesarean Sections in India: A Socio-Legal Analysis of Medical Practice, Maternal Rights and Institutional Accountability

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ABSTRACT: India has witnessed a near four-fold increase in caesarean section (C-section) deliveries over the past decade and a half, rising from approximately 6.4 per cent of institutional deliveries in 2008-09 to 27.46 per cent in 2024-25, and reaching over 47 per cent in private healthcare facilities per National Family Health Survey-5 (NFHS-5, 2019-21), far exceeding the World Health Organisation's clinically justified ceiling of 10-15 per cent. This paper undertakes a socio-legal examination of the phenomenon of medically unnecessary caesarean sections in India, situating the issue at the intersection of medical jurisprudence, consumer protection law, constitutional health rights and institutional regulatory failure. The paper argues that the unchecked rise in non-indicated C-sections in India is not merely a clinical or public-health anomaly but a manifestation of systemic legal and institutional deficits: the absence of binding, enforceable clinical protocols across most States; the commercialisation of obstetric care under a largely unregulated private hospital sector; inadequate implementation of the Clinical Establishments (Registration and Regulation) Act, 2010; weak enforcement of informed-consent standards articulated by the Supreme Court in *Samira Kohli v. Dr. Prabha Manchanda*; and the practical difficulty women face in establishing medical negligence under the Consumer Protection Act, 2019 and the tort standards affirmed in *Jacob Mathew v. State of Punjab*. Employing doctrinal legal analysis alongside secondary quantitative data (NFHS-4, NFHS-5, Health Management Information System data placed before Parliament, and recent State-level audit initiatives such as Andhra Pradesh's 2026 mandatory C-section audit circular), the paper evaluates the adequacy of India's existing regulatory and rights-based framework governing maternal healthcare. It further examines the right to health and reproductive autonomy under Article 21 of the Constitution, the doctrine of informed consent, and the accountability gap created by fee-for-service payment structures and defensive medical practice.

1. INTRODUCTION

Childbirth occupies a singular place in law and medicine: it is simultaneously a physiological event, a matter of profound personal autonomy, and, increasingly in India, a site of commercial transaction. The caesarean section, once reserved for obstetric emergencies threatening the life of the mother or the foetus, has in the last two decades become one of the most frequently performed surgical procedures in Indian hospitals.

According to National Family Health Survey data placed before Parliament, caesarean deliveries in India rose from 12.03 lakh in 2008-09 to over 54.35 lakh in 2024-25, even as the total number of reported deliveries remained comparatively stable at around 1.9-2 crore.¹

The share of institutional deliveries conducted by C-section crossed the double-digit mark in 2012-13 (11.47 per cent), breached 20 per cent in 2020-21, and reached 27.46 per cent by 2024-25.² The World Health Organisation has repeatedly affirmed that population-level C-section rates beyond 10-15 per cent are not associated with reductions in maternal or neonatal mortality, and that rates in excess of this ceiling reflect over-medicalisation rather than improved clinical outcomes.³

The distribution of this rise is not uniform. Public-sector institutional deliveries by C-section stood at 14.3 per cent in NFHS-5 (2019-21), broadly consistent with clinical necessity, whereas private-sector deliveries by C-section reached 47.4 per cent nationally, and above 55-60 per cent in States such as Andhra Pradesh, Telangana and Tamil Nadu.⁴ This sharp public-private divergence, replicated with remarkable consistency across successive rounds of the NFHS, constitutes what public health researchers term 'supplier-induced demand' and what this paper characterises, in legal terms, as a structural failure of informed consent, professional self-regulation and statutory oversight.

