
BEYOND THE MEDICAL TERMINATION OF PREGNANCY ACT: HARMONIZING INDIA’S LEGAL REGIME ON ABORTION AND REPRODUCTIVE JUSTICE

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ABSTRACT

This article critically examines the legal framework governing Medical Termination of Pregnancy in India, focusing on the intersection of statutory provisions, judicial interpretations, and public health implications. While the Medical Termination of Pregnancy Act, 1971 (MTP Act) was a progressive step in legalizing abortion under specified conditions, its implementation reveals deep-seated contradictions and systemic shortcomings. The article analyzes penal provisions under the Indian Penal Code that criminalize abortion, juxtaposed against the liberal intent of the MTP Act. It further explores the complexities arising from the concurrent enforcement of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, and the Protection of Children from Sexual Offences (POCSO) Act, 2012, which often create conflicting obligations for healthcare providers and hinder adolescents’ access to safe abortion services.

The article identifies critical gaps, including over-medicalization, denial of reproductive autonomy to unmarried women, lack of rural access, and the failure to address pregnancies resulting from marital rape or coercion. It concludes with concrete recommendations for legal reform—such as clarifying key statutory terms, harmonizing contradictory laws, expanding provider eligibility, and reinforcing a rights-based approach—to align abortion access with constitutional guarantees of dignity, equality, and bodily autonomy.

I. INTRODUCTION

There is no freedom, no equality, no full human dignity and person-hood possible for women until they assert and demand control over their own bodies and reproductive process. The right to have an abortion is a matter of individual conscience and conscious choice for the women concerned.

- Betty Friedan¹

During the last few years many countries have liberalized their laws regarding Termination of pregnancy. Many countries are having very restricted abortion laws and there are many countries where abortion is available at the request of woman. Among all those countries India made the abortion laws liberal in 1971 by enacting Medical Termination of Pregnancy Act which was designed to create certain exceptions to the strict provisions of IPC and PNDT Act 1994.²

Abortion policy in India is consistent with safeguarding reproductive rights as envisaged by International Conference on Population and Development (ICPD)³ and similar other international agreements. It does not advocate abortion as a family planning measure. Rather, it encourages the promotion of family planning services to prevent unwanted pregnancies and at the same time recognizes the importance of providing safe, affordable, accessible and acceptable abortion services to women who need to terminate an unwanted pregnancy.⁴

There is a strapping controversy pertaining to the mother's right to abortion, foetus right to life and balancing of interests of the mother and the foetus. Judiciaries of various jurisdictions have considered these cases with prudence and discretion. A clear-cut hierarchy of rights has been made wherein the mother's right to abortion trumps the rights of pre-viable foetuses under all circumstances, and the rights of viable foetuses whenever the mother's health, liberally

¹ Betty Friedan was an American feminist writer and activist. A leading figure in the women's movement in the US, her 1963 book *The Feminine Mystique* is often credited with sparking the second wave of American feminism in the 20th century.

² Bandewar Sunita, "Abortion services and providers perceptions: gender dimensions", *Eco. and Pol. Weekly* 2075-8 (2003).

³ International Conference on Population and Development, Cairo (Egypt), 1994.

⁴ Benshoof Janet. "Weakened Right to Abortion". *Lawyers Collective* (1998).

construed, is in jeopardy. The legal status of unborn, acts as a catalyst in this discourse.⁵

In India, after the introduction of the Medical Termination of Pregnancy (MTP) Act in 1972, legalising abortion, reported Medical Termination of Pregnancy (MTP Cases have been on the increase. According to available statistics, the number of approved institutions providing Medical Termination Cases facilities has increased from 1,877 in 1976 to 7,121 in 1991. Similarly, the number of Medical Termination cases from a mere 25 reported in the year 1972-73, has gone up to 632, 526 in 1991-92. However, these figures are only the tip of an iceberg as it is estimated that in India, every year approximately, an additional 5-6 million abortions are conducted by private practitioners. Majority of these cases are done in rural areas having inadequate facilities and hence done in an unhygienic and unscientific way. All such abortions conducted in unrecognized clinics are considered as illegal and hence not reported in any statistics.⁶ These illegal abortions carried out by untrained village practitioners are a major determinant of continued high levels of maternal morbidity and mortality in India. In India each year an estimated 453 women die due to maternal causes for every 100,000 live births (UNFPA 1997). This statistic varies from state to states. While national and state estimates are imprecise, they are able to represent certain trends. Orissa and Madhya Pradesh had approximately 738 and 711 maternal deaths per 100,000 births in 1992. Among the larger states, Kerala has a singularly low ratio of 87 maternal deaths reported per 100,000 births. On an average, roughly fifteen percent of maternal deaths in India are thought to result from unsafe abortion.

