

A STUDY OF REPRODUCTIVE RIGHTS IN INDIA: FROM CRIMINALISATION TO CONSTITUTIONAL FREEDOM

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Abstract

Reproductive rights in India have undergone an extensive transformation, from being governed by a rigid colonial criminal framework under the Indian Penal Code (IPC) to becoming central to the constitutional identity of privacy, dignity, and bodily autonomy. This research examines the evolution of abortion law from criminalisation to conditional medicalisation under the Medical Termination of Pregnancy Act, 1971, and further to rights-based constitutional interpretation after landmark judicial decisions such as *Suchita Srivastava v. Chandigarh Administration* (2009), *K.S. Puttaswamy v. Union of India* (2017), and *X v. NCT of Delhi* (2022). The study integrates historical, doctrinal, medical, ethical, and socio-legal aspects of reproductive rights. It uses the transition from IPC provisions to the Bharatiya Nyaya Sanhita (BNS), 2023 to illustrate the shifting criminal law landscape. It incorporates contemporary data from the National Family Health Survey (NFHS-5), the Health Management Information System (HMIS), and the Sample Registration System (SRS), along with recent case law and amendments to the MTP Act (2021). Employing doctrinal and analytical methodology, the research identifies persisting shortcomings in legal access, medical infrastructure, and judicial inconsistencies. It concludes by proposing a rights-based reform model aligning statutory law with constitutional mandates to secure comprehensive reproductive justice for all women in India.

Keywords: reproductive rights, abortion law, constitutional freedom, MTP Act, Bharatiya Nyaya Sanhita, privacy, autonomy, women's rights

1. Introduction

Reproductive rights form a crucial component of constitutional liberty, gender justice, and human dignity in India. Historically, abortion has fluctuated between strict criminalisation and narrowly defined exceptions grounded in medical necessity. During the colonial period and continuing well into post-Independence India, termination of pregnancy was regulated as a criminal offence under the Indian Penal Code (IPC) and, now, under the Bharatiya Nyaya Sanhita (BNS), 2023. Neither the IPC nor the BNS conceptualises abortion as an aspect of personal autonomy; instead, the act is treated as an offence unless it falls within legally recognised exceptions.¹

The Medical Termination of Pregnancy (MTP) Act, 1971, marked a significant shift by creating statutory exceptions that enabled legal abortion under specific circumstances. Even so, the Act adopts a medicalised framework in which the ultimate power to authorise termination lies with the registered medical practitioner rather than the woman herself.² Although amendments in 2002 and 2021 sought to expand access, the law continues to impose gestational limits and procedural requirements that constrain reproductive autonomy.

Constitutional jurisprudence, however, has moved toward a rights-based understanding of reproductive choice. The Supreme Court's decisions in *Suchita Srivastava v. Chandigarh Administration* (2009), *Justice K.S. Puttaswamy v. Union of India* (2017), and *X v. NCT of Delhi* (2022) recognise reproductive decision-making as intrinsic to dignity, privacy, bodily integrity, and equality under Article 21.³ Consequently, abortion is increasingly viewed not merely as a medical concern but as a fundamental constitutional freedom.

Empirical evidence reveals continuing challenges. The National Family Health Survey–5 (NFHS-5) reports that nearly 27% of abortions occur at home, reflecting gaps in formal healthcare access.⁴

¹ Government of India. (2023). *Bharatiya Nyaya Sanhita, 2023*. Ministry of Law and Justice. Indian Penal Code, 1860.

² Sharma, R. (2014). Medicalisation and control in abortion regulation. *Indian Journal of Medical Ethics*, 11(2), 87–93.

³ *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

Justice K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

X v. NCT of Delhi, 2022 SCC OnLine SC 1321.

⁴ National Family Health Survey–5. (2021). *NFHS-5 (2019–21) National Report*. Ministry of Health and Family Welfare.

