
A CRITICAL EVALUATION OF INDIA'S ABORTION LAWS AND THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971 FROM A WOMEN'S RIGHTS PERSPECTIVE

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ABSTRACT

The abortion laws in India are a manifestation of a legal dichotomy where women are allowed to practice their reproductive agency, but within strictly defined boundaries. The researcher analyse the abortion laws of India, and specifically the Medical Termination of Pregnancy Act, 1971 (MTP Act), from a legal standing of women's rights. The researcher conduct a doctrinal legal study to develop an understanding of the legal framework for abortion in India within the statutory laws, the Constitution, and the framework of judicial precedent and the data available on abortion in India. The Research find that the MTP Act, as revised in 2021, has, in a few significant ways, relaxed the legal framework of abortion. This is especially evident in the changes that removed many of the explicit marital requirements to define women in a particular sense. Researcher also find that the Supreme Court has partially introduced the right to abortion through the right to privacy and dignity, a woman's right to equality, bodily integrity, and informed consent. On the other hand, Researcher argue that the abortion laws of India still operate within a conditional dimension, and as a 'medically mediated' social contract from a rights perspective. Researcher find that the real social constraints in India that restrict women's ability to exercise legal reproductive agency are: physician control, abortion laws and social policies, dependence of Medical Boards, and late stage abortion laws that are only implemented through judicial precedent. In order to liberalize the abortion laws, India has to relax the restrictive social framework and combine within it women/family rights, and through reproductive justice relax social control and provide legal, affordable, and accessible abortion on request.

Keywords: Abortion law in India; Reproductive autonomy; Medical Termination of Pregnancy Act, 1971; Women's rights; Reproductive justice.

Introduction

India, throughout much of its history, has had an ambiguous and, in some cases, contradictory attitude towards abortion legislation. While many jurisdictions in the Global South still today criminalise the expression of reproductive rights and the right to legal abortion, the Medical Termination of Pregnancy Act in India, which was enacted in 1971, legitimised abortion in more liberal grounds. However, the legitimacy was rooted in the exceptional and medico-legal provisions of the law. The focus in the Act was to control unsafe abortions and high rates of maternal deaths; however, the provisions in the law placed doctors, approved abortion facilities, and gestational limits in the position of controlling the reproductive rights of women, thus, while proved legal, the law did not ensure autonomy, equality, and genuine accessibility for women in different socioeconomic and historic contexts.¹

This tension sharpened in the era of the Medical Termination of Pregnancy (Amendment) Act, 2021.² On the one hand, the Act removed the requirement of marriage in the ground of contraceptive failure, and expanded the access to the upper cap of 24 weeks of pregnancy in certain designated categories. On the other, the bulk of the evidence confirms the fact that most of the abortions in India remain mail-order modifications of the abortion pill, and thereby, women go outside the formal legal channels on their own.³ The difference between the intended and the actual remains the most important consideration in any deep critique of systems of law.

This paper critiques the Indian abortion law in the context of women's rights, and in the context of judicial and legislative frameworks, and the continuing structural barriers to afford access to women. It posits that the Supreme Court, in *X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi and Another*⁴, tends to glide on the jurisprudential constructs of autonomy, dignity, and privacy, and the most important of elements remains the equality. There still exists the legal framework that views abortion as a medical condition, and impositions of value judgment on the law and the legislative judgment remain. Therefore, the domains of women's right to reproduce remain in the hands of the legal and medical gatekeepers, in the hands of a failed and unequal health system.

¹ The Medical Termination of Pregnancy Act, 1971 (Act 34 of 1971), s. 3.

² The Medical Termination of Pregnancy (Amendment) Act, 2021 (Act 8 of 2021), ss. 2, 3.

³ Susheela Singh, Chander Shekhar, et.al., "The Incidence of Abortion and Unintended Pregnancy in India, 2015", 6 *The Lancet Global Health* e111 (2018).

⁴ (2023) 9 SCC 433.