It is surprising that even after twenty four years of legalizations of MTP its availability particularly in rural area is very limited. Recently, however there is a growing realization towards an urgent need to increase safe MTP facilities both in rural and urban areas, so that a woman could have access to safe and hygienic abortion facilities, if she desires to terminate her pregnancy. Necessity for such facilities is crucial not only from family planning perspective, but more importantly as a measure to ensure safe motherhood. The first step towards this initiative is perhaps to understand what and where the lacunas are? Why even after two and half decades of liberalized law, it has not been possible to provide a safe abortion

⁵ Chitnis Varsha and Wright Danaya, "The Legacy of Colonialism: Law and Women's Rights in India", 64(4) Washington & Lee L. R. 1315 (2007).

⁶ Basu Banibrata "Economic Prosperity of Killing of Female – An Interstate Experience

service to a woman who desires it and what can be the lacunas in Indian laws on abortions which are preventing women to access to safe termination of pregnancy?

The present article makes an attempt to answer some of these questions.

This article sets out to explore the multi-layered legal and social environment surrounding abortion in India. It begins with an examination of abortion-related offences under the Indian Penal Code, highlighting the colonial underpinnings and moral assumptions that continue to influence reproductive rights jurisprudence. It then moves to a detailed analysis of the MTP Act — its legislative intent, scope, and evolution over time, particularly in light of recent amendments aimed at increasing access and inclusivity. The paper also scrutinizes the interplay between the MTP Act and other legal instruments like the PCPNDT and POCSO Acts, which, despite serving distinct policy objectives, often create conflicting obligations for healthcare providers and reinforce stigmatization of abortion, especially among minors and unmarried women.

Furthermore, the article undertakes a critical review of judicial interpretations and case law, underscoring how courts have both advanced and limited reproductive rights depending on the context. It also addresses the pressing issues of unsafe abortions, regional disparities in access to services, and the alarming maternal mortality rates associated with unregulated procedures. Through this comprehensive legal, medical, and social analysis, the article argues that while India's abortion laws are progressive in intent, they fall short in guaranteeing universal, equitable, and stigma-free access in practice.

II. Abortion and the Indian Penal Code, 1860

Section 312 to 316 of the Penal Code deal with the penal abortions. These sections have been placed under the chapter of offences affecting human body.

Section 312 of the Penal Code provides that a person, who voluntarily causes a miscarriage to a woman with child, will be punished with the imprisonment for three years or fine or with both. The offence is not cognizable, bailable and not-compoundable. If the woman is quick with child the sentence may go up to seven years and fine, unless the miscarriage is caused in

good-faith for saving the life of the woman.⁷

Section 313 of the Indian Penal Code makes it punishable to cause miscarriage without the consent of the woman. To appreciate fully the implications of section 312 the words "voluntarily," "with child" "good-faith" and "quick with child" may understood first. Section 39 of the Penal Code defines "voluntarily," as "a person is said to cause and effect "voluntarily" when he causes it by means whereby he intended to cause it, or by means which, at the time of employing those means, he knew or had reasons to believe to be likely to cause it." It would be noted that word "voluntarily" has been defined in relation to the causation of effects and not to the doing of acts from which those effects result. It has been given a peculiar meaning differing widely from its ordinary meaning.⁸

Voluntarily causing miscarriage would include such act as the delivery of medicine for that purpose. Acts unrelated to such causation do not come within the purview of the Penal Code. Where the accused merely pledged ornaments to raise money with the intention to aid and facilitate the abortion of a pregnant woman he was held not liable for the offence of miscarriage but could be properly charged with the abatement of the offence.

Unlike section 312, section 313 draws no distinction between "woman with child" and "woman quick with child", and punishes only the person who causes miscarriage, obviously because woman is not a consenting party. The prosecution has to prove all the ingredients of the offence of section 312 and also the absence of the women's consent. The offence is cognizable, not bailable, and not compoundable and is triable by the court of sessions.

Under section 316 of the Indian Penal Code the offender need not necessarily cause abortion or intend to kill the inner life. But, if he does an act likely to cause its death though neither intended nor desired, he would be guilty of this offence.

This offence can only be committed after the woman became 'quick' with child, and before the birth. Thus under this section, causing of death of a quick unborn child [advanced stage of pregnancy] by an act amounting to culpable homicide is punishable up to ten years of

⁷ Paranjape V N, Indian Penal Code 482-485 (Central Law Publications. All. 1st edn, 2010).

⁸ Dasgupta Suprio, The Right to Abortion, Lawyers Collective 16-8 (1994).

imprisonment and fine. The offence under section 316 is cognizable, not bailable, not compoundable and triable by the Court of Session.

When an accused intending to cause only miscarriage to a woman with child causes her death, he is convicted under section 314 of the Penal Code. The offence is aggravated if the accused has acted without the consent of the woman. In order to render the accused liable it is sufficient to prove that the act was done to cause miscarriage. It is immaterial whether the act done was or was not intended or known to cause death. Since the accused did the act which was illegal, he must be liable, to all its consequences.