The Health Management Information System (HMIS) recorded approximately 8.93 lakh abortions in 2024–25, a dramatic increase over five years, although this figure represents only a small portion of the estimated 15.6 million annual abortions reported by the Guttmacher Institute.⁵ Unsafe abortions still contribute significantly to maternal mortality, accounting for around 8% of maternal deaths in India.⁶

This study critically traces India's shift from criminalisation to conditional medicalisation to the contemporary emergence of reproductive freedom as a constitutional right. It undertakes a doctrinal, analytical, and empirical assessment of statutory frameworks, judicial interventions, medical realities, ethical debates, and the transition from IPC to BNS. Ultimately, it argues for harmonising statutory law with constitutional and international human rights obligations to achieve meaningful reproductive justice.

2. Research Problem

Despite substantial legal developments, women in India continue to encounter numerous obstacles in accessing safe and legal abortion services. These challenges stem from restrictive statutory provisions, uneven healthcare infrastructure, procedural delays (including those caused by Medical Boards), entrenched social stigma, overlapping criminal provisions under the BNS, inconsistent judicial decisions, and limited public awareness of reproductive rights.⁷ Although the Constitution recognises reproductive choice as a component of personal liberty, the current statutory regime does not fully implement this right. The study therefore seeks to identify and analyse the gaps preventing the realisation of a rights-based framework for reproductive freedom.

3. Objectives of the Study

- To examine the conceptual, historical, and ethical foundations of abortion and reproductive rights.
- To analyse the legal framework governing abortion under the IPC, BNS, and MTP Act.

⁵ Ministry of Health and Family Welfare. (2024). *Health Management Information System (HMIS) 2024–25*.

Guttmacher Institute. (2020). *Unintended pregnancy and abortion in India*. Guttmacher Institute.

⁶ World Health Organization. (2022). *Safe abortion: Technical and policy guidance for health systems* (3rd ed.).

⁷ Wagle, S. (2021). The MTP Amendment 2021: Expanding or restricting rights? *Indian Journal of Gender Studies*, 28(1), 96–118.

- To evaluate landmark judicial decisions and their contribution to reproductive autonomy in India.
- To critically assess the strengths and limitations of the MTP Act and its subsequent amendments.
- To analyse pro-choice and pro-life debates within India's socio-legal context.

4 Research Methodology

This research relies on doctrinal and analytical methods supported by empirical data.

Primary Sources include:

- The Medical Termination of Pregnancy Act, 1971 & 2021 amendments
- Bharatiya Nyaya Sanhita (2023) and the Indian Penal Code (1860)
- The Constitution of India
- Supreme Court and High Court judgments
- National Family Health Survey, Sample Registration System, and HMIS data

Secondary Sources include:

- Peer-reviewed journals and academic books
- Reports by WHO, UNFPA, and the Guttmacher Institute
- Law Commission Reports and parliamentary debates on MTP amendments

5. Conceptual Foundations of Abortion and Reproductive Rights

The term “abortion” originates from the Latin *aboriri*, meaning “to miscarry” or “to detach prematurely.” Traditionally, abortion denotes the termination of pregnancy through the removal or expulsion of the embryo or foetus, resulting in or causing its death. Medically, the definition is tied to viability, with abortion generally referring to termination before the foetus is capable of surviving outside the uterus typically before 20–24 weeks or before reaching a weight of 500

grams.⁸ Classification varies depending on whether termination occurs before placental formation, during early gestation, or later, when miscarriage or premature delivery may be distinguished

5.1 Medical and Legal Definitions of Abortion

From a medical standpoint, abortion refers to the termination of pregnancy before foetal viability usually before 20–24 weeks, or in accordance with WHO criteria, before the foetus weighs 500 grams or reaches 22 weeks of gestation.⁹ Medical literature distinguishes between early, second-trimester, and late-term abortions depending on gestational age.

Legally, abortion is defined in relation to intent, method, gestation, medical justification, and consent. Indian law embeds these criteria within statutory grounds and procedural requirements under the MTP Act.