Evolution of the Statutory Framework

To properly interpret the Indian abortion laws, one must look beyond the letter of the current law. The contours of the Indian abortion laws are better understood through the lens of the interplay of selective liberalisation, public health law, and regulation of the criminal law. Therefore, Indian abortion laws allow for the possibility of abortion in a restricted manner and in the absence of the straightforward expression of reproductive rights.⁵

From Penal Exception to Regulated Access

Without considering the flexible construct of criminalisation, the 1971 Medical Termination of Pregnancy Act and the exceptions it notified was primarily a response to the high rates of maternal death and morbidity linked to the unsafe abortions. The response to criminalisation through this law matters from the perspective of women's rights. The Indian abortion law positioned abortion at the end of the spectrum of the medicalised, therefore sanctioned, crime, thereby restricting the law's presumptive space of the women's autonomous decision therein. Thus the law recognised the health of women, but only within the confines of lawful abortion, and, therefore, strict statutory grounds, registered providers, and approved places.⁶

That structure indicates why abortion has retained a unique interaction with criminal law in India. Although the Indian Penal Code has now been replaced by the Bharatiya Nyaya Sanhita, 2023, the wider pattern remains the same: abortion maintaining its relationship with criminal law, while legal abortion occurs windowed within a specific framework of law. This framework reveals criminal law in a symbolic way. Women are not seen as law-makers in this pattern; their reproductive choices are legal only after constituents of criminal law are statute.⁷

The 2021 Amendment and Delegated Rules

The Medical Termination of Pregnancy (Amendment) Act, 2021, greatly and gradually opened the doors for reproductive choices. It widened the legal boundary to include a 20 to 24 week period for a wider group of women, and provided for the replacement of the marital contraceptive failure to include “any woman or her partner.” The law now more accurately

⁵ Rebecca J. Cook, Joanna N. Erdman, et.al., *Abortion Law in Transnational Perspective: Cases and Controversies* 88 (University of Pennsylvania Press, Philadelphia, 1st edn., 2014).

⁶ *Supra* note 3.

⁷ The Bharatiya Nyaya Sanhita, 2023 (Act 45 of 2023), ss. 88, 89, 90, 91, 92.

reflects reproductive realities in India, particularly the reality of unintended pregnancy beyond mResponder. Still, from a legal point of view, pregnancy is not seen as a buried and hidden right, and abortion is not seen as a right in law; the law has simply enlarged the framework in which the State has permitted abortion.⁸

The Rules are critical to how the law works because categorizing women up to twenty-four weeks and constructing an administrative pathway through which access can be achieved are two things the Rules accomplish. Rule 3B encompasses rape or incest survivors, minors, and women whose marital status changes during the pregnancy, as well as women with disabilities, women with significant foetal deformities, and women who are in humanitarian or emergency situations. Still, inclusion in a category does not mean that access is easy or even possible. A woman who is included in a category must now deal with clinical discretion, the need to document things, the delays that the institutional bureaucracy and/or the law or regulations may create, and the uneven access to trained abortion providers, especially those who work outside the larger, urban areas.⁹

The Limits of Administrative Reform

The ongoing, provider-centred nature of the law is also demonstrated in the government guidelines. Although the Comprehensive Abortion Care Training and Services Delivery Guidelines place abortion within a wider, woman-centred public health system and include services and care for women, they still construct access around the way that the care service providers are qualified, which facilities they are permitted to work at, how service providers are connected to one another through a referral system, and how to regard the procedures. That is, while the rationale is based on improving the services and the safety of the system, even that example demonstrates that relying on the administration of medical services alone to improve the law is always going to be a limited response. A law can be framed within a safety rationale and yet still be patronizing because it puts a woman's right to access what the law entitles her to at the mercy of a medical provider and ultimately a system of bureaucratic controls.¹⁰

⁸ *Supra* note 4.

⁹ The Medical Termination of Pregnancy Rules, 2003, r. 3B.

¹⁰ Government of India, "Comprehensive Abortion Care: Training and Service Delivery Guidelines" 15 (Ministry of Health and Family Welfare, 2023).

Constitutional Foundations of Reproductive Autonomy

The realm of abortion law in India can arguably be classified as the most active in terms of constitutional jurisprudence. The courts have also been increasingly situating reproduction choices along Article 14 and 21, and gradually moving away from the narrow medical or penal constructs within which abortion law is usually framed.¹¹

Privacy, Dignity, and Bodily Integrity

The leading decision is the case of *Suchita Srivastava and Another v. Chandigarh Administration*¹², where the Supreme Court placed a woman's right to make a decision pertaining to her reproduction within the domain of personal liberty, right to privacy, dignity, and the right to bodily integrity. The significance of that decision is not just in the articulation of the right to choice, but in the refusal to entertain the notion that the State can abdicate its role in decision making to a pregnant woman. By asserting that reproductive decisions are to remain within the province of the individual, the Court provided the normative language that subsequent decisions would employ in order to traverse the constricted language of the statute. The decision signals the shift from welfare-based approach to constitutional agency.