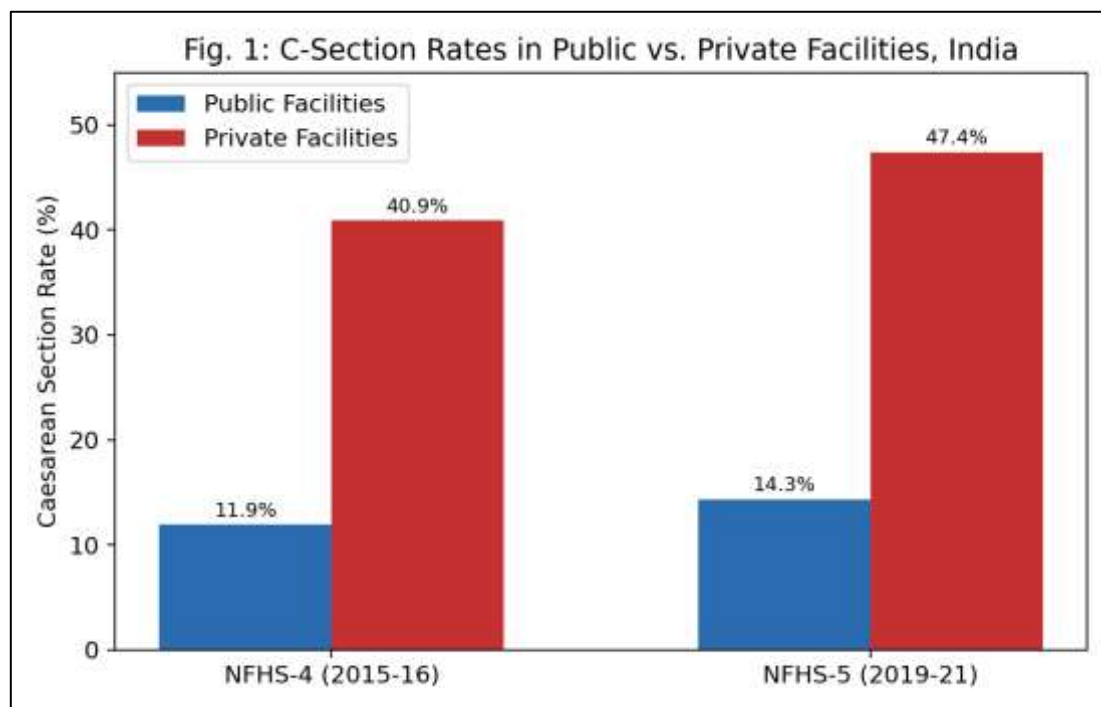


Fig. 1: C-Section Rates in Public vs. Private Health Facilities, India (NFHS-4 and NFHS-5). Source: National Family Health Survey rounds 4 and 5, Ministry of Health and Family Welfare, Government of India.

This paper proceeds from the premise that the unnecessary caesarean section is a legally cognisable harm — an unconsented, non-indicated surgical invasion of bodily integrity — rather than merely a matter of clinical practice variation or patient

¹C-Section Births in India Rise Four-fold Since 2008-09: Govt, Kashmir Observer (12 March 2026), available at: <https://kashmirobservers.net/2026/03/12/c-section-births-in-india-rise-four-fold-since-2008-09-govt/> (last visited 20 Aug. 2026).

²Ibid.

³World Health Organisation, WHO Statement on Caesarean Section Rates, WHO/RHR/15.02 (2015); see also World Health Organisation, Robson Classification: Implementation Manual (2017).

⁴Ministry of Health and Family Welfare, Government of India, National Family Health Survey-5 (2019-21): India Fact Sheet, International Institute for Population Sciences, Mumbai (2021); see also CEDA-Ashoka University, GenderStats 4: C-Section Deliveries (24 Oct. 2024), available at: <https://ceda.ashoka.edu.in/genderstats-4-c-section-deliveries/>.

preference. The inquiry accordingly engages four interlocking legal frameworks: (i) constitutional health and reproductive rights jurisprudence under Article 21; (ii) the tort and consumer-protection law of medical negligence, including the informed-consent doctrine; (iii) the regulatory architecture governing clinical establishments and medical professional conduct; and (iv) emerging institutional accountability mechanisms, including clinical audit, insurance-linked empanelment conditions and consumer fora remedies.

The paper is organised as follows. Part II reviews the existing literature — medical, public-health and legal — on the caesarean section epidemic in India and comparable jurisdictions. Part III undertakes an analytical and doctrinal discussion of the statutory, constitutional and case-law framework governing maternal rights and institutional accountability. Part IV sets out the paper's principal findings. Part V offers policy and doctrinal recommendations. Part VI concludes.

1.1 Statement of the Problem

Despite a demonstrable and sustained divergence between public and private-sector C-section rates, India lacks a nationally binding, judicially or statutorily enforceable mechanism requiring clinical justification, independent audit or informed-consent documentation specific to caesarean delivery. The Clinical Establishments (Registration and Regulation) Act, 2010, though enacted with the object of standard-setting, remains unadopted or weakly enforced in several major States, including some with the highest recorded C-section rates.⁵ Meanwhile, existing consumer-protection and tort remedies, centred on proof of negligence under the Bolam-derived standard affirmed in *Jacob Mathew*, place a substantial evidentiary burden upon an aggrieved woman seeking redress for an unnecessary or non-consented surgical delivery.

1.2 Objectives of the Study

- (a) To examine the scale and pattern of medically unnecessary caesarean sections in India through available epidemiological data;
- (b) To analyse the constitutional, statutory and case-law framework governing maternal rights, informed consent and institutional accountability in obstetric care;
- (c) To assess the adequacy of the Clinical Establishments (Registration and Regulation) Act, 2010, the Consumer Protection Act, 2019, and professional regulatory mechanisms in curbing non-indicated surgical intervention;
- (d) To recommend doctrinal and policy reforms suited to India's mixed public-private maternal healthcare delivery system.

1.3 Research Methodology

This paper adopts a doctrinal and analytical socio-legal methodology. Primary legal sources include the Constitution of India, the Clinical Establishments (Registration and Regulation) Act, 2010, the Consumer Protection Act, 2019, the Indian Penal Code, 1860 (and its successor, the *Bharatiya Nyaya Sanhita*, 2023) provisions on medical negligence, and reported judgments of the Supreme Court and High Courts on informed consent and medical negligence. Secondary sources include NFHS-4 and NFHS-5 reports, Lok Sabha and Rajya Sabha parliamentary responses, peer-reviewed public-health literature, and recent (2025-2026) State-level regulatory circulars. The paper does not undertake primary empirical fieldwork; its quantitative claims are drawn from and attributed to secondary governmental and peer-reviewed sources cited throughout.