5.2 Types of Abortion

1. **Natural Abortion:** Occurs due to biological or physiological causes beyond the woman's control.
2. **Accidental Abortion:** Results from unintentional external trauma.
3. **Spontaneous Abortion (Miscarriage):** Caused by pathological factors such as hormonal imbalance or genetic abnormalities.
4. **Induced Abortion:** Deliberate medical intervention to terminate pregnancy. It may be therapeutic (protecting maternal life or health), foetal-indication-based (preventing birth of a severely impaired child), or elective. Indian law recognises only medically and legally justified induced abortions.

6. Comparative Religious Perspectives

Religious traditions profoundly shape moral attitudes toward abortion. In India's pluralistic context, legal regulation must coexist with diverse theological views.

⁸ World Health Organization. (2022). *Safe abortion: Technical and policy guidance for health systems* (3rd ed.). WHO Press.

⁹ World Health Organization. (2022). *Global Abortion Policies Database*. WHO.

- **Hinduism:** Classical texts describe abortion (*garbhahatya/bhrunahatya*) as a grave sin, equating it with *brahmahatya*. Hindu embryological thought often asserts that the soul enters the foetus at conception, rendering abortion morally impermissible.¹⁰
- **Buddhism:** Generally condemns deliberate termination as a violation of *ahimsa*. Life is believed to begin at conception when consciousness (*vijnana*) arises. The Vinaya prohibits abortion by monastics.¹¹
- **Islam:** Jurisprudence focuses on “ensoulment,” widely believed to occur at 120 days. Abortion before ensoulment may be permitted for legitimate reasons (rape, severe foetal impairment, maternal health), but after ensoulment it is largely prohibited unless necessary to save the mother’s life.¹²
- **Christianity:** Roman Catholic doctrine opposes abortion on the ground that life begins at conception. Protestant denominations adopt more contextual approaches, permitting termination under exceptional circumstances such as rape, serious foetal anomalies, or risk to maternal health.¹³

India’s secular legal framework navigates these divergences by giving primacy to the woman’s health, life, and constitutional rights rather than theological definitions of when life begins.

7. Human Rights and Reproductive Autonomy

International human rights instruments have shaped modern understandings of reproductive rights.

- The International Conference on Population and Development (ICPD, 1994) recognised reproductive rights as central to human development.¹⁴
- CEDAW obligates states to eliminate discrimination in healthcare and ensure access to reproductive services.¹⁵

¹⁰ Sharma, A. (2004). *Hindu bioethics for the twenty-first century*. State University of New York Press.

¹¹ Harper, M. (2014). *Buddhism and reproductive ethics*. Oxford University Press.

¹² Khan, M. (2012). Islamic bioethics: Implications for reproductive rights. *Journal of Islamic Law and Society*, 19(2), 123–145.

¹³ Sheldon, S., & Thomson, M. (2022). Christian perspectives on abortion in modern legal systems. *International Journal of Law, Policy and the Family*, 36(2), 145–163.

¹⁴ United Nations. (1994). *Programme of Action of the International Conference on Population and Development*.

¹⁵ Committee on the Elimination of Discrimination against Women. (1999). *General Recommendation No. 24: Women and Health*. United Nations.

- The UN Human Rights Committee has held that forcing a woman to continue a pregnancy may violate the rights to privacy and freedom from cruel, inhuman, or degrading treatment.¹⁶

Indian constitutional jurisprudence reflects these global norms, interpreting reproductive autonomy as an essential aspect of Article 21.

8. Historical Development of Abortion Law in India

The regulation of abortion in India cannot be understood without reference to its global and colonial roots. Early nineteenth-century English law, particularly the 1803 Lord Ellenborough Act, criminalised abortion as a felony, and this legal philosophy influenced subsequent codifications throughout the British Empire.¹⁷ India inherited this restrictive approach through the Indian Penal Code (IPC), 1860, which treated all non-therapeutic abortions as punishable offences.