Equality, Marital Status, and Sexual Citizenship

Equality enhances constitutional analysis because restrictions on abortion are layered on social assumptions about sexuality, marriage, motherhood, and respectable femininity. The Supreme Court's 2022 decision in *X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi and Another*¹³ stated that married women and unmarried women cannot be denied access to the 20 to 24 weeks' framework, because Rules were constructed with marriage in mind. The decision defied the social imposition of drawing lines to restore constitutional meaning to "all women" in the legal context. Further, it emphasized that the legal equality gap cannot sustain the legislative framework imposing that only reproductive lives of women within the institution of marriage are legitimate.

The equality aspect of the 2022 decision is critical because the previous abortion legislation

¹¹ Neha Singh, Seema Gupta, et.al., *Reproductive Rights of Women in India* 102 (Bloomsbury India, New Delhi, 1st edn., 2023).

¹² (2009) 9 SCC 1.

¹³ *Supra* note 6.

constructed marriage as an implicit marker of deservingness. That approach ignored the reproductive lives of unmarried women, women in non-marriage relationships, and pregnant women who were socially or economically vulnerable, and as such, did not have formal familial arrangements. The social moral order that the law is bound to within the legal constructs of marriage relations, legitimacy, and socially acceptable sexuality and relationships must be interrogated. For that reason, the decision is critical as it dismantled the reproductive healthcare law framework that ignored the social reality of sexual relations that occur outside of marriage.¹⁴

Consent, Disability, and Sexual Violence

The constitutional frame also needs to be critical of the issues of consent and disability. The earlier case of autonomy stressed that mental disability does not end reproductive choice, and, more vitally, the decision of *Devika Biswas v. Union of India*¹⁵ stated that reproductive healthcare must also be supported by the principles of informed consent and freedom from coercion. This body of decisions are linked by a total common constitutional ethic. Women are not the objects of demographic, familial, or therapeutic control or management. Abortion law must safeguard access to abortion but relate to protection of the conditions that make consent meaningful, that the information is intelligible, and the decisions of healthcare, in the context of disability, are not prejudicial nor an act of institutional convenience.

In *X v. Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi and Another*¹⁶, the Supreme Court advanced the interpretation of sexual violence in the Constitution. The Court determined that, under the Medical Termination of Pregnancy Rules, a case of rape may include a husband engaging in the sexual assault/rape of his wife. The Court also acknowledged the forced continuation of an 'unwanted' pregnancy worsens the trauma, as opposed to the idea that it would negate the trauma. This interpretation is noteworthy as it harmonizes abortion legislation with the reality of the experiences of those who suffer harm. A women's rights perspective is unfulfilled by the traditional criminal definitions and classifications. It must also include relational compartmentalization of coercion, the social perceptions of the society, and the physical and psychological effects of a denial of

¹⁴ Rashmi Pradhan, *Gender Justice under Indian Constitution* 90 (Satyam Publishing House, New Delhi, 1st edn., 2019).

¹⁵ (2016) 10 SCC 726.

¹⁶ *Supra* note 6.

reproductive health services in a timely manner.

A Women's Rights Critique of the Medical Termination of Pregnancy Act

Despite recent changes, the female rights-based review of the Medical Termination of Pregnancy Act shows that with respect to women's rights, the Act remains structurally ambivalent. Some access is protected, but at the cost of self-determination and, for the most part, medical discretion, procedural filtering, and temporal, administrative convenience.¹⁷

Medical Paternalism and Provider Control

The primary and most unrelenting challenge is medical paternalism. The statute prescribes a medical determination, choosing to forego a woman's right of self-determination in relation to her unwanted pregnancy, by inquiring whether the medical practitioner stamping the document is persuaded that the conditions of the statute are satisfied. This model may be defended as a safety mechanism, but what such redistribution accomplishes, in the absence of the protection of (and respect for) the reproductive self-determination by the woman directly, is the unfettered control of a medical (and legal) cleric. From the viewpoint of a woman unable to assert herself because of her limited social, economic, and educational standing, the nexus of reproductive self-determination is not, for a provider of health services, the realization of her reproductive freedom. In many cases, the medical consultation is merely an administrative process.¹⁸

Feminist legal theory is already useful here by establishing that formal permission can exist side by side with substantive subordination. A protective-looking regulatory scheme can still reproduce hierarchy by treating women as individuals who need their choices to be authenticated by a privileged expert, a family, or an institutional body. This is the case in the abortion context when a right is claimed but the case is recast as a demand for professional certification. The issue with medicine is not that it is dispensable, but that it is not a replacement of a woman's choice, but community of clinical expertise. A women's rights perspective prioritizes the retention of safety regulation but not the conversion of medical advice to moral ambivalence.¹⁹

¹⁷ *Supra* note 7 at 189.

