FROM CRIMINALISATION TO CHOICE: THE JOURNEY OF ABORTION LAW IN INDIA

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ABSTRACT

The legal history of abortion in India reflects the country's changing relationship with women's reproductive autonomy, public health, and social morality. After being criminalized under the Indian Penal Code, 1860, abortion was viewed for a long time as a breach of morals and laws, rather than as a public health matter. The introduction of the Medical Termination of Pregnancy Act, 1971, was a decisive point for the conditional legalization for medical and humanitarian reasons. The ensuing amendments, especially the Medical Termination of Pregnancy (Amendment) Act, 2021, have broadened access by lengthening the gestation period allowed, confirming that unmarried women have the right to access legal abortion services, and guaranteeing confidentiality. Judicial readings ;sin cases such as Suchita Srivastava v. Chandigarh Administration (2009)[1] have redefined an abortion as a constitutional right in the context of privacy, dignity, and personal liberty, in Article 21 of the Constitution. Nonetheless, barriers in practice, such as insufficient healthcare services and providers, the stigma associated with abortion, and inconsistencies in the law related to other statutes keep many women from accessing safe legal abortion care. This paper will analyse the legislative history, judicial history, and socio-legal context of abortion in India and asserts that true reproductive justice requires not just liberal law, but also implementation that promotes equity, awareness, and social change**.**

Keywords: Abortion, Medical Termination of Pregnancy, Indian Penal Code

1. AIR 2010 Supreme Court, 2005

INTRODUCTION

Abortion laws in India evolved alongside the country's development in the arenas of public health, politics, and society. Beginning with a colonial legal framework that virtually outlawed abortion in all circumstances, India began to transition away from encoding reproductive rights in purely punitive and moral terms.

Most of the nineteenth and early twentieth century, abortion was conceptualized through a strict moral and punitive lens under the Indian Penal Code[2], which imposed harsh penalties on both women and practitioners. This strict regime provided no autonomy to women over their own bodily functions and compelled a large part of the practice underground with increasingly unsafe procedures and escalating rates of maternal mortality. The catastrophic consequences, which included highly preventable maternal death, presented enough urgency to begin questioning this penal regime, with rising awareness concerning population, reproductive health, and pressure to begin addressing these issues.

In the mid-1960s, in response to growing public health concern, the Government of India established the Shantilal Shah Committee to analyse international abortion legislation and consider its applicability to the socio-medical context of India. The recommendations from that committee resulted in the passage of the Medical Termination of Pregnancy (MTP) Act in 1971[3.], which paved the way for legalized abortion under specified circumstances for the first time. It became the initial moment in a legislative history related to abortion in India.

This law was a key shift away from abortion as a crime to a legal medical service that addressed women's health and well-being. Over the next few decades, new medical technologies, an increasing amount of case law, and a growing emphasis on rights helped to take stock of what was lacking in the original Act.

All of this led to the MTP Amendment Act of 2021, which continues to expand access, increase gestational limits, and more importantly prioritise reproductive autonomy, privacy, and dignity. The amendment did not just highlight the shortcomings of the existing law; it also brought Indian abortion law more in line with leading global and constitutional values. The leading judgments of the Supreme Court also reaffirmed the notion that reproductive choice is a precondition for personal liberty under Article 21 of the Constitution.

2.The Indian Penal Code,1860. NO 45, Acts of Parliament ,1860(INDIA)
3.The Medial Termination of Pregnancy Act,1971, No.34, Acts of Parliament ,1971

The history of abortion law, and the movement from criminalisation to choice, is more than just the story of legal reform; it also reflects the continuing commitment of the country to gender equality, public health, and human rights. In particular, it reflects how law can change and develop in order to be responsive to social needs, advancements in medical technology, and the ongoing tension between ethics, autonomy, and justice while navigating the social, ethical, and legal complexities of reproductive health and justice in practice.

EVOLUTION OF ABORTION LAWS IN INDIA

Before 1970, abortion was deemed illegal in India; it was only after the implementation of the Medical Termination of Pregnancy Act ,1971 that abortion became permissible, though only under certain specified conditions outlined in the legislation.

INDIAN PENAL CODE,1860

In order to consider the moral, social, religious and ethical background of the Indian community, section 312 -316 of the Indian Penal Code ,1860, deals with the punishment for the unlawful conduct of miscarriage[4]. Section 312 of the code states that "*whoever voluntarily causes a women with child to miscarry, shall if such miscarriage be not caused in good faith for the purpose of saving life of the women be punished with imprisonment of either description for a term which may extend to three years ,or with fine, or with both ,and ,if the women be quick with the child ,shall be punished with imprisonment of either description for a term which may extend to seven years and shall be liable to fine".* Explanation -A women who causes herself to miscarry is within the meaning of this section.