Globally, the shift toward liberalisation of abortion laws is often attributed to the landmark U.S. Supreme Court decision in *Roe v. Wade* (1973), which recognised a constitutional right to privacy encompassing reproductive choice.¹⁸ Although this judgment has since been overturned in *Dobbs v. Jackson Women's Health Organization* (2022), its earlier impact significantly shaped abortion law reforms worldwide. India's Medical Termination of Pregnancy Act, however, predated *Roe* by two years though its underlying rationale stemmed not from a rights-based approach but from public health and demographic concerns.¹⁹

Before the enactment of the MTP Act in 1971, abortion in India was governed exclusively by the IPC, which criminalised both attempting to terminate one's own pregnancy and assisting another in doing so.²⁰ Recognising high maternal mortality from unsafe abortions and the growing need for population control, the Indian government appointed the Shantilal Shah Committee in 1964 to

¹⁶ United Nations Human Rights Committee. (2016). *General Comment No. 36: Article 6 – Right to Life*.

¹⁷ Dyer, C. (2003). Lord Ellenborough's Act of 1803: Historical implications for abortion law. *British Journal of Legal History*, 45(2), 112–130.

¹⁸ *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁹ Basu, A. (2017). Abortion law reform and public health in India. *Health and Human Rights Journal*, 19(1), 85–98.

²⁰ Indian Penal Code, 1860.

examine the issue. Its 1966 report recommended liberalisation of abortion laws primarily to protect women from unsafe procedures and reduce unwanted fertility.²¹

Notably, the committee's justification relied heavily on utilitarian arguments. Some members as reflected in the comments of Dr. H.N. Shivapuri emphasised national interest over individual choice, suggesting even sterilisation for those deemed "unfit" for parenthood.²² These views reveal that early reforms were aimed not at safeguarding women's autonomy but at protecting medical practitioners from criminal liability and advancing public health goals.

The MTP Act, 1971, based on the committee's recommendations, created conditional exceptions to criminal liability. Yet its structure remained paternalistic, positioning the doctor not the woman as the central decision-maker.

9. The Era of Criminalization: Penal Provisions and the Shift to the Bharatiya Nyaya Sanhita (BNS)

Under the IPC, termination of pregnancy outside legally permitted grounds was criminalised as an offence against society, premised on protecting "potential life."²³ These provisions have largely been retained in the Bharatiya Nyaya Sanhita (BNS), 2023, with renumbered sections but similar substance.

The relevant sections compare as follows:

Table 1: Comparison of Criminal Provisions: IPC (1860) to BNS (2023)

²¹ Shantilal Shah Committee Report. (1966). *Report of the Committee to Study the Question of Legalisation of Abortion*. Government of India, Ministry of Health & Family Planning.

²² Ibid

²³ Ibid

Offence Description	IPC (1860) Section	BNS (2023) Section	Punishment
Voluntarily causing miscarriage (With consent)	IPC 312	BNS 88	Imprisonment (3 to 7 years) and/or fine
Causing miscarriage without woman's consent	IPC 313	BNS 89	Life imprisonment or 10 years and fine
Death caused by act done to cause miscarriage	IPC 314	BNS 90	Up to Life imprisonment
Act done with intent to prevent child being born alive or to cause it to die after birth	IPC 315	BNS 91	Up to 10 years and fine (Foeticide)
Causing death of quick unborn child by act amounting to culpable homicide	IPC 316	BNS 92	Up to 10 years and fine

The continuity of these provisions reflects the state's enduring interest in regulating termination, with criminal liability attached unless the procedure is covered by the MTP Act.²⁴ The BNS recodification has modernised language but has not decriminalised abortion; rather, it preserves the offence outside narrow statutory exceptions.