An accused administered a poisonous drug to a woman to procure miscarriage which resulted in her death. But it was not proved that he knew that the drug was likely to cause death. The accused was, therefore, not convicted for murder but under section 314 of the Penal Code. In another case, when it remained uncertain whether the deceased was murdered or had died from the effects of an attempt to cause the miscarriage against her will it was held that the accused could be convicted either under section 302 for the offence of Murder or under section 314.⁹

In view of the surreptitious activities involved in the offence of miscarriage, availability of direct evidence is often difficult. The absence of such evidence against the accused leads sometimes to the harassment of innocent or in failure to fix the criminal liability. In *Dr. I. K. Kazi v. The State of Gujarat*,¹⁰ one Chandan, a twenty eight year old widow had four children.

The eldest one was a daughter, about twelve years of age. The deceased had conceived out of wedlock and appeared to have agreed to abortion as a way out of the embarrassing situation.

The timing of the alleged abortion was crucial in the case. Chandan was seen last in the company of her daughter in the afternoon of March 29, 1961; thereafter she was allegedly brought to her sister's place in the noon of March 30, 1961 by the appellant who was a civil surgeon. At that time Chandan was sick and the appellant had given her some medicines. The appellant again called on her on April 1, 1961 and wanted to give her more medicines, but the sister of the deceased and her husband did not allow him to do that Chandan stayed at her sister's place up to April 7, 1961 and was taken on April 8, 1961 at her instance to the hospital

⁹ Queen Empress v. Musemmat Bitana, Oudh S.C. 157.

¹⁰ Criminal appeal no. 181/63 decided on September, 9, 1965. The judgment has not been reported in law reports. See the Supreme Court of India Blueprints.

of which the appellant was the in charge. The appellant got her admitted to the septic ward as a patient suffering from septic due to incomplete abortion. The lady doctors subordinate to the appellant examined Chandan and diagnosed her patient of acute peritonitis. She was removed, on April 9, 1961, to another bigger hospital, where the attending doctors advised immediate operation and asked the sister and brother-in-law of Chandan to give their consent and donate blood for her. They refused. However, the honorary specialist doctor performed the operation. Chandan could not survive and died on April 13, 1961. She was declared to have died of tetanus arising out of a criminal abortion. Dr. Kazi was prosecuted under section 314 for having caused death through illegal abortion and also under section 336 of the Penal Code for having rashly or negligently endangered Chandan's life by giving her an intra uterine douche. The trial court acquitted the appellant in respect of both the charges.

On an appeal filed by the state, the Gujarat High Court upheld his acquittal under section 336 but convicted him under section 314, part I and sentenced him to simple imprisonment for one year. Dr. Kazi appealed to the Supreme Court. Justice Sarkar (as he then was) delivered the judgement of the Court, and held that the sole question in the instant case was whether the recorded evidence established that the surgical interference with Chandan took place between 4-00 p.m. on March 29 and the noon of March 30, 1961, and whether the appellant was responsible to bring about the abortion? The learned Judge found no evidence to disbelieve the appellant's version that the deceased had seen him first in the noon of March 30, 1961 at his hospital. She had told him that she was carrying for three months and was bleeding for a week. And that he had begun to treat her to prevent the threatened miscarriage. He had told Chandan's sister about the indisposition and advised the patient complete rest. The defence arguments that (1) the alleged act could not have been the act of the doctor of the appellant's eminence; (2) as the sister and brother-in-law of Chandan disallowed Dr. Kazi to continue the treatment, they might have been interested in getting Chandan aborted, might have procured it and that act had actually resulted in the fatal complication; (2) that for fear of detection of their involvement they refused to give their consent for the operation or to donate blood. Justice Sarkar, disagreeing with the High Court, concluded on the basis of the proved evidence and facts, that neither it could be said that the alleged abortion was during the crucial period, nor that the appellant had caused it. The appellant was, therefore, acquitted.

The provisions of section 315 and 316 though deal with the acts akin to miscarriage, in main, penalise causing death to born or unborn child at the time of birth. Section 315 punished an act

done with intention of "preventing the child from being born alive or" causing "it to die after its birth," except when it is done in good faith for the purpose of saving the life of the mother. The act resulting in death of the child after its birth, is not, strictly speaking, an act of causing miscarriage. In some situations it may be only a technical offence, in other cases it may be a case of deliberate infanticide to prevent an inheritance, or other civil rights accruing to the born child.

The offence committed under this section is of foeticide of the fully developed foetus in case the child is killed before its birth or infanticide when death is caused immediately after birth. The difference between infanticide and such foeticide is only of sequence although considerable in consequences. The former is committed after delivery and may amount to murder and the latter before delivery while the child is still in the womb. The offence is cognizable, not billable, not compoundable and triable by the court of sessions.¹¹

Section 316 on the hand, designated the act which results in causing death to the quick unborn child, as culpable homicide, it would have caused death of the person (mother) against whom it was directed. The accused under this section need not necessarily cause miscarriage or intend to kill the child in womb. However, if the accused does an act likely to cause its death, though neither intended nor desired, he would be guilty under this section. In other words where an act or omission is of such a nature and done under such circumstances as would constitute the culpable homicide, if the sufferer were a living person, if done to a quick unborn child, whose death is caused by it, will be punishable under this section.