¹⁸ Satvik N. Pai, Krithi S. Chandra, "Medical Termination of Pregnancy Act of India: Treading the Path between Practical and Ethical Reproductive Justice", 48 *Indian Journal of Community Medicine* 510 (2023).

¹⁹ Robin West, Cynthia Grant Bowman, *Research Handbook on Feminist Jurisprudence* 183 (Edward Elgar Publishing, Cheltenham, 1st edn., 2019).

Gestational Limits and the Burden of Delay

Gestational limits bring about a second issue. Time limits on abortion jurisdiction are very common, but the impacts are inequitable because delay is characterized by social inequality. Women who learn of their pregnancies late, adolescents who are afraid to divulge, survivors of violence, and those forced to forgo in-country travel to access care are among the most legally constrained. In this situation the law's compassionate language is mostly absent and exceptional litigation is the norm. While the law may seem fair on the surface, in practice the goal of such a system is to shift the legal constraints toward a state of imbalance. A practice-focused rights framework and legal theory would shift the constraint of delay away from biology and toward the inequities, social stigma, lack of public health infrastructure, and the fragile nature of the public health and social health systems.²⁰

Medical Boards and Late-Term Access

The government's control of pregnancies over twenty-four weeks demarcates this issue. Access is primarily mediated by Medical Boards when faced with severe foetal abnormalities or facilitated by a court when continuation is a danger to someone's life or well-being. The Supreme Court's decision in *A (Mother of X) v. State of Maharashtra and Another*²¹ showcases both the potential and the frailty of this system. The court chose to negate a strict denial and reinstated the focus on the minor's welfare. However, a rights system that is hinged on emergency constitutional litigation is functionally incomplete, especially for the litigation disadvantaged and those who do not have easy access to the higher courts.

Confidentiality, Stigma, and Surveillance

Confidentiality components in legislation are examples of incomplete reforms. The law defends the identity of women who undergo a pregnancy termination, which is protective in the face of social stigma. However, legal confidentiality does not guarantee actual confidentiality. Women are still subjected to informal breaches of confidentiality, and are subject to community morality, police referrals, and the unwanted presence of bystanders. This issue is even greater with adolescents, single women, and women who have experienced sexual

²⁰ Keertana Kannabiran Tella, *Abortion Rights, Reproductive Justice and the State: International Perspectives* 95 (Routledge, Abingdon, 1st edn., 2022).

²¹ 2024 INSC 371.

violence. In this context, confidentiality is a challenge to go beyond simple written records and create a system that has the dignity and respect of the women accessing it. It has to be polite and considerate.²²

Judicial Development and Contemporary Case Law

Judicial interpretation has increasingly adapted the rights language that is not present within statutes themselves. While case law reflects the uncertain and fragile nature of abortion access, when women must rely on constitutional courts to guarantee abortion access that is typically and as a matter of right, health system guarantee and provide to their users.²³

From Foundational Principle to Constitutional Method

From the point of view of women's rights, the most important feature of the case of the fundamental autonomy decision, abortion in this case, has to do with the abandonment of a general and the reasoning of *parens patriae* autonomy. Abortion law is vulnerable to the imposition of a judgment exercised by the courts, parents, institutions, and/or physicians, on the premise that their actions are in the 'best interests' of a woman. By placing a right of choice in the domain of the right to self-determination and the right to personal liberty, the Court made it clear that the State has no right to exercise its constitutional authority by allowing a woman to give birth. The subsequent development of Indian abortion law is viewed as a slow but steady attempt to give life to this principle.²⁴

The judgment of the three-judge bench in 2022 is the brightest example of the translation of this approach. The judgment aimed to read the Rules purposively. It dismissed discrimination based on marital status, acknowledged the importance of IPV, and supported the view that Reproductive Autonomy includes the right to decide whether to procreate and bear a child, and if yes, to decide when to do so. The judgment also went so far as to say that, for the purpose of Reproductive Autonomy to be a reality, the definition of the term "woman" must be so generously construed as to go beyond - and encompass - the right to Abortion - besides, Maintaining the status quarantine - for the ease of constitutional adjudication - will be the best equality - to compensate - for the absence of broadly empowering delegated legislation - will

²² Flavia Agnes, *Law and Gender Inequality: The Politics of Women's Rights in India* 112 (Oxford University Press, New Delhi, 1st edn., 1999).

