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Beyond 24 Weeks: Should India adopt a 'Fetal Viability' Standard Like the US Roe Framework?

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ABSTRACT

This paper analyzes the various bioethical and legal issues present during late-term abortions in India, adopting the position that the U.S. pre-Dobbs Roe v. Wade standard of "fetal viability" should be implemented in that country. In India, the Medical Termination of Pregnancy (MTP) Act was amended in 2021, allowing abortions up to 24 weeks under very prescriptive circumstances —but with restrictive gestational limits that do not take into consideration advances in neonatal care nor the nuanced realities of women's reproductive autonomy. Based on the comparative analysis of the abortion laws in US, UK, and Canada with qualitative insights from Indian health care providers and legal experts, Lastly this paper reveals how fixed gestational limits bring many challenges as they include diagnostic delays, judicial bypass requirement, socioeconomic disparities in access to safe abortion.

The study argues India's existing framework fails to strike an appropriate balance between fetal viability and women's rights, often driving vulnerable groups to unsafe procedures or at the mercy of prolonged court cases. It suggests a revised, rights-based model that includes viability assessments or UK-style medical panels for post-viability cases, along with a focus on protections such as anti-discrimination language, provider training, and equitable access to health care. The paper highlights the need to address these issues in order to move towards a more compassionate abortion policy that is in line with contemporary medical practices and international human rights standards, and ultimately, one that values women's autonomy and well-being.

Keywords*: Reproductive rights, Abortion laws, Medical Termination of Pregnancy Act, comparative legal analysis.*

I. INTRODUCTION

The anguish of Kavya, a 26-year-old woman, echoes the complex ethical and legal dilemmas surrounding late-term abortions in India. In late 2022, Kavya sought permission to terminate

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her 33-week pregnancy after ultrasound scans revealed a cerebral abnormality in the fetus. Though the medical board deemed the fetus "compatible with life," the High Court of Delhi, recognizing the paramount importance of the mother's autonomy and mental health, ultimately permitted the abortion.[3] Kavya's case throws light on the urgent need to re-evaluate India's abortion laws, particularly the gestational limits, in light of evolving medical realities and a woman's fundamental right to choose.

India's Medical Termination of Pregnancy (MTP) Act of 1971, significantly amended in 2021[4], permits abortion up to 24 weeks of gestation for specific categories, including cases of fetal anomalies, rape survivors, and women with disabilities.[5] This amendment extended the previous limit of 20 weeks, largely due to the activism of figures like gynecologist Nikhil Datar, who fought legal battles to expand women's reproductive rights.[6] Globally, the debate on abortion has been significantly shaped by the US Supreme Court's landmark 1973 Roe v. Wade decision[7], which, before being overturned in 2022, established a woman's right to an abortion based on a trimester framework, with fetal "viability" as a key determinant in the later stages of pregnancy. This "viability doctrine" influenced abortion laws worldwide, setting a precedent for balancing women's rights with the potential for fetal survival.

However, advancements in neonatal care are rapidly blurring the lines of fetal viability. Neonates born at increasingly early gestational ages, some as young as 22 weeks, now have a chance of survival thanks to intensive medical interventions.[8] A recent study demonstrated that standardized care significantly increased the survival rate of 22-week-old neonates from zero to 25%.[9] This progress challenges the rigidity of fixed gestational limits, potentially forcing women with late-diagnosed fetal anomalies or other compelling reasons to seek court approvals for abortions beyond the stipulated timeframe, or worse, resort to unsafe, illegal procedures.[10]

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[3] Mrs. X v. Govt. of NCT of Delhi & Anr., W.P.(C) 12529/2022 (Delhi High Ct. Dec. 6, 2022), https://www.barandbench.com/news/litigation/mothers-choice-is-ultimate-delhi-high-court-allows-33-week-pregnant-woman-to-terminate-pregnancy.

[4]The Medical Termination of Pregnancy (Amendment) Act, 2021, No. 8, Acts of Parliament, 2021 (India), https://prsindia.org/files/bills_acts/acts_parliament/2021/Medical%20Termination%20of%20Pregnancy%20Amendment%20Act%202021.pdf.

[5] Nidhi Suresh, India: Late-term abortion ruling highlights mothers' rights, DW (Dec. 12, 2022), https://www.dw.com/en/india-late-term-abortion-ruling-highlights-mothers-rights/a-64068504.

[6] Shivani Gupta, Meet the Doctor Who Fought An Archaic Law for 14 Long Years to Raise The Abortion Limit, The Better India (Apr. 1, 2024), https://thebetterindia.com/346145/termination-of-pregnancy-act-india-dr-nikhil-datar-case-legal-battle-to-raise-abortion-limit/.

[7] Roe v. Wade, 410 U.S. 113 (1973).

