Abortion in India: Legal Evolution, Social Impact, and Human Rights Discourse

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Abstract
The issue of abortion has remained a complex and contentious matter in the Indian socio-legal landscape. While the enactment of the Medical Termination of Pregnancy Act, 1971, and its subsequent amendments have laid down a structured framework for abortion under specific conditions, these provisions fall short in treating abortion as an unconditional and enforceable right of women. This paper undertakes a doctrinal examination of the evolution of abortion laws in India, the prevailing legal regime, the role of judicial pronouncements, and the continued struggle for recognition of reproductive autonomy as a fundamental right. In addition, the paper analyses the intersection of socio-economic, cultural, and religious factors that influence access to abortion services. The study seeks to highlight the lacunae within the existing statutory and institutional mechanisms and advocates for a more inclusive, rights-based legal approach that foregrounds bodily autonomy, gender equality, and healthcare access.

Keywords: Abortion, Medical Termination of Pregnancy Act, Reproductive Rights, Women's Autonomy, Bodily Integrity, PCPNDT Act, Socio-legal, Indian Judiciary, Human Rights, Gender Equality.

1. Introduction

The term 'abortion' originates from the Latin root *aboriri*, signifying premature detachment. Medically and legally, abortion denotes the termination of pregnancy leading to the death of the embryo or foetus. In India, the right to abortion has been viewed not as a standalone entitlement but as a conditional medical exception governed by the statutory provisions of the Medical Termination of Pregnancy Act, 1971.

The subject of abortion brings to the fore the tension between the woman's right to bodily autonomy and the societal interest in protecting potential life. The matter touches upon constitutional principles such as personal liberty under Article 21, equality under Article 14, and dignity of life. Historically, abortion was criminalised under the Indian Penal Code, 1860, except in circumstances where the procedure was necessary to save the life of the pregnant woman. This restrictive position persisted until the formation of the Shantilal Shah Committee in 1964, which led to the enactment of the MTP Act, 1971.

However, even after legalisation, abortion has not been recognised as an unequivocal right of the woman. The control over the decision to terminate a pregnancy largely rests with registered medical practitioners, and, in certain cases, with medical boards and the judiciary. Such a structure reinforces a paternalistic approach wherein the autonomy of the woman is subjected to external validations.

It is essential to note that reproductive rights are not merely medical issues but lie at the intersection of constitutional law, public health, gender justice, and human rights. In *Suchita Srivastava v. Chandigarh Administration*, the Supreme Court acknowledged that a woman's reproductive choice is a part of her personal liberty and privacy under Article 21. Despite such recognition, the practical enforcement of this right remains ambiguous.

This paper examines the statutory framework, judicial pronouncements, and socio-cultural underpinnings that define and limit the exercise of abortion rights in India. The purpose is to identify legal and policy gaps and recommend reforms aligned with constitutional guarantees and international human rights obligations.

2. Evolution of Abortion Law in India

Prior to 1971, abortion in India was governed by the Indian Penal Code, 1860, and the Code of Criminal Procedure, 1898. These provisions treated abortion as a punishable offence, save in cases where the life of the woman was endangered. Even the language used avoided the term "abortion" in favour of "miscarriage", reflecting the conservative social mores of the time.

In 1964, the Government of India constituted the Shantilal Shah Committee to study the medical, legal, and social dimensions of abortion. The Committee, in its report submitted in 1966, recommended the liberalisation of abortion laws in order to prevent deaths and complications arising from unsafe abortions. These recommendations culminated in the enactment of the Medical Termination of Pregnancy Act, 1971.

The MTP Act legalised abortion under specific circumstances and sought to protect registered medical practitioners from legal liability, provided the procedure was conducted in good faith. Inspired by the UK's Abortion Act, 1967, the Indian law permitted termination on grounds such as risk to the life or health of the woman, substantial foetal abnormalities, or pregnancies resulting from rape or contraceptive failure.

In *Suchita Srivastava v. Chandigarh Administration*, the Supreme Court held that a woman's reproductive choice forms an essential part of her personal liberty and bodily autonomy under Article 21. However, the legal framework continued to impose restrictions in the form of gestational limits, mandatory medical opinions, and lack of autonomy in decision-making.

The Act was amended in 2002, substituting the term 'lunatic' with 'mentally ill' and updating rules regarding facilities and practitioners. The more recent MTP (Amendment) Act, 2021, introduced several notable changes. It raised the upper gestational limit from 20 to 24 weeks for certain categories and extended the benefit of abortion to unmarried women. However, the reliance on medical boards for approvals beyond 24 weeks has raised concerns regarding delays, inconsistent interpretations, and intrusion into personal autonomy.

Although India's legal regime has evolved, it continues to treat abortion as an exception to the general prohibition rather than as a matter of right. This reveals an enduring reluctance to place full trust in the decision-making ability of women.

3. Statutory Framework Governing Abortion in India

3.1 The Medical Termination of Pregnancy Act, 1971 (as amended)

The MTP Act was enacted with the intention to provide legal sanction for abortion under specific conditions while safeguarding the health and dignity of the woman. It allows abortion up to 20 weeks of gestation by a registered medical practitioner on recognised grounds. The 2021 amendment extended this limit to 24 weeks for certain categories including rape survivors, minors, and cases of foetal anomalies, subject to the approval of a medical board.

Despite these changes, the structure of the Act still reflects a protectionist and paternalistic attitude. The requirement for multiple approvals from medical boards and professionals places undue burden on the pregnant woman and delays the timely exercise of her right. The judicial system has also shown varied interpretations, with some judgments favouring autonomy and others placing emphasis on foetal viability.