²³ *Supra* note 7 at 167.

²⁴ *Supra* note 13.

be the best equality.²⁵

Late-Term Litigation and the Supreme Court

Late-term litigation explicates both the continuity and the tension that prevailed. In *A (Mother of X) v. State of Maharashtra and Another*²⁶, the Supreme Court addressed a child pregnancy beyond the statutory limit and restored focus on the welfare of the minor. *A (Mother of X) v. State of Maharashtra and Others*²⁷ subsequently reaffirmed that foetal-interest reasoning cannot be used to the detriment of social reality, bodily trauma, and the future consequences of women.

High Court Autonomy Jurisprudence

High Courts have also contributed to the autonomy-centred reading of abortion law. In *High Court on its Own Motion v. State of Maharashtra*²⁸, the Bombay High Court accepted that compelling a woman to carry an unwanted pregnancy amounts to a violation of the principle of bodily integrity. State may not impose motherhood. This reasoning is certainly of significance and indeed, takes the argument a notch above the raw sympathy that an onlooker of the situation may feel, and places it in the realm of the constitution. However, the long and short of it is that the overall situation does not offer any great hope. The grant of judicial relief is usually bound by the speed of listing, the delays, and the willingness of certain benches to take a purposive view of the law. All these factors cause avoidable cacophony in the ecosystem.

The cumulative effect of the case law, then, is a double-edged sword. On the one hand, the courts have taken a definitive step toward dignity, privacy, and equality, and decisional autonomy in Indian abortion jurisprudence. On the other, the persistent litigation in late-term abortion cases. Women are often forced to take the litigation path because hospital administrators adopt a 'wait and watch' approach. Medical Boards 'delay' deliberative democracy, and lower level bureaucratic authorities misinterpret the provisions of the Statute. The law is invariably on the side of the complainant. The jurisprudence is decidedly progressive, but 'within the walls of a castle' the statutory jurisprudence 'remains substantially'

²⁵ Dipika Jain, "Supreme Court of India Judgement on Abortion as a Fundamental Right: Breaking New Ground", 31 *Sexual and Reproductive Health Matters* 1 (2023).

²⁶ *Supra* note 23.

²⁷ Civil Appeal No. 827 of 2026, decided on February 6, 2026.

²⁸ 2016 SCC OnLine Bom 8426: 2017 Cri LJ 218.

reactive. In the view of the authors and from a women's right perspective, the objective is to have 'rights' made in administrative constructs and not be subsequently 'provided' in the judiciary.²⁹

Access, Evidence, and Structural Exclusion

Indian abortion law faces its most powerful criticism when aspirations from theory contrast with reality. Available evidence suggests that beyond the written law, abortion access for women is impacted by geography, distribution of service providers, cost, stigma, medication abortion, and the convenience of skipping the facility.³⁰

National Abortion Incidence and Informal Access

National data collected in 2015 show the size of the problem. In India, 15.6 million abortions were reported, with an abortion rate of 47 for every 1,000 women aged 15 to 49 years. Most worrying is the fact that around 22 per cent of abortions were performed in health facilities, but 73 per cent were reported to be medication abortion outside health facilities and 5 per cent were performed outside health facilities through other means. This data can also be viewed in figure 1. The trend is that women tend to find abortion through paths that are shorter and less visible, or are more accessible than the formal health system, despite the fact that these paths are likely to be characterized by inadequate information and follow-up.³¹

²⁹ *Supra* note 7 at 131.

³⁰ World Health Organisation, "Abortion Care Guideline" 12 (2022).

³¹ *Supra* note 5 at 152.