The offence under section 316 is committed where the pregnancy has advanced beyond the stage of quickening and where the death is caused after the quickening and before the birth of the child. The ingredients of the offence are (1) that the woman was quick with the child; (2) that the accused did an act to cause the death (3) that the circumstances under which such act was done were such as to make the accused guilty of culpable homicide, if death had been caused; and (4) that such act did cause the death of the quick unborn child.¹² For example, if a person hits a pregnant woman and causes death of quick unborn child, he would be guilty of the offence defined in this section, if the blow was intended to cause death of the woman or one which he knew or had reason to believe to be likely to cause a death, the act complained

¹¹ Cr.P.C. 1973, Sch. I, Cr.P.C. 1898, the only difference was that the offence was non-cognizable.

¹² *Biranchi Gour v. Subhagi Dei*, 1970 Cut., L.T. 711.

of must be done with requisite intention or knowledge as to constitute means rea under criminal law. Merely because death of the child in womb has taken place will not attract this section. It will be the burden of prosecution to prove that the accused had acted in such a manner from which it can be inferred that he had the intention or knowledge to cause death of the victim of his assault and which would have amounted to be an offence of culpable homicide.¹³ If the death of the victim has resulted then it will not be covered by section 316.¹⁴

III. Overview of the Medical Termination of Pregnancy Act, 1971

In our country, unwanted pregnancy sets forth a problem and this problem amounts to very fatal consequences in case of unwed girls due to social pressure. Pregnancy without wedlock is counted to be a strange and disgraceful phenomenon in our country.

In India, the Central Family Planning Board on August 25, 1964 recommended the Ministry of Health to constitute a committee to study the need of legislation on abortion. The recommendation was adopted in the latter half of 1964 constituting a committee which consisted of members from various Indian public and private agencies. The committee called Shantilal Shah Committee was constituted. After analyzing a vast expanse of statistical data available at that time, this committee issued its report on December 30, 1966. On the basis of this report, the government passed the Medical Termination of Pregnancy Act, 1971 (MTP Act of 1971) and liberalized abortion laws in India.

The Act, consisting of just 8 sections, deals with the various aspects like the time, place and circumstances in which a pregnancy may be terminated by a registered medical practitioner. It legalizes abortion in case where there is a failure of contraceptives or where the pregnancy will adversely affect the physical or mental termination of pregnancy, consent of the pregnant woman is a must unless she is a minor or lunatic when her guardians consent is required.

Broadly, the Act provides for the termination of pregnancy on medical, social, humanitarian and eugenic grounds, up to 20 weeks of gestation in a safe environment by a recognized registered and adequately qualified medical practitioner.

¹³ Jabbar v. State, A.I.R. 1966 All 590; 1966 Cr. J.L. 1363

¹⁴ Pappan v. State, A.I.R. 1953 T.C. 374, 1953 Cr. L. J. 1551.

The MTP Act 1971 accords importance to the consent of an adult woman, aged 18 years and above for terminating her pregnancy and a physician is to play a central role in counseling the pregnant woman about the relative merits and demerits of continuation or termination of pregnancy in a given case. And whoever performs MTP without proper consent of pregnant woman shall be prosecuted.

This Act provides for the termination of pregnancy up to 12 weeks of gestation on the basis of the opinion of single registered medical practitioner, and pregnancy between 12 and 20 weeks of gestation on the basis of two registered medical practitioners.

The grounds include grave risk to the physical or mental health of the woman in her actual or foreseeable environment, as when pregnancy results from contraceptive failure, or on humanitarian grounds, or if pregnancy results from a sex crime such as rape or intercourse with a mentally-challenged woman, or on eugenic grounds, where there is reason to suspect substantial risk that the child, if born, would suffer from deformity or disease. The law allows any hospital maintained by the Government to perform abortions, but requires approval or certification of any facility in the private sector. In the event of abortion to save a woman's life, the law makes exceptions: the doctor need not have the stipulated experience or training but still needs to be a registered medical practitioner, a second opinion is not necessary for abortions beyond 12 weeks and the facility need not have prior certification.

It may be noted that the M.T.P. Act does not protect the unborn child. Any indirect protection it gains under the Act is only a by-product resulting from the protection of the woman. An important feature of the Act is that it does not permit termination of pregnancy after twenty weeks. Under the MTPA, Abortion is legal up to the second trimester, but it is at the absolute discretion of medical opinion. It is important to note that the MTP Act does not permit induced abortions on demand

The Medical Termination of Pregnancy Rules and Regulations 1975, define the criteria and procedures for approval of an abortion facility, procedures for consent, keeping records and reports, and ensuring confidentiality. Any termination of pregnancy done at a hospital or other facility without prior approval of the Government is deemed illegal and the onus is on the hospital to obtain prior approval.