10. The Medical Termination of Pregnancy Act (MTP), 1971

²⁴ Government of India. (2023). *Bharatiya Nyaya Sanhita, Comparative Table of Sections*. Legislative Department.

10.1 Objectives and Foundational Structure

The MTP Act's preamble emphasises providing termination “in certain cases” by registered medical practitioners, highlighting its limited and exception-based character.²⁵ Section 3(1) shields registered medical practitioners from criminal prosecution if the termination complies with the Act, confirming that its purpose is primarily protective of providers.

Originally, the Act prescribed:

- **Up to 12 weeks** — opinion of **one** registered medical practitioner
- **12 to 20 weeks** — opinion of **two** registered medical practitioners
- Termination only at **approved facilities**, mainly government hospitals or certified private centres²⁶

10.2 Grounds for Termination (Section 3(2))

Termination was permissible if continuing the pregnancy posed:

- A risk to the woman's life
- Grave injury to her physical or mental health
- A substantial risk of serious foetal abnormality

Two **Explanations** broadened “mental health” considerations:

- Pregnancies resulting from **rape**
- **Contraceptive failure**, but **only for married women** and their husbands²⁷

10.3 Critique of the Provider-Centric Structure

The 1971 Act exhibited several limitations:

²⁵ Medical Termination of Pregnancy Act, 1971, No. 34, Acts of Parliament, 1971 (India).

²⁶ Ministry of Health and Family Welfare. (1972). *MTP Rules and Regulations*. Government of India.

²⁷ Medical Termination of Pregnancy Act, 1971, No. 34, Acts of Parliament, 1971 (India).
(*Explanation II*: “married woman or her husband”)

1. **Discrimination against unmarried women:** By restricting the contraceptive failure clause to married women, the law excluded unmarried women from obtaining abortions on mental health grounds.²⁸
2. **Medical paternalism:** Undue power was vested in doctors, who acted as gatekeepers. Ambiguous terms like “grave injury” left women dependent on provider discretion rather than exercising autonomous choice.²⁹
3. **Facility bias:** Government hospitals were automatically deemed approved centres, whereas private facilities faced stringent certification, leading to uneven service quality.³⁰
4. **Outdated gestational limits:** Severe foetal abnormalities are often detected only at 20–24 weeks. The 20-week cap forced many women into urgent litigation. Courts between 2016–2019 saw nearly 200 writ petitions seeking permission for late-term abortions revealing systemic inadequacies.³¹
5. **Privacy concerns:** Mandatory documentation and reporting created risks of privacy violations, particularly for vulnerable groups in public health facilities.³²
6. **Civil law conflicts:** In *Sushil Kumar v. Usha*, a woman who legally terminated her pregnancy under the MTP Act was later accused of “cruelty” in divorce proceedings highlighting inconsistencies between MTP rights and civil law remedies.³³

10.4. Legal Evolution through Amendments: 2002 and 2021

10.4.1 MTP Amendment Act, 2002

The 2002 amendment sought procedural improvements rather than substantive reform. Key changes included:

²⁸ Wagle, S. (2021). The MTP (Amendment) Act, 2021: Expanding rights or reinforcing control? *Indian Journal of Gender Studies*, 28(1), 96–118.

²⁹ Ghosh, S. (2019). Provider-centric barriers restricting abortion access. *Journal of Reproductive Health*, 23(4), 221–232.

³⁰ Radhakrishnan, V. (2003). Amendments to the MTP Act: Legal and policy implications. *Indian Journal of Law and Society*, 2(1), 45–58.

³¹ Pradhan, M., & Singh, A. (2021). Structural barriers to safe abortion in India. *Indian Journal of Public Health*, 65(3), 215–221.

³² Kapoor, A. (2018). Privacy, documentation, and abortion law in India. *Economic and Political Weekly*, 53(16), 33–39.

³³ *Sushil Kumar v. Usha*, AIR 1994 P&H 1.