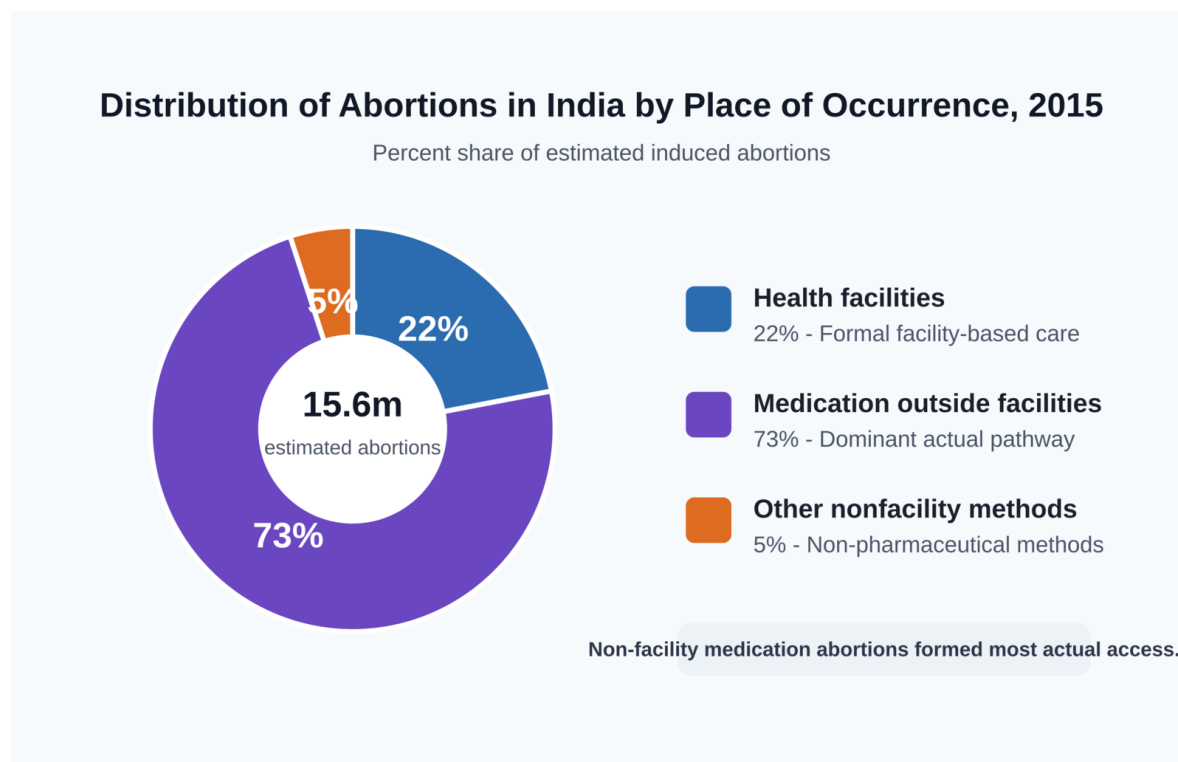


Figure 1. Distribution of abortions in India by place of occurrence, 2015.

State Variation and Service Distribution

Evidence from six major states attests to the fact that this pattern cannot be classified as an isolated or marginal phenomenon. The Guttmacher Institute's state study reported that a minority of abortions took place in health facilities across states, with the proportion of facility-based abortions estimated to be about 11 percent in Uttar Pradesh and 32 percent in Tamil Nadu. This is represented in Figure 2. The same study noted that, in many states, medication abortion outside of facilities accounted for at least two thirds to more than 80 percent of abortions. These figures show that the formal legal system is not.³²

³² Susheela Singh, Rubina Hussain, et.al., "Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programmes" 8 (2018).

