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DISSERTATION

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PUBLIC HEALTH IMPACTS OF LEGAL TERMINATION OF PREGNANCY –A COMPARATIVE STUDY

Under the Guidance and Supervision of

Dr. Mini. S, Professor, NUALS
The National University of Advanced Legal Studies, Kochi

Submitted By:

Adhunik M. Lal

Register No: LM0320006

LLM (Public Health Law)

CERTIFICATE

This is to certify that Adhunik M Lal, REG NO: LM0320006 has submitted his Dissertation titled **"Public health impacts of legal termination of Pregnancy –a comparative study"** in partial fulfillment of the requirement for the award of Degree of Masters of Laws Public Health Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by him is original, bonafide and genuine.

Prof. (Dr) Mini S,
Guide and Supervisor
Professor of Law
NUALS, KOCHI

Date: 11.10.2021
Place: Ernakulam

DECLARATION

I declare that this Dissertation titled **"Public health impacts of legal termination of Pregnancy –a comparative study"** is researched and submitted by me to the National University of Advanced Legal Studies, Kochi, in partial fulfillment of the requirement for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of Prof. (Dr) Mini. S and is an original, bona fide and legitimate work. It has been pursued for academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University

Adhunik M. Lal

Reg No: LM032006

LL.M, Public Health Law

NUALS, KOCHI

Date: 11.10.2021

Place: Ernakulam

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ABBREVIATIONS

AIR	All India Reporter
CAC	Comprehensive abortion care
CEDAW	Convention On Elimination of All Forms of Discrimination Against Women
CFPB	Central Family Planning Board
CJ	Chief Justice
COVID-19-	Coronavirus Disease 2019
DCA	Drugs and Cosmetics Act, 1940
IPC	Indian Penal Code 1860
IMA	Indian medical Association
MA	Medical Abortion
MMA	Medical methods of abortion
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MTP Act	Medical Termination of Pregnancy Act, 1971
PCPNDT Act	Abortion Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994
POCSO Act	Protection of Children from Sexual Offenses Act, 2012
RMP	Registered Medical Practitioner
SC	Supreme Court
SCC	Online Supreme Court Cases Online
UNFPA	United Nations Population Fund
Vol	Volume
WP-	Writ Petition
U.S	United States

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CHAPTER 1- INTRODUCTION

"No woman can call herself free until she can choose consciously whether she will or will not be a mother."

—Margaret Sanger

The word "abortion" comes from the Latin word "aboriri," which means "to detach from the right place." According to medical language, abortion is defined as the termination of a pregnancy before the period of viability, or the removal, expulsion, or extraction of all or any part of the placenta or membrane without an identifiable foetus or stillborn child, Legally abortion the premature expulsion of the product of conception from the uterus at any time before the full term is reached.

Abortion laws and regulations have an impact on the lives and health of women. Medical abortion is critical in ensuring that women have access to abortion care that is safe, effective, and acceptable. In a 1967 Assembly resolution, the World Health Organization (WHO) identified abortion to be a significant public health issue.[1]. Public health is concerned with promoting health, preventing disease, and prolonging life through society's organized efforts. The rationale for the need for public health response to a health problem is determined by the scope of the problem and its impact on persons and society at large, and whether the problem is preventable and, cost-effective public health interventions are available.

Whether or not abortion is legal in a given country, women have needed it throughout history, and they have also put their health or lives at risk in the process. Women cannot be considered passive reproducers. When confronted with an unwanted pregnancy, they can use whatever means are available to terminate it. The right to health has also been recognized as a fundamental right under Article 21 of the Constitution. The social, moral and ethical aspects in abortion have

1 Twentieth world health assembly resolution 20.14: health aspects of population dynamics. Official records of the World Health Organization No. 160, WHO, Geneva, Switzerland (1967)

impacts in access to safe abortions. As we know, the topic of abortion touches most controversial cultural aspects in society. An unmarried girl who needs s to get a legal abortion should go through various procedures and hardships affecting her physical and mental health. These cultural aspects hugely contribute to the increasing number of illegal abortions conducted throughout the country, which seriously affects women's health. Even in the case of rape victims where accessing legal termination, various hindrances occur due to certain social norms. People tend to hide these issues and, as a result, opt for unsafe abortion. This happens mostly in women coming from socio-culturally backward sectors. Also, our abortion laws are highly regulated that even women without such social-cultural problems tend to find easy methods which are potentially unsafe. Lack of clarity and awareness of the correct process termination of pregnancy causes further public health issues. Unwanted pregnancy is a risk factor for poor maternal mental health and may negatively affect existing children. According to studies, unwanted pregnancy has also been linked to poorer mental health outcomes later in life. The forced continuation of unwanted pregnancy due to time lost in the litigation process is detrimental to women's physical and mental health. Unwanted pregnancies are a significant public health problem, and third-party permissions for the authorization to abortion access create more negative implications.

In India, the Medical Termination of Pregnancy Act, 1971("the MTP Act") provides the legal framework for abortion services. It lays down the law and procedure with respect to medical termination of pregnancy. The Indian Penal Code, 1860, was the only legal provision for women dealing with miscarriage and abortion until 1971. The Central Family Planning Board proposed to the Ministry of Health in 1964 for legalizing abortion. **The Shantilal Shah Committee** was constituted for this purpose, and with its report delivered in 1966, the Government passed the Medical Termination of Pregnancy (MTP) Act, 1971. The MTP Act was first introduced in 1970, was passed in August 1971, and went into effect on April 1, 1972, after the government drafted rules for its implementation. The Act was amended once since then, in 2002, and new rules were framed in 2003.The Bill of 2020 attempts to bring about a third amendment to the MTP Act. The Preamble of the Act states, "An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto"[2]

[2] Medical Termination of Pregnancy Act, 1972 (Act of 1971), Preamble.

The Indian Penal Code 1860, which is the country's main criminal law, has rendered induced abortion a criminal offense under sections 312 to 316 of the IPC 1860[3] taking into account the religious, moral, social, and ethical backgrounds of Indian society. The MTP Act allows for pregnancy termination under certain instances, and such termination outside of such instances is a criminal offense under the Indian Penal Code, 1860. Since the enactment of the Medical Termination of Pregnancy Act in 1971, abortion has been legally available in India under a variety of conditions, including saving a woman's life to protect her physical and mental health. Our regulatory regime has the capacity to jeopardize the complete wellbeing of women, leaving them confused, scared and unable to attain medically safe and affordable abortion services. So the MTP Act provides for pregnancy termination under certain circumstances, and any termination beyond certain conditions is a criminal offense under the Indian Penal Code, 1860.

Our current legal framework before 2020 amendment lacked various aspects for safeguarding the health of women. This was one of the reasons why many women opt for illegal abortion, which is potentially unsafe. Women's access to safe abortions was hindered by the outdated act's lack of clarification and a lack of knowledge of the law among women and physicians. Doctors denied abortions, citing a regulation against sex-selective abortion and legal procedures in cases of child sexual assault, even though none of these laws prohibit abortion. Women's health and safety are also jeopardized by delays in court decisions on abortions and the stigma associated with abortion.

There were serious criticisms on the time period allowed for termination of pregnancy and huge number of controversial cases were filed in various courts dealing with the same. The new amendment solves some of the issues upto a limited extend.

An amendment for The Medical Termination of Pregnancy passed on March 17, 2020 amends the Act to increase the upper limit for termination from 20 to 24 weeks for certain categories of women, removes this limit in the case of substantial foetal abnormalities, and amends the Act to increase the upper limit for termination from 20 to 24 weeks for certain types of women, removes this restriction in cases of significant foetal abnormalities, and establishes state-level

[3] Section 312 IPC defines miscarriage as “Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage is not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman is quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine”.

Medical Boards. Medical Boards at the state-level. Developments in the field of medicine and technological advancements make are possible to conduct medical termination of pregnancy even at a difficult period of time. So the changes in the time limit were inevitable and the government of India has done a good job considering all these aspects for updating the provisions which will definitely make huge impacts in public health. The latest amendment tried to acknowledge different aspects like contraception failure and allowed termination to "any woman or her partner[4]" replacing the old provision for "only married woman or her husband." The new law is forward-looking, empathetic, and looks at a compassionate issue with a human face.

Unsafe abortion is one of the significant public health consequences of medical termination of pregnancy. Poor women have no choice but to resort to unsafe abortions in countries where abortion is prohibited by law. In contrast, abortions that meet safety requirements can become the advantage of the wealthy who can afford medical healthcare expenses. Given India's situation, access to medical abortion has become so regulated that it has become difficult for women to obtain a safe abortion. It is one of the main reasons women opt for an illegal abortion, which is highly unsafe.

Although India's abortion policy and law are progressive, effective translation into improved access to safe abortion care is often impeded by misguided and unnecessary practices.
With the new amendment, the medical boards have a huge role in safeguarding the health of women by providing comprehensive abortion services. The medical board has a significant role in deciding whether pregnancy could be terminated or not. Sometimes the pregnant woman would be referred to multiple medical boards, which returned differing opinions, ultimately delayed the matter to a point where the pregnancy had advanced beyond twenty-four weeks and could no longer be terminated. Abortion is a very time-specific process and requires fast decisions from the deciding authorities. It is required to be checked how far the establishment of medical boards helps with respect to that aspects. While considering the recent issues and cases, we could identify that The need for a double layer of authorization from the court and then the

[4] The medical termination of pregnancy (amendment)Bill, 2020 ,amendment of section 3, explanation 1

medical board is unnecessary, especially because the decision to terminate is finally made based on the opinion of registered medical practitioners.

There are various health issues that are yet to be discussed by the law, especially on the matter regarding rape victims. According to the amendment act 2020, only in circumstances where a Medical Board detects significant foetal abnormalities after 24 weeks is abortion permitted. This means that if an abortion is required due to rape and the pregnancy is more than 24 weeks, the only option is to file a Writ Petition. The viability of the foetus has been a factor in the decision-making process, which marks a departure from the original standard that took into account the impact of a pregnancy on a woman's mental or physical health. Even in cases when rape survivors have requested abortions, courts have relied on medical boards' recommendations, which have been based on various inconsistent parameters. The possibility of having to seek court permission is intimidating, and for some women, this deters them from seeking the option at all, causing them to resort to unsafe abortion practices.

There are various ambiguities in provisions dealing with the matter of which all categories of women are considered for termination of pregnancy between 20 -24 weeks. It is leaved to be prescribed by the rules. This creates ambiguity in the provision and such a matter should be specified by the parliament and not by the government.

The shortage of doctors, who can provide abortion care with the required specializations in the provision, would have several negative implications for women in rural and economically backward areas who wish to access secure and accessible abortion services.

The MTP Act, which legalized abortion in 1971, has failed to produce the desired results in India. The lack of complexity in procedures adds to the burden of maternal morbidity and mortality significantly. Given the presence of moderate policies, the vast majority of women prefer to use unsafe abortion procedures. Many countries permit the legal abortion procedure throughout pregnancy in cases of fetal impairment to protect a pregnant woman’s health. But in India, certain abortion regulations and vagueness in laws creates several health issues in the society.

How far the actual legal framework of medical termination of pregnancy in our country helps in safeguarding women's physical and mental health can only be analyzed through the

comprehensive study on the judicial decisions regarding the matter. As the judiciary and medical board's decision plays a significant role in deciding whether a termination has to be carried out, their view in this particular matter is very important. It has particularly great impacts in deciding the matters of rape victims and minors. Because they would be the ones, who are mostly affected by unwanted pregnancies, it will seriously affect their mental and physical health. How far our judiciary helps them by providing quick decisions without affecting their health has to be identified. It should be compared with that of the judicial decisions of USA. Even though in the USA each state has there on respective views regarding abortion, the aspects of health remain the same. It is important to look upon where does Indian courts actually stands in front of international standards.

The abortion service has a significant impact on public health. The World Health Assembly first highlighted the public health reason for tackling unsafe abortion in 1967, declaring that "abortions and high maternal and child mortality constitute a severe public health problem in many countries," necessitating international intervention.[5] There is an ethical obligation to fix unsafe abortion in addition to the public health rationale for doing so. In America, Government public health agencies have been involved with abortion for close to 50 years. Historically, these organizations have concentrated on collecting abortion-related data, improving clinical quality and researches.

Before the nineteenth century, no laws covering the legality of abortion had been enacted in the United States. To make judgments, American courts relied on British common law doctrine. Since the 1973 landmark U.S. Supreme Court decision on abortion, ***Roe v. Wade***[6], the issue of abortion has generated a vast literature, spanning many disciplines. ***Roe v. Wade***[7] is almost synonymous with the US and abortion laws. According to it medical judgement may be exercised in the light of all factors, physical, emotional and psychological, allowing the attending physician the room he needs for making the best medical judgment. Later in *Planned* ***Parenthood v Casey***[8], changes have been brought in the legal standard by which restrictions on

[5] World Health Assembly, 20. (1967). Twentieth World Health Assembly, Geneva, 8-26 May 1967: part II: plenary meetings: verbatim records: committees: summary records and reports. World Health Organization. https://apps.who.int/iris/handle/10665/85801

[6] *Roe v. Wade* 410 U.S. 113 (1973)

[7] Ibid.