2. LITERATURE REVIEW

2.1 Public Health and Epidemiological Literature

A substantial body of public-health scholarship has documented the scale of the Indian C-section rise. Gavvala, Thomas and Jennifer's district-level study of Andhra Pradesh found C-section prevalence ranging from 22.2 per cent in Anantapur district to 66 per cent in Krishna district, with private institutions accounting for 68.49 per cent of all C-sections performed in the state,

⁵Clinical Establishment Act Updates 2026: What Clinics Must Change, *Adrine Health Blog* (11 Mar. 2026); see also Wikipedia, *Clinical Establishments (Registration and Regulation) Act, 2010*, available at: [https://en.wikipedia.org/wiki/Clinical_Establishments_\(Registration_and_Regulation\)_Act,_2010](https://en.wikipedia.org/wiki/Clinical_Establishments_(Registration_and_Regulation)_Act,_2010).

against 31.51 per cent in public institutions.⁶ Their multivariate regression analysis found that facility ownership (private versus public) was among the strongest predictors of C-section likelihood, independent of clinical risk factors.

A 2025 spatial-epidemiological study using NFHS-4 and NFHS-5 micro-data found that private health facilities recorded the sharpest rise in C-section prevalence between survey rounds — from 40.9 per cent to 47.4 per cent nationally — and identified statistically significant geographic clustering of high C-section districts along the eastern coast and in north-eastern India, using Moran's I and Getis-Ord statistics.⁷ The study's authors concluded that geospatial clustering patterns reflect institutional and market-driven factors rather than clinical risk distribution, since obstetric complication rates do not exhibit comparable spatial clustering.

A national burden-estimation study analysing NFHS-5 data estimated that India accounts for approximately 1.8 million medically unnecessary caesarean sections annually — the highest absolute number among lower-middle-income countries globally — with States such as Telangana and Tamil Nadu recording private-sector C-section rates exceeding 50 per cent.⁸ The same body of literature situates India's C-section trajectory against a broader global concern: global estimates suggest approximately 8.8 million unnecessary caesarean sections occur annually, of which roughly 6 million occur in upper-middle-income countries, with India representing the principal outlier among lower-middle-income economies.⁹

Quality-improvement literature offers a rare counter-example: an urban private hospital serving fee-for-service patients reduced its institutional C-section rate from 79 per cent in 2001 through structured clinical governance, standardised protocols and peer audit, demonstrating that the phenomenon is remediable through institutional intervention rather than being an immutable feature of private obstetric practice.¹⁰

2.2 Socio-Economic and Health-Financing Literature

Health-financing scholars have linked the public-private C-section divergence to India's fee-for-service payment architecture, under which obstetricians and private hospitals derive materially greater revenue from surgical delivery than from vaginal birth, and under which the shorter, more schedulable duration of a caesarean procedure creates operational incentives for busy private practitioners managing high patient volumes.¹¹ Out-of-pocket expenditure data indicate that C-section delivery in a private facility costs substantially more than a normal delivery, a cost differential that literature identifies as a direct financial incentive operating independently of clinical indication.¹²

2.3 Legal and Socio-Legal Literature

Indian legal scholarship on medical negligence has extensively analysed the Supreme Court's decision in *Samira Kohli v. Dr. Prabha Manchanda*, which remains, per recent commentary, 'the doctrinal anchor for Indian consent law' and the operative test applied by consumer fora and courts in medical-negligence disputes.¹³ Commentators have noted that the Court in *Samira*

⁶Nagendra Gavvala, Benson Thomas M. & Gladius Jennifer H., Disparities in Elective and Emergency Caesarean Section Rates Among Public and Private Hospitals in the Districts of Andhra Pradesh, India, 16(2) *Cureus* e54320 (2024), DOI: 10.7759/cureus.54320.

⁷Spatial Clusters of Caesarean Sections across India — Insights from NFHS Data, medRxiv (17 Apr. 2025), DOI: 10.1101/2025.04.15.25325862.

⁸Preventing the Preventable: Assessing the Burden of Incessant Caesarean Deliveries in Select Indian States Using NFHS-5, PMC12017520 (2025).

⁹*Ibid.*, citing global unnecessary C-section burden estimates.

¹⁰Abhishek Bhartia, Rinku Sen Gupta Dhar & Saru Bhartia, Reducing Caesarean Section Rate in an Urban Hospital Serving Women Attending Privately in India — A Quality Improvement Initiative, 20 *BMC Pregnancy & Childbirth* 538 (2020), DOI: 10.1186/s12884-020-03234-x.

¹¹The C-Section Surge in India: Uncovering the Impact of Profit on Childbirth, Observer Research Foundation (7 Apr. 2025), available at: <https://www.orfonline.org/expert-speak/the-c-section-surge-in-india-uncovering-the-impact-of-profit-on-childbirth>.

¹²*Ibid.*

¹³Informed Consent — What Your Doctor Must Obtain Before Treatment, Legal Republic (2026), available at: <https://www.legalrepublic.in/everyday-law/informed-consent-doctor/>.

Kohli deliberately adopted the Bolam/Sidaway 'real consent' standard over the more patient-protective Canterbury 'reasonably prudent patient' standard prevailing in the United States and, increasingly, Canada and Australia, citing India's distinct socio-economic and healthcare conditions.¹⁴ Scholars have criticised this choice as insufficiently protective of patient autonomy in a healthcare market increasingly characterised by commercial, rather than purely professional, relationships between provider and patient.