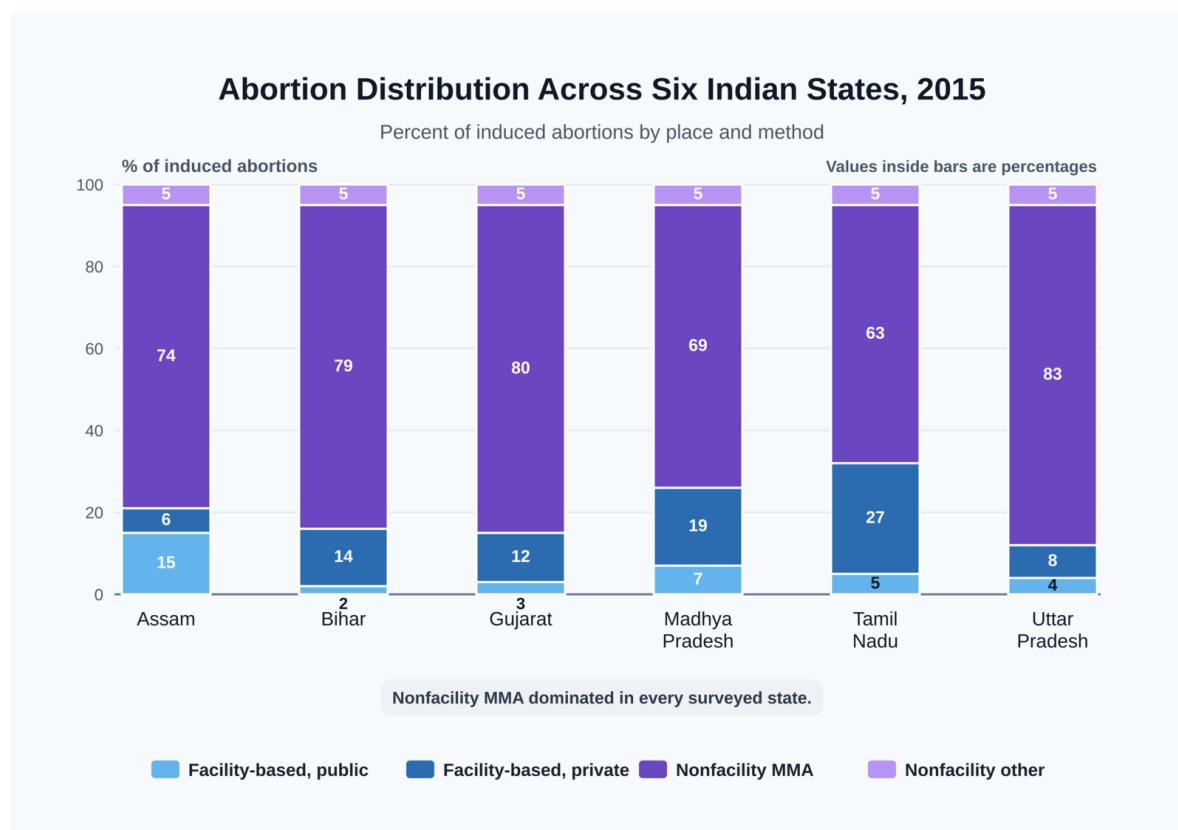


Figure 2. Abortion distribution across six Indian states, 2015.

Provider Quality and Institutional Inequality

Provider distribution offers important insights into the gap between formal legality and substantive accessibility. At the district level, the contribution ratio of the private and public sectors in medical termination of pregnancy services varies significantly, resulting in women's options being contingent upon the local health-system architecture instead of a national uniform promise.³³ Quality studies indicate gaps in consent, choice of methods, counselling, and the troublesome absence of care.³⁴ The problem is not a legal one. The problem is the poor institutional quality of the channels through which legality is formally enforced.

Medication Abortion, Violence, and Unequal Risk

The widespread reliance on medical abortion also indicates that an alternative and safe option

³³ Shantanu Sharma, Ajit Kumar Jaiswal, et.al., "Differential Access to Facilities for Medical Termination of Pregnancy and Delivery in India: A Secondary Analysis", 12 *Clinical Epidemiology and Global Health* 100825 (2021).

³⁴ Chander Shekhar, Manas R. Pradhan, et.al., "Providing Quality Abortion Care: Findings from a Study of Six States in India", 24 *Sexual and Reproductive Healthcare* 100497 (2020).

is available, which, in some instances, is the only option working to expand safe surgical abortion services in India. The differentiated use of medical abortion by some women in India to exercise their reproductive autonomy does not justify the gaps in the provision of safe surgical abortion. For some women, they believe they are participating in reproductive autonomy by self-terminated options and easily available medical abortion. They see it as challenging and safe, but in actuality these refereed options are circumvented, and the informal provision of care, if not surgical, is not in the best interests of women.³⁵

Structural exclusion is highly apparent at the crossroads of gender, class, and violence. Studies of use of self-managed abortion in India demonstrate the reality that numerous women who are survivors of intimate partner violence are more likely to use abortion services, specifically self-managed abortion, showing that reproductive decisions are made in the context of domestic coercion and legal prohibition. For young women, rural women, and the women of low and limited socio-physical means, the challenges of travel and the obstacles of waiting, and disclosing are even more insurmountable. To address this from a women's rights perspective, more is needed than the removal of the legal ban. It is also the need for a system that responds to the reality of vulnerability and does not respond to vulnerability with control or outright denial of rights.³⁶

Conclusion

An analysis of Indian abortion laws through a feminist lens allows some progress to be observed. Laws have shifted toward recognizing the autonomy of the individual and the principle of equality, but have not gone as far as recognizing that abortion laws should be secret, should be voluntary, and should be a constitutional right.³⁷

The Medical Termination of Pregnancy Act, 1971, as amended 2021, has removed some of the distorting restrictions that were present in the earlier law. The Supreme Court has interpreted the laws more faithfully to the principles of dignity, and of privacy, and of equality. The law has been slow to recognize the experiences of unmarried women, women who have been the victims of sexual assault, and women of childbearing age. The law has been even slower to

³⁵ Shuchita Mundle, Susheela Singh, et.al., "Increasing Access to Safe Abortion Services in Rural India: Experiences with Medical Abortion in a Primary Health Centre", 76 *Contraception* 66 (2007).