In *Nikhil D. Dattar v. Union of India*,¹⁵ section 3 and 5 of MTP Act was challenged on the ground of non-inclusion of eventualities vires of the Act. In this case the foetus was diagnosed for complete heart block thus the Petitioner, in her twenty sixth week of pregnancy, had sought termination of pregnancy. The petitioner contended that section 5(1) of the MTP Act should be read down to include the eventualities in section 3 and consequently, a direction should be issued to the respondents to allow the petitioner to terminate the pregnancy. While dismissing the petition the court further held that since twenty six weeks of pregnancy has already passed the court could not pass any direction for exercise of right under section 3. This case further reiterated that the physical and mental trauma which may be experienced by women in such circumstances. The case also highlighted the ethical issue faced by the doctors in similar situations.

The amended MTP Rules also recognize medical abortion methods and allow a registered medical practitioner (e.g. the family physician) to provide mifepristone + misoprostol in a clinic setting to terminate a pregnancy up to seven weeks, provided that the doctor has either on-site capability or access to a facility capable of performing surgical abortion in the event of a failed or incomplete medical abortion. However, the Drug Controller of India has approved mifepristone provision only by a gynaecologist, thus effectively restricting access to women in urban areas. National consensus guidelines and protocols for medical abortion are currently being developed.

Relation between MTP Act, 1971 and Pre-Conception Pre-Natal Diagnostic Techniques ACT, 1994

The Medical Termination of Pregnancy Act, 1971 (MTP Act) and the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act) form two critical components of India's legal framework surrounding reproductive rights and prenatal care. While the MTP Act seeks to provide women with access to safe and legal abortion under specific circumstances, the PCPNDT Act is designed to curb the misuse of diagnostic technologies for sex selection and prevent female foeticide. Though both legislations serve essential societal interests, their intersection often leads to practical challenges, legal ambiguities, and ethical dilemmas in implementation.

¹⁵ S.L.P. (Civ.) No. XXXX of 2008 (Supreme Court of India)

The MTP Act permits abortion in situations where the pregnancy poses a risk to the woman's life or health, is a result of rape or incest, results from contraceptive failure (expanded to include unmarried women after the 2021 amendment), or involves significant foetal abnormalities. On the other hand, the PCPNDT Act prohibits the use of any diagnostic techniques, including ultrasound, for determining the sex of the foetus and penalizes any person or medical practitioner involved in sex selection before or after conception.

The complementary nature of these laws is evident in their shared goal of safeguarding women's health and dignity. However, their implementation sometimes places healthcare providers in a legal and ethical bind. For instance, diagnostic tools such as ultrasonography, which are essential for detecting congenital anomalies (a ground for legal abortion under the MTP Act), are simultaneously regulated under the PCPNDT Act due to their potential misuse for sex determination. This overlap creates an environment where medical professionals may hesitate to perform certain tests or procedures, fearing accusations under the PCPNDT Act even when acting within the bounds of the MTP Act. Consequently, access to necessary prenatal care and lawful abortion services may be compromised, especially in rural or resource-limited settings.

Legal scrutiny becomes more complex when abortions are sought based on detected foetal abnormalities. These conditions are often identified only after the 20th week of pregnancy, a limitation that, prior to the 2021 amendment of the MTP Act, significantly restricted access to timely medical termination. Although the amendment extended the permissible gestational limit to 24 weeks in select cases and removed the upper limit entirely for substantial foetal abnormalities (as determined by a medical board), the concurrent enforcement of the PCPNDT Act continues to raise questions about whether certain terminations are genuinely based on medical necessity or are veiled attempts at sex selection.

Judicial responses have varied in attempting to balance these considerations. While courts have recognized a woman's right to reproductive autonomy under Article 21 of the Constitution, as in *Suchita Srivastava v. Chandigarh Administration*¹⁶, they have also strongly upheld the strict implementation of the PCPNDT Act to counter the declining child sex ratio, as seen in *Voluntary Health Association of Punjab v. Union of India*¹⁷. These dual imperatives, though

¹⁶ AIR 2010 SC 235

¹⁷ AIR 2016 SC 5122

justified, sometimes lead to an overly cautious medical environment, with professionals either refusing to provide abortion services or demanding excessive documentation to protect themselves from legal repercussions.

Administrative challenges further complicate the scenario. The PCPNDT Act imposes rigorous documentation and registration requirements for diagnostic clinics, and noncompliance can attract harsh penalties, even for clerical errors. This has led to an environment of fear and overregulation, which inadvertently affects access to essential diagnostic services and may discourage qualified practitioners from offering prenatal care.

A nuanced and integrated approach is necessary to harmonize the objectives of both laws. Regulatory clarity, better training for medical professionals, streamlined compliance mechanisms, and increased public awareness can ensure that women are not forced to choose between their rights and societal constraints. Both the MTP and PCPNDT Acts are cornerstones in India's journey towards gender justice and reproductive autonomy, but they must function in a balanced manner to effectively protect both the unborn girl child and the rights of women.

V. Contradiction between POCSO ACT, 2012 and MTP Act, 1971

India's legal framework on sexual and reproductive rights concerning minors is characterized by contradictory obligations placed on medical professionals under two key legislations: the Protection of Children from Sexual Offences (POCSO) Act, 2012, and the Medical Termination of Pregnancy (MTP) Act, 1971 (amended in 2021). While the POCSO Act was enacted to safeguard children from sexual abuse, its rigid criminalization of all sexual activity involving individuals below the age of 18, irrespective of consent, collides with the reproductive rights framework of the MTP Act. This conflict has profound consequences on adolescents' access to safe abortion care.