- Creation of district-level committees for approving private abortion facilities
- Enhanced penalties for illegal terminations
- Replacement of outdated terms (e.g., “lunatic” → “mentally ill person”) to align with modern psychiatric understanding³⁴

However, it did not address discriminatory provisions or gestational limits.

10.4.2 MTP Amendment Act, 2021: A Significant Rights-Oriented Shift

The 2021 amendment represents the most substantial reform since 1971, motivated by judicial developments and commitments under the Sustainable Development Goals (SDGs).

Key features:

a) Reduced Medical Gatekeeping + Extended Gestation Limits

- **Up to 20 weeks** — only **one** registered medical practitioner’s opinion required
- **20 to 24 weeks** — two practitioners’ opinions required, but **only for specific categories**:
 - rape survivors
 - minors
 - women with disabilities
 - widowed/divorced women
 - women with major foetal abnormalities
 - other vulnerable groups notified by the Government³⁵

b) Inclusion of Unmarried Women

The phrase “married woman or her husband” was replaced with “any woman or her partner,” extending protection to unmarried women seeking termination due to contraceptive failure.³⁶

³⁴ Medical Termination of Pregnancy (Amendment) Act, 2002, No. 64, Acts of Parliament, 2002 (India).

³⁵ Medical Termination of Pregnancy (Amendment) Act, 2021, No. 8, Acts of Parliament, 2021 (India).

³⁶ Ibid

c) Removal of Upper Limit for Foetal Abnormalities

In cases where a Medical Board confirms substantial foetal abnormalities, the 24-week limit does not apply.³⁷

d) Strengthened Confidentiality

Healthcare providers are prohibited from revealing a woman's identity. Breach of confidentiality is punishable with imprisonment or fine reflecting *Puttaswamy*'s privacy mandate.³⁸

11. Reproductive Rights as Constitutional Freedom

While the MTP Act historically functioned as a public health statute and a legal shield for medical practitioners, constitutional interpretation expanded its meaning. Over time, the judiciary progressively recognised a woman's decision regarding pregnancy as falling within the ambit of the fundamental rights to dignity, autonomy, privacy, and bodily integrity under Article 21.

This doctrinal shift repositioned the MTP Act not merely as a statutory exception but as the "procedure established by law" enabling women to exercise a constitutionally protected freedom. After 2009, courts began treating reproductive choice as intrinsic to Article 21, requiring the State to ensure access to lawful abortion and to avoid imposing unnecessary burdens on pregnant women.

11.1 Expansion of Article 21

Article 21 guarantees that no person shall be deprived of life or personal liberty except according to procedure established by law. Indian constitutional jurisprudence has consistently adopted an expansive interpretation, recognising various facets of personal liberty such as bodily integrity, mental well-being, privacy, and decisional autonomy.

³⁷ Supreme Court of India. (2017). *Meera Santosh Pal v. Union of India*, (2017) 3 SCC 462

³⁸ Justice K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

Reproductive autonomy has now become an internal component of this framework. Judicial reasoning holds that compelling a woman to carry an unwanted pregnancy amounts to a violation of her dignity and control over her own body.

12. Landmark Judgments Defining Reproductive Autonomy

12.1 *Suchita Srivastava v. Chandigarh Administration* (2009)

This landmark decision firmly established reproductive autonomy as a fundamental right. The Court held that a woman has the exclusive right to make reproductive choices, including whether to conceive, carry a pregnancy to term, or terminate it.³⁹

Key constitutional principles from *Suchita*:

- **Bodily integrity:** The State cannot intrude upon a woman's control over her body without compelling justification.
- **Decisional autonomy:** Only the woman *not* her family, guardians, or medical authorities has the ultimate authority over pregnancy decisions.
- **Equality and non-discrimination:** Using eugenic or paternalistic rationales to override a woman's choice violates Article 14.

The Court also warned against misusing disability or fetal impairment as grounds to enforce compulsory termination, calling such practices anti-democratic.

12.2 Justice *K.S. Puttaswamy v. Union of India* (2017)

Although primarily known for recognising the fundamental right to privacy, the *Puttaswamy* judgment explicitly affirmed reproductive autonomy as an essential element of privacy.⁴⁰

The Court held:

- Privacy includes the freedom to make intimate personal decisions.

³⁹ *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

⁴⁰ *Justice K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1.

- Reproductive decisions fall squarely within this domain.
- The State must avoid arbitrary restrictions on a woman's ability to terminate a pregnancy.

This decision provided the strongest constitutional protection for abortion rights, ensuring that the woman not the State or society is the ultimate decision-maker.

12.3 *X v. NCT of Delhi* (2022)

This judgment is arguably the most progressive articulation of reproductive freedom in Indian jurisprudence. The Court held that **unmarried women are entitled to termination up to 24 weeks**, invalidating Rule 3B(c) as discriminatory.⁴¹

Key contributions:

- Recognised that the term “woman” includes **unmarried women, single women, and persons capable of pregnancy**, including transgender persons.
- Affirmed that reproductive autonomy is linked to equality, dignity, and bodily integrity.
- Held that distinctions based on marital status violate Articles 14 and 15.

This judgment effectively constitutionalised abortion, emphasising that a woman's autonomy cannot be conditional on her marital status.

13. Government Data: Reality Behind the Law

Despite progressive legal developments, real-world data reveals persistent barriers.

13.1 HMIS (2020–2025): Increase in Recorded Abortions

The Health Management Information System (HMIS) reports a steady rise in recorded abortions:

Year	Reported MTPs	Trend
2020–21	5.34 lakh	—

⁴¹ X v. NCT of Delhi, 2022 SCC OnLine SC 1321.

Year	Reported MTPs	Trend
2021–22	5.93 lakh	↑
2022–23	7.11 lakh	↑
2023–24	8.01 lakh	↑
2024–25	8.93 lakh	↑ 67% over five years

Implication: demand for abortion care is increasing significantly.⁴²

13.2 Guttmacher Institute Estimate (2018)

According to Guttmacher:

- India experiences **15.6 million abortions annually**.
- Only **22% (3.4 million)** occur in formal health facilities.
- **73%** are medical abortions conducted outside facilities.
- The remainder involve unsafe or traditional methods.⁴³

This indicates that official HMIS data captures only a fraction of actual abortions.

13.3 NFHS-5 (2019–21)

NFHS-5 highlights behavioural and access-related issues:

- **27%** of abortions occur at home.
- **53%** occur in private or government facilities.
- **37%** felt it was “not necessary” to visit a facility.
- **18%** reported cost or time as barriers.
- **72.6%** do not use contraception post-abortion.⁴⁴

⁴² Ministry of Health and Family Welfare. (2024). *Health Management Information System (HMIS): Abortion Statistics 2020–2025*. Government of India.

⁴³ Singh, S., Remez, L., & Nanda, P. (2018). *Abortion and unintended pregnancy in India*. Guttmacher Institute.

⁴⁴ National Family Health Survey–5. (2021). *NFHS-5 National Report (2019–2021)*. Ministry of Health and Family Welfare.

Implication: Unsafe practices persist due to limited awareness and access barriers.

13.4 Maternal Mortality: SRS & MoHFW (2023)

- Maternal Mortality Ratio: **97 per 100,000 live births.**
- Unsafe abortions contribute to **8% of maternal deaths.**⁴⁵

Implication: Improving access to safe abortion is critical for reducing maternal mortality.

14. Balancing Rights: Woman vs. Unborn Child

Indian law does not recognise the unborn foetus as a legal “person” entitled to rights under Article 21. This position aligns with international jurisprudence and English common law, such as *De Martell v. Merton and Sutton HA*, which holds that legal personhood begins at birth.⁴⁶

Scientific evidence also supports this distinction: the foetus is unlikely to feel pain before approximately 26 weeks, and viability outside the womb generally arises only in the third trimester.⁴⁷

Therefore:

- **Pre-viability:** Woman’s autonomy prevails.
- **Post-viability:** State’s interest in protecting potential life increases.