A parallel strand of literature examines the tort standard of medical negligence articulated in *Jacob Mathew v. State of Punjab*, which imported the Bolam test into Indian criminal and civil negligence law, requiring that a doctor's conduct be measured against the standard of an ordinary competent practitioner in the same field, and holding that a mere error of judgment does not, without more, constitute negligence.¹⁵ Subsequent decisions, including *Kusum Sharma v. Batra Hospital and Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*, have refined this standard, emphasising that negligence must be assessed with reference to prevailing practice and available resources, a standard that has been criticised as excessively deferential to professional judgment in cases involving elective, non-emergency surgical decisions such as caesarean sections performed absent objective clinical indication.¹⁶

Scholarship on the Clinical Establishments (Registration and Regulation) Act, 2010 has consistently flagged the Act's principal structural weakness: as health remains a State subject under the Seventh Schedule, the Central Act applies directly only to Union Territories and requires individual State legislatures to adopt it by resolution under Article 252 of the Constitution.¹⁷ Several States with the highest recorded C-section rates, including Tamil Nadu and Telangana, have not adopted the Central Act, instead relying on pre-existing or no equivalent nursing-home registration legislation, a regulatory gap that commentators identify as directly relevant to the persistence of unchecked private surgical practice.¹⁸

2.4 Recent Regulatory and Policy Developments (2024-2026)

Recent developments indicate growing State-level regulatory attention to the issue. In a written reply to the Lok Sabha in early 2026, the Union Minister of State for Health confirmed that CGHS-empanelled hospitals are required to prominently display their institutional ratio of caesarean to normal deliveries, and that a dedicated C-section audit component has been incorporated into the LaQshya quality-assurance checklist for maternity operation theatres in government hospitals nationally.¹⁹ Following a cluster of reported post-C-section maternal complications and deaths in Rajasthan and Telangana in mid-2026, the Andhra Pradesh government issued a circular in July 2026 making clinical audit mandatory for every caesarean delivery performed under the State's Dr. NTR Vaidya Seva insurance scheme, directing empanelled hospitals to maintain detailed contemporaneous records of the medical indication, diagnostic evidence and clinical reasoning for each C-section, on pain of the scheme's insurance panel sanctions.²⁰ This represents one of the first instances in India of an insurance-empanelment-linked audit mechanism being used as a proxy regulatory tool in the continued absence of comprehensive statutory reform, and is discussed further in Part III below.

¹⁴*Samira Kohli v. Dr. Prabha Manchanda & Anr.*, (2008) 2 SCC 1; AIR 2008 SC 1385, paras 31-33 (discussing *Bolam v. Friern Hospital Management Committee*, [1957] 1 WLR 582; *Sidaway v. Board of Governors of the Bethlem Royal Hospital*, [1985] AC 871; and *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972)).

¹⁵*Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1.

¹⁶*Kusum Sharma v. Batra Hospital and Medical Research Centre*, (2010) 3 SCC 480; *Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*, (2009) 9 SCC 221.

¹⁷Clinical Establishments (Registration and Regulation) Act, 2010, Preamble and s. 1(3)-(4); Constitution of India, Seventh Schedule, List II, Entry 6; Art. 252.

¹⁸*Ibid.*; see also Adrine Health Blog, *supra* note 5.

¹⁹*Ibid.*, s. 12 (registration and standards) and s. 13 (enforcement).

²⁰Kashmir Observer, *supra* note 1 (LaQshya audit checklist and CGHS empanelment display requirement, citing Lok Sabha reply of Minister of State for Health, Prataprao Jadhav, 6 Feb. 2026).