The Protection of Children from Sexual Offences Act, 2012 establishes the age for consensual for sexual intercourse at 18. Therefore, POCSO treats all pregnant women under the age of 18 as rape survivors and mandates the provider to report the abuse.⁸ This obligation to report contradicts the confidentiality and privacy protections under the MTP Act.

This mandatory reporting requirement can act as a deterrent for those women under the age of 18 from accessing safe abortion services in situations where the pregnancy resulted from

consensual marital or non-marital sex. As stated in the section on rape, courts unanimously allow minor rape survivors to terminate and even express their frustration with doctors, police, and magistrate judges who create unnecessary delays. Where a rape survivor's pregnancy has passed the 20-week limit established under the MTP Act, courts traditionally split.

However, in 2015 the Supreme Court allowed termination post-20 weeks where a team of doctors determined that the pregnancy would harm the girl's mental and physical health setting. It is an important precedent paving the way for increased access to safe abortion services for minor rape survivors.

The POCSO Act, although passed a decade later, is regressive insofar as it criminalizes all sexual activity among children, not acknowledging consensual sexual activity among adolescents. An unwanted pregnancy resulting from consensual sexual activity involving an adolescent also ends up being viewed as an outcome of sexual violence by the law. Therefore, the POCSO Act needs urgent amendments in order to allow consensual sexual activity among minors with an adequate level of secrecy to terminate teenage pregnancies with the least legal resistance possible.¹⁸

VI. Critical Review of the Medical Termination of Pregnancy Act, 1971

The MTP Act does not define 'health', 'substantial risk', 'seriously handicapped' and so on. It is left to the medical practitioner to decide how these terms are to be interpreted, although two explanatory notes indicate that pregnancy in the case of rape (excluding marital rape) and contraceptive failure (in the case of married woman) may be treated as causing injury to mental health. In fact, even the words 'abortion', 'miscarriage' and 'termination of pregnancy' have not been defined, which leaves the medical opinion on these matters sacrosanct.¹⁹

It is true that after 20 weeks of pregnancy, it is not medically wise to terminate pregnancy but the earlier period should belong to the women concerned where it is medically feasible to terminate pregnancy, to give content to the right to life and liberty of the women. It is submitted that the liberty of the born i.e. of the female concerned should be given its due instead of taking

¹⁸ JUSTICE J.S. VERMA COMMITTEE, Report of the Committee on Amendments to Criminal Law, 443-444 (January 23, 2013)

¹⁹ V. Hemalatha Devi, "Abortion Law in India – Socio Legal Implications", 1 SC Journal (1990).

the right of life to absurd limits to protect liberty of the unborn which has still to see the face of light.²⁰

The Act does not define the phrase 'grave injury to physical and mental health of the pregnant woman' contained in S. 3(2)(b)(i) of the Act. The definition is inclusive i.e. includes certain events under which the pregnant lady may be deemed to have suffered from grave injury to her mental health. Explanations appended to S. 3 provide that if pregnancy is caused by rape, or is the result of failure of any device or method used by the married woman or her husband for the purpose of limiting the number of children then the anguish caused by such pregnancies may be said to constitute a 'grave injury to the mental health of the pregnant woman'. However, the anguish caused by pregnancies which are outcomes of illegitimate sexual relations though by consent is not regarded as grave injury and such a woman could probably not avail of the benefit of termination of pregnancy provided by the Act.²¹ According to the canons of original jurisprudence, a man is presumed to be innocent unless his guilt is established in a Court of law beyond reasonable doubt. If a woman is subjected to rape, the question arises whether she should postpone the procurement of abortion till the charge of rape is established in a Court of law and the accused is found guilty or get the pregnancy terminated during the pendency of case. In the former case, no abortion is possible because the case would take 3 to 4 years to be disposed of and in the latter if the man is acquitted the woman would be liable under S. 312 of the IPC.

According to S. 376 C of the Code by the Criminal Law (Amendment) Act 2013, sexual intercourse by a man in authority with woman not amounting to rape have been made punishable. If pregnancy is caused by such act she cannot get it terminated. Also S. 376 B of the Code fails to take note of a special situation where the husband and wife are living separately under a decree of judicial separation by mutual consent. In such a situation, marriage subsists in law, and if the husband has sexual intercourse with his wife against her will and consent, neither the husband can be convicted for the offence of rape nor the wife can go for abortion, should she become pregnant.

Section 3 of the MTP Act does not provide for termination of pregnancy caused as a result of sexual offences relating to marriage in the I.P.C., such as bigamy, adultery and the offences of

²⁰ Sunita Bandewar, "Abortion services and providers perceptions : gender dimensions", 38(21) Economic and Political Weekly (2003).