This section speaks of causing women to miscarry in two circumstances: When women is "with child" (as soon as gestation begins); and women is "quick with child" (when motion is felt)[2]. Given the nature and seriousness of the offence in the latter case, the section prescribes punishment in the form of either description of imprisonment, which can last to a period of seven years and a fine, whereas in the former case punishment can extend up to three years imprisonment or fine or both in prison similarly depending upon what the nature of the offence in question.

Section 312 only permits abortion on therapeutic (medical) grounds to protect the life of the mother. The provision indirectly recognizes the foetus as being entitled to life in an unintended situation.

4.S.313-316 of the I.P.C deals with enhanced punishment in case of an aggravating nature.
5. See Abortion in India: A Legal Study by K.D Gaur,349-350,(1986)

The protection of life, however, does not have to be imminent or certain. If the act is completed in good faith, a person is entitled to the protection of the law. But good faith is one of those terms that is clever enough to allow protection to probably most therapeutic abortions if the abortion is ostensibly performed to preserve the life of the mother. Of course, what constitutes good faith is not a question of law but a question of fact to be resolved in each and every case, depending on the facts and circumstances[6].

In **R v Bourne**[7], a noted gynaecologist, committed an abortion on a fifteen-year-old girl who had been made pregnant by rape. He was then prosecuted for a violating section 58 of the Offences Against the Person Act 1861,. The principal issue raised before the court was whether the abortion could constitute 'unlawful' in light of its performance to safeguard the health of the girl. Mr Justice Macnaghten explained to the jury that it was not unlawful to perform an abortion done in good faith with the purpose of preserving the life of the mother, which he made clear, included a situation where the woman would nevertheless become 'a physical or mental wreck' if she carried on with the pregnancy. The jury acquitted Dr. Bourne, establishing that a termination for the purpose of protecting a woman's physical or mental health could be lawful. The case was an important expansion of the meaning of 'preserving life'.

During that period, abortion laws in India were quite restrictive and they were broken more often than followed. It was estimated prior to MTP Act came into force, five million induced abortions annually, three million of which were occurring illegally[8]. Furthermore, it was found that approximately one-seven of the women pregnant in India during any one year, went for back street abortions, administered by unqualified or inexperienced persons, remain unscrupulous and severely unqualified practitioners also or para-medical persons like nurses and midwives, through a variety of crude and unhygienic methods, for nominal sums of money ,charges ranging from Rs.5 to Rs.300,with all the risks of morbidity and mortality involved[9].

MEDICAL TERMINATION OF PREGNANCY ACT ,1971

In 1964, the Central Family Planning Board of India set up a committee led by Shanti Lai Shah

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6. See Abortion in India: A Legal Study by K.D Gaur,349-350,(1986)

7.Siddhivinayak S Hirve, Abortion Law, Policy and services in India: A Critical Review, Reproductive Health Matters,12:sup 24,114-121,(2004)

8.(1938) 3AllE.R,615at 621,

9.Asit K Bose, Abortion in India: A legal study,16JILI.535

to assess the possibility of liberalising the then-current abortion legal position and suggest reform measures to the over stringent provisions of the code, which render any abortion or miscarriage punishable under section 312[10], except when necessary to save the life of the woman.

After conducting a thorough appraisal of the entire issue in terms of pros and cons, with a practical legal perspective to the socio-legal problems of unwanted pregnancies, the committee recommended to the government the liberalisation of the law against miscarriage. The committee provided a comprehensive report and made specific recommendations as to various circumstances or situations that justify termination of pregnancy in law. It was considered that pregnancy can be terminated not for just saving the life of the pregnant woman but for avoiding injury to Mental and physical health. As a result Medical Termination of Pregnancy Act (MTP) passed in August 1971 and came into operation on 1 April 1972 which is based on the principles of the British Act passed by its parliament in 1967 and it allowed abortion till 20 weeks of pregnancy[11].

OBJECTIVES

- Health measures, when there is danger to the life or risk to physical or mental health of the women.
- Humanitarian grounds, such as when pregnancy is caused as a result of a sex crime or intercourse with lunatic women etc.
- Eugenic grounds, when there is a substantial risk that the child, if born, would suffer from deformities and disesase[12].

PROVISIONS OF THE ACT

- A registered medical practitioner may terminate a pregnancy if the length of the pregnancy doesn't exceed twelve weeks or if the length of the pregnancy exceeds twelve weeks but not twenty weeks, furthermore the two or more registered doctors are of the opinion that such pregnancy.

    1. would involve a risk to the life of the pregnant women or of grave injury to her physical and mental health[13].

10.Section 312, Indian Penal Code 1860
11.Abortion Law in India by Diksha Paliwal,ipleaders,(July19,2023)
12. See Abortion in India: A Legal Study by K.D Gaur,350-352, (1986)
13.The Medical Termination of PregnancyAct1971, Sec 3

2. would involve a potential risk that if the child is born, it would suffer from such mental or physical abnormalities.
3. is a result from rape.
4. has occurred as a result of the failure of contraceptive device or method[11]
5. Risk to health of the pregnant women by reason of her actual or reasonably foreseeable environment .

- Pregnancy must be terminated either at a hospital established or maintained by government or a place which is approved by Government or a District Level Committee[14].
- No suit shall be filed against any registered medical practitioner for any damage caused or likely to be caused by anything which is done in good faith.
- The Central government will possess the power to make rules in accordance with the provisions of this act by notification in the official Gazette[15].

The Act did resolve the issue of unwanted pregnancies in certain situations. However, it did come with a couple of limitations, such as the fact that the legislation only allowed termination of pregnancies in situations where the pregnancy was the result of rape. Thus, in any case where the resulting pregnancy was the result of illegal sexual intercourse, other than rape, termination of the pregnancy would be a criminal act punishable under section 312. The act has failed its objective of protecting pregnant women and empowering them by providing a very limited right to determine the course of their bodies at their own discretion. Further, the act caused unnecessary complication and confusion in what was already an unnecessarily complex, multifaceted issue.

MEDICAL TERMINATION OF PREGNANCY RULES,2003

The abortion law was briefly amended in 2002 which primarily pertained to women in the private health industry and provided provisions such as the fact that psychological illness should not be seen as a felonious mental disability, that the term 'lunatic' should be amended to 'mentally ill person' and that a committee situated primarily at the district level had the responsibility of deciding whether private establishments can assist in the provision of abortion services and also allow the use of then -new abortion pills, mifepristone and misoprostol.

14.Medical Termination of Pregnancy Act,1971, Sec4
15. Medical Termination of Pregnancy Act,1971, Sec5

While the act provided some modification, there are certain shortcomings which need to be solved and as a result The Medical Termination of Pregnancy Rules2003s came into force. The provisions are as follows:

1. Establish a district-level committee to enhance the implementation of policies and processes, consisting of at least one woman, one gynaecologist or surgeon, and local healthcare professionals, along with representatives from NGOs[16].
2. The Chief Medical Officer must conduct an on-site visit to examine the location where abortions are carried out, assessing both its sanitation and medical safety conditions, along with those of nearby areas[17].
3. Ensure the inclusion of necessary resources, equipment, suitable ancillary medical technology, and relevant services essential for carrying out the procedure and purpose of pregnancy termination.
4. If the Chief Medical Officer determines that the facility where the pregnancy termination procedure is conducted falls short in certain respects, they should draft a report on the issue and present it to the committee in relation to the committee's role in licensing approval[18].

MEDICAL TERMINATION OF PREGNANCY ACT,2021

The Medical Termination Act was enacted on September 24, 2021, after the Rajya Sabha ratified the MTP (Amendment) Bill, 2021 on March 16, 2021, which received approval from the President and was passed in the Lok Sabha on March 17, 2020[17.]. This legislation aimed to implement significant modifications to the previous Act. It addresses a variety of issues, including the fundamental rights of women to make reproductive choices and to address the unauthorized application of these procedures. The new amendment expanded the law's scope and introduced comprehensive changes that allow women to terminate a pregnancy up to 24 weeks along. Rule 3B of the act provides the following.

a) Survivors of sexual assault, rape, or incest.

b) Minors.

c) Changes in marital status during the ongoing pregnancy (such as widowhood and divorce).

d) Women with physical disabilities (major disabilities as defined by the Rights of Persons with

16.Medical Termination of Pregnancy Rules,2003, Sec 3
17. Medical Termination of Pregnancy Rules,2003, Sec 6
18. Medical Termination of Pregnancy Rules,2003, Sec7

Disability Act,2016)

e) Women with mental health conditions, including intellectual disabilities.

f) Foetal malformations that pose a significant risk of being incompatible with life or could result in serious physical or mental disabilities for the child upon birth.

g) Women experiencing pregnancy in humanitarian situations or during emergencies declared by the government.

Rule 3B of the Medical Termination of pregnancy Rules, 2003

Consequently, the current amendment has updated the term "mental retardation" to a more inclusive phrase, "women with intellectual disabilities." As a result, the category of mentally ill women now encompasses women with intellectual disabilities, allowing them to terminate a pregnancy up to 24 weeks of gestation.

Additionally, the 2021 Act introduced two new definitions in Section 2, specifically 'medical board' in section 2(aa) and 'termination of pregnancy' in clause 9(e). The former term denotes the committee or board established under section 3(2C), while the latter refers to the surgical or medical procedures employed to terminate pregnancy. A new provision was also included, mandating that registered medical practitioners keep confidential, the information of women undergoing an abortion, although exceptions apply under the law that allow the information to be shared with authorized individuals if necessary.

In September 2022, the Supreme Court allowed a petitioner to terminate her 22-week pregnancy in the case of **X v Principal Secretary**[19] the Court held that making distinctions in rights based solely on marital status is unconstitutional.

The judgement asserted that the choice to carry a pregnancy to term or to terminate it is fundamentally connected to a woman's right to bodily autonomy and her ability to determine her life's direction. It further recognized that an unwanted pregnancy can severely impact a woman's life, potentially disrupting her education, career, and mental health[20].

19.SLP(C)No12612 of 2022

20.Uncertainity of Abortion: A case comment on X v. Union of India, Law School Policy Review(NOV 27,2023)

A year after the ruling in X v Principal Secretary, this pro-rights movement encountered a significant obstacle in the case of **X v Union of India**[21], a 27-year-old married woman, who is also a mother of two, discovered her pregnancy at approximately 24 weeks due to lactational amenorrhea, which causes breastfeeding women not to menstruate. After an initial refusal at a healthcare facility, the petitioner quickly turned to the apex court to obtain necessary healthcare access. In a striking reversal of events within the Supreme Court, arguments regarding foetal viability and the rights of unborn children were prioritized over the reproductive autonomy of the petitioner.

Despite meeting the legal requirements related to mental health issues, her reproductive rights were evaluated against an eligibility checklist for termination beyond 24 weeks, ultimately deemed insufficient. The Court stated that she did not meet the protections laid out in Section 3(2B), which are designed for survivors of sexual assault, minors, widows or divorcees, disabled individuals, mentally ill persons, cases of foetal abnormalities, or pregnancies resulting from humanitarian crises. She also did not qualify for the protections provided in Section 5, which allows for termination in situations where it is critical to save a woman's life.

The Court's interpretation of mental illness as a valid reason for termination was ambiguous. Despite X's numerous submissions concerning her mental health, including postpartum depression and psychosis, suicidal tendencies, and risk of harm to herself and her children, the Court declined to allow termination on those grounds. Secondly, given that the Court dismissed the petitioner's concerns regarding suicide, the ruling raises the question of what exactly constitutes a threat to a woman's life[22].

The judgement implies that, to fully exercise reproductive autonomy, a woman must demonstrate the dangers of her situation and an absolute necessity for an abortion. Consequently, the Court effectively reverted its stance in X v Principal Secretary, which had previously affirmed a woman's role as the "ultimate decision-maker" regarding her reproductive choices.

21.AIRONLINE 2021DEL527
22.Abortion Law in India:*A step Backward after going Forward*, SUPREME COURT OBSERVER(NOV.27,2023)

Emphasizing a provider-centric approach, India had progressed with the 2021 amendment and the 2022 ruling, but this does not indicate a complete departure from the grounds-based and gestational limit frameworks. Despite the amendment, the MTP Act remains centered around providers and grants decision-making power to them rather than recognizing that abortion should be accessible at the request of pregnant individuals when needed.

CONCLUSION

The support of partners, families, and friends. The experience of fear, stigma, and genuine inability to access abortion services shapes the realities of women who seek abortion after the legal abortion is accessed.

Rather than offering a defence of free choice and autonomy, there remain barriers to access for women, including the criminalisation of abortion in some jurisdictions and the real or imagined stigma attached to abortion. The true test of legislative developments can be shown in how they translate into access, especially for these women, who have already been abandoned and/or neglected in the health care system or economically marginalised because of the need for abortion.

Although legally sanctioned, safe services are not feasible. National and state laws are re-forwarded with universal human rights, accessible and redressable systems and services, so that women can actually self-provide, or that others can truly embody, those actions. Universality for women, in many jurisdictions around the world, is in the legal and systemic approach also arbitrarily shaped by the plurality of jurisdictional jurisdictions from the we broader context whereby we would work to more autonomous and legal representation in systems that either prescribe or endorse health care practices derived from autonomous measures limiting specific provision characteristics for any forms of abortion services or acting for women seeking it. Hence the rigid gatekeeping of potential pathways to citizenship or rights to which women, like anyone else, have a right to and at the same time not define supplements or develops to self-survey's on certain actions that are co-created for other biological outcomes because women are born human or by paradigm itself is inherently an appropriate construct to provide a needs-based assumption for relevant service provision.