³⁶ Sophie L. Goemans, Abhishek Singh, et.al., "The Association between Intimate Partner Violence and Recent Self-Managed Abortion in India", 1 *AJOG Global Reports* 100029 (2021).

³⁷ *Supra* note 24 at 267.

interpret the experiences of women of childbearing age and to incorporate these experiences of the law of reproduction. While abortion has been legalized in this country, women are forced to get surgeries, from an ethical standpoint, and are forced to get the permission of mine and often of the government. Additionally, women are forced to endure long downtimes. Additionally, women are coerced to accept an ethically and legally unjust law. In effect, this country has not at any time, have ethical and legally just laws.³⁸

The question is not whether law in India can recognize some conditions in which abortion can be legally justified. The question is whether the law can be designed to recognize reproductive autonomy such that reproductive autonomy is no longer viewed as the exception. A women's rights perspective argues that safety, privacy, and informed and supported advocacy (clinical support) strengthen women's decisions and should not be viewed as filters to be placed before women to decide and choose in a disciplined and mannered way. Therefore, reducing the provider veto, minimizing unnecessary court dependence, maximizing good public service, and ensuring that the statutory design fulfils the constitutional goals and promises of integrity of the body and citizenship and equals, should be the goals of abortion law reform in India.³⁹

Suggestions

The issues discussed above posit a need for the legalization of comprehensive reproductive autonomy such that it integrates into the health care system and does not remain within the sanctity of the court.

1. Recognise abortion as a rights-based health service: Reproductive autonomy, dignity, equality, and health all speak to the right to an abortion. Legislative changes should safeguard abortion access as a constitutional right to amendment-protected reproductive health, as opposed to the right to exercise legislative permission. This does not remove access safeguards.
2. Reduce provider veto power: The law should gradually remove itself from placing the burden of decision-making on women and the practitioners on providing a moral exit. Clinical practice support should not be solely at the practitioners dare, and autonomy

³⁸ *Supra* note 13.

³⁹ *Supra* note 22.

for practitioners should be for solely justified medical contraindications based on documented preceding safety protocols.

3. Reform the twenty-four week framework: Gestational regulation should consider delayed discovery, teenage pregnancy, sexual violence, disability, and rural case. More flexible statutory devices would reduce dependence on hard case urgent writ litigations.
4. Standardise and monitor Medical Boards: When Medical Boards are necessary, state uniformity should include their appointment, time frames, report forms, and standards. Delayed or contradictory opinions should activate administrative review and should not compel women to undergo unnecessary judicial processes.
5. Expand public-sector abortion capacity: States must guarantee that district hospitals, sub-district hospitals, and primary-level referral networks can deliver medications, and secure and timely legal abortions. EM investment will include trained personnel, medications, and privacy, unit, and transport pathways, and emergency-follow up.
6. Strengthen confidentiality in practice: Privacy must be assured by record procedures, trained staff, discipline, and private counselling space. Women should not be exposed to the family, police, or community, unless the law needs to be reported within narrowly defined, legal circumstances.
7. Improve consent and counselling standards: Informed consent, unbiased counselling, and transparent communication about methods and associated risks should govern all abortion-related contacts. Consent practices should be particularly sensitive to adolescents, women with disabilities, and survivors of violence.
8. Integrate medication abortion into primary care responsibly: Medication abortion is a mainstay of access and public policy should focus on improving quality and not denying this fact. Reliable information, support, and complication management should be provided and easily accessed from a wider level, complemented by effective integration of primary care.
9. Create faster review mechanisms short of constitutional litigation: There ought to be fast internal review processes for hospitals and district authorities for cases that become contentious and are near the gestational limits. Such processes would lessen the burden

on the High Courts and the Supreme Courts and would protect women from the denial caused by the time lags.

10. Adopt a reproductive justice approach: Reform should consider changing the material conditions that determine one's choices of abortion. Such conditions include, but are not limited to, poverty, distance from rural centres, the presence of violence, disability, stigma, and dependent status on the basis of age. Until the abortion laws are linked to the broader obligations of public health, social support, and the right to gender equality, they will be only partially protective of rights.

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