²¹ Geeta Ramaseshan, "Abortion are not for the asking", Lawyers Collective 25 (1994).

fraudulent conduct in marriage. A woman finds herself in a difficult situation in cases of pregnancies resulting from the above offences. Thus, Section 3 of MTP Act should be according amended to include the above noted circumstances.

Provisions of MTP Act and Hindu Marriage Act in conflict: In *Sushil Kumar v Usha*,²² the wife got the fetus aborted in accordance with the provisions of MTP Act without her husband's consent. A petition for divorce was filed by the husband's consent. A petition for divorce was filed by the husband's on the ground of cruelty and the Delhi High Court passed the decree of divorce. The married woman who had done a legal thing under the MTP Act became victimized. It clearly reveals that the provisions of MTP Act and Hindu Marriage Act are in conflict. Thus, to get the pregnancy terminated under the MTP Act husband's consent is not mandatory.²³

A major critique of the MTP Act is its apparent over-medicalisation and physician's only policy that reflect a strong medical bias and ignore the socio-political aspects of abortion. The need for two doctors to certify opinion for a second trimester MTP is an unnecessary restriction imposed by law.²⁴ Though abortion law allows for termination of pregnancy for a wide range of reasons construed to affect the mental and physical health of the woman, it remains with the doctor (and not the woman) to opine in good faith, the need for such a termination. Such a provider- dependent policy might result in denial of abortion care to women in need, especially the more vulnerable amongst them, for various reasons, including conscientious objection.²⁵

Another major critique of the abortion policy is its lack of a link with good clinical practice and research. The MTP Rules define person and place requirements, but do not refer to any national or international technical guidelines for safe abortion care. In the absence of such linkages with guidelines for good clinical practice, providers continue to use unsafe abortion practices like sharp curettage, check curettage following a vacuum aspiration, general anaesthesia, different drug dosage schedules and protocols for medical abortion, etc. The scope

²² AIR 1987 Del 86.

²³ Poonam Pradhan Saxena, "Abortion as a ground for divorce under Hindu Law", 29 JILI 423 (1988).

²⁴ Kristi Lemoine and John Tanagho, "Gender discrimination Fuels Sex Selective Abortion : The Impact of the Indian Supreme Court on the Implementation And Enforcement of the PNDA Act", 15 U. MIAMI INTL & COMP. L. REV. 203 (2007).

²⁵ Joseph Minattur, "Medical Termination of Pregnancy and Conscientious Objection" 16(4) JILI (1974).

of an abortion policy needs to be broad enough to internalise emerging advances in reproductive technology and newer practices within the legal framework.²⁶

While the MTP Act permits women to seek legal termination of an unwanted pregnancy for a wide range of reasons, the clause about contraceptive failure applies only to married woman. The critique in this perspective would be that the focus of safe abortion care has been traditionally for women who are married, implying a denial of such care to an unmarried woman in need of terminating an unwanted pregnancy. It is as if unmarried women do not become pregnant outside of wedlock in 'our society'. Such a gross discrepancy needs to be corrected, as the latter category of women perhaps requires a significant amount of attention to their dilemma.

Another very disturbing aspect is that of quality control under the MTP Rules. While it allows for monitoring of quality of abortion care in the private sector, its recognition of all public health institutions as abortion facilities by default exempts the public sector from certification. The assumption that a health institution by virtue of being in the public sector is accountable to the public at large, has regulatory processes and does not need extra checks on their functioning, is not valid as such accountability is often only in theory and not in practice. This leads to a substantial discrepancy between the abortion facilities offered by the public sector and the private sector.²⁷

While defining punitive measures to deter abortion facilities that provide unsafe abortion care, the MTP Act offers complete protection to registered practitioners from any legal proceedings for any injury caused to a woman seeking abortion. The MTP Act, The Medical Termination of Pregnancy Rules, 1975 (hereinafter referred to as the MTP Rules) and The Medical Termination of Pregnancy Regulations, 2003 define when (gestation limits etc.), under what conditions, by whom and where an unwanted pregnancy can be legally terminated. The act offers full protection to a registered medical practitioner against any criminal proceedings for any harm or injury caused to a woman seeking abortion, provided that the abortion has been or intended to be done in good faith under the provisos of the MTP Act.²⁸ The law is liberal enough in its

²⁶ Indu S Nair, 'Rights of the Child : Challenges for Law in the new era of technology'. Cochin University Law Review, Vol. 27, No. 1 and 2, (Mar-Jun.) 2004.