3. ANALYSIS AND DISCUSSION

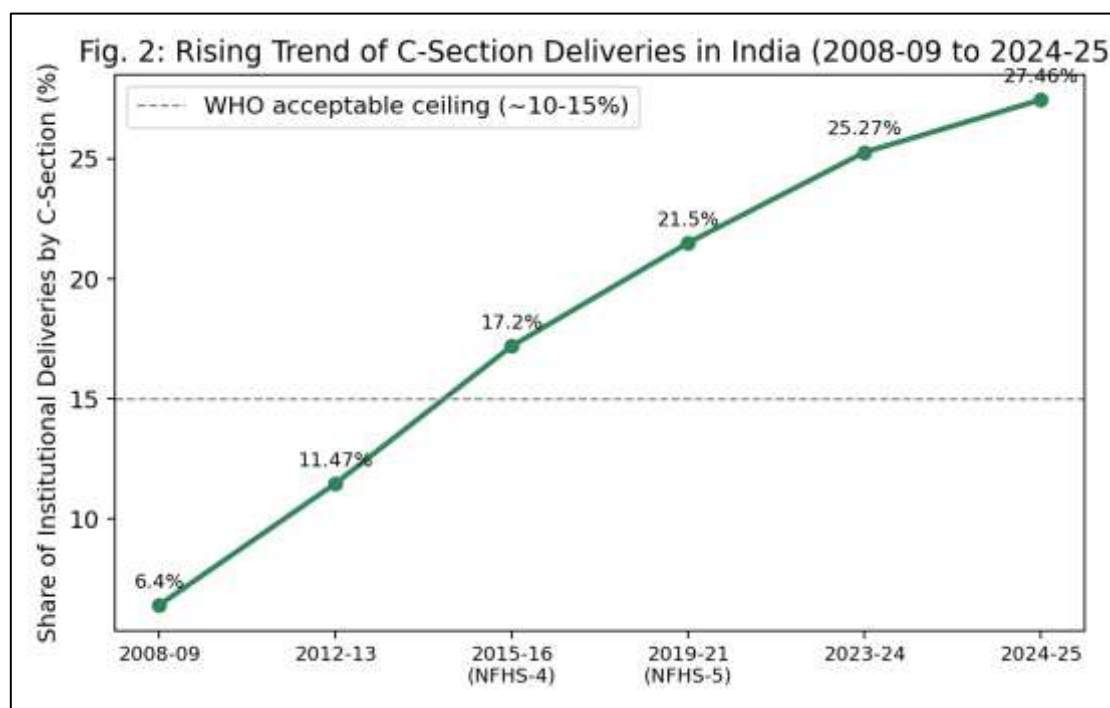


Fig. 2: Rising Trend of C-Section Deliveries in India, 2008-09 to 2024-25. Source: Reply of Minister of State for Health and Family Welfare, Lok Sabha, cited in Kashmir Observer (12 March 2026); Health Management Information System, Ministry of Health and Family Welfare.

3.1 The Constitutional Dimension: Article 21 and Reproductive Autonomy

The right to health, bodily integrity and reproductive autonomy has been read into Article 21 of the Constitution across a consistent line of Supreme Court authority. In *Suchita Srivastava v. Chandigarh Administration*, the Court held that a woman's right to make reproductive choices is itself an integral facet of personal liberty under Article 21, encompassing the right to carry a pregnancy to term, to refuse participation in sexual activity, and, by extension, to determine the manner of childbirth absent a genuine medical emergency.²¹ In *Devika Biswas v. Union of India*, concerning coercive sterilisation camps, the Court further affirmed that the right to reproductive health under Article 21 imposes an affirmative obligation on the State to ensure that medical interventions affecting reproductive capacity are performed with informed consent and in conditions that respect bodily autonomy and dignity.²²

Read together, this jurisprudence supports the proposition that a caesarean section performed without a genuine clinical indication, and without the mother's informed and voluntary consent, constitutes not merely a tortious act but a violation of the constitutionally protected right to bodily integrity and reproductive autonomy. The doctrinal difficulty, addressed further below, lies in translating this constitutional guarantee into an enforceable cause of action against private hospitals, which, not being 'State' within the meaning of Article 12 in the ordinary case, fall outside the direct reach of writ jurisdiction, leaving statutory tort and consumer-protection remedies as the principal available avenues.

²¹AP Government Orders Mandatory Audit of C-Section Deliveries at Empanelled Hospitals, Medical Dialogues (26 Jul. 2026), available at: <https://medicaldialogues.in/news/health/hospital-diagnostics/ap-government-orders-mandatory-audit-of-c-section-deliveries-at-empanelled-hospitals-175716>; Andhra Orders Audit of All Cesarean Deliveries in Empanelled Hospitals, Newsmeter (2026), available at: <https://newsmeter.in/science-health/andhra-orders-audit-of-all-cesarean-deliveries-in-empanelled-hospitals-772340>.

²²*Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

3.2 Informed Consent: Samira Kohli and Its Application to Caesarean Delivery

The Supreme Court's judgment in *Samira Kohli v. Dr. Prabha Manchanda* remains the governing authority on informed consent in Indian medical law. The Court held that consent obtained for a diagnostic procedure does not extend to a more radical therapeutic procedure performed in the same sitting, save where a genuine life-threatening emergency arises during the procedure; that consent must be procedure-specific and cannot be inferred merely because the additional procedure was, in the surgeon's opinion, beneficial to the patient; and that the consent of a competent adult patient cannot be substituted by that of a relative where the patient herself is available, or could reasonably have been consulted in advance.²³

Applied to obstetric practice, *Samira Kohli* suggests that consent obtained during antenatal counselling for a 'trial of labour' or vaginal delivery does not, without more, extend to an intrapartum decision to perform a caesarean section absent a genuine and contemporaneously documented obstetric emergency, such as foetal distress, obstructed labour, or cord prolapse. In practice, however, the near-universal practice of obtaining a single, generic consent form at the time of hospital admission — authorising 'delivery, including caesarean section if required' — dilutes the procedure-specific consent standard the Court articulated, and shifts the practical burden of proving the absence of a genuine indication onto the patient after the fact, precisely the evidentiary difficulty the *Samira Kohli* Court sought to prevent in the gynaecological surgery context.²⁴

The Court's express preference for the Bolam 'real consent' standard over the American Canterbury 'reasonably prudent patient' standard compounds this difficulty: under Bolam, the adequacy of disclosure is measured by reference to a responsible body of medical opinion, rather than by reference to what a reasonable patient would wish to know before consenting to major abdominal surgery. Where, as in the Indian private obstetric sector, a 'responsible body of medical opinion' among fee-for-service practitioners has itself normalised elective caesarean delivery for non-medical convenience, the Bolam standard risks validating precisely the practice pattern that gives rise to the underlying harm.

3.3 The Negligence Standard: Jacob Mathew and Its Limits in the Obstetric Context

The Supreme Court in *Jacob Mathew v. State of Punjab* held that a doctor is not liable in negligence merely because a professional judgment, exercised bona fide and in accordance with an accepted mode of practice, subsequently proves erroneous, and that expert medical evidence establishing a breach of the standard of the 'ordinary competent practitioner' is generally required before criminal or civil liability can attach.²⁵ This standard, while appropriate to protect bona fide clinical judgment from hindsight-driven litigation, poses a distinctive difficulty in the caesarean-section context: because C-section has itself become the modal, rather than exceptional, mode of delivery in much of the private sector, an 'accepted mode of practice' defence is often available to a practitioner even where the decision to operate lacked genuine clinical indication, since a body of similarly situated practitioners can be shown to follow an equivalent pattern.²⁶ This dynamic illustrates a broader point in the sociology of professional regulation: where an entire practice community has normalised a departure from evidence-based protocol, a negligence standard anchored in peer practice ceases to differentiate lawful from unlawful conduct.