[8] Erika M. Edwards et al., Survival of Infants Born at 22 to 25 Weeks' Gestation Receiving Care in the NICU: 2020–2022, 154 Pediatrics e2024065963 (2024).

[9] Lucy K. Smith et al., Effect of National Guidance on Survival for Babies Born at 22 Weeks' Gestation in England and Wales: Population Based Cohort Study, 2 BMJ Med. e000579 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10649719/.

[10] Rebecca J. Cook & Bernard M. Dickens, *Abortion Laws in Commonwealth Countries*, World Health

Approximately 800,000 unsafe abortions occur annually in India, highlighting the dire consequences of restricted access.[11]

This research paper aims to explore whether a "fetal viability" standard, similar to the pre-Dobbs Roe v. Wade framework, could offer a more nuanced and ethically sound approach to abortion regulation in India. The central research questions guiding this inquiry are:

1. Can a viability-based standard effectively replace fixed gestational limits in India's abortion laws, reflecting advances in neonatal care and respecting women's autonomy?
2. Would implementing a viability standard undermine women's reproductive rights or, on the other hand, enhance equity in healthcare and access to safe abortion services for those in tragic situations?

To answer these questions, the research will adopt a comparative legal methodology, analysing abortion laws and practices across the United States, United Kingdom and Canada. These jurisdictions have different approaches to regulating abortion, and insight into what the implications of a viability standard might be. In addition, qualitative data will be included in this research, derived from interviews with gynecologists, lawyers, and women's rights activists within India. These will be supplemented by case laws that will provide insights into the practical, ethical and legal challenges of late-term abortions and the potential consequences of a movement towards a viability framework.

This is not intended to be a broad review of the literature, but rather we hope to provide original insights and analysis on a complicated and rapidly changing topic. Enhancing international legal awareness and stakeholder engagement, this research aims to play a role in shaping a more nuanced understanding of abortion rights in India, one that respects and understands contemporary concerns of fetal viability alongside the necessity of women's autonomy.

II. THE SCIENCE OF VIABILITY

Fetal viability, or the stage of fetal development at which a fetus may be able to live outside a woman's body, is a key aspect of legal and ethical discussions of abortion. But viability is not a line; it is a moving target influenced by medical innovation and disparate access to medical care. This chapter would reflect on the science behind the term viability and fetal viability in particular, the medical definition of viability, technological advances available at diagnostic level and the role of neonatal intensive care unit (NICU) followed by the practical aspects of

Organization (1979), https://iris.who.int/handle/10665/40078.

[11] id.

neonatal care of the newborns in neonatal units in India.

(A) Medical Definition of Viability

Medically, viability is not a precise moment but rather a range of gestational ages associated with increasing probabilities of survival. While there is no universally agreed-upon threshold, two gestational ages are often cited: 22 weeks, where survival rates are around 5%, and 28 weeks, where survival rates climb to approximately 90%.[12] These figures represent averages, and individual outcomes can vary significantly based on factors such as birth weight, sex, and the presence of congenital anomalies.

The survival rates at these gestational ages are directly linked to the development of the fetal lungs. Before 22 weeks, the lungs lack sufficient surfactant, a substance that prevents the air sacs from collapsing, making independent breathing extremely difficult. As gestational age increases, surfactant production rises, improving the chances of respiratory function.[13]

Advances in NICU technology have been essential to expanding the limits of viability. The survival rates of premature infants have been drastically improved through advances in mechanical ventilation, surfactant replacement therapy, and nutritional support. For example, the use of less aggressive types of mechanical ventilation has decreased the risk of lung injury, a common complication of prematurity. In a similar way, advanced ways of feeding nutrition through intravenous delivery have made it possible for extremely premature babies to be given the calories and nutrients they need to grow and develop.[14] As NICU technology continues to improve, the gestational age at which survival is possible will likely continue to decrease, further complicating the legal and ethical let-outs that surround fetal viability.

(B) India's Neonatal Realities

NICU technology, while providing hope for premature infants, is not universally available, especially in India. Neonatal mortality is a critical clinical challenge in India, with India being home to most of the world's neonates and challenges such as regional imbalances in access to neonatal intensive care units (NICUs), a shortage of trained personnel, and high costs of care. Such realities need to be weighed against the ethics and feasibility of adopting a fetal viability standard akin to those enshrined in the US Roe framework.

There are challenges, most notably the urban-rural divide. Due to the availability of

[12] Irene Guat Sim Cheah, Economic Assessment of Neonatal Intensive Care, 8 Transl. Pediatrics 246 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6675687/pdf/tp-08-03-246.pdf

[13] Id.