²⁷ Dr. Mukesh Yadav and Dr. Alok Kumar, 'Medical Termination of Pregnancy (Amendment) Act, 2002 : An Answer To Mother's Health & Female Foeticide', 27(1) 46 JIAFM (2005)

²⁸ Varsha Chitnis and Danaya Wright, "The Legacy of Colonialism : Law And Women's Rights In India," 64(4) Washington and Lee L.R. 1315(2007).

scope such that it allows an unwanted pregnancy to be terminated under any condition which may be presumed to construe a grave risk to the physical or mental health of the woman in her actual or foreseeable milieu-for example such as when pregnancy results from a sex crime as in rape or intercourse with a mentally challenged woman, or on eugenic grounds where there is reason to suspect substantial risk to the child, if born, to suffer from malformation or disease. The act allows medical termination of pregnancy up to 20 weeks gestation. In the event of a termination which is imperative to save the life of pregnant woman, the law makes some notably generous exceptions. The doctor need not have the necessary experience or training criteria stipulated in the MTP Rules but still needs to be a registered allopathic medical practitioner, a second opinion is not necessary for abortions beyond 12 weeks, and the facility may not have prior certification. In such situations the provider is required to report an abortion done to save a woman's life within one working day. The law however is unclear about an abortion beyond 20 weeks done to save a woman's life.

Another area of potential abuse if woman's reproductive right is the mandatory reporting of post-abortion contraceptive use required by MTP Regulations (Form 2) which state may use to compel abortion providers to achieve family planning targets. Such monitoring often results in a form of coercion of women seeking abortion especially in the public sector.²⁹

VII. Conclusion and Suggestions

The evolution of abortion law in India represents a nuanced effort to balance individual autonomy, public health, and moral values rooted in societal structures. Although the enactment of the Medical Termination of Pregnancy Act, 1971 marked a significant liberalization of the Indian abortion regime, its implementation continues to be hampered by outdated statutory language, overlapping legal mandates, and persistent social stigma.

The IPC provisions on abortion, drafted in a colonial era, are poorly reconciled with the rights-based framework of the MTP Act. Even the MTP Act, though progressive in intention, continues to rely on a highly medicalized model that sidelines the agency of women. The Act prioritizes the opinions of medical practitioners over the autonomy of the pregnant woman, reinforcing gate keeping structures that often delay or deny access to safe abortion. Moreover,

²⁹ Ganatra B, Hirve S, Walawalkar et al. induced abortions in a rural community in western Maharashtra: prevalence and patterns. Working paper series, New Delhi : Ford foundation, 1998.

it lacks inclusive provisions for pregnancy resulting from marital rape, incest, or fraudulent sexual conduct, leaving women in these circumstances without clear legal remedies.

The conflict between the MTP Act and statutes like the PCPNDT Act and POCSO Act further complicates the landscape. While the former permits abortion on grounds including contraceptive failure and fetal anomaly, the latter impose procedural and criminal burdens that deter healthcare providers from offering lawful services. Particularly concerning is the impact on minors, whose pregnancies — even when consensual — are treated as criminal under POCSO, forcing mandatory reporting that violates privacy and deters access to care.

A disturbing pattern also emerges from the enforcement of abortion regulations: ruralurban disparities, a lack of certified facilities, and widespread illegal and unsafe abortion practices have led to maternal mortality that is both tragic and preventable. Structural inequalities and patriarchal norms continue to marginalize the reproductive rights of unmarried women, adolescents, and socioeconomically disadvantaged groups. Without urgent reform, India's legal framework will remain out of step with constitutional promises of dignity, equality, and freedom.

Suggestions:

1. Amend and Modernize the MTP Act:

- a) Clearly define key terms like *health*, *substantial risk*, and *grave injury to mental health* to reduce subjective and inconsistent application.
- b) Expand grounds for termination to include circumstances such as marital rape, coercion, bigamy, and fraudulent sexual relationships.
- c) Remove the discriminatory clause that limits abortion due to contraceptive failure to *married women*; unmarried women must be explicitly included in the statutory text.

2. Ensure Women's Autonomy in Decision-Making:

- a) Shift from a doctor-centric to a woman-centric model, especially for firsttrimester abortions. Where medically safe, allow abortion on the woman's request without mandatory doctor certification.

- b) Reduce the requirement for multiple medical opinions, particularly in rural and underserved regions, by empowering trained mid-level providers to perform early abortions under appropriate protocols.

3. Harmonize Contradictory Statutes:

- a) Introduce clarificatory amendments to harmonize the POCSO and MTP Acts to allow consensual sexual activity among adolescents to be treated differently from coercive or exploitative sexual conduct.
- b) Develop legal and procedural guidelines that shield providers acting in good faith under the MTP Act from penal liability under PCPNDT and POCSO.

4. Improve Infrastructure and Access:

- a) Increase the number of approved abortion facilities, especially in rural and tribal areas, through public-private partnerships and streamlined certification.
- b) Expand training programs for paramedics and auxiliary nurse-midwives to provide medical abortion under supervision in compliance with WHO guidelines.

5. Regulate Without Overburdening:

- a) Simplify the PCPNDT compliance mechanisms to avoid penalizing healthcare providers for clerical errors, while maintaining strong safeguards against sexselective practices.
- b) Conduct periodic reviews to ensure the PCPNDT Act is not used to impede legitimate medical terminations.

6. Public Awareness and Social Reform:

- a) Launch sustained educational campaigns to normalize abortion as a legal and health-related decision, particularly among youth and rural populations.
- b) Integrate reproductive rights education in school curricula and community outreach programs, with special focus on dismantling stigma against unmarried pregnant women.