

ABORTION LAWS IN INDIA

“No woman can call herself free until she can choose consciously whether she will or will not be a mother” - Margaret Sanger

INTRODUCTION

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

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

In India each year an estimated 453 women die due to maternal causes for every 100,000 live births (UNFPA 1997). This statistic varies from state to states. While national and state estimates are imprecise, they are able to represent certain trends. Orissa and Madhya Pradesh had approximately 738 and 711 maternal deaths per 100,000 births in 1992. Among the larger states, Kerala has a singularly low ratio of 87 maternal deaths reported per 100,000 births. On an average, roughly fifteen percent of maternal deaths in India are thought to result from unsafe abortion.

MEANING OF THE TERM

The term “abortion”, in criminal law, is ordinarily used to describe an intentional termination of pregnancy. The term 'Abortion' in common usage means premature expulsion of foetus during the time of pregnancy.

Abortion is the intentional termination of gestation by any means and at any time during pregnancy from conception to full term.

According to medical terminology, Abortion is the termination of pregnancy before the foetus is capable of extra-uterine life generally considered to be prior to the 20 week of gestation or the conceptus achieving a mass of less than 500 gm or a crown-rump length of 18 cm.

'Abortion' as already noted is the premature termination of pregnancy prior to birth. It is a technique of removing a developing embryo or foetus from the maternal uterus for the purpose of preventing its birth.

What exactly are the intentions of the women seeking abortion is surely an empirical question. In absence of specific survey, some indications that can be inferred are i) practice of female foeticide prompted by existence of dowry system ii) financial burden and hardship iii) preference of male children iv) parents' likelihood to stop bearing children after obtaining a son than after obtaining a daughter -that is to continue to reproduce to obtain a boy v) premarital sexual activities by teenage girls, vi) pregnancy caused to sex workers because of men's reluctance to use condoms.

TYPES OF ABORTION

The Shah committee (1971) estimated that prior to the liberalization abortion laws, the abortion rate was 10% per 1000 population (5 spontaneous and 8 induced).

Abortion is of various types, all of which are not the concern of Ethics. Generally, abortion has two broad classes- natural or spontaneous abortion and induced or artificial abortion. An abortion is natural when it occurs owing to natural causes. Natural abortion occurs either spontaneously or accidentally and about 80% spontaneous abortion occurs during second and third month of pregnancy.

Spontaneous or natural abortion is of following types: (a) Threatened abortion, which occurs in 20% of all spontaneous abortion, (b) Inevitable abortion, which occurs in 10% of all spontaneous abortion. (c) Incomplete abortion, which occurs in 10% of all spontaneous abortion, (d) Septic abortion, which occurs in 10% of all spontaneous abortion, (e) Missed abortion, which is estimated at 2% of all spontaneous abortion, and (f) Habitual abortion, which is estimated at 2% of all spontaneous abortion.

An artificial or induced abortion, on the other hand is an elective termination of pregnancy prior to viability. It is a sort of abortion where expulsion of foetus is caused forcibly by artificial means- both mechanical and medicinal. In artificial or induced abortion, there are some purposes which necessitate the termination of pregnancy.

An artificial abortion becomes justifiable when it is earned out in good faith for the safety of mother's life as when continuation of pregnancy materially endangers the life of mother. And an abortion becomes criminal when it is done with the desire of causing destruction of the foetus with or without the consent of mother, which does not concern the question of safety of mother's life.

Abortion as a Fundamental Right

In Suchita Srivastava and V. Krishnanan, the Supreme Court and the High Court of Madras have respectively affirmed women's rights to choose in the context of continuing a pregnancy. In Suchita Srivastava, the Supreme Court clearly held that the state has an obligation to ensure a woman's reproductive rights as a component of her Article 21 rights to personal liberty,

dignity, and privacy. In *Laxmi Mandal v. Deen Dayal Hari Nagar Hospital*, the Delhi High Court ruled that preventable maternal death represents a violation of Article 21 of the Constitution. The High Court required the NCT of Delhi to implement the service guarantees in the National Rural Health Mission, including safe abortion services, to prevent maternal deaths. This landmark judgment created a state obligation to take steps to end preventable maternal death, including deaths caused as a result of inadequate access to safe abortion.