[14] Id.

comparatively limited health services, like healthcare facilities, inadequate infrastructure and shortage of trained medical paramedics, the neonatal mortality rate is much higher in rural areas of India as compared to that of urban areas. According to the recent cross-sectional study by Yonemoto et al., analysing the NFHS-5 data between 2019 and 21, 18.24% of the total babies in India were low birth weight (less than 2500g), which was more prevalent in rural (18.58%) than in urban areas (17.36%).[15] The Staff Inspection Unit SIU(N) Norms recommend : 1:2 nurse to neonates in NICUs however due to structural barriers, nurse-patient ratio can reach to 1:25 in rural public hospitals.[16] This difference in resources affects the survival rates for premature infants.

The cost burden of extreme preemie care is another significant concern. In India, the cost of treating an extremely premature infant can range from ₹1 to 2 crore per child.[17] While the India National Action Plan (INAP) has allocated funds to establish Special Newborn Care Units (SCNUs), the estimated amount to cover the costs of all SCNUs is INR40 billion (almost $3 million), which would be only 0.8% of the Indian national health expenditure. A study of neonatal admissions to an Indian tertiary referral teaching hospital found that the cost per hospital admission was $4,950 for 500–999 gm birth weight, and costs borne by families ranged from $520 to $4,500 per infant from 500–999 gm birth weight. Given the limited resources and high poverty rates in many parts of India, the cost of NICU care can be prohibitive for many families.[18]

Furthermore, LBW was significantly higher among Hindus (17.93%), Schedule Caste group (18.74%), pregnancies delivered at home (20.83%), and poor wealth index households (21.01%) in urban areas. In rural areas too, application of RLHF results in higher LBW observed amongst other religious, Schedule castes (19.79%), home births (21.68%), and poor wealth index households (20.18%).[19] These statistics illustrates the dynamic interdependencies of sociodemographic factors leading to poor neonatal outcomes in the country.

We cannot shun the reality of neonatal care in India, even as the science of viability advances further. Any attempt to introduce a fetal viability standard needs to be done in light of the vast differences in access to NICU technology across regions of the world, the scarcity of trained

[15] Ramendra Nath Kundu et al., Regional with Urban–Rural Variation in Low Birth Weight and Its Determinants of Indian Children: Findings from National Family Health Survey 5 Data, 23 BMC Pregnancy & Childbirth 616 (2023), https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-023-05934-6.
[16] Id.
[17] Irene Guat Sim Cheah, supra note 10.
[18] Irene Guat Sim Cheah, supra note 10.
[19] Kundu et al., supra note 12.

healthcare professionals, and the cost of care.

III. LEGAL FRAMEWORKS COMPARED

The question of abortion legality and accessibility is a complex interplay of legal, ethical, and social considerations. Different nations have adopted varied approaches, reflecting their unique cultural and historical contexts. This chapter compares the legal frameworks governing abortion in India, the United States (pre- and post- Dobbs), the United Kingdom, and Canada, highlighting their key features, limitations, and potential implications for women's reproductive autonomy.

(A) India’s MTP Act: A Gestational Straightjacket?

India's abortion law is primarily governed by the Medical Termination of Pregnancy Act, 1971 (MTP Act), which was enacted to reduce unsafe abortions and improve maternal health. Before this act, abortion was criminalized under the Indian Penal Code.[20] The MTP Act allows registered medical practitioners to terminate pregnancies under specific conditions, establishing gestational limits.[21] A single registered medical practitioner can terminate pregnancies up to 20 weeks. Termination is only allowed after 20-24 weeks if two registered medical practitioners agree that the woman’s life or health is at risk, or if the fetus might be affected by a range of conditions, including abnormalities. The Medical Termination of Pregnancy (Amendment) Act, 2021 brought the MTP Act in tandem with Sustainable Development Goals, particularly Goal-3: reducing maternal mortality and ensuring universal access to sexual and reproductive health and rights.[22]

As per the provision under Section 3(2)(b) of the MTP Act certain categories of women are exempted from the 24 weeks limit including survivors of rape, incest and woman with physical disabilities. Termination beyond 20 weeks is permitted under Section 5 of the MTP Act if it is immediately necessary to save the life of the pregnant woman. However, the Act has been criticized for not providing women with an unrestricted right to abortion and for a selective approach to abortion rights.[23]

A significant aspect of the Indian framework is the "judicial bypass" requirement. While the

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[20] Indian Penal Code, 1860, Sec. 312–316 (India), https://www.indiacode.nic.in/bitstream/123456789/4219/1/INDIAN_PENAL_CODE.pdf.

[21] Medical Termination of Pregnancy Act, No. 34 of 1971, Sec, 3 (India), https://www.indiacode.nic.in/bitstream/123456789/1593/1/A1971-34.pdf.

[22] The Medical Termination of Pregnancy (Amendment) Act, 2021, No. 8, Acts of Parliament, 2021 (India), https://prsindia.org/files/bills_acts/acts_parliament/2021/Medical%20Termination%20of%20Pregnancy%20Amendment%20Act%202021.pdf.