In *X v Principal Secretary* (2022), the Supreme Court permitted an unmarried woman to terminate a 22-week pregnancy, affirming that marital status cannot be a ground to deny reproductive rights. Conversely, in *X v Union of India* (2023), a woman with severe mental distress was denied abortion beyond 24 weeks, highlighting the discretionary and inconsistent nature of the current legal system.

3.2 The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994

The PCPNDT Act was enacted to curb the rising trend of sex-selective abortions and the consequent decline in the child sex ratio. It prohibits the use of pre-natal diagnostic techniques for sex determination except for detecting genetic abnormalities. The Act imposes strict penalties for violations and mandates the registration of diagnostic laboratories.

The Supreme Court in *CEHAT v. Union of India* (2003) upheld the constitutional validity of the Act and directed the authorities to ensure its strict implementation. However, concerns have been raised about its misuse and overreach. In *Vijay Sharma v. Union of India* (2008), it was clarified

that the Act does not prohibit the sharing of medical information with the woman if not used for sex-selective purposes.

The interaction between the MTP Act and PCPNDT Act often leads to a conflict, wherein measures aimed at preventing sex-selective abortions end up creating barriers for legitimate access to abortion services.

4. Abortion as a Human Rights Issue

The Universal Declaration of Human Rights, 1948, affirms the inherent dignity and equal rights of all individuals. Article 3 guarantees the right to life, but it remains silent on the status of the unborn. The International Covenant on Civil and Political Rights (ICCPR), to which India is a party, reiterates the right to life for every human being and obliges states to protect this right through law.

There exists an ambiguity in whether the term "human being" includes the unborn. While some argue that foetal rights are implicit, others contend that the criminalisation of abortion undermines the rights of the woman, particularly her right to life, privacy, health, and non-discrimination.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) places an obligation on states to eliminate discrimination in the field of healthcare, including access to family planning. General Recommendation 35 of CEDAW recognises the denial of safe abortion as a form of gender-based violence.

In the Indian context, the decision in *K.S. Puttaswamy v. Union of India* (2017) marked a watershed moment by affirming the right to privacy as a fundamental right. This includes the freedom to make reproductive choices and decisions concerning one's body.

5. Sociological Perspective on Abortion Laws in India

5.1 Cultural and Religious Influences

In Indian society, abortion is not merely viewed as a medical procedure but is deeply enmeshed in moral, cultural, and religious discourses. Religious texts and traditional beliefs often condemn abortion, considering it equivalent to taking a life. This has contributed to a societal perception wherein abortion is stigmatised and women who seek abortions are judged and marginalised.

In many communities, the decision regarding abortion is not taken solely by the woman but involves family elders, spouses, and religious considerations. The woman's bodily autonomy is often secondary to familial honour and social reputation. Martha Nussbaum's conception of bodily integrity, which affirms a person's right to control over one's body, finds little resonance in such a tradition-bound setting.

Abortion stigma can be classified into three types: felt stigma (internalised shame), enacted stigma (discrimination by others), and internalised stigma (acceptance of negative stereotypes). This stigma influences women's access to timely medical help and may result in secrecy, delay, or recourse to unsafe methods.

5.2 Socio-Economic Dimensions

Access to abortion is heavily influenced by socio-economic factors such as income level, education, and geographical location. Women from disadvantaged backgrounds often face challenges in accessing quality reproductive healthcare. Lack of awareness, coupled with economic dependency, makes them vulnerable to unsafe abortion practices.

Studies show that low-income women have limited access to contraceptives and reproductive health education. Additionally, healthcare services in rural areas are inadequate, and legal abortion facilities are often located in urban centres. This rural-urban divide results in delays, complications, and sometimes mortality.

Educational status also plays a decisive role. Women with lower education are more likely to experience unintended pregnancies and are less likely to be informed about their legal rights or available services. This reinforces cycles of poverty and gender inequality.

Although the MTP Act and PCPNDT Act provide a legal structure, the actual implementation is marred by ambiguity, lack of training, and infrastructural limitations. There is also considerable judicial inconsistency in interpreting the grounds for abortion, particularly in late-term cases.

The requirement of medical boards for termination beyond 24 weeks has led to delayed decisions and judicial backlogs. Furthermore, the concept of mental health as a valid ground is often misunderstood or narrowly interpreted, as seen in *X v Union of India* (2023), where despite psychiatric evidence, abortion was denied.

A comprehensive understanding of abortion must incorporate socio-cultural realities, access to services, and the emotional well-being of women. The present framework does not adequately address these aspects.

6. Conclusion

The legal and social discourse on abortion in India reflects the intersection of constitutional values, societal norms, and medical ethics. While the Medical Termination of Pregnancy Act and the PCPNDT Act have laid the groundwork for safe abortion practices and prohibition of sex-selective abortions, they fall short in recognising abortion as a woman's fundamental right.

Judicial pronouncements, though progressive in parts, have not uniformly upheld the principle of bodily autonomy. The interpretation and implementation of these laws continue to be influenced

by patriarchal attitudes and institutional biases. The burden placed upon women to justify their decisions to third parties such as doctors, courts, or boards undermines the principle of autonomy.

There is an urgent need for legislative and administrative reforms that shift the focus from conditional permission to the affirmation of rights. Laws must be harmonised with the principles of gender equality, dignity, and reproductive justice. Education, awareness, and access to healthcare must be enhanced, particularly in rural and marginalised communities.

Ultimately, the discourse on abortion must move beyond moral judgments and towards a rights-based approach that recognises women as autonomous individuals capable of making informed decisions about their bodies and their lives.

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