The Indian Penal Code

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

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

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

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

Section 313 of the Indian Penal Code makes it punishable to cause miscarriage without the consent of the woman. The gravity of the offence is enhanced.

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

When an accused intending to cause only miscarriage to a woman with child causes her death, he is convicted under section 314 of the Penal Code.

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

This offence can only be committed after the woman became 'quick' with child, and before the birth. Thus under this section, causing of death of a quick unborn child [advanced stage of pregnancy] by an act amounting to culpable homicide is punishable up to ten years of imprisonment and fine. The offence under section 316 is cognizable, not bailable, not compoundable and triable by the Court of Session.

The Medical Termination of Pregnancy, 1971

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

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

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

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

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

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

The grounds include grave risk to the physical or mental health of the woman in her actual or foreseeable environment, as when pregnancy results from contraceptive failure, or on humanitarian grounds, or if pregnancy results from a sex crime such as rape or intercourse with

a mentally-challenged woman, or on eugenic grounds, where there is reason to suspect substantial risk that the child, if born, would suffer from deformity or disease. The law allows any hospital maintained by the Government to perform abortions, but requires approval or certification of any facility in the private sector. In the event of abortion to save a woman's life, the law makes exceptions: the doctor need not have the stipulated experience or training but still needs to be a registered medical practitioner, a second opinion is not necessary for abortions beyond 12 weeks and the facility need not have prior certification.

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

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

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

The amended MTP Rules also recognise medical abortion methods and allow a registered medical practitioner (e.g. the family physician) to provide mifepristone + misoprostol in a clinic setting to terminate a pregnancy up to seven weeks, provided that the doctor has either on-site capability or access to a facility capable of performing surgical abortion in the event of a failed or incomplete medical abortion. However, the Drug Controller of India has approved mifepristone provision only by a gynaecologist, thus effectively restricting access to women in urban areas. National consensus guidelines and protocols²⁸ for medical abortion are currently being developed.

The Protection of Children from Sexual Offenses Act, 2012

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

contradicts the confidentiality and privacy protections under the MTP Act. This mandatory reporting requirement can act as a deterrent for those women under the age of 18 from accessing safe abortion services in situations where the pregnancy resulted from consensual marital or non-marital sex. As stated in the section on rape, courts unanimously allow minor rape survivors to terminate and even express their frustration with doctors, police, and magistrate judges who create unnecessary delays. Where a rape survivor's pregnancy has passed the 20-week limit established under the MTP Act, courts traditionally split. However, in 2015 the Supreme Court allowed termination post-20 weeks where a team of doctors determined that the pregnancy would harm the girl's mental and physical health setting. It is an important precedent paving the way for increased access to safe abortion services for minor rape survivors. The POCSO Act, although passed a decade later, is in violation of the Convention and is regressive insofar as it criminalises all sexual activity among children, not acknowledging consensual sexual activity among adolescents. An unwanted pregnancy resulting from consensual sexual activity involving an adolescent also ends up being viewed as an outcome of sexual violence by the law. Therefore, the POCSO Act needs urgent amendments in order to allow consensual sexual activity among minors with an adequate level of secrecy to terminate teenage pregnancies with the least legal resistance possible.

Pre-conception Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT Act)

The Medical Termination of Pregnancy Act 1971 (MTP Act), legalized abortion in India and the National Health Mission ensures access to safe abortion as part of a 2 broader strategy to reduce maternal mortality in India. Despite laws and policies, thousands of women die every year as a result of unsafe abortion and providers, the police, and NGOs remain in the dark on implementation of the Act, especially since newer laws, including the Pre-Conception Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT Act) and the Protection of Children from Sexual Offenses Act, 2012 (POCSO Act), contradict protections in the MTP Act.