This framework explains why Indian law permits extensive rights-based access up to 24 weeks but requires stronger justification thereafter.

15. Philosophical and Moral Crossroads: Pro-Choice vs. Pro-Life

15.1 Pro-Choice Perspective

⁴⁵ Registrar General of India. (2023). *Sample Registration System Statistical Report 2023*. Office of the Registrar General.

⁴⁶ *De Martell v. Merton and Sutton Health Authority*, [1993] QB 204 (Court of Appeal, England).

⁴⁷ Royal College of Obstetricians and Gynaecologists. (2010). *Fetal Awareness: Review of Research and Recommendations*. RCOG Press.

The pro-choice view centres on **bodily autonomy**, arguing that decisions about pregnancy must rest with the woman.

Key arguments:

- Foetus lacks independent viability or interests before the third trimester.
- Restrictive laws push women toward unsafe abortions.
- Compulsory pregnancy, especially in cases of rape or risk to mental health, constitutes a violation of dignity.
- Autonomy over reproduction is essential for equality and self-determination.

This perspective aligns with the constitutional emphasis on privacy and bodily integrity.

15.2 Pro-Life Perspective

The pro-life position asserts that life begins at conception and that the foetus deserves moral and legal protection.

Common arguments:

- The foetus is biologically distinct from the mother.
- Termination constitutes the taking of an innocent human life.
- Accepting abortion in cases of disability risks promoting discriminatory attitudes.
- International laws, such as the Missouri statute upheld in *Webster v. Reproductive Health Services*, recognise state interest in unborn life from conception.⁴⁸

India's legal framework navigates both positions through a secular, medico-legal standard prioritising the health and rights of the living woman.

16. Proposed Reforms for Abortion Law in India

This study proposes several reforms to strengthen reproductive rights:

⁴⁸ *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989).

1. **Complete Decriminalisation:** Treat abortion as a health service rather than a criminal offence, except in cases of coercive or unsafe procedures.
2. **Rights-Centric Model:** Centre decision-making on the woman; limit the doctor's role to medical assessment.
3. **Abortion on Request:** Permit on-request termination up to 12–16 weeks, following global best practices.
4. **Universal Public Access:** Expand training, allow nurse practitioners to provide early medical abortion, increase facility certification, and ensure availability of medical abortion pills.
5. **Reform Medical Board System:** Introduce strict timelines (e.g., 72 hours) and allow virtual evaluations.
6. **Inclusive Definitions:** Explicitly include transgender and non-binary persons capable of pregnancy.
7. **Supportive Services:** Provide optional counselling and post-abortion contraception without coercion.
8. **Civil Law Harmonisation:** Ensure exercising MTP rights does not negatively affect matrimonial or civil disputes.

17. Conclusion

The evolution of reproductive rights in India reflects a gradual yet significant shift from absolute criminalisation, to conditional medicalisation, to the current recognition of abortion as a qualified constitutional freedom under Article 21.

Initially, abortion was strictly criminalised under the IPC, reflecting colonial attitudes toward foetal protection over women's autonomy. The MTP Act, 1971 introduced medical exceptions but did not centre women's rights. Constitutional jurisprudence, especially after 2009, reframed reproductive choice as a matter of dignity, privacy, and bodily integrity.

The MTP (Amendment) Act, 2021 marked a major legislative step by expanding access, extending gestational limits, recognising unmarried women, and strengthening privacy. However, the statutory framework still positions doctors as gatekeepers and retains criminal penalties under BNS.

A complete transition toward reproductive justice will require aligning statutory law with constitutional guarantees and global human rights standards. India must move from a system where abortion is a medical privilege to one where it is recognised as a fundamental component of women's autonomy and equality.

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