3.4 Consumer Protection Law as an Alternative Remedial Route

Since *Indian Medical Association v. V.P. Shantha*, medical services rendered for consideration (that is, other than free services) have been held to fall within the definition of 'service' under consumer-protection legislation, permitting patients to approach consumer fora rather than civil courts for redress.²⁷ The Consumer Protection Act, 2019 retains this position and additionally introduces product-liability provisions and enhanced pecuniary jurisdiction across District, State and National Commissions, along with a statutory mediation mechanism intended to reduce the delay historically associated with medical-negligence litigation.²⁸

²³*Devika Biswas v. Union of India*, (2016) 10 SCC 726.

²⁴*Samira Kohli v. Dr. Prabha Manchanda & Anr.*, (2008) 2 SCC 1, paras 31-33; see also Casemine, *Samira Kohli v. Dr. Prabha Manchanda and Another*, available at: <https://www.casemine.com/judgement/in/58117f912713e17947932a78>.

²⁵*Ibid.*; see also *International Journal of Integrated Law Review*, Case Analysis: *Samira Kohli vs. Prabha Manchanda* (2024).

²⁶*Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1, paras 41-48.

²⁷*Kusum Sharma v. Batra Hospital and Medical Research Centre*, (2010) 3 SCC 480.

²⁸*Indian Medical Association v. V.P. Shantha*, (1995) 6 SCC 651.

In practice, however, a consumer complaint alleging an unnecessary caesarean section confronts two structural obstacles. First, the complainant must ordinarily adduce expert medical evidence establishing both the absence of clinical indication and the breach of the accepted standard of care, evidence that is costly, time-consuming to obtain, and often unavailable from practitioners reluctant to testify against professional colleagues. Second, the causation and quantum of harm in an unnecessary-but-successfully-performed surgery, where the mother and child survive without severe complication, is difficult to particularise in monetary terms recognisable to a consumer forum accustomed to quantifying loss by reference to disability, death or demonstrable physical injury, as opposed to the dignitary harm of an unconsented surgical invasion.

3.5 Regulatory Architecture: The Clinical Establishments Act and Its Limits

The Clinical Establishments (Registration and Regulation) Act, 2010 was enacted to provide for the registration of, and prescription of minimum standards for, clinical establishments across India. Because health is a State subject under Entry 6 of List II of the Seventh Schedule, the Act applies of its own force only to the Union Territories; its extension to the States requires either adoption by State legislative resolution under Article 252, or the enactment of equivalent State legislation.²⁹ As of the most recent available compilations, several States, including some recording the highest C-section rates nationally, have either not adopted the Central Act or have adopted it without notifying binding standard treatment guidelines specific to obstetric care, leaving compliance largely aspirational.³⁰

Where the Act has been adopted, its registration and standard-setting functions have rarely been used to mandate C-section-specific audit, public disclosure of institutional C-section ratios, or a second-opinion requirement for non-emergency operative delivery, notwithstanding that the statutory framework, on a purposive reading of Sections 12 and 13 (empowering prescription and enforcement of minimum standards and standard treatment guidelines), would appear to accommodate such conditions without further primary legislation.³¹

3.6 Emerging Institutional Accountability Mechanisms: Insurance-Linked Audit as a Regulatory Proxy

In the continued absence of comprehensive statutory reform, State governments have in 2025-2026 begun to use insurance empanelment as a regulatory lever. The Andhra Pradesh government's July 2026 circular making clinical audit mandatory for every caesarean section performed under the Dr. NTR Vaidya Seva scheme requires empanelled hospitals to maintain contemporaneous documentation of diagnostic evidence and clinical reasoning for each C-section, on pain of empanelment sanctions, following reports of maternal complications and deaths linked to C-section deliveries in Rajasthan and Telangana.³²

This mechanism is analytically significant for two reasons. First, it demonstrates that audit and disclosure conditions can be operationalised through the State's contractual and fiscal relationship with empanelled private hospitals, without requiring fresh primary legislation or amendment of the Clinical Establishments Act — a potentially replicable model for other States and for the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) empanelment framework at the Union level. Second, its narrow scope — confined to insurance-scheme beneficiaries rather than all obstetric patients in a given facility — illustrates the incompleteness of audit-through-insurance as a substitute for comprehensive statutory regulation, since self-paying patients outside the scheme's ambit, who constitute a substantial share of India's private obstetric caseload, remain wholly outside its protective reach.

²⁹Consumer Protection Act, 2019, ss. 2(42) (definition of 'service'), 34-53 (District, State and National Commission jurisdiction), 74-81 (mediation).

³⁰Clinical Establishments (Registration and Regulation) Act, 2010, s. 1(3)-(4); Constitution of India, Art. 252.

³¹Adrine Health Blog, *supra* note 5; Wikipedia, Clinical Establishments (Registration and Regulation) Act, 2010, *supra* note 5.

³²Clinical Establishments (Registration and Regulation) Act, 2010, ss. 12-13.

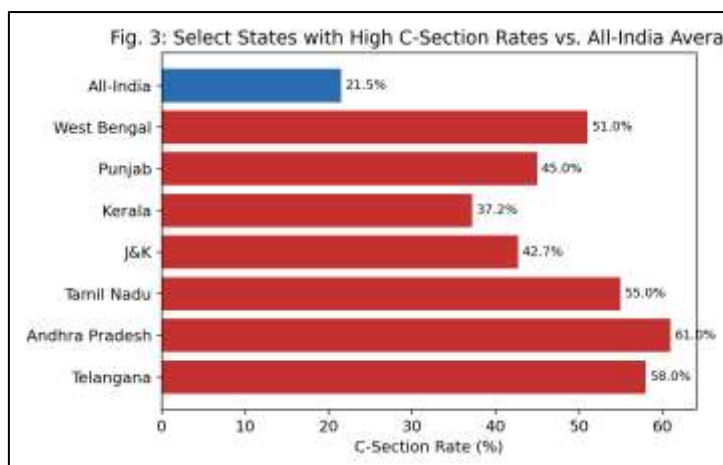


Fig. 3: Select States with High C-Section Rates Compared to the All-India Average (NFHS-5 and subsequent State data).
Source: NFHS-5 State Factsheets; CEDA-Ashoka University GenderStats analysis.

3.7 Comparative Note

Comparative experience is instructive. The United Kingdom's National Institute for Health and Care Excellence (NICE) maintains binding auditable clinical standards for caesarean section, including mandatory documentation of indication and a structured audit tool applied across the National Health Service, against which individual trusts are benchmarked and publicly reported.³³ Brazil, which historically recorded C-section rates exceeding those of India in its private sector, introduced mandatory disclosure of institutional C-section rates and a national maternal-rights charter following sustained civil-society and judicial pressure, achieving a measurable, if partial, decline in elective private-sector caesarean rates.³⁴ These examples suggest that mandatory audit, public disclosure and rights-based maternal charters — rather than reliance on negligence litigation alone — constitute the more effective regulatory lever, a conclusion that directly informs the recommendations in Part V below.

4. FINDINGS

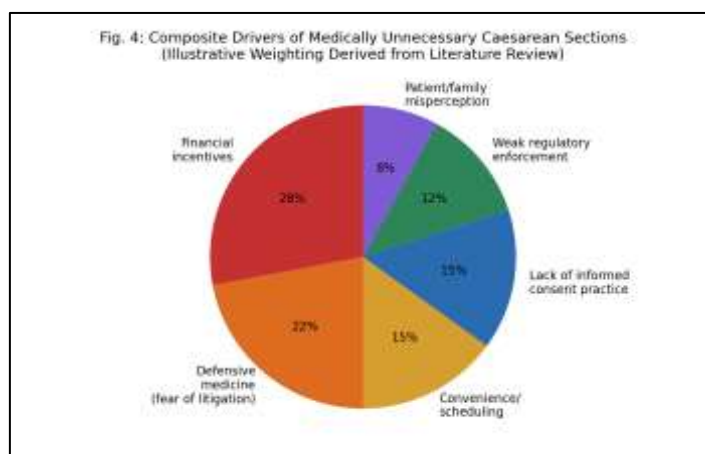


Fig. 4: Composite Drivers of Medically Unnecessary Caesarean Sections in India — Illustrative Weighting Derived from the Literature Reviewed in Part II.

³³National Institute for Health and Care Excellence (NICE), Caesarean Birth, NICE Guideline NG192 (2021, updated 2024); NCBI Bookshelf, Auditable Standards — Caesarean Section, available at: <https://www.ncbi.nlm.nih.gov/books/NBK115307/>.

³⁴Ministry of Health, Brazil, Programa Parto Adequado (Adequate Birth Programme) evaluation reports (2016-2022); World Health Organisation, Robson Classification: Implementation Manual (2017) (discussing Brazil case study).

1. India's national C-section rate (27.46 per cent in 2024-25) exceeds the WHO's clinically justified ceiling of 10-15 per cent, and the private-sector rate (over 47 per cent nationally, exceeding 55-60 per cent in several States) is more than three times the public-sector rate, a divergence unexplained by differential clinical risk profiles and consistently attributed in the literature to financial and operational incentives rather than obstetric necessity.
2. The doctrine of informed consent articulated in *Samira Kohli v. Dr. Prabha Manchanda*, though doctrinally sound, is systematically diluted in obstetric practice through the use of generic, non-procedure-specific consent forms obtained at admission, undermining the procedure-specific consent standard the judgment was intended to enforce.
3. The Bolam-derived negligence standard affirmed in *Jacob Mathew v. State of Punjab*, which measures liability against an 'accepted mode of practice', loses its differentiating function in a practice environment where non-indicated caesarean delivery has itself become the modal practice among a body of private practitioners, effectively immunising normalised over-medicalisation from negligence liability.
4. Consumer-protection remedies under the Consumer Protection Act, 2019, while formally available following *Indian Medical Association v. V.P. Shantha*, are practically inaccessible to most aggrieved patients owing to the cost and difficulty of securing independent expert medical evidence and the absence of a clear damages framework for dignitary harm arising from unconsented but medically 'successful' surgery.
5. The Clinical Establishments (Registration and Regulation) Act, 2010 remains unadopted, weakly enforced, or adopted without binding obstetric standard treatment guidelines in several States recording the highest C-section rates, reflecting a persistent Centre-State regulatory gap rooted in the constitutional allocation of health as a State subject.
6. Emerging insurance-empanelment-linked audit mechanisms, exemplified by Andhra Pradesh's July 2026 circular under the Dr. NTR Vaidya Seva scheme, demonstrate a workable, immediately implementable regulatory pathway that does not require fresh primary legislation, but which remains under-inclusive because its protective reach is confined to scheme beneficiaries rather than all obstetric patients.
7. Comparative jurisdictions (the United Kingdom and Brazil) that have adopted mandatory clinical audit, public disclosure of institutional C-section rates and rights-based maternal charters have achieved measurable moderation of private-sector C-section rates, suggesting that audit-and-disclosure-based regulation is more effective than reliance on ex post negligence litigation alone.

5. RECOMMENDATIONS

5.1 Legislative and Regulatory Reform

- (a) Amend the Clinical Establishments (Registration and Regulation) Act, 2010, or issue binding standard treatment guidelines thereunder, to mandate procedure-specific documentation of clinical indication for every caesarean section, verified against an enumerated list of accepted obstetric indications (e.g., foetal distress, obstructed labour, placenta praevia, prior classical caesarean, eclampsia).
- (b) Incentivise remaining States to adopt the Clinical Establishments Act through Union health-financing conditionalities under the National Health Mission, given the persistent Centre-State adoption gap identified in Part III.
- (c) Extend the Andhra Pradesh insurance-empanelment audit model, through the National Health Authority, to all Ayushman Bharat-PMJAY empanelled hospitals nationally, with escalating sanctions (financial penalty, suspension of empanelment) for hospitals whose C-section rates and audit compliance fall outside prescribed statistical and documentary benchmarks.

5.2 Strengthening Informed Consent Practice

- (a) Prescribe, through Medical Council/National Medical Commission regulation, a mandatory procedure-specific consent form for caesarean delivery distinct from the general admission consent, requiring documented disclosure of the specific indication, alternatives considered, and risks, consistent with the procedure-specific consent standard articulated in *Samira Kohli*.

(b) Introduce a statutory second-opinion mechanism for non-emergency (elective, non-labour) caesarean sections in private facilities, modelled on international 'mandatory second obstetric opinion' schemes, to be documented in the patient's case file before surgery.

(c) Mandate real-time entry of the clinical indication for every C-section into a facility-level electronic register, auditable by State health authorities and accessible to empanelling insurance schemes.

5.3 Reform of Remedial and Accountability Mechanisms

(a) Recognise a distinct, quantifiable head of damages for dignitary and bodily-integrity harm arising from unconsented or non-indicated surgical delivery before consumer fora, independent of proof of physical complication, to address the evidentiary gap identified in Part III.

(b) Establish State-level independent medical audit panels, insulated from hospital administration, empowered to review complaints of unnecessary caesarean section and issue findings admissible before consumer fora, reducing patients' dependence on privately sourced expert testimony.

(c) Mandate public disclosure of institutional and practitioner-level C-section ratios (elective and emergency, disaggregated) on hospital websites and empanelment portals, following the NICE/NHS and Brazilian disclosure models discussed in Part III.

5.4 Systemic and Institutional Measures

(a) Reform fee-for-service reimbursement structures under public insurance schemes to remove the financial differential currently favouring surgical over vaginal delivery, addressing the incentive structure identified in the literature review.

(b) Scale up midwife-led and standardised-protocol antenatal care models, along the lines of the LaQshya initiative, with C-section audit built into facility-level quality certification for both public and private maternity units.

(c) Support continuing medical education and professional-body (FOGSI) sensitisation on evidence-based obstetric protocols, coupled with periodic peer-review audit, to counter the normalisation of non-indicated caesarean delivery within specific practice communities.

6. CONCLUSION

The rise of the medically unnecessary caesarean section in India is, at its core, a problem of unaccountable institutional and professional discretion operating within a regulatory vacuum. The constitutional guarantee of reproductive autonomy under Article 21, the doctrinal standard of informed consent articulated in *Samira Kohli v. Dr. Prabha Manchanda*, and the negligence framework affirmed in *Jacob Mathew v. State of Punjab* together furnish the conceptual vocabulary for holding institutions and practitioners accountable, yet each is, in practice, undermined by structural features of India's mixed public-private maternal healthcare system: generic rather than procedure-specific consent practice, a peer-practice negligence standard that cannot differentiate lawful from normalized-but-non-indicated surgical intervention, and a Clinical Establishments Act rendered substantially inoperative by incomplete State adoption.

Encouragingly, 2025-2026 has witnessed the first concrete institutional responses to this accountability gap, most notably Andhra Pradesh's insurance-empanelment-linked mandatory audit circular, following reported maternal complications linked to unaudited C-section practice in more than one State. These developments demonstrate that meaningful reform is achievable through existing administrative and contractual levers, without awaiting comprehensive legislative overhaul. The task ahead is to generalise such measures — mandatory clinical audit, procedure-specific informed consent, public disclosure of institutional C-section rates, and a recognised remedial pathway for dignitary harm — across the entirety of India's public and private maternal healthcare landscape, so that the caesarean section is restored to its proper place: an indispensable, life-saving intervention deployed on the basis of clinical necessity and genuine maternal consent, rather than institutional convenience or commercial incentive.

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