Two laws that prohibit the determination of sex of a foetus in India are the Medical Termination of Pregnancy Act, 1971 (MTP), as amended in 2002, and the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PNDT), as amended in 2002. The former Act prohibits abortion except only in certain qualified situations, while the latter prohibits the sex selection or sex determination of a foetus with a view towards aborting it.

The objective of the PNDT Act was therefore twofold. First, to regulate pre-natal diagnostic techniques and limit it to the detection of genetic/ metabolic disorders, chromosomal abnormalities, congenital malformations or sex linked disorders. Secondly, to prevent the use or rather misuse of such technology for the purpose of pre-natal sex selection which in turn would lead to sex-selective abortions.

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The Supreme Court's final decision in CEHAT included sweeping orders obligating states to immediately improve PCPNDT implementation.

Raids throughout Haryana have “cracked down” on clinics that do not comply with the requirements in the MTP Rules. In February 2016 authorities arrested the owner of a private clinic in Panchkula, Haryana. With the assistance of decoys, authorities found that the abortion provider did not have a medical degree. The District now has a system where anyone can leave an anonymous tip about a violation of the MTP Act or the PCPNDT Act and receive Rs. 1 lakh for the information. Officials had conducted raids at two additional Haryana clinics in February 2016. Generally, where providers violate administrative components of either the MTP Act or the PCPNDT Act, courts will grant leeway for clinics to make adjustments. However, where providers have been accused of performing illegal services, courts will refuse bail and impose substantial sentences.

In *Roe V. Wade*, the U.S. Supreme Court determined that the constitution protected a woman’s decision whether or not to terminate her pregnancy. In *Doe V. Bolton*, the Court further held that a state may not unduly burden a woman’s fundamental right to abortion by prohibiting or substantially limiting access to the means of effectuating her decision.

In 1973, the Court’s ruling in *Roe v. Doe* cases rested upon a woman’s right to privacy in her decision whether to carry a pregnancy to term. The Supreme Court’s decisions in *Roe* and *Doe* did not address a number of important abortion-related issues which were raised subsequently by state actions seeking to restrict the scope of the Court’s rulings. These include the issue of informed consent, spousal consent, parental consent, and reporting requirements. In addition, *Roe* and *Doe* never resolved the question of what, if any, type of abortion procedures may be required or prohibited by the statute. In 1989, the Court indicated in *Webster v. Reproductive Health Services*, that while it was not overruling *Roe* and *Doe*, it was willing to apply a less stringent standard to review state restrictions respecting a woman’s right to an abortion.

Conclusion

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

Before concluding and drawing an inference, it would be relevant to understand the basic aim behind legislating with regards to abortion. One can deduce that the foremost objective is to provide all women with quality abortion care, which is sensitive to their needs by increasing aspects such as easy accessibility and affordability to safe abortion services. This may be done by mobilising human, financial and material resources for provision of care and safety in abortion procedure and increasing the number of trained persons and equipped abortion centres. In addition to this by efficiency is increased and ambit is broadened by integrating abortion services into primary and community health centres, increasing investment in public amenities, broaden the base of abortion providers by training paramedics to do first trimester abortions, simplifying registration procedures, link policy with up-to-date technology, addressing the need for appropriate post-abortion care etc.

There is also a need to amend POCSO Act to do away with its clash with MTP Act. India's medical and legal infrastructure too needs improvement. Therefore, the need of the hour is for government and elements of civil society to come together and improve the substantive and implementation elements of India's abortion laws and policy.

There is a need to enhance awareness of both contraceptive and abortion services, especially amongst adolescents, within the larger context of sexual and reproductive health, integrating strategies and interventions within value systems and family and gender relations. For these policies to be implemented effectively, they need to be backed by political will and commitment in terms of adequate resource allocation, training and infrastructure support, accompanied by social inputs based on women's needs.

Rightly said, "An evil practice can be curbed not by cutting the stems growing on the trunk above the ground, but by eliminating the roots standing beneath. Social awakening, equality, vigorous campaigning against female foeticide, honest and full enforcement of dowry prohibition, sexual harassment laws are the steps towards uprooting the practice of female foeticide.