[23] Shraileen Kaur, Medical Termination of Pregnancy Act, 1971, iPleaders (July 9, 2022), https://blog.ipleaders.in/medical-termination-of-pregnancy-act/.

MTP Act doesn't explicitly mandate judicial approval, courts often become involved, especially in cases involving pregnancies resulting from rape or when termination is sought beyond 24 weeks.[24] In such instances, women are compelled to seek permission from the courts, effectively turning them into "abortion panels." For example, in R vs The Union Of India Through Secretary, 2024, the Delhi High Court initially permitted termination beyond 24 weeks, but later recalled the order after considering reports from AIIMS indicating fetal viability and potential risks of preterm delivery.[25] The court ultimately denied the termination, highlighting the balancing act between the woman's health and fetal viability.

The case of X v. Principal Secretary[26] was referenced in the R vs The Union Of India Through Secretary case, which extended Rule 3(B)(c) of the MTP Rules to single and married women facing material changes in their marital life.

Courts consider several factors, including the risk to the pregnant woman's life and mental health, medical opinions on the feasibility of abortion, and the presence of fetal impairments.[27] They are generally reluctant to authorize termination if the medical board raises concerns about the risks associated with the woman's health. However, courts tend to permit abortions post-20 weeks when there are fetal impairments incompatible with extra-uterine life, stating that carrying such a pregnancy to term poses risks to the woman's mental and physical health. Differing interpretations of Section 5 exist, with some courts adopting a strict interpretation and others extending its ambit to cover situations where pregnancy results in grave mental stress.[28]

The Supreme Court has emphasized that in cases where the Court is deciding the permissibility of abortion, it should consider the "best interest" of the woman concerned. [29]Section 3(4)(a) of the MTP Act mandates the written consent of the guardian of a minor girl or a "mentally ill" woman or girl before termination of her pregnancy. The MTP Act does not require the husband’s consent for terminating the pregnancy of a major woman.

(B) The US Roe Model (Pre-Dobbs)

Prior to the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization (2022),[30] The legal framework for abortion in the United States was largely defined by Roe v.

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[24] Aparna Chandra & Mrinal Satish, Securing Reproductive Justice in India: A Casebook 169 (NLUD & Ctr. for Reprod. Rts. 2019), https://reproductiverights.org/wp-content/uploads/2020/12/SecuringReproductiveJustice India-Chpt05.pdf.

[25] R v. Union of India, W.P.(C) 13994/2023, 2024 SCC Del 440 (India), https://indiankanoon.org/doc/188485615/.

[26] X v. Principal Secretary, Health & Family Welfare Department, Civil Appeal No. 5802 of 2022, 2022 SCC OnLine SC 1321 (India), https://indiankanoon.org/doc/123985596/.

[27] Chandra & Satish, supra note 20.

[28] Chandra & Satish, supra note 20.

[29] Bhavikaben v. State of Gujarat & Ors., (2016) 3 RCR (Cri) 362 (India), https://indiankanoon.org/doc/74387922/.

[30] Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

Wade (1973). Roe set up a trimester framework, giving women the right to an abortion but permitting states to restrict abortions in the second trimester and to outlaw abortions in the third trimester, except when needed to save the life or health of the mother. This framework allowed states to meaningfully curtail abortions after viability (generally understood to be around 24 weeks).

But the Roe framework came with its own problems. It resulted in a patchwork of state laws, with differing levels of access to abortion based on state. "What sort of limits, like waiting periods, parental consent requirements and other types of availability, were imposed by some states?

The Dobbs decision overturned Roe v. Wade, eliminating the constitutional right to abortion and returning the authority to regulate abortion to individual states. This has led to a dramatic shift in the legal landscape, with many states enacting near-total bans on abortion. In November 2024, an estimated 79,960 clinician-provided abortions took place in the United States in states without total bans and states bordering states with total bans have seen a significant increase in out-of-state patients seeking abortion care.[31] This demonstrates the impact of the Dobbs decision and the resulting disparities in access to abortion across the country.

(C) Alternative Models

In contrast to the gestational limits and judicial oversight present in India and the variable landscape in the US, some countries have adopted more liberal approaches to abortion.

The UK's Abortion Act 1967 permits abortion up to 24 weeks if two doctors agree that continuing the pregnancy would pose a greater risk to the woman's physical or mental health than having an abortion.[32] After 24 weeks, abortion is only permitted in limited circumstances, such as when there is a substantial risk to the woman's life, or in cases of severe fetal abnormality.[33] In 2005, the vast majority of abortions (95.6%) were carried out under category C, which allows for legal abortion under 24 weeks on the ground that continuing with the pregnancy poses a greater risk to the physical or mental health of the woman than having an abortion.[34] While the law requires two-doctor approval post-24 weeks for health risks, the decision-making locus rests with doctors.[35]

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[31] Guttmacher Institute, Monthly Abortion Provision Study, https://www.guttmacher.org/monthly-abortion-provision-study (last visited Apr. 6, 2025).
[32] Abortion Act 1967, c. 87, Sec. 1(1)(a) (UK), https://www.legislation.gov.uk/ukpga/1967/87/section/1.
[33] Id. at Sec. 1(1)(b)–(d).
[34] Jonathan Gornall, Where do we draw the line?, 334 BMJ 285 (2007), https://pmc.ncbi.nlm.nih.gov/articles/PMC1796725/.
[35] Catriona Ida Macleod, Sian Beynon-Jones & Merran Toerien, Articulating Reproductive Justice Through

Despite the relatively liberal legal framework, access to abortion in the UK is not without its challenges. Some women experience judgmental encounters with health professionals, and requests for "late" or "re-occurring" abortions are often positioned as problematic. Problems with NHS commissioning in some areas mean that access to both early and late abortion services varies significantly across the country.[36]

Canada, on the other hand, has no federal legal restrictions on abortion, making it legal throughout all nine months of pregnancy. However, in practice, different clinics and hospitals have different limits for how far into pregnancy they offer abortions, and provinces and territories have different guidelines related to abortions. Late-term abortions are rare in Canada and usually occur because of serious medical issues. No providers in Canada offer care beyond 23 weeks and 6 days.[37]

The legal frameworks governing abortion vary significantly across different countries, reflecting diverse cultural, ethical, and social values. India's MTP Act, while progressive in its aim to reduce unsafe abortions, imposes gestational limits and a judicial bypass requirement that can restrict women's access to abortion. The US, following the Dobbs decision, presents a highly fragmented landscape, with abortion access largely determined by individual state laws. The UK offers a more liberal framework, but practical challenges and societal stigmas persist. Canada's no-limit approach, while legally permissive, is tempered by practical considerations and hospital policies. Ultimately, the effectiveness of any legal framework depends on its ability to balance the competing interests of women's reproductive autonomy, fetal viability, and societal values, while ensuring equitable access to safe and legal abortion services.

IV. Ethical & legal dilemmas in India's abortion law

The debate surrounding abortion in India is a complex interplay of legal frameworks, ethical considerations, and socioeconomic realities. While India's abortion laws are considered relatively liberal, particularly after the 2021 amendment to the Medical Termination of Pregnancy (MTP) Act of 1971, significant ethical and legal dilemmas persist, especially concerning abortions beyond 24 weeks of gestation. This chapter will delve into these dilemmas, exploring the conflicting rights, practical challenges, and socioeconomic factors that shape the landscape of late-term abortions in India. The analysis will also consider the evolving

Reparative Justice: Case Studies of Abortion in Great Britain and South Africa, 19 Culture, Health & Sexuality 601, 607 (2017) (author manuscript at 7), https://eprints.whiterose.ac.uk/108563/1/Reproductive_Justice_author_accepted_version.pdf.

[36] Id. at 10.

[37] Public Health Agency of Canada, Abortion in Canada, https://www.canada.ca/en/public-health/services/sexual-health/abortion-canada.html (last visited Apr. 7, 2025).

concept of fetal viability and its implications for reproductive rights, drawing parallels with the US Roe framework.

(A) Rights Conflict: Woman vs. Fetus

At the heart of the abortion debate lies the fundamental conflict between a woman's right to bodily autonomy and the perceived rights of the fetus. The Indian Constitution, under Article 21, guarantees the right to life and personal liberty, which the Supreme Court has interpreted to include reproductive autonomy. In Suchita Srivastava v. Chandigarh Administration, the court affirmed a woman's right to make reproductive choices as part of her personal libert.[38] This landmark case established a crucial precedent for recognizing a woman's autonomy in reproductive decisions.

However, the debate intensifies when considering fetal viability, the point at which a fetus can survive outside the womb. While the MTP Act sets gestational limits for abortions, the concept of viability introduces a moral and ethical dimension. Is viability a "bright line" that clearly defines when fetal rights begin to outweigh a woman's autonomy, or is it an arbitrary marker influenced by advancements in neonatal care?[39] Some argue that post-viability, the "potential child" becomes a part of the determination, with the "right to life of the fetus" outweighing the "mental trauma" of the mother.[40]

Recent court cases reflect this tension. In 2023, the Supreme Court disallowed an abortion at 26 weeks because it could not "stop the [fetal] heartbeat" .[41] This decision highlights the growing consideration of fetal rights in Indian courts, creating a tension with women's reproductive rights. The court has also expressed aversion to passing an order to stop the heart of the fetus for termination, holding that it may amount to foeticide.

The MTP Act initially prohibited late-term abortions to reduce sex-selective abortions, possible as early as 10 weeks. The Act uses fetal viability and the ability of the fetus to perceive pain as grounds for choosing the upper limit for termination. However, there is no conclusive evidence-based proof that the fetus can perceive pain at this stage, nor is there evidence that the fetus

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[38] Suchita Srivastava & Anr. v. Chandigarh Administration, (2009) 9 S.C.C. 1 (India).

[39] Aiswarya Sasi, Ethical Issues Concerning Legislation in Late-Term Abortions in India, 11 Asian Bioethics Rev. 367 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7747435/.

[40] Adsa Fatima & Sarojini Nadimpally, Abortion Law in India: A Step Backward After Going Forward, SUP. CT. OBSERVER (Nov. 17, 2023), https://www.scobserver.in/journal/abortion-law-in-india-a-step-backward-after-going-forward/.

[41] X v. Union of India, Civil Appeal No. 5559 of 2023, Judgment dated Oct. 16, 2023 (India), https://www.scobserver.in/journal/averse-to-stilling-heart-of-a-viable-foetus-supreme-court-rejects-plea-for-termination-of-26-week-pregnancy/.

cannot perceive pain before this stage.[42]

(B) Practical Challenges

Even within the existing legal framework, numerous practical challenges impede access to safe and legal abortions, particularly in late-term cases.

(C) Diagnostic Errors

Advances in technology have made it possible to detect certain genetic anomalies prenatally, such as the Arnold Chiari malformation, However, this prenatal diagnosis is often only possible after 20 weeks of gestation, around 24 weeks.[43] This delay can push women beyond the gestational limits set by the MTP Act, forcing them to seek court intervention or resort to unsafe methods.

(D) Stigma and Doctor Refusal

Stigma surrounding abortion, particularly late-term abortions, can lead to doctors refusing to perform the procedure, fearing legal liability or facing ethical objections. The MTP Act, while legalizing abortion under certain conditions, is framed as an exception to the Indian Penal Code, which criminalizes abortion. This leads doctors to seek protection from civil and criminal lawsuits.

The Amendment Act still requires the permission of doctors for abortions to take place, making it a doctor-centric legislation, and does not take into account doctors' hesitation to grant abortions for fear of prosecution under the IPC or conflations with the Protection of Children from Sexual Offences Act, 2012 (POCSO Act) and other laws.[44] This inconsistency on the part of the legal system has further led to uncertainty among doctors in the field about the extent of their authority in the decision-making process.

(E) Medical Boards

The MTP Amendment Act provides for the constitution of Medical Boards at approved facilities, which may "allow or deny termination of pregnancy" beyond 24 weeks.[45] This additional layer of third-party authorization could act as a significant barrier to accessing safe

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[42] Sasi, supra note 35.
[43] Satvik N. Pai & Krithi S. Chandra, Medical Termination of Pregnancy Act of India: Treading the Path between Practical and Ethical Reproductive Justice, 48 Indian J. Cmty. Med. 510 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10470576/.
[44] Dipika Jain, Supreme Court of India Judgement on Abortion as a Fundamental Right: Breaking New Ground, 31 Sexual & Reprod. Health Matters 2225264 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10321178/.
[45] The Medical Termination of Pregnancy (Amendment) Act, 2021, No. 8, Acts of Parliament, 2021 (India), Sec. 3(2C), https://egazette.nic.in/WriteReadData/2021/226130.pdf.

abortion, especially for marginalized socio-economic backgrounds.

(F) POCSO

Provisions under laws such as the mandatory reporting requirement under the Protection of Children from Sexual Offences Act (POCSO Act) create additional barriers to accessing safe and legal abortions.[46]

(G) Socioeconomic Factors

Socioeconomic factors significantly impact access to abortion services and exacerbate the ethical and legal dilemmas surrounding late-term abortions.

(H) Class Bias

Poor women often lack the resources to navigate the legal system, access quality healthcare, or afford neonatal intensive care (NICU) for premature infants.[47] This creates a disparity in access to safe abortion services, with marginalized women disproportionately bearing the burden of restrictive laws. A study on trends and socioeconomic inequalities in early neonatal mortality (ENNM) in India found that in 2019-21, children born in the richest families had significantly 39% less chance of death than children born in the poorest families.[48]

The Supreme Court has recognized structural barriers to abortion access, including lack of access to health services, caste discrimination, bureaucracy, and poverty.[49] The court directed the government to ensure access to abortion and contraception services, information, and medical facilities in every district, with sensitivity towards marginalized persons. Justice Chandrachud acknowledged the link between reproduction and political, social, and economic structures.[50]

(I) Data Gaps

The absence of a national registry on denied late-term abortions further hinders efforts to understand the scope of the problem and develop targeted interventions.[51] Without

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[46] The Protection of Children from Sexual Offences Act, 2012, No. 32, Acts of Parliament, 2012 (India), Sec. 19–21, https://www.indiacode.nic.in/bitstream/123456789/2079/1/AA2012-32.pdf.
[47] Radhikaa Sharma, Access to Abortion, Foetal Viability, and the Laws Thereof: Women Are Caught in the Crossfire, The Hindu (Mar. 2, 2024), https://www.thehindu.com/sci-tech/health/access-to-abortion-foetal-viability-and-the-laws-thereof-women-are-caught-in-the-crossfire/article69373089.ece.
[48] Gokhale Inst. of Pol. & Econ., Trends and Socio-economic Inequalities in Early Neonatal Mortality in India (2024), https://gipe.ac.in/wp-content/uploads/2024/03/Trends-and-Socio-economic-Inequalities-in-Early-Neonatal-Mortality-in-India.pdf.
[49] X v. Principal Secretary, Health & Family Welfare Department, Civil Appeal No. 5802 of 2022, 2022 SCC OnLine SC 1321 (India), https://indiankanoon.org/doc/123985596/.
[50] Id.
[51] Sharma, supra note 43.

comprehensive data, it is difficult to assess the impact of restrictive laws on women's health and well-being.

a. Rural Areas

There is a nearly 70% shortage of obstetricians and gynecologists at community health centers in rural areas.[52]

b. Maternal Mortality

Unsafe abortion remains India's third leading cause of maternal mortality, with eight women dying every day.[53] Approximately 800,000 unsafe abortions are carried out in India annually, and most of these are provided to people from marginalized communities. The prevailing stigma and taboo around abortion multiplies when an abortion seeker is unmarried.[54]

The ethical and legal dilemmas surrounding late-term abortions in India are multifaceted and deeply intertwined with issues of women's autonomy, fetal rights, and socioeconomic justice. While the MTP Act and subsequent amendments have expanded access to abortion services, significant challenges remain in ensuring equitable and safe access, particularly for marginalized women.

Moving forward, it is crucial to adopt a rights-based approach that prioritizes women's autonomy and well-being while addressing the practical and socioeconomic barriers that impede access to safe abortion services. Further, the legislative framework must be amended to remove ambiguities and barriers. By fostering a more inclusive and compassionate legal and social environment, India can better protect the reproductive rights and health of all women.

V. Reforming India's Approach

India's Medical Termination of Pregnancy (MTP) Act, initially enacted in 1971 and amended in 2021, permits abortion up to 20 weeks, with extensions to 24 weeks under specific circumstances, and beyond that only if a medical board diagnoses substantial fetal abnormalities. While these amendments have expanded access, they still fall short of fully embracing a woman-centered, rights-based approach. The current legal framework in India is provider-centric, granting decision-making powers to medical practitioners rather than

[52] Gov't of India, Ministry of Health & Family Welfare, Rural Health Statistics 2021–22, at 8 (2022), https://main.mohfw.gov.in/sites/default/files/RHS%202021%2022.pdf.
[53] United Nations Population Fund (UNFPA), State of World Population Report 2022: Seeing the Unseen 8 (2022), https://india.unfpa.org/en/state-of-the-world-population-report-2022-seeing-the-unseen.
[54] Center for Reproductive Rights, National Law University, Delhi, Legal Barriers to Accessing Safe Abortion Services in India: A Fact-Finding Study 8 (2021), https://reproductiverights.org/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India_Final-for-upload.pdf.

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recognizing abortion as a fundamental right of the pregnant person. This chapter proposes reforms to India's approach to align with international human rights standards and ensure greater reproductive autonomy for women.

(A) Proposal: Viability + Rights-Based Model

In order to expand on the rights guaranteed by the existing MTP Act, India should adopt a viability-informed, rights-based model that acknowledges both fetal interests and women's autonomy and well-being. The model will consist of two primary options:

Option 1: Amend MTP Act to tie limits to hospital viability assessments.

This option will require amending the MTP Act to say that abortion can be done beyond 24 weeks in case a viability assessment by the hospital suggests that foetus is not viable yet. Implementing this model would be a substantial investment in infrastructure and training to ensure that hospitals can perform successful and timely viability assessments.

Option 2: Adopt UK-style medical panels for post-viability cases.

India can follow a UK-like system, where medical panels are constituted to assess any such abortion requests after 24 weeks of gestation.[55] These panels would take into account the woman's physical and mental health and any fetal abnormalities to decide whether an abortion is warranted. Such a model would necessitate setting quantifiable guidelines and protocols for medical panels to follow to maintain consistency and transparency in the decision-making process.

The Human Fertilisation and Embryology Act in November 1990 lowered the gestation limit for abortions in the UK from 28 weeks to 24 weeks, considered the point of fetal viability outside the mother's body.[56]

The Royal College of Obstetricians and Gynaecologists recommends feticide for abortions at 22 weeks and over, prior to the evacuation of the uterus, to stop the fetal heart.[57]

Both options would require a shift towards a more woman-centered approach, recognizing the pregnant person as the primary decision-maker in abortion care. This shift would involve providing comprehensive counseling and support services, ensuring that women have access to accurate information about abortion, and respecting their decisions without coercion or

[55] Office for Health Improvement & Disparities, Abortion Statistics, England and Wales: 2021 (July 26, 2024), https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021.

[56] Human Fertilisation and Embryology Act 1990, c. 37, Sec. 37 (UK), https://www.legislation.gov.uk/ukpga/1990/37/section/37.

[57] Royal College of Obstetricians & Gynaecologists, Fetal Awareness: Review of Research and Recommendations for Practice 20 (2010), https://www.rcog.org.uk/media/xujjh2hj/rcogfetalawarenesswpr0610.pdf.

judgment.

(B) Safeguards Needed

Providing safeguards for an ethical and effective reform of abortion law in India will require efforts, such as:

- **Anti-discrimination clause:** An explicit anti-discrimination clause needs to be included in the MTP Act prohibiting disability-selective abortions. This clause would ensure that decisions about abortion are not based on discriminatory attitudes towards disability and that women are provided with comprehensive information and support to make informed choices.
- **Training for providers:** Standardised viability testing should be implemented, and training for healthcare providers to prevent biased information given to women. These programs should cover both clinical and non-clinical aspects of abortion care, including reproductive rights, legal considerations, and counseling skills.
- **Accessibility and Infrastructure:** A significant barrier women and girls face in accessing safe, timely, and legal abortion services is the inadequate numbers of registered health care providers trained to provide abortion services and a dearth of facilities that are properly equipped to perform the procedure.
- **Data Privacy:** The program needs to ensure the privacy of patient data. Telehealth adds a disproportionate burden on the person seeking health services and is not appropriate for all health conditions.
- **Comprehensive Care:** The program needs to ensure that women have access to comprehensive sexual and reproductive health services, including contraception and family planning.

(C) Counterarguments

Several counterarguments may arise in response to the proposed reforms:

- **Religious/conservative opposition:** Religious and conservative groups may oppose any expansion of abortion access, arguing that it violates the sanctity of life and could lead to a "slippery slope" towards infanticide.[58] Some interpretations of Hindu texts compare abortion to the killing of a priest or consider it a worse sin than killing one's

[58] Zeke J. Miller, Huckabee: Abortion Start of Slippery Slope to Euthanasia, TIME (Feb. 28, 2014), https://time.com/23123/huckabee-abortion-start-of-slippery-slope-to-euthanasia/.

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parents.[59] However, it is important to note that international human rights standards maintain that human rights begin at birth and that states cannot prioritize interests in prenatal life over the legal rights granted to women.[60]

- **Judicial overload:** Concerns may be raised that expanding access to abortion could lead to judicial overload, as courts are already overwhelmed with petitions related to abortion requests.[61] However, the current system of requiring women to petition courts for abortion creates additional barriers and procedural delays. Addressing the legal framework and prioritizing women's health and rights can reduce the need for judicial intervention.
- **Disability-selective abortions:** Concerns about disability-selective abortions have been raised.[62] However, an explicit anti-discrimination clause in the MTP Act and comprehensive counseling can help ensure that decisions about abortion are not based on discriminatory attitudes towards disability.

VI. CONCLUSION

Reforming India's approach to abortion law is essential to ensure that women have access to safe, legal, and comprehensive abortion care. By adopting a viability-informed, rights-based model and implementing appropriate safeguards, India can uphold women's reproductive autonomy and well-being while respecting ethical considerations. Addressing religious and conservative opposition through open dialogue and education, and streamlining legal processes, will be crucial for successful implementation. Ultimately, prioritizing women's health and rights will lead to a more just and equitable society for all.

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[59] Kaushitaki Upanishad 3.1, translated by Kiarash Aramesh, Perspectives of Hinduism and Zoroastrianism on Abortion: A Comparative Study Between Two Pro-Life Ancient Sisters, 12 J. Med. Ethics & Hist. Med. 1, 2 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7166242/.
[60] Center for Reproductive Rights, Whose Right to Life? Women's Rights and Prenatal Protections under Human Rights and Comparative Law 2 (2014), https://reproductiverights.org/wp-content/uploads/2020/12/GLP_RTL_ENG_Updated_8-14_Web.pdf.
[61] Fatima & Nadimpally, supra note 36.
[62] Martin E. Gold, The Demise of Roe v. Wade Undermines Freedom of Religion, AM. CONST. SOC'Y EXPERT FORUM (Aug. 30, 2022), https://www.acslaw.org/expertforum/the-demise-of-roe-v-wade-undermines-freedom-of-religion/.