[8] *Parenthood v Casey* 505 U.S. 833 (1992)

abortion are evaluated, having a profound effect on access to reproductive health care in the United States.

Gestational limits vary between eight to twelve weeks. Twenty-two states have banned the use of procedures anywhere between 13 and 25weeks. Recent policy and legal reforms, medical technology advancements, and the continued maternal deaths from illegal abortion are all indicators of abortion's importance in women's reproductive lives. Because of the quality of health facilities, first-trimester abortions in the United States are safer than many other standard healthcare procedures and carry a shallow risk of death. The increasing availability and use of legal abortion in the United States has many significant effects on public health. The increased availability and use of abortion in the United States has affected public health in the last decade. Legalizing abortion has resulted in a decline in the number of deaths and surgical complications among women of childbearing age, the advancement of safer abortion procedures, and the availability of low-cost outpatient facilities. Two potential negative consequences of the increased abortion rate are adverse effects in subsequent births and an increased risk of breast cancer. Legalizing abortion tends to bring the notion of considering abortion as a public health requirement instead of a heinous crime. There is some concern regarding possible negative outcomes in future planned pregnancies and the possibility of increased breast cancer risks in certain women..

By replacing unsafe, illegal abortions with safer, legal procedures, women suffered less severe complications. Hospitalization of women with complications from illegal abortion decreased steadily after this decision, according to studies conducted at the national, state, and local levels in the United States. It changed abortion from a dangerous, illegal procedure to one carried out under medical supervision. As the availability of legally induced abortion increased, mortality due to abortion dropped sharply.

The topic of abortion should also be considered a reproductive health issue because access to safe and affordable abortion services is directly linked with women's reproductive rights. Abortion has long been regarded as a matter of reproductive rights. It includes your legal ability to make decisions about when and if you have a child. The right to reproductive health is also an inextricable aspect of human rights, which are universal, inalienable, indivisible, and interrelated, and are protected by the Indian Constitution.

Abortion is still one of the most contentious issues in public affairs. Despite entrenched opposition to legal abortion, public health data has aided in the development of judicial decisions, legislative actions, and surgeon's general reports, all of which have resulted in safer options for women of reproductive age. Treating abortion as a healthcare issue, making it available at the woman's request, allowing the woman to make the final decision in consultation with her doctor, rather than forming convoluted laws and restrictions, makes abortion safe, simple, affordable, and accessible.

Relevance

Unsafe abortion contributes to a significant portion of maternal mortality in India. The majority of women in India still lack access to safe abortion care. Inadequate buildings and infrastructure, incorrect priorities, and insufficient and improperly utilized finances afflict the public health services. Despite moderate policies, most women still resort to unsafe abortion, especially in rural areas, due to the lack of awareness of the patients and the lack of surveillance by the government. The shortage of doctors specializing in gynecology or obstetrics in community health centers in rural areas is essential Countries impose different conditions and time limitations for legalizing abortions based on the health of the foetus and the risk to the pregnant woman. Access to legal, safe procedures to end a pregnancy is a part of the reproductive rights of the women and reproductive rights have significance because they give all people access to safe reproductive health care. If those rights are restricted, one may not be able to make their own decisions about pregnancy or birth control. This could leads to a high proportion of unwanted pregnancies, unsafe abortions, and unnecessary death and injury during pregnancy and childbirth. There are various shortcomings in India’s current abortion law, particularly harming the health of women. The 24 weeks’ time limit is only provided in cases where a Medical Board diagnoses substantial foetal abnormalities. In cases where rape survivors have requested abortions, the courts have relied on the opinion of medical boards, which offer advice based on inconsistent standards. And if that exceeds 24 weeks, the only recourse remains through a Writ Petition. The Act does not provide a time frame within which the Board must make its decision. Termination of pregnancies is a time-sensitive matter, and delays in decision-making by the Medical Board may result in further complications for the pregnant woman. Access to timely and affordable access to abortion services is critical for marginalized persons. For women and girls who rely on the public healthcare system and have limited access to post-abortion care, the risk

of serious complications or even death is higher. Abortion in various countries is placed within a healthcare framework. It would be good to compare the current abortion framework with that of countries like the US to identify where we stand in providing access and facilities to safe abortion services.

Statement of Problem

India's current legal framework for abortion has a significant role in safeguarding public health concerning women. The new amendment in Medical termination of pregnancy Act is progressive, empathic, and tends to solve various health issues faced by women by extending the upper limit for termination. Still, it does not resolve most of the mental/physical health issues and barriers faced by women and ensure them access to safe and affordable abortion services. The established medical council to make decisions on specific cases of abortion could be seen as a violation of reproductive rights of women and cause delays in access to abortion. It is questionable to what extent it helps women provide safe abortion services to women, especially those who are from socially and economically backward sectors.

Objective

- To conduct a comparative study of the current regulatory framework for medical termination of pregnancy.
- To study the impacts of regulations in public health issues concerning women
- To identify the role of medical boards in providing comprehensive abortion services.
- To have a comparative study of the role of the judiciary on various public health issues of abortion.
- To study that how far our current laws protect the reproductive health and autonomy of women dealing with abortion.

Research Methodology

Doctrinal research methodology will be adopted for conducting this study.

Hypothesis

The current legal framework on abortion in India is not sufficient enough in curtailing public health issues relating to termination of pregnancy with respect to women.

Research questions

1. What are the public health impacts of current legal framework of abortion in India?
2. What are the barriers faced by women in accessing safe and affordable abortion services?
3. What are the impacts of judicial decisions in providing access to safe abortion and protect the reproductive health of women?
4. Does our current legal framework of abortion protect the reproductive rights of women?
5. Whether states and medical boards provide comprehensive abortion care to safeguard the health of women to avoid unsafe abortions?

Chapterisation

1) Introduction

2) Current legal framework -Comparison with U.S

3) Impact of the current legal framework on public health issues relating to women.

4) Abortion - A reproductive health issue

5) Access to safe abortion care- Role of state and medical boards in safeguarding the health of woman

6) Conclusion and suggestions

Chapter overview

- CHAPTER I: INTRODUCTION

It deals with the introduction of this paper, research question, objectives, hypothesis, and methodology used to answer the research questions.

- CHAPTER II: Current legal framework -Comparison with the U.S.

  This chapter deals with all legislations and regulations of termination of pregnancy in India and the USA. It also deals with the evolution of these laws and significant events, relevant case laws, which happen to be an important factor on the course of its enactment. It further analyses various aspects in our current regulation, which gives more importance to the health of women. It particularly mentions the MTP Act 1971 and its latest 2020 amendment and various significance, advantages and disadvantages of the same.

- CHAPTER III: Impact of the current legal framework on public health issues relating to women.

  This chapter contains a detailed study on various public health issues affecting women during the abortion and at how our current legal framework addresses these issues. This chapter also tries to find out specific parts in our legal system, creating barriers for abortion and thus hurting the health of women. It further extends it study particularly towards the topic of unsafe abortion and its impacts of public health dealing with women since that being a major health issue of abortion.

- CHAPTER IV: Abortion - A reproductive health issue

  This chapter deals with the significance of reproductive rights and reproductive autonomy of women and how our current regulation on abortion deals with this aspect. It studies abortion as a reproductive health issue and analysis our current laws and regulations in such a perspective. It discusses how our state authorities and medical boards address the aspect of women's reproductive health and autonomy. Using a comparative study on case laws, we discuss the judiciary's view on this matter. It also addresses the need to decriminalize abortion for the ensuring right to the reproductive health of women.

- CHAPTER V: Access to safe abortion care- Role of state and medical boards in safeguarding the health of the woman

  This chapter deals with the need for access to safe and affordable abortion services and the role of state and medical boards in providing facilities and authorization for the same. It discusses the international human rights standards on access to abortion and comparison with that of the USA. Further research is conducted using various case laws, and a critical analysis is conducted. A critical analysis is conducted on the current functions of state and medical boards in protecting the health of the women. It also studies on drawbacks of creating third-party authorization for accessing abortion.

- CHAPTER VI: Conclusion and Suggestions

  This chapter deals with the conclusion, suggestions and findings made in the research, followed by the bibliography

Chapter 2 - Current legal framework of Abortion -Comparison with USA

INTRODUCTION

Medical abortion is critical in ensuring that women have access to abortion care that is safe, effective, and acceptable. Health care facilities can play a larger role in the provision of abortion services and provide high-quality care, including post-abortion care. Interventions are required to increase access to abortion services by improving the equipment of existing facilities, assuring appropriate and continuous supplies of abortion medication, and increasing the number of trained clinicians.

The Indian Penal Code 1860[9], the country's fundamental criminal law, has rendered induced abortion a criminal offence under sections 312 to 316 of the IPC 1860, taking into account the religious, moral, social, and ethical context of Indian society. Abortion was criminalized in India's penal code, which featured severe penalties for both the woman and the abortion provider. In an effort to prevent maternal fatalities due by unsafe abortions, the Government of India established the Shantilal Shah Commission in 1966. Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971 based on their suggestions.

The Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971 with the goal of regulating and ensuring access to safe abortion. The law permits only registered medical practitioners at certified abortion facilities to perform abortions to save a woman's life or to preserve her physical or mental health; it also permits abortion in cases of economic or social necessity, rape, incest, fetal impairment or the failure of a contraceptive method used by a married woman or her husband. Consent from the woman's spouse or other family members is not required for the abortion; however, a guardian's consent is required if the woman seeking the abortion is under the age of 18 or mentally ill. The act allows for the termination of unintended pregnancies up to 20 weeks of pregnancy; however, if the pregnancy is more than twelve weeks, a second doctor's approval is required. There are a few exceptions: The gestational age limit does not apply and a second opinion is not required if the doctor believes that an abortion is immediately important to protect a woman's life.

[9] Act No 45 of 1860

While dealing with the United States, we can see Abortion is lawful in the United States and its territories, though restrictions and availability vary from state to state. Abortion is a contentious and divided issue in American society, culture, and politics, with anti-abortion laws in place in every state since at least 1900. The abortion restrictions are dependent on the ruling political party and recently various bans can see in many states of USA.

The MTP Act, 1971[10] has been defined in its opening lines as 'An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental there to[11]'. Since 1971, when the Medical Termination of Pregnancy Act was passed, abortion has been legal in India under a broad range of circumstances, including saving a woman's life and protecting her physical and mental health.

The Medical Abortion of Pregnancy Act was amended on March 17, 2020, to raise the upper limit for termination from 20 to 24 weeks for certain types of women, remove this restriction in the case of substantial foetal abnormalities, and establish state-level Medical Boards.

The MTP Act 1971 establishes a gestational limit for abortion at 20 weeks, after which abortions may be performed only when the pregnant woman's life is endangered. Even within this restriction, doctors are frequently reluctant to perform abortions out of fear of scrutiny and prosecution. This is due not only to the Indian Penal Code's prohibition of abortion, but also to the ambiguity surrounding the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, and the Protection of Children from Sexual Offences (POCSO) Act, 2012. These impediments to safe abortion access have resulted in a slew of lawsuits throughout the country.

With a progress in Indian abortion law United States has seen record number of measures restricting access in the year 2021 wherein a total of 19 states have enacted 94 restrictions on abortion since January, including 12 bans, with more likely to be passed in the future. Abortion is one of the most contentious problems in the United States, with opponents invoking religious beliefs to proclaim it immoral, while proponents argue that a woman should have the right to choose about her body.

[10] Act No. 34 of 1971
[11] Medical Termination of Pregnancy Act, 1972 (Act of 1971), Preamble.

PROVISIONS IN INDIAN PENAL CODE

The Indian Penal Code 1860, the country's basic criminal law, has made induced abortion a criminal offence. keeping in view the religious, moral, social and ethical background of the Indian community. It has made induced abortion a criminal offence under sections 312 to 316 of IPC 1860 provides for criminal punishment for causing miscarriages, without and without the consent of the woman bearing a child, for causing the death of such woman while causing miscarriage, for preventing a child from being born alive or for causing its death after birth and for causing such death by act amounting to culpable homicide.

LEGAL REGULATION OF ABORTION- HISTORICAL SETTING

In British India, the Indian Penal Code 1860 and the Code of Criminal Procedure 1898 designated abortion as a 'criminal act.' It was a punishable offence under the colonial administration for both the woman and anyone else who sought to do so with or without the woman's agreement. **Sections 313 to 316** are specified under the title: 'Of the causing of miscarriage, of injuries to unborn children, of the exposure Of infants, and of the concealment of births' in the IPC 1860. The same carefully explain the term 'causing miscarriages' of an unborn child during and after gestation. These sections permitted only medically indicated abortions performed in 'good faith' in order to preserve women's lives.[12]

Abortion was, in fact, banned in nearly every country throughout the world at the turn of the twentieth century. However, ***Roe v. Wade,***[13] historic decision by the United States Supreme Court on the legality of abortion, transformed how other nations viewed abortion legislation.

The ruling struck down restrictive abortion regulations, upholding the Fourteenth Amendment's Due Process Clause**.**

The Fourteenth Amendment to the United States Constitution guarantees the "Right to Privacy," which also protects a woman's right to choose whether or not to obtain an abortion.[14]. Soon after this judgement, European countries began to legalize abortion.

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[12] Hirve S, 'Abortion Law, Policy And Services In India: A Critical Review' (*Taylor & Francis*, 2005) https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2804%2924017-4

[13] *Roe v. Wade* 410 U.S. 113 (1973)

[14] 'Roe V Wade: What Is US Supreme Court Ruling On Abortion?' (*BBC News*, 2020) https://www.bbc.com/news/world-us-canada-54513499

In India, the debate over the necessity for an abortion law began in the 1960s, when the government began discussing whether the country required an abortion law. Because abortions were strictly illegal at the time under Section 312 of the Indian Penal Code, 1860, and causing a woman's miscarriage constituted a crime punishable by up to three years in prison and/or a fine.

In 1964, India began to liberalize its abortion laws in response to high maternal mortality caused by unsafe abortion. Doctors frequently encountered women who were critically ill or dying as a result of unsafe abortions performed by inexperienced practitioners. They recognised that the majority of women seeking abortions were married and were not under social pressure to conceal their pregnancies, and that decriminalizing abortion would encourage women to seek abortion services in a legal and safe settings.[15]

On August 25, 1964, the Central Family Planning Board conducted its 16th meeting and expressed worry about the growing number of unauthorized abortions and the harm they represented to women's lives and health.[16] This prompted the formation of the 'Shah Committee' in 1964, headed by Shanti Lal Shah, the former Minister for Health and Law in the Maharashtra Government, to investigate the legality of abortion.

The Committee was established to conduct an investigation of maternal mortality as a result of unsafe abortions. The Committee conducted an examination of the legal, medical, and sociocultural elements of abortion and recommended that abortion be legalised and that a comprehensive abortion care law be enacted. The Committee's members travelled around the country and met with community women, and their results suggested that septic abortion was responsible for a significant proportion of these deaths. The Committee's recommendation to legalize abortion on humanitarian and medical grounds eventually resulted in the passage of the MTP Act, 1971, which permits solely medical abortions.

Shah committee key highlights

- The Shah Committee was appointed by the Government of India in 1964.

[15] . Chhabra R, Nuna SC. Abortion in India: An Overview. New Delhi7 Veerendra Printers, 1994

[16] Sarosh Framroze Jalnawalla, "Medical Termination of Pregnancy Act: A Preliminary Report of the First Twenty Months of Implementation", Journal of Obstetrics and Gynaecology of India, 1974.

- The Committee carried out a comprehensive review of the socio-cultural, legal and medical aspects of abortion.
- The Committee in 1966 recommended "legalizing abortion in its report to prevent wastage of women's health and lives on both compassionate and medical grounds".
- According to the report, in a population of 500 million, the number of abortions per year will be 6.5 million – 2.6 million natural and 3.9 million induced.[17]

Until 1971, the Indian Penal Code, 1860, was the sole legal provision addressing miscarriage and abortion for women. Following its 1966 report, the Government enacted the Medical Termination of Pregnancy (MTP) Act, 1971. The MTP Act was introduced in Parliament in 1970, passed in August 1971, and took effect on 01.04.1972, following the formulation of rules for its implementation by the Government. In contrast to the Shantilal Shah Committee's plan for comprehensive abortion care for women, the MTP Act provides limited protections for women and more for doctors performing medical terminations.

The Act has been amended once since then, in 2002, and new rules were prepared in 2003. The amended new act of 2020 seeks to amend the MTP Act for the third time. Prior to the passage of the MTP Act, around 5 million terminations were performed in India each year, 3 million of which were illegal.[18]

The Medical Termination of Pregnancy Act, 1971

The Medical Termination of Pregnancy Act of 1971 was adopted by the Indian Parliament with the goal of giving legal certainty for registered medical practitioners to terminate certain pregnancies. It establishes the law and practice governing medical abortion. While this was not a rights-based legal provision; it did provide women in India with the right to a safe abortion under certain defined situations. Among these circumstances were define who might be able to perform a termination, when and where, all of which are essential for maintaining patient safety and treatment quality.

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[17] Government of India Report of the Committee to Study the Question of Legalisation of Abortion (Shantilal Shah Committee Report), Ministry of Health and Family Planning, Government of India, (1966),

[18] N. R. Madhava Menon, "Population Policy, Law Enforcement and the Liberalization of Abortion : A Socio Legal Inquiry into the Implementation of the Abortion Law in India", 16 JILI 626 at 632- 33 (1974)

Specificities of Medical Termination of Pregnancy Act 1971

The MTP Act 1971 contains only eight sections and regulates many aspects of pregnancy termination, including the time, place, and conditions under which a pregnancy may be terminated. It permits abortion on the basis of pregnancy caused by contraceptive failure, rape, or serious physical or mental injury to the woman. It permits termination in cases where there is a substantial risk to the foetus.**,** for instance, if the foetus suffers from severe physical or mental abnormalities to be seriously handicapped.[19]

Additionally, it permitted medical abortion up to twenty weeks of gestation. The Act makes it mandatory to acquire approval from the woman's mother or guardian if she is a minor or a 'lunatic.' While this legislation had a great motive and purpose, its implementation and logistical challenges left much to be desired.

The legislation got revised in 1975 to eliminate time-consuming procedures and make services accessible[20]. The Medical Termination of Pregnancy Rules and Regulations 1975[21] define the criteria and procedures for approval of an abortion facility, procedures for consent, keeping records and reports, and ensuring confidentiality. Any pregnancy termination performed in a hospital or other facility without previous approval from the government is considered illegal, and the hospital is responsible for obtaining prior approval. It was further amended in 2002, 2005 and 2020.[22]

Thus, the MTP Act permits termination of pregnancy under certain circumstances, and such termination beyond those circumstances becomes a criminal offence under the Indian Penal Code, 1860. Thus, while Section 312 of the IPC remains in force, neither the MPT Act nor the Bill decriminalizes medical termination of pregnancy; rather, they specify certain permissible grounds for a woman to undergo a medical termination, and only under these specified and

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[19] 'MTP ACT, 1971, Ministry Of Health And Family Welfare, GOI (*Main.mohfw.gov.in*) https://main.mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-1971

[20] 'Medical Termination Of Pregnancy Regulations, http://www.bareactslive.com/RAJ/rj607.htm

[21] 7. Government of India. The Medical Termination of Pregnancy Rules and Regulations. Vide GSR 2543, New Delhi7 Gazette of India, (1975).

[22] 'MTP ACT (Amendment), 2002 | Ministry Of Health And Family Welfare | GOI' (*Main.mohfw.gov.in*) https://main.mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-amendment-2002

permissible categories/conditions may a woman undergo a termination, unless directed by the Court concerned.

Medical Termination of Pregnancy (MTP) Act, 1971 establishes the legal basis for the provision of Comprehensive Abortion Care in India. Pregnancy termination is permissible for a variety of reasons up to 20 weeks gestation, as mentioned below:

The MTP Act specifies –

(i) who can terminate a pregnancy;

(ii) till when a pregnancy can be terminated; and

(iii) where can a pregnancy be terminated.

ELIGIBILITY OF THE PROVIDER

According to the MTP Act, abortion can be performed only by a registered medical practitioner (RMP) who possesses a recognised medical qualification recognised by the Indian Medical Council Act and whose name is entered in the State Medical Register. In India's current abortion laws, health care personnel who are not allopathic physicians are not permitted to be trained as abortion providers or legally providing abortions.[23] Only obstetrician-gynecologists and other allopathic practitioners who have earned a bachelor of medicine/bachelor of surgery degree, completed particular government-approved abortion training, and acquired certification are permitted to legally provide abortion.[24]

ELIGIBILITY OF THE PLACE

By default, all government hospitals are permitted to provide Comprehensive Abortion Care. Abortion is permitted in all public facilities, given the provider is certified to perform abortions. Each state is required by the MTP Act to provide abortion services at tertiary-level health care institutions (medical colleges) and secondary-level health care institutions (district hospitals and first referral units). Private sector facilities are permitted to conduct first- and second-trimester abortion services, but they must obtain government clearance. The clearance is requested from a

[23] . Patel L et al, Support for provision of early medical abortion by mid-level providers in Bihar and Jharkhand, India, Reproductive Health Matters, ,70–79 (2009)

[24] Ministry of Health and Family Welfare, Comprehensive Abortion Care Training and Service Delivery Guidelines, New Delhi: Government of India, (2010)

body comprised of three to five district-level members called the District Level Committee (DLC). The 1975 Medical Termination of Pregnancy Rules and Regulations, which operationalized the MTP Act, establish the criteria and processes for an abortion facility's approval which applies exclusively to private sector facilities.[25] The MTP Rules, 2003 prescribes forms for approval of a private place to provide MTP services.

REQUIRED OPINION AND CONSENT

The MTP Act requires simply the agreement of the woman whose pregnancy is being terminated. However, agreement of the guardian is required in the case of a minor or a mentally ill lady. This does not imply that only parents are required to consent.) is required for termination. According to the MTP Act, terminations up to 12 weeks require the opinion of a single Registered Medical Practitioner (RMP), while terminations between 12 and 20 weeks require the opinion of two RMPs.

MTP ACT, AMENDMENTS, 2002

The Medical Termination of Pregnancy (MTP) Act of 1971 was amended in 2002 to improve implementation and enhance access for women, particularly in the private health sector.[26] The new Act decentralised regulation of abortion facilities from the State level to District Committees that are empowered to approve and regulate abortion facilities in an effort to decrease bureaucracy in gaining facility approval. Individual providers and owners of institutions that are not approved or maintained by the government face punishment ranging from 2 to 7 years imprisonment.

The term 'lunatic' was replaced with "mentally ill person." This modification in terminology was implemented to emphasise that a mentally ill person is someone who requires care for a mental condition other than mental retardation. To ensure women's compliance and safety, the Act imposed harsher penalties for MTPs performed in prohibited locations or by untrained medical practitioners.

[25] Government of India, Medical Termination of Pregnancy Rules and Regulations, Vide GSR 2543, (1975).
[26] Government of India. Medical Termination of Pregnancy (Amendment) Act, 2002, No.64 of Acts of Parliament

MTP Rules, 2003

The Rules of the MTP Act were amended in 2003 to conditionally allow certified physicians to conduct medical abortion services up to seven weeks outside of registered institutions. The MTP Rules improve implementation and expand access for women, particularly in the commercial health sector. The amended MTP Rules define a time frame for registration and require The District Committee must inspect a facility within two months of receiving an application for registration and process the approval within two months if no flaws are discovered, or within two months following correction of any highlighted defects. However, the amended MTP Rules do not indicate what actions should be taken if approval procedures are still not completed within the time range specified.

The committee's composition is defined in the MTP rules 2003. It also includes particular standards for the equipment, facilities, medications, and referral links to higher facilities that a certified facility must have in order to deliver quality CAC and post-abortion treatments. The guidelines also included provisions for the cancellation or suspension of a certificate of approval for a private place.

PROPOSED AMENDMENTS TO THE MTP ACT, 2014

A national consultation in 2013 attended by a wide range of stakeholders emphasised the need for amendments to the MTP Act. The Medical Termination of Pregnancy Amendment Bill 2014 was made public by the Ministry of Health and Family Welfare in 2014. The proposed MTP Act amendments were primarily aimed at increasing the availability of safe and legal abortion services in the country for women. However, it did not become an act because it contained numerous contraindicated proposals in comparison to the original act.

Guidelines for Comprehensive Abortion Care

In India, the MTP Act of 1971 establishes the legal framework for the provision of induced abortion services. However, standards, guidelines, and standard operating procedures are required to ensure the effective roll-out of services.

The Government of India has taken several measures to ensure the implementation of the MTP Act and make CAC services available to women. Some of them include:

- Guidelines for Comprehensive Abortion Care–Service Delivery and Training MoHFW issued a directive in 2010 to These guidelines provide comprehensive information for programme managers and doctors on all aspects of abortion care, including counselling, legal issues, abortion provision, and post-abortion contraception. In 2014, MoHFW recognised technological advancements and global best practises and formed an expert group to update these guidelines..
- CAC training package was developed to ensure consistency in CAC trainings across the country including trainer's manual, provider's manual, and operational guidelines.
- The Trainer's manual is intended to give thorough instructions and assistance to trainers for conducting CAC trainings. The manual seeks to improve doctors' abilities to provide women with courteous, confidential, and high-quality CAC services.
- Provider's manual: The document is intended to give providers with the necessary clinical skills, strengthen the capacity of nursing staff to support providers, and provide thorough guidance on how to conduct CAC services.
- There are State Program Implementation Plans, which require all states and union territories to submit annual Program Implementation Plans as part of the National Health Mission for the implementation of health interventions in public health institutions. These are reviewed by MoHFW and fund allocation is made on the Record of Proceedings (RoPs) after approval in the National Program Coordination Committee (NPCC). .
- he World Health Organization has published the Clinical Practice Handbook for Safe Abortion Care, which aims to facilitate the practical application of clinical recommendations from the World Health Organization's second edition of Safe Abortion: Technical and Policy Guidance for Health Systems, which was published in 2012.
- The Health Management Information System (HMIS) is an initiative of the Ministry of Health and Family Welfare under the National Health Mission to provide comprehensive information on all indicators for health services largely provided in the public sector. It provides health service delivery reports by indicator and state.

Pre-Conception and Pre-Natal Diagnostic Techniques Act

The introduction in the 1980s of technologies that allowed parents to determine the sex of the fetus prior to birth was embraced by many as a way to both achieve a smaller family and be

assured of having at least one son. Widespread use of this technology has elicited public concern over the discriminatory aborting of female fetuses and the resulting sex imbalance in the population.[27] To address this issue, the government passed a law in 1994 with the goal of eliminating prenatal sex determination and associated sex-selective abortions and arresting the declining sex ratio in India. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act,[28] amended in 2003,[29] prohibits the misuse of antenatal diagnostic tests for the purpose of sex determination. The Act also prohibits the advertisement of such tests, requires registration of all facilities that use them and prohibits those conducting the tests from revealing the sex of the fetus to the expectant parents. But unfortunately this Act has adversely affected the access to medical abortions for the needed patients.

MEDICAL METHODS OF ABORTION (MMA)

MMA is a method of terminating a pregnancy that involves the use of a number of medicines. The Drug Controller General of India has approved these medications for usage in India. The Maternal Health division of the MoHFW published the Handbook on Medical Methods of Abortion Archived in 2016 to provide extensive technical information to CAC qualified Gynecologists and Medical officers on providing MMA services to women at their institutions. The handbook contains in-depth information on medicines, counselling, documentation formats, contraception, and the treatment of side effects and probable consequences.

Evolution of abortion law in United States

Abortion is legal in every state and territory of the United States and its possessions, though limits and accessibility vary from state to state. Abortion was a felony in every state in 1900. Certain states incorporated abortion provisions, primarily to safeguard the woman's life or to

[27] George SM, Millions of missing girls: from fetal sexing to high technology sex selection in India, Prenatal Diagnosis, 604–609(2006).
[28] Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994.No. 57, Acts of Parliament,1994 (India)
[29] Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2003, No.14, Acts of Parliament,2003(India)

terminate pregnancies resulting from rape or incest.[30] In 1964 Gerri Santoro of Connecticut died in 1964 while attempting to have an illegal abortion, and her photograph became a symbol of the abortion-rights movement. In 1965, the U.S. Supreme Court case ***Griswold v. Connecticut***[31] struck down one of the contraception for married persons Comstock laws in Connecticut and Massachusetts. ***Eisenstadt v. Baird***[32] case of 1972 extended its holding to unmarried persons as well.

Decriminalization of abortion in the United States began in the late 1950s and culminated with the ***Roe v. Wade***[33] decision in 1973. Prior to *Roe v. Wade*, states prohibited abortion without exception, 16 states prohibited abortion unless in exceptional cases (e.g., rape, incest, or a harm to the mother's health), three states permitted residents to acquire abortions, and New York permitted abortions in general. On January 22, 1973, the Supreme Court in Roe v. Wade invalidated all of these bans and established criteria for abortion access. *Roe* established that the right of privacy of a woman to obtain an abortion "must be considered against important state interests in regulation".[34] *Roe* established a "trimester" threshold of state interest in the life of the fetus corresponding to its increasing "viability "over the course of a pregnancy, such that States were not permitted to prohibit abortions early in pregnancy, but were permitted to impose increasing restrictions or complete prohibitions later in pregnancy.

In deciding *Roe v. Wade*, The Supreme Court held that a Texas law prohibiting abortion unless it is absolutely essential to save the mother's life was unconstitutional. The Court reached its conclusion by holding that abortion and abortion rights are protected under the right to privacy.

In the 1973 judicial decision ***Doe v. Bolton***[35], it was specified "that the medical judgment may be exercised in the light of all factors physical, emotional, psychological, familial, and the woman's age relevant to the well-being of the patient". Women in the United States can lawfully choose

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[30] "A Political, Public & Moral Look at Abortion". New York University. February 16,(2016).

[31] *Griswold v. Connecticut* 381 U.S. 479 (1965)

[32] *Eisenstadt v. Baird* 405 U.S. 438 (1972)

[33] *Roe v. Wade* 410 U.S. 113 (1973)

[34] Roe v. Wade, 410 U.S. 113, 154 (1973) "We, therefore, conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified, and must be considered against important state interests in regulation."

[35] *Doe v. Bolton* 410 U.S. 179 (1973)

abortion after viability if screenings indicate abnormalities that do not cause the baby to die early after birth[36].

The trimester framework established by ***Roe v. Wade*** allowed for greater state regulation of abortion in later trimesters and resulted in increase in anti-abortion legislation during the 1990s. With the exception of public funding restrictions4 and parental involvement laws, courts declared most other types of anti-abortion legislation unconstitutional in the years following Roe v. Wade. However, in 1989 the Supreme Court in ***Webster v. Reproductive Health Services***[37] found constitutionally permissible some additional State restriction on abortion.

In the 1992 case of ***Planned Parenthood v. Casey***[38], The Court deserted with Roe's rigorous trimester structure, but upheld the core finding that women have the right to choose whether or not to have an abortion before viability. Roe decided that laws restricting abortion must be subjected to **strict scrutiny**, the traditional Supreme Court test for encroachment on fundamental constitutional rights. Instead, Casey used the lower, **undue burden standard** to evaluate state abortion restrictions, reiterating the right to abortion as grounded in the general sense of liberty and privacy protected by the constitution. Thus in 1992, additional latitude to regulate abortion, Supreme Court abandoned the trimester framework established in *Roe v. Wade* in favour of a doctrine of "undue burden." This allowed states to regulate abortion as long as the regulations did not pose an "undue burden" to the woman seeking an abortion. As such, the Supreme Court found constitutional many of the policies contained in **Pennsylvania's Abortion Control Act,** including a waiting period and an informed consent law. The Due Process Clause of the Fourteenth Amendment provides constitutional protection for a woman's decision to terminate her pregnancy. No state may deprive any individual of life, liberty, or property without due process of law. In the situations before us, the operative word is **liberty.**

Health professionals' concerns about the dangers of illegal abortions, the women's movement, and changing societal mores, as well as, in the views of some, concerns about overpopulation, all contributed to legalization. In the 1960s, these forces came together to produce a formidable social campaign to decriminalize abortion. However, today's health professionals are concerned

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[36] "Abortion after the First Trimester in the United States" Planned Parenthood. https://wp.aleteia.org/wp-content/uploads/sites/2/2015/04/abortion_after_first_trimester.pd

[37] *Webster v. Reproductive Health Services* (1989)492 U.S. 490

[38] *Planned Parenthood v. Casey* 505 U.S. 833 (1992)

about the risk of abortion being recriminalized. As a result, while considering the current legal and public health situation of abortion, it's especially instructive to start with a moment in American history when abortion was first criminalised. Abortion became a strongly regulated and criminalised medical treatment in the United States during the latter part of the nineteenth century, shifting from a practice governed by older British common law to a heavily regulated and criminalised medical process. The degree of controversy and debate around abortion during this time period was comparable to our own. Many of the ideas that characterise the current debate arose from events that transpired during this time period.

The United States House of Representatives and Senate have tried multiple times since 1995, led by congressional Republicans, to enact legislation prohibiting intact dilation and extraction, sometimes known as partial birth abortion. The laws were passed by large votes both times, but President Bill Clinton vetoed them in April 1996 and October 1997 because they did not include health exclusions.

The Born-Alive Infants Protection Act of 2002 ("BAIPA")[39] was enacted August 5, 2002 by an Act of Congress and signed into law by George W. Bush. It asserts the human rights of infants born after a failed attempt to induce abortion.

On October 2, 2003, the House approved the Partial-Birth Abortion Ban Act which prohibits partial-birth abortion with an exception in situations of life-threatening risks to the woman. For administering such a surgery, a doctor might face up to two years in prison and civil litigation under this legislation. Under the law, a woman who undergoes the treatment will not be prosecuted. The law's constitutionality was contested almost soon after it was signed. Three different U.S. district courts declared the law unconstitutional, which includes ***Planned Parenthood v. Ashcroft***[40]***, National Abortion Federation v. Ashcroft, Opinion and Order***[41], and ***Carhart v. Ashcroft***[42], and all three cited the law's omission of an exception for the health of the womanIt made a judgement in the matter of ***Gonzales v. Carhart***[43], on April 18, 2007, addressing a federal law known as the Partial-Birth Abortion Ban Act of 2003, which President

[39] 1 U.S.C. § 8 (Supp. III 2003)
[40] *Planned Parenthood v. Ashcroft* 462 U.S. 476 (1983)
[41] *National Abortion Federation v. Ashcroft, Opinion and Order* 287 F. Supp. 2d 525 (S.D.N.Y. 2003)
[42] *Carhart v. Ashcroft* 530 U.S. 914(2004)
[43] *Gonzales v. Carhart* 550 U.S. 124 (2007)

George W. Bush had signed into law. The law prohibited intact dilation and extraction, also known as partial-birth abortion by opponents of abortion rights, and provided that anybody who violated the rule would face a prison sentence of up to 2.5 years. So the law was enacted in 2003, and in 2007 its constitutionality was upheld by the U.S. Supreme Court in the case of *Gonzales v. Carhart*[44].

On April 1, 2004, President Bush signed the Unborn Victims of Violence Act, often known as Laci and Conner's Law, into law, allowing two charges to be filed against someone who kills a pregnant woman (one for the mother and one for the fetus). It expressly prohibits accusations against the mother and/or the doctor for abortion treatments. Nonetheless, it has sparked great debate among pro-abortion rights activists, who see it as a possible step toward outlawing abortion.

The Pain-Capable Unborn Child Protection Act is a bill introduced in the United States Congress that would prohibit late-term abortions after 20 weeks of pregnancy on the grounds that the foetus is capable of feeling pain during and after the abortion. The bill was introduced in Congress for the first time in 2013. It passed the House of Representatives three times in 2013, 2015, and 2017, but not the Senate. The bill's opponents refute the supporters' arguments about embryonic development and contend that such a restriction would jeopardize women's health.

In the case of ***Whole Woman's Health v. Hellerstedt***[45], the Supreme Court in a 5–3 decision on June 27, 2016, swept away forms of state restrictions on the way abortion clinics can function.

Prior to the nineteenth century, no legislation governing the legality of abortion had been passed in the United States. To make decisions, American courts relied on British common law principles. Abortion was only illegal under common law if the pregnant mother sensed foetal movement (quickening). Abortion was not illegal prior to quickening since it was medically impossible to confirm a pregnancy with certainty before quickening had occurred. Many state legislatures passed legislation regulating the practice of abortion for the first time during the first part of the nineteenth century. These statutes, for the most part, upheld the common law notion of quickening, but they also established precedents for the practice of abortion to be regulated by

[44] Ibid
[45] *Whole Woman's Health v. Hellerstedt* 579 U.S (2016)

statute rather than common law. State legislatures again interfered in the abortion debate from 1860 through 1880. As various historians have pointed out, the legal status of abortion during the majority of the twentieth century was primarily determined by legislative activity during this time period in the nineteenth century.

The laws passed at the time abolished the quickening doctrine, making abortion illegal at any stage of pregnancy. However, some state laws created an exemption for abortions performed to save the mother's life. Furthermore, several laws made both the woman and the abortionist criminally responsible. An developing group of organised doctors mostly linked with the American Medical Association and anti-obscenity crusaders led by Anthony Comstock were the main proponents of making abortion illegal. Surprisingly, feminists backed doctors in their anti-abortion stance, while religious groups stayed out of the debates.

In order to appreciate the basis of these organizations' perspectives and how the abortion debates were developed, a review of the primary arguments and individual reasons is helpful. Physicians affiliated with the American Medical Association (A.M.A.), which was founded in 1847, were a dominant, if not the leading, factor in criminalizing abortion. These doctors mobilized efforts to ban abortion through their publications, lectures, and, perhaps most importantly, their effective lobbying of state legislators to adopt antiabortion statutes. Historians attribute anti-abortion positions to a variety of motivations, ranging from doctors' explicit concern for maternal health (many believing that abortion was a greater risk to health than childbirth and morality in effect, an early expression of concern about foetal rights and an interpretation of the Hippocratic Oath to more subtle and often unspoken designs for a more virulent form of abortion.

CURRENT ABORTION FRAMEWORK IN USA

In USA restrictions and accessibility vary from state to state. Abortion is a contentious political topic, with attempts to limit it occurring on a regular basis in the majority of states. Two such cases, originating in Texas and Louisiana, led to the Supreme Court cases of ***Whole Woman's***

Health v. Hellersted[46] and ***June Medical Services, LLC v. Russo*** [47]in which several Texas and Louisiana restrictions were struck down.[48]

Minors and abortion problems are regulated at the state level, with 37 states mandating parental involvement, whether in the form of parental consent or parental notice. Parental restrictions that are necessary in some instances can be overruled by a court.[49] Abortion laws frequently include mandatory waiting periods, ultrasounds, and pre-abortion counselling. Abortion laws in conservative Southern states are frequently harsher than in the rest of the country.

The Reproductive Health Act (RHA) of New York was approved in 2019, repealing a pre-Roe clause that prohibited third-trimester abortions except in situations when the continuation of the pregnancy risked a pregnant woman's life.[50]

Abortion is banned in the Northern Mariana Islands, a United States Commonwealth territory. Alabama House Republicans passed a law on April 30, 2019, that will criminalize abortion if it goes into effect. Dubbed the "**Human Life Protection Act"[51],** it offers only two exceptions: serious health risk to the mother or a lethal fetal anomaly. It will also make the procedure a Class A felony. Alabama governor signed the bill into law, primarily as a symbolic gesture in hopes of challenging *Roe v. Wade* in the Supreme Court.[52]

Since Alabama passed the first contemporary anti-abortion legislation in April 2019, five additional states, including Mississippi, Kentucky, Ohio, Georgia, and, most recently, Louisiana on May 30, 2019, have passed abortion laws.

In May 2019, the United States Supreme Court upheld an Indiana state statute requiring aborted foetuses to be buried or cremated.[53] n a case decided in December 2019, the Supreme Court

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[46] *Whole Woman's Health v. Hellersted* 579 U.S. (2016)

[47] *June Medical Services, LLC v. Russo* 591 U.S.(2020)

[48] "Strict Texas abortion law struck down". *BBC News*. June 27, 2016.

[49] "Parental Involvement in Minors' Abortions" March 14, 2016.

[50] "Parental Involvement in Minors' Abortions" March 14, 2016.

[51] The Human Life Protection Act, also known as House Bill 314 (HB 314) and the Alabama abortion ban, is an Alabama statute enacted on May 15, 2019, that was set to impose a near-total ban on abortion in the state starting in November 2019

[52] Kelly, Caroline "Alabama governor signs nation's most restrictive anti-abortion bill into law"(2019).

[53] "Supreme Court Upholds Indiana Provision Mandating Fetal Burial or Cremation"

declined to hear an appeal of a lower court judgement upholding Kentucky statute mandating doctors to do ultrasounds and reveal foetal pictures to patients before performing abortions..[54]

On June 29, 2020, the United States Supreme Court appeared to uphold prior Supreme Court judgements prohibiting abortion restrictions when it struck down Louisiana's anti-abortion law. It was also pointed out that Supreme Court Chief Justice John Roberts, who agreed that the Louisiana anti-abortion statute was unconstitutional, had previously voted to preserve a Texas anti-abortion law that was later overturned by the United States Supreme Court in 2016[55].

In response to the COVID-19 epidemic, anti-abortion politicians in numerous American states implemented or sought to enact abortion restrictions, defining it as a non-essential practice that can be halted during a medical emergency. Human rights organisations and national medical organisations, including the American Medical Association, have filed lawsuits challenging the orders. Most of the orders have been temporarily halted due to legal challenges brought on behalf of abortion providers, many of whom are represented by the American Civil Liberties Union and Planned Parenthood.

➢ Federal and State Bans and Restrictions on Abortion

At the federal level, the Hyde Amendment and a federal abortion ban both limit abortion access nationwide. With very few exceptions, the Hyde Amendment prevents abortion from receiving federal Medicaid funding across the board. It's an intrusive and discriminatory insurance coverage restriction for millions of low-income people, and it's an example of lawmakers meddling with safe and legal abortion access. However, in 2021, President Joe Biden reversed his previous support for the Hyde Amendment and proposed a budget for 2022 that did not include the Hyde Amendment at all.

Federal Abortion Ban- The United States Supreme Court affirmed the first-ever federal statute prohibiting abortion procedures on April 18, 2007, giving government permission to intervene in people's reproductive health care decisions. Abortions in the second trimester of pregnancy,

[54] "Supreme Court declines to hear Kentucky ultrasound law", December 9, 2019.
[55] Najmabadi, Shannon (June 29, "Supreme Court affirms abortion protections, strikes down Louisiana abortion law". *The Texas Tribune*. (2020).

which experts say are typically the safest and best option to protect a pregnant woman's health, are illegal under the federal abortion ban.

THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) ACT, 2021

In March 2020, the Indian government introduced the MTP (Amendment) Bill to address several concerns. In March 2021, both the Lok Sabha and the Rajya Sabha passed the bill. The Medical Termination of Pregnancy (Amendment) Act 2021 extends the period during which a pregnancy can be terminated to 24 weeks. The voyage of this current modification to the MTP Act 1971 has spanned several decades with the constant studies and discussions on many socio-cultural, political, and legal backdrop and the different conflicts that have occurred along the route..

The Medical Termination of Pregnancy (Amendment) Act of 2020 aims to increase women's access to safe and legal abortions for therapeutic, eugenic, humanitarian, or societal grounds. The amendments include the substitution of certain sub-sections and the insertion of certain new clauses under specific sections of the existing Medical Termination of Pregnancy Act, 1971, with the goal of raising the upper gestation limit for termination of pregnancy under certain conditions and strengthening access to comprehensive abortion care under strict conditions, without jeopardizing service and quality of care. When we look into the MTP Act before the 2020 amendment we could see that, for a long period This Act was also ignorant towards the change in technology. Much has changed since then in terms of societal shifts and the advancement of abortion technology leads to the increase in gestational period. For women who need to terminate a pregnancy, the proposed increase in gestational age will promote dignity, autonomy, confidentiality, and justice.

The revisions take into account developments in medical technology, simplify provider requirements, raise the upper gestation limit for termination of pregnancy under certain circumstances, and abolish the gestation restriction for situations that potentially put a strain on the health system. The purpose is to provide access to complete abortion care for women who require safe and high-quality services without jeopardizing their dignity, autonomy, confidentiality, or justice.

If a foetal abnormality is discovered after twenty-four weeks of pregnancy. In such circumstances, a medical board made up of a gynecologist, a pediatrician, a radiologist, or other members will identify and treat the problem.

Additionally, if any doctor reveals the details of women undergoing an abortion, they shall be punishable with imprisonment, which may extend to one year, or with a fine or with both.[56]

CHANGES BROUGHT BY NEW MTP AMENDMENT

These are the key changes that the Medical Termination of Pregnancy (Amendment) Act, 2021, has brought in:

- The gestation period for abortions has been increased from 20 weeks to 24 weeks, but only for certain categories of pregnant women. As a result, rape survivors, incest victims, and differently abled women and girls can get abortions up to 24 weeks of pregnancy. However, two licensed doctors would have to sign off on the abortion.
- All pregnancies up to 20 weeks require the approval of one doctor. The MTP Act of 1971 required one doctor's approval for pregnancies of up to 12 weeks and two physicians' approval for pregnancies of 12 to 20 weeks. Only two doctors' approval is now required for the 20-24 time frame set out for abortion applicants in exceptional categories.
- Regardless of their marital status, women can now terminate unwanted pregnancies caused by contraceptive failure. Previously, only a married woman and her husband were allowed to do so.
- In cases of significant foetal abnormalities (following diagnosis by a medical board), women can seek abortions at any time during their pregnancy.
- In the event of foetal disability, there is no upper gestation limit for abortion if it is decided by a medical board of specialized doctors, which state governments and union territories' administrations would establish.
- For abortions up to 20 weeks, only one abortion provider's opinion is required.

[56] The Medical Termination of Pregnancy (Amendment)Act, 2021 no. 8 acts of parliament, 2021(India)

- The personal details of women undergoing abortions will be confidential.

DRAWBACKS OF OUR CURRENT REGULATION

The current amendment restricts the MTP provision to experienced Obstetrics and gynaecology specialists. Considering that many areas, especially rural sectors, do not have easy access to OB-GYN.

Women do not have complete authority over their reproductive decisions, including abortion, under the law. The new MTP Act falls well short of addressing women's empowerment, as well as respecting, protecting, and fulfilling their rights. It still sees women as benevolent paternalism's victims or protectorates. The power of decision-making not only remains with the doctor, but it is now shared by a whole new group of doctors in the shape of Medical Boards.

Essentially, the Act was designed to protect doctors from criminal prosecution. Various examples of the same can be found at various times. Most sections of MTP Act begin with "*Notwithstanding anything contained in the Indian Penal Code*.", clearly indicating that this was more of a protection for doctors performing "medical terminations" than comprehensive abortion care for women, as the Committee had initially advertised. This particular wording in the law is intended to avoid retaining the penal provision that protects doctors from criminal prosecution. **Section 3** of the MTP Act, which bases a woman's decision to undergo a medical termination completely on the opinion of her doctor, demonstrates a lack of autonomy for women.

The main drawback of our current legislations, even with the new amendment is that, these amendments does not bring about a shift in power from the doctor/healthcare provider to persons who do not want to continue the pregnancy. i.e. essentially they are still prioritizing the interest of the medical practitioner instead of pregnant woman. They make no attempt to increase the pregnant woman's autonomy and agency in this regard. While it appears that there is enhanced autonomy for a woman, it is not entirely choice oriented. The amendment does not decriminalize abortion, and it does not even mention it. It does not assure that no one is turned away or compelled to have an unsafe abortion or to carry on with an unwanted pregnancy.

The terms of the MTP Amendment Act 2021, According to Suchitra Dalvie, a gynecologist and coordinator for Asia Safe Abortion Partnership[57], are "progressive in a paternalistic, victimhood kind of sense."

It does not improve public sector transparency or accountability. The lack of sensitive and discreet high-quality services in the public sector, combined with contraception compulsion, is the reason why women find up in the informal or formal private sector. The new amendment failed to assure that all government hospitals offer a complete range of abortion services, including second-trimester abortions, and that contraception is not coerced.

The 1971 Act and the new amendment both narrow the objective to "pregnant women" and exclude other genders. Despite the fact that India's Transgender Persons (Protections and Rights) Act, 2019, is progressive, the current Bill does not acknowledge transgender pregnancy.

It is unclear how this Bill would prevent abortion based on sex. While the Pre-Conception and Pre-Natal Diagnostic Techniques Act covers female foeticide, the extent to which it overlaps with the MTP Bill is unclear. It is also unclear if the Bill would encompass transgender people.

They do not provide for better access to Medical Abortion Pills. The WHO guidelines proposed an abortion service with only one pill to help limit clinic visits and necessary testing to maintain continuity of treatment, especially during this pandemic situation, but our laws were nowhere near addressing such concerns. The most recent amendment does nothing to improve the regulation of the private sector.

There has been some tiny but welcome change, such as expanding the contraception failure clause to include "woman and her partner" rather than just "married lady and husband," although legislators might have made it more inclusive by using the term "pregnant person" instead of "woman." Another improvement is that just one provider is required to approve a termination up to 20 weeks of pregnancy, as opposed to two previously, when one practitioner may approve up to 12 weeks but two for 12-20 weeks. However, the provider must be an ObGyn or an MBBS

[57] A pan-Asia network for safe abortion advocacy

doctor who has completed the necessary training and certification. Over the last decade, there have been several initiatives to integrate job sharing, at least for first trimester abortions, with doctors from other medical systems such as Ayurveda and Homeopathy, as well as trained nurses. However, due to strong opposition from the Indian Medical Association (IMA) and members of the Federation of ObGyn Societies of India, these efforts failed (FOGSI).

The top limit for terminating a pregnancy, which was previously set at 20 weeks, has now been raised to 24 weeks. However, this increase in the highest limit to 24 weeks is only applicable to certain types of women. This has not been specified at this time, although survivors of rape, incest victims, and other vulnerable women such as differently-abled women and minors are thought to be among them.

It fails to account for the ongoing healthcare catastrophe brought on by the pandemic. Given this, and India's chronic dearth of doctors, they argue that requiring women to seek the advice of two practitioners and a medical board for some types of abortions is unjust. Activists for disabled people have also expressed their displeasure with this topic. This MTP Amendment Bill 2020, which was passed in the midst of a pandemic and lockdowns that exposed the flaws in all of our systems, might have been a game changer, addressing the real barriers that women and pregnant people confront in our patriarchal culture. This amendment is the result of the efforts of a broad and diverse number of advocacy groups and tactics that have been working on the subject for more than two decades, and it excludes some of the recommendations that could have increased access to services by task shifting.

THIRD PARTY AUTHORIZATION FOR MTP -MEDICAL BOARD

Each state and territory has established a Medical Board to make decisions about pregnancy termination after 24 weeks in the event of foetal abnormalities. A gynecologist, one radiologist or sonologist, one pediatrician, and other members appointed by the state or union territory will make up each Board.

However, because the majority of specialists are concentrated in urban areas, getting authorization from these Boards will result in significant expenditures and delays for underprivileged people, particularly those in rural areas. As previously stated, this will

disproportionately affect Dalits and Adivasis, for whom caste and class hierarchies already operate as impediments to receiving decent treatment.

CONFIDENTIALITY

The amended law states "Name and other particulars of a woman whose pregnancy has been terminated shall not be revealed except to a person authorized in any law for the time being in force."[58] While some have applauded this, the reality is that it weakens the strong confidentiality established by the original Act. According to the MTP Act of 1971 regulations, the person's name must not appear on any register and must instead be recognized by a code that has been assigned. It further indicates that the Admission Register is a confidential document, and that the information contained therein about the pregnant woman's identity and other personal information will not be given to anybody.

Certain aspects of the MTP Act overlap with other laws, resulting in privacy violations. The Protection of Children from Sexual Offenses Act (POCSO) stipulates that if a minor becomes pregnant, even though consensual intercourse, and wishes to abort the pregnancy, the case must be reported to the police. The modified MTP statute, on the other hand, substantially protects the privacy of those participating in abortion. Medical abortion pills are also categorized as Schedule H drugs, which require a pharmacist to keep a sales record under the Drugs and Cosmetics Act. Abortion activists claim that this contradicts the MTP Act 2021's promise of confidentiality. Because the decision is predicated on good faith and no verification of any information provided by the client is necessary, the 'failure of contraception' clause has been viewed as a more or less free pass.

CONCLUSION

The new Medical Termination of Pregnancy (Amendment) Act of 2021 is expected to increase access to safe and legal abortion services for therapeutic, eugenic, humanitarian, and social reasons, ensuring universal access to comprehensive treatment. The new law, which took effect on March 25, 2021, will help to achieve the Sustainable Development Goals by reducing preventable maternal mortality.

[58] Section 5A(1), MTP (amendment)Act 2021

The list of reasons for terminating a pregnancy up to 20 weeks gestation was likewise rather broad, and included threat to the woman's life as well as her bodily and mental health. The rationale to terminate a pregnancy caused by rape was that continuing it would affect her mental health. Additionally, terminations were made due to foetal abnormality and the failure of a married woman and her husband to utilize contraceptives effectively. Many countries allow termination of pregnancy for saving the life of the woman, mental and physical health and foetal anomalies. The section allow termination of a pregnancy due to contraceptive failure, on the other hand, makes the MTP Act considerably more permissive than others. In addition, this section was written expressly for a married lady and her husband.

Our MTP Act is not a rights-based framework, and Medical Boards are harsh and intrusive, depriving pregnant women of their liberty. Many people, especially those from marginalized groups, will find it more difficult to obtain abortions as a result of this law change." In India, women's access to abortion is extremely tough, and it is even more difficult for those who live in rural areas.

Even with adequate access, manpower, and infrastructure, citizens in the United States want to defund Planned Parenthood, one of the country's leading providers of preventative health care, sex education, and contraception.

Recent study[59] by the University of Texas estimating that more than 100,000 Texas women have tried to self-induce their own abortions. Which is in a state where a recent law closed more than half of the abortion clinics, and in a country where abortion is a woman's constitutional right. However, several states have made adjustments in response to the tyranny.

Comparing these two situations we can find that legality doesn't necessarily translate into availability, but lack of availability does translate into increased injury and death. So the political conversation we really needed at this point shall not be over abortion's legality or morality, but about accessibility. The priority shall be given for the health of women.

[59] https://www.cbsnews.com/news/100000-texas-women-have-tried-to-self-induce-abortion/

Chapter 3 - Impact of the current legal framework on public health issues relating to women.

Introduction

The Medical Termination of Pregnancy Act, 1971, opened a new era in women's health by establishing a framework that empowered women to exercise basic control over their bodies, because causing a miscarriage voluntarily was a crime under the Indian Penal Code, 1860, and women were also subject to prosecution. The Act established a structure that permits women to seek medical help without fear of bodily injury at the hands of untrained people by formalizing the procedure.

An issue on the public health impact of unsafe abortion has existed for a long time. As early as 1967, unsafe abortion was recognized as a severe public health problem by the World Health Assembly in many countries.[60]. The World Health Organization's Reproductive Health Strategy, established by the World Health Assembly in 2004, aims to accelerate progress toward the achievement of worldwide development goals and targets noted:

"As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets."[61]

The growing number of declarations and resolutions signed by countries over the last two decades indicates that unsafe abortion is a major cause of maternal death that can and should be avoided by promoting sexuality education, family planning, and safe abortion services to the full extent of the law in all cases. There is also agreement that post-abortion care should always be available and that increasing access to modern contraception is vital to preventing unintended pregnancy and unsafe abortion. As a result, the public health case for avoiding unsafe abortion is apparent. The availability of public health measures, as well as the financial savings associated

[60] Resolution WHA20.41. Health aspects of population dynamics, Twentieth World Health Assembly, Geneva, World Health Organization, 1967

[61] Resolution WHA57.12. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets. Fifty-seventh World Health Assembly, Geneva, World Health Organization, (2004)

with fewer abortion complications, emphasize the need to address unsafe abortion. Reducing the need for abortion via family planning, providing safe abortion to the full extent of the law, treating abortion complications, and providing post-abortion care are all priorities are all examples of public health measures.

Eliminating unsafe abortion is one of the key components of the WHO Global reproductive health strategy[62]. The plan is based on international human rights treaties and global consensus statements that call for the respect, preservation, and realization of human rights, including everyone's right to the best health possible. Programmatic, legal, and policy issues of providing safe abortion must be effectively addressed in order to actualize these rights and save women's lives.

The health evidence, methods, and human rights rationale for providing safe, comprehensive abortion treatment have all evolved significantly over the last two decades. Abortion-related fatalities are a significant tragedy, not only because virtually all of them could have been avoided but also because many women die in secrecy, unable to disclose their illness or seek adequate medical assistance. It's almost as though these ladies are being forced to pay with their lives for becoming pregnant when they had not intended to do so. Safe abortions are allowed in nearly all developed countries upon request or on the basis of broad social and economic considerations, and services are generally freely accessible and available. Safe abortion has frequently become the privilege of the wealthy in countries where induced abortion is legally restricted or unavailable, leaving poor women with little choice but to turn to unsafe providers, resulting in deaths and morbidities that become the social and financial responsibility of the public health system.[63].

One in every four women in the United States will terminate a pregnancy throughout her lifetime, but 90 percent of counties lack an abortion provider due to decades of anti-abortion legislation. Despite the fact that the majority of maternal deaths in the United States are preventable, the country has the highest maternal mortality rate among developed economies.

[62] Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Geneva, World Health Organization, 2004.
[63] Singh S et al. Abortion worldwide: a decade of uneven progress. New York, Guttmacher Institute, 2009

Furthermore, contraception and assisted reproduction options are frequently pricey and out of reach for the majority of people.

Access to abortion in India has been challenging even under the best of circumstances. According to the research prepared by Pratigya Campaign for Gender Equality & Safe Abortion, "112 cases of abortion appeals were heard across 14 high courts in India during pandemic-induced lockdowns in the four months leading up to August 2020."[64]. Lack of knowledge about the legal status of abortion, inability to negotiate these options with husbands and family members, lack of physical and financial access, and insensitive attitudes of healthcare providers have all been observed in studies throughout the years.

History of Indian laws addressing women's health in abortion

During the third Five year plan (1961-1966) family planning was declared the very center of planned development and emphasis shifted from clinic center to an extensive approach. Introduction to the loop led to the creation of a separate department of family welfare in the ministry of health in 1966. In 1964 the government of India set up the Shanti Lai Shah committee on the recommendation of the Central family planning board, to look into the problems of illegal abortion. The committee estimated nearly 4 million illegal abortions were being conducted annually, resulting in high maternal mortality and morbidity rates. It, therefore, recommended for legalization of abortion to ensure better health and avoid risk to life of the pregnant woman. As a result the MTP act was passed by Indian parliament in 1971 and came into force in 1972. It was a legislation, which was introduced as a health care measure aimed at reducing maternal mortality and morbidity. It was also expected to initiate women into adopting some form of contraception. But by analyzing the register general of India report in 1990 we could see that e liberalization of legal abortions has not had the desired impact either in terms of decreased mortality or in the provision of safe abortion services to all seekers showing the importance of improving our legislations. While identifying the history, various researchers have proposed several theories in the attempt to explain the higher proportion of illegal and. all too often unsafe MTPs. The theories include greater privacy for women needing MTPs, higher

[64] Pratigya Campaign for Gender Equality and Safe Abortion is a network of individuals and organisations working towards protecting and advancing women's rights and their access to safe abortion care in India. The campaign advocates with governments, organisations and media at the national and state levels on issues of women's empowerment and women's access to healthcare services

quality care from private providers, limited access to legal providers, barriers to care on the basis of age or marital status, contraceptive acceptance and unfamiliarity with availability of legal MTPs etc. So these were the issues needed to sort out and unfortunately even now some of these issues are still prevailing with large intensity.

International calls for public health action

Numerous international appeals support the public health justification for addressing unsafe abortion as a severe public health concern. In 1994, the United Nations International Conference on Population and Development's Programme of Action stated: "All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services".[65]The Report of the Fourth World Conference on Women, held in Beijing in 1995, noted that "unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk"[66]. At a Special Session of the UN General Assembly in June 1999, governments agreed that "in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible"[67]. The WHO Global reproductive health strategy, adopted by the World Health Assembly in 2004 calls, in one of its key components, for programmatic, legal, and policy aspects of the provision of safe abortion to be adequately addressed[68].

[65] UNFPA. Programme of action of the international conference on population and development, paragraph 8.25. New York: United Nations Population Fund; 1994.
[66] United Nations. Report of the Fourth world conference on women, beijing, 4e15 september, 1995. New York: United Nations; 1995.
[67] UNFPA. Key actions for the further programme of action of the international conference on population and development, adopted by the twenty-first special session of the general assembly, New York, June 30eJuly 2, 1999. New York: UNFPA; 1999.
[68] World Health Organization. Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Resolution WHA57.12. Geneva: Fifty-seventh World Health Assembly; May 2004.

Health issues faced by women in the current legal framework of India

There are a variety of legal issues and barriers that cause abortion access to be delayed. Misconceptions about the laws, in particular, lead to such delays. Certain legal factors, such as providers' incorrect inquiries for spousal consent despite the fact that it is not required by law, and courts' enforcement of requirements that rape survivors verify their charges before being authorized to access abortion, cause individuals to have concerns

1) Practical Barriers in accessing safe abortion

The lack of registered health care practitioners trained to provide abortion services, as well as a lack of facilities that are fully prepared to execute the procedure, is a significant barrier for women and girls seeking safe, quick, and legal abortion services. Despite policy guarantees allowing abortion services to be offered in all government health facilities, there are still shortages across India.[69]. These obstacles disproportionately affect women in disadvantaged rural settings. Due to a lack of understanding about their legal rights, legal ambiguity, and societal stigma around abortion, women and girls encounter delays in getting an abortion early in pregnancy.[70].

i. Lack of access of abortion care in rural areas

Access to healthcare is asymmetric between rural and urban India.[71] Both the availability and accessibility of abortion services in rural areas in India is sparse[72]. 70% of India's population lives in rural areas, where legal abortion facilities are scarce. This is especially troubling given that inaccessibility is associated to more than half of abortion-related deaths. In fact, women in rural areas have a 26 % higher risk of dying from complications than their urban

[69] Government of India, Framework for Implementation: National Health Mission 2012-2017 2, 32 (2014). See also Melissa Stillman et al., Abortion in India: A Literature Review, 17 (2014) https://www.guttmacher.org/report/abortion-india-literature-review [hereinafter Abortion in India: A Literature Review

[70] Abortion in India: A Literature Review, supra note 27.

[71] Debasis Batik & Amit Thorat, Issues of Unequal Access to Public Health in India, Frontiers in Public Health (2015)

[72] Stillman, M., Frost, J. J., Singh, S., Moore, A. M., & Kalyanwala, S. Abortion in India: a literature review. 12-14. *New York: Guttmacher Institute*, (2014).

counterparts.[73] Aside from the inadequate infrastructure that surrounds abortion clinics, especially in rural places, complications are still seldom recorded. Indigenous women in India face disproportionate socioeconomic disadvantages. Compounded by the fact that the general public has little understanding of safe abortion clinics.[74] The lack of contraception use, combined with the absence of access to abortion care, robs Indigenous women of their reproductive autonomy, aggravating their disproportionate demographic, economic, and social issues. When we look upon the new amendment of MTP Act, termination needs the opinion of medical practitioner. Particularly from twenty to twenty-four weeks, it would require the approval of two licensed medical practitioners. However, women in rural areas struggle to find registered medical practitioners who have all the facilities and training to provide abortion services.

According to the All-India Rural Health Statistics (2018-19), there are only 1,351 gynecologists and obstetricians in rural India's community health clinics. We are also short of 4,002, implying a 75 % shortfall of qualified doctors**.**[75] Due to a shortage of competent medical practitioners, women's access to safe abortion treatments may be limited in the future. According to the National Health and Family Survey (2015-16), only 53% of abortions are done by a qualified medical practitioner, with the remainder being conducted by a nurse, auxiliary nurse-midwife, family member, or self.**[76]**.

ii. Lack of awareness and training among healthcare professionals

According to the Consortium for Safe Abortions in India's study findings, there is a widespread lack of understanding of the limited legal services that do exist, resulting in a greater reliance on and knowledge of illegally operated facilities.[77]

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[73] Nuffield Department of Population Health . Two-thirds of abortions unsafe in over half of Indian states studied. Retrieved fromhttps://www.ndph.ox.ac.uk/news/two-thirds-of-abortions-unsafe-in-over-half-of-indian-states-studied

[74] Nuffield Department of Population Health . Two-thirds of abortions unsafe in over half of Indian states studied. Retrieved from (2019, May 3). https://www.ndph.ox.ac.uk/news/two-thirds-of-abortions-unsafe-in-over-half-of-indian-states-studied

[75] 'The Medical Termination Of Pregnancy (Amendment) Bill, 2020' (*PRS Legislative Research*) https://prsindia.org/billtrack/the-medical-termination-of-pregnancy-amendment-bill-2020

[76] Unstarred Question No. 599, Ministry of Health and Family Welfare, Lok Sabha, July 20, 2018.

[77] Stillman, M., Frost, J. J., Singh, S., Moore, A. M., & Kalyanwala, S,. Abortion in India: a literature review. 12-14.*New York: Guttmacher Institute*, (2014)

The majority of failed abortions can be traced back to the purchase of non-prescriptive medications that may be erroneously marketed by pharmacists as a less expensive alternative to prescription abortion drugs. Only half of chemists surveyed in Bihar and Jharkhand in 2005 knew the proper dosage and use of the medical abortion pill, and only a quarter knew if abortion was legal.

Similarly, reproductive health education is notably lacking from medical school curricula, and there is widespread misunderstanding about the procedure's legality.[78] The availability of medical abortions might differ substantially depending on the doctor's personal beliefs, just like the subjective judgement that goes into pricing an individual a given amount. These prejudices can be increased in some situations, particularly when doctors have a paternalistic or culturally ingrained attitude of young and unmarried women.

2) Health issues due to pregnancy resulting from Rape

Due to the stigma and personal risks associated with reporting rape, many victims of rape wait until their pregnancy is discovered by medical testing or made public before requesting an abortion, either directly or through their parents.[79] Many petitioners, particularly minors, do not realise they are pregnant until after the 20-week mark, according to a survey of post-20-week cases. This is due to a lack of awareness of the likelihood of becoming pregnant from rape or the indications of pregnancy.[80] Furthermore, the case law demonstrates that when state officials fail to appropriately respond to and investigate rape charges, delays in identifying pregnancy might be compounded. fail to provide rape victims with pregnancy testing kits, as mandated by national guidelines; or cast doubt on petitioners' rape allegations.[81]. In ***R v. State of Haryana***[82], Delays in post-rape medical exam due to negligence was occurred from the part of medical authorities. In another case ***Jamana Suthar v. State of Rajasthan, S.B***[83] **and** ***Indu Devi v. State of Bihar***[84],

[78] Apte, K. (2019, June 27). Sexual health largely neglected, reproductive health not a priority in policy discourse. Retrieved from https://yourstory.com/socialstory/2019/06/sexual-health-reproductive-health-policy-discourse
[79] Abortion in India: A Literature Review, supra note 27 at 17.
[80] Alakh Alok Srivastava v. Union of India & Ors. W.P.(C) 565 of 2017, S.C.C. 28 July 2017.
[81] Government of India, Ministry of Health and Family Welfare, Guidelines and Protocols: Medico-legal care for survivors/victims of sexual violence (2014), available at https://mohfw.gov.in/sites/default/files/953522324.pdf.
[82] *R v. State of Haryana* W.P.(C), 6733 of 2016
[83] *Jamana Suthar v. State of Rajasthan, S.B* Civil Writ No. 6683/2009
[84] *Indu Devi v. State of Bihar* C.W.J.C. 5286 of 2017

Court questioned petitioner's rape allegations for the same reasons according to the provisions. In a case of ***Ms. Z v. The State of Bihar and Others,***[85] , the Court explains, "There was no justification to obtain the consent of the father or the husband for termination of pregnancy".

Several petitioners seeking abortion after 20 weeks have highlighted the psychological trauma and suffering, including suicidal thoughts, that being forced to continue their pregnancy has caused them. In ***R v. State of Haryana***[86], the Court stated, "Due to the less evolved society, more so in this part of the world, till date the rape victim carries more stigma than the person accused of the offence of rape. Those assaulted repeatedly at a very young age may need treatment and counselling for the rest of their lives.[87]

Indian courts have recognized the severe physical and mental health risks that pregnancy can cause women and girls. In ***X v. Govt of NCT of Delhi***[88], the court opined that "To carry a child in her womb by a woman as a result of conception through an act of rape is extremely traumatic, humiliating and psychologically devastating."; Bashir Khan v. State of Punjab[89], the Court considered that since the victim was raped it should be presumed that the pregnancy could cause her severe mental harm. In Vijender v. State of Haryana[90], It was held that "A rape victim shall not be further traumatized by putting through a needless process of approaching Courts for taking permission. "These risks are compounded for younger girls for whom pregnancy is twice as likely to result in maternal mortality[91].

3) Mental health issues

Numerous instances have surfaced of women being denied abortions by doctors on "moral" grounds or being requested to bring partners or parents present for the surgery. This is true if the abortion is seek for reasons other than a woman's physical health, as defined by the MTP Act, and may result in "injury to her mental health."

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[85] *Ms. Z v. The State of Bihar and Others* C.A. 10463 of 2017
[86] *R v. State of Haryana* W.P.(C), 6733 of 2016
[87] Suchitra S. Dalvie, Second Trimester Abortions in India, 16 Reproductive Health Matters 31, 41 (2008), http://www.tandfonline.com/doi/pdf/10.1016/ S0968-8080%2808%2931384-6

[88] *X v. Govt of NCT of Delhi* W.P.(CRL) 18262 of 2013
[89] , W.P.(C) 14058 of 2014
[90] , W.P.(C) 20783 of 2014
[91] Hallo Bi v. State of Madhya Pradesh, W.P.(C) 408 of 2013, H.C. M. & P. 16 Jan. 2013. See also World Health Organization, Fact Sheet: Violence Against Women: Health Consequences (2016)

Doctors may withhold abortion approval due to changed psycho-social circumstances that make a pregnancy unwanted, unintended pregnancy, and unwillingness in a young, single woman to have a child..

In ***Suchita Srivastava and Anr v Chandigarh Administration***[92]. the Supreme Court held that the State must respect the personal autonomy of a "mentally retarded" woman concerning decisions about terminating her pregnancy. In this case, the pregnant woman had clearly expressed her wish to have the child. It further reasoned that the requirement of consent could not be diluted since it would "amount to an arbitrary and unreasonable restriction on the reproductive rights of the victim. To emphasise its position on personal autonomy, "mental retardation," and the MTP Act, the Court cited the 1971 United Nations Declaration on the Rights of the Mentally Retarded, which states that mentally retarded people have the "same rights as other human beings." The Court also cited the 2007 Convention on the Rights of Persons with Disabilities, the provisions of which were obligatory on India.

While the case law is significant in its interpretation of consent as well as other issues in the context of abortion, it also reflects the need for further understanding and debate with regard to psychosocial disability, and the perception of capacity of the person with disability as well as the process of consent in the context of disability; for example, between "mental disability" and "mental retardation".

4) Delay in Abortion Services affecting health of women

Abortion is a necessary and time-sensitive procedure in our health care system. Any delay, whether it is days or weeks, can have a significant impact on women's health and well-being. Safe abortion is a critical health treatment that must not be overlooked due to its extreme responsiveness to time. Even if non-urgent and elective services are halted, it is an important aspect of women's health care that must continue. Abortion is a time-sensitive procedure, and delaying it can push women past their gestational limits, putting additional strain on already overburdened surgical facilities and exposing our health-care workers to additional risks. Delays

[92] Suchita Srivastava and Anr v Chandigarh Administration, (2009) 9 SCC 1

in obtaining safe abortions are caused by legal and practical obstacles. Legal and practical constraints limit women's and girls' ability to obtain safe abortion services quickly.

Providers' misunderstanding that abortion before 20 weeks require judicial approval also causes delays. For example ***Bashir Khan v. State of Punjab***[93]**,** the Punjab-Haryana High Court heard a case in which a 14-year-old rape victim requested a pregnancy termination, and the court explained that doctors should proceed with MTP as long as the pregnancy does not reach 20 weeks. In ***Vijender v. State of Haryana and others***[94] , The Punjab and Haryana High Court granted the petitioner's request for an abortion, stating that court approval is not required after 12 weeks.

Abortion has a low rate of mortality and morbidity as compared to carrying a pregnancy to term. After 8 weeks of pregnancy, the risks increase rapidly with each successive week of pregnancy. There is evidence that abortion rates are similar whether abortion is freely available or restricted, but women who have limited access are more likely to resort to unsafe abortions outside of medical regulation. Women, their families, and the healthcare system all suffer as a result of these disorders. Demanding that women obtain the opinions of two practitioners and a medical board for specific types of abortions is discriminatory and causes many health difficulties for the patient, especially in this pandemic circumstance when we are suffering a chronic scarcity of doctors in India. Young adolescent girls are particularly vulnerable to unsafe abortions because they may postpone the procedure until later in their pregnancies, when there are often more legislative limitations and fewer experienced physicians providing safe abortion.[95]

5) Socio-Economic issues

The stigma in society is the driving force behind these helpless women's decision to get an unsafe abortion. Women's sex life has always been an appealing issue to debate in a patriarchal society. Women are more likely to choose a risky abortion method over a legal option. Women must also examine the facility's location and whether or not they will need their husband's

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[93] *Bashir Khan v. State of Punjab* 14058 of 2014

[94] *Vijender v. State of Haryana and others* CWP No. 20783 of 2014

[95] Woog, V., Singh, S., Browne, A., and Philbin, J. *Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries* New York: Guttmacher Institute. (2015). www.guttmacher.org/pubs/Adolescent-SRHS-Need-Developing-Countries.pdf

permission. The approval of the husband is not required by law, but it is an informal ‘requirement' imposed by many primary and community health centres, depending on whether their visit will be kept private, the gender of the healthcare practitioner, and the assistance provided from their staff.[96]

Our laws also have a tendency to express an interest in providing abortion services to women who are victims. That is to say, we are concerned about the character of women and the circumstances in which they became pregnant. Such cultural judgments may be seen all over the world, and because people are afraid of being judged, they tend to hide the problem. It is one of the most critical issues we must address while discussing abortion. We may expect a large number of unsafe abortions to occur across the country in a society where women's dignity takes precedence over their lives. Imagine entrusting a woman's fate to someone with no medical training, no appropriate equipment, and no access to a clinic, but who claims to be "experienced" in terminating pregnancies. In comparison to a safe abortion, this would be more cruel to both the mother and the foetus. Sexuality education is inevitably hampered when having a physical relationship is prohibited. An open-minded society, on the other hand, would lead to a more formal education system and the Legalisation of abortion in some circumstances. The only way to get rid of the stigma is to raise awareness.Fear of being judged or harassed, as well as the limited services accessible especially for young unmarried women, push women into taking risky and sometimes harmful actions. Women are legally able to make a ‘choice,' but most women do not feel empowered to do so or are not given the opportunity to consider doing so.[97].

In developed countries, the worldwide public health problem of unsafe abortion may be overlooked, as it is viewed as a problem primarily affecting the poor. The problem may be ignored in developing countries since it is seen as a woman's issue in societies where women are disregarded. Many women are not dying because of untreatable illnesses; they are dying because

[96] Bhate-Deosthali, P., & Rege, S. (2019). Denial of safe abortion to survivors of rape in india. *Health and human rights*, *21*(2), 189.
[97] Agnihotri, S. Abortion Rights In India And The Absence Of The Pro-Life/Pro-Choice Debate. *Feminism in India*. (2016, April 11). https://feminisminindia.com/2016/04/11/abortion-rights-india/

communities have yet to decide that their lives are worth saving, according to an inconvenient fact.[98]

i. Cost of Accessing safe abortion

Abortions that satisfy safety standards may become the luxury of the wealthy, while impoverished women are forced to resort to hazardous abortions. Abortion that is safe saves money. The expense to health-care systems of addressing the consequences of unsafe abortion is enormous, particularly in developing countries such as India. However, the economic consequences of unsafe abortion to a country's health system exceed the direct expenses of providing post-abortion treatment.

The cost of an abortion varies depending on the woman's medical condition, her demographic features, the type of procedure performed, and her reasons for obtaining an abortion, unmarried women are paid more, and women who appear to be poor are charged less.[99] Our current law makes no provision for financial or logistical assistance to pregnant women who wish to attend medical boards. Making a pregnant woman with a disabled foetus rush to medical boards where doctors and officials will make the decision for her is "extremely demeaning to her, an invasion of her privacy, an invasion of her choice, and also, creating more bureaucratic hurdles than necessary at a time when she needs to make that decision."[100]

ii. Caste and socioeconomic status

Cost of an abortion is a major barrier to abortion access for the socially backward sectors especially Dalit and Adivasi groups.[101] Women in these groups experience poorer maternal health outcomes as a result of the barriers in accessing healthcare services[102], due to excessive bureaucracy and caste-based discrimination. This is illustrated well by the case of ***Amita Kujur v. State of Chhattisgarh*** where the petitioner, an Adivasi girl and rape survivor, wanted to

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[98] Fathalla, M. F.. "Human Rights Aspects of Safe Motherhood." *Best Practice & Research: Clinical Obstetrics & Gynaecology* : 20, 409–419. (2006)

[99] Stillman, M., Frost, J. J., Singh, S., Moore, A. M., & Kalyanwala, S Abortion in India: a literature review. 12-14 *New York: Guttmacher Institute*, . (2014).

[100] MP Priyanka Chaturvedi said in parliament, http://164.100.47.7/newdebate/253/16032021/Fullday.pdf

[101] Ravi Duggal & Vimala Ramachandran, The Abortion Assessment Project India: Key Findings and Recommendations, 12 Reproductive Health Matters 24, 122-129 (2004).

[102] Linda Sanneving et al., Inequity in India: the case of maternal and reproductive health, Global Health Action (2013).

terminate a pregnancy at twelve weeks.[103] The District Hospital referred her to the Chhattisgarh Institute of Medical Sciences (CIMS), where she was asked to produce a copy of the FIR, medico-legal documents, and a reference letter from the District Hospital.[104] She was unable to obtain these documents, allegedly due to the callous attitude of the police station in charge. She then approached the Court seeking permission to terminate the unwanted pregnancy. The court directed CIMS to constitute a team of two doctors to examine the petitioner, who determined that her pregnancy was at twenty-one weeks, thus putting her outside the confines of the MTP Act. Fortunately, the court granted an order for termination of pregnancy, in the interest of the petitioner. However, this case demonstrates the range of social and legal issues that impede access to abortion services for marginalized persons.

Caste-based discrimination is embedded in public health services.[105] Human Rights Watch has noted that access to maternal health services is challenging for Dalit and Adivasi communities.[106] They face 'triple discrimination due to their gender, caste and socioeconomic status.[107] A study in Meenkera, Karnataka found that caste "operates through both formal and informal structures and networks" and that all significant positions in local public health facilities are occupied by dominant castes[108]. Another study conducted in Ballabgarh, Haryana, found that caste is one of the major determinants for induced abortions; declining socioeconomic status and caste location are directly correlated with lower odds of an induced abortion.[109] An analysis of data from the 1998-1999 National Family Health Survey also revealed that those who are in a more favourable position in the caste system have elevated odds of abortion, as compared to women in rural areas or Dalit and Adivasi women.[110]

iii. Socio-Economic barriers in United States

[103] Amita Kujur v. State of Chhattisgarh, WP (C)No. 976 of 2016, decided on 13-4(2016)
[104] Sama - Resource Group for Women and Health, From the Margins to the Centre: A study on the health inequities among the tribal communities in selected districts of Chhattisgarh, Jharkhand and Odisha, available at http://nhrc.nic.in/sites/default/files/SAMA/ 20Final / 20Report.pdf
[105] Sobin George, Reconciliations of Caste and Medical Power in Rural Public Health Services, 54 Economic and Political Weekly40 (2019)
[106] Human Rights Watch, Unaccountable: Addressing Reproductive Health Care Gaps (2010)
[107] Parisa Patel, Mahua Das & Utpal Das, The perceptions, health-seeking behaviours and access of Scheduled Caste women to maternal health services in Bihar, India, 26 Reproductive Health Matters54, 114-125 (2018)
[108] George, supra note 64.
[109] Shashi Kant et al., Induced abortion in villages of Ballabgarh HDSS: rates, trends, causes and determinants, 12 Reproductive Health 51 (2015).
[110] Saseendran Pallikadavath & R. William Stones, Maternal and Social Factors Associated with Abortion In India: A Population-Based Study, 32 International Family Planning Perspectives 3(2006)

In the United States, women of lower socioeconomic class and women of race have greater abortion rates than those of higher socioeconomic rank. The United States has a higher abortion rate than most other developed countries.[111] Abortion rates differing by income are also considered as proof of exploitation by abortion providers, who are accused of profiteering aggressively from state funding of abortion for low-income women. Unintended pregnancy disparities, as well as disparities in contraceptive use, are linked to disparities in abortion rates. These conclusions are based on structural variables such as economic deprivation, community features, lack of access to family planning, and mistrust of the medical system. In recent years, disparities in abortion rates have gained more political attention, with opponents of abortion rights claiming disparities in abortion rates as proof of the devilish nature of the abortion business.

6) Third party authorization- issues

The new amendment also requires medical boards to approve subsequent terminations of pregnancies in cases of foetal abnormalities, legitimizing third-party authorisation and adding to women's difficulties and delays for abortion service. Access to care may also be hampered by time-consuming medical authorization procedures, particularly if required specialists or hospitals are inaccessible. The requirement for permission from a spouse, parent, or hospital official may violate the woman's right to privacy and her access to health care, and it disproportionately affects poor women, adolescents, those with poor education, and those who have experienced or are at risk of domestic conflict and violence, resulting in access disparities.

7) Post-abortion care and follow-up

Following an abortion, women should receive information and counselling about post-abortion health care, including how to avoid another abortion in the future. Before leaving the health care institution, all women should be given contraceptive information and offered counselling and methods of post-abortion contraception, like emergency contraception. For women whose abortions were performed in an unsafe manner, post-abortion care is used as a strategy to reduce the morbidity and mortality in associated with complications, such as uterine aspiration for

[111] *World Abortion Policies, 2011*. New York, NY: Department of Economic and Social Affairs Population Division; (2011)

incomplete abortions, the provision of contraception to prevent future unintended pregnancies, and connecting women to other community resources.

8) Barriers of POCSO Act and PCPNDT Act

The Prevention of Children from Sexual Offenses Act of 2012 (POCSO Act) and the Pre-Conception Pre-Natal Diagnostic Techniques Act of 1994 (PCPNDT) prove to be substantial impediments to the MTP Act 1971's implementation. Doctors are generally hesitant to provide abortion services to women and young girls because of these two regulations.[112] It leads to denials of abortion or requests for judicial authorization.[113] The PCPNDT Act of 1994, which forbids sex determination but expressly prohibits abortion on any grounds, has been illegally used to target MTP providers in government crackdowns on sex-selection.[114] The chilling impact of the PCPNDT Act is most pronounced in the second trimester, when many severe and fatal foetal impairments are diagnosed, despite the fact that only a small number of these abortions are sex-selective.

Providers also fear inquiry as a result of a provision in the Protection of Children from Sexual Offenses Act of 2012 that requires obligatory reporting of sexual assault of a minor by providers. Because the law defined any sexual activity involving a minor as rape, physicians interpreted it to mean that any pregnant adolescent patient must be reported, even if she is seeking an abortion.[115]. Providers also report a heightened fear of providing abortions to unmarried adolescent girls, due in part to concerns of backlash from girls' families[116].

The POCSO Act makes it mandatory for doctors who perform a termination on a pregnant minor to report the case to law enforcement. If the doctor fails to report and proceeds with the abortion, they may face legal consequences. As a result, minors avoid going to licenced doctors and

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[112] 'A Critical Analysis On The Abortion Laws In India' *iPleaders*, (2018) https://blog.ipleaders.in/critiquing-indias-abortion-laws/#_ftn181

[113] Lalita Panicker, Hindustan Times, The MTP Act 2014 Makes Safe Abortion Easier, It Should Be Passed and Roli Srivastava, Reuters, 'Not a Woman's Choice': India's Abortion Limit Puts Women at Risk, Say Campaigners (2017).

[114] Suchitra Dalvie , "If a woman has even one daughter, I refuse to perform the abortion," Sex determination and safe abortion in India, 23 Reproductive Health Matters 45, 2-3 (2015)

[115] Indian Penal Code, 1860; India's Protection of Children From Sexual Offences Act, No. 32, 2012; The MTP Act 2014 Makes Safe Abortion Easier, It Should Be Passed, supra note 33 (2017).

[116] Second Trimester Abortions in India, supra note 31.

perform unsafe abortions This defeats the entire purpose of the MTP Act, as it violates the ‘anonymity' clause..

The belief that enforcing abortion restrictions will prevent sex-selective abortion is unfounded. Policies must ensure that measures to prevent sex selective abortion do not obstruct genuine abortion seekers' access to safe abortion care. Despite the fact that abortion has been legal in India since 1971, the public is unaware of this, and as a result, the majority of women are subjected to unsafe illegal abortion methods. To raise community awareness about this issue, more advocacy is required.

In 2013, **Pratigya Campaign for Gender Equality and Safe Abortion** was launched. This campaign serves as a platform for addressing the issue of sex selection while also safeguarding women's right to safe, legal abortion in India. The campaign also created a media information kit on the topic.

Even with the new amendment, it is unclear how sex-selection-based abortion can be avoided. While the Pre-Conception and Pre-Natal Diagnostic Techniques Act covers female foeticide, the extent to which it overlaps with the MTP Bill is unclear.

9) Accidental pregnancies and unmet need for family planning

Unmet need for family planning, broadly defined as Despite a slight decrease, the number of women who wish to avoid or postpone a pregnancy but are not using any kind of contraception continues to rise.[117] As long as women's family planning requirements are not addressed, they will continue to experience unplanned pregnancies. Meeting unmet family planning needs is thus an effective intervention for reducing unplanned pregnancy and induced abortion. The accidental pregnancies could be avoided in a good extent through the usage of modern contraceptive use. Proper education for the use of contraception would be helpful for avoiding unnecessary health issues of abortion. In such cases, because of legal restrictions and stigma linked to having an abortion, women may be reluctant to seek timely medical care if post-abortion complications occur. In the absence of safe abortion services, some may resort to unskilled providers and the others may end up having unwanted births. The implications of unwanted births are not well

[117] The Millennium Development Goals report 2010: statistical annexes. New York, United Nations,(2010)

studied, but the effects can be harmful and long-lasting for women and for those who are born unwanted.[118]

Unsafe abortion and its impacts in public health

i. Definition of unsafe abortion

Unsafe abortions are defined by the World Health Organization as procedures for terminating a pregnancy performed by people who lack the necessary skills, or performed in a setting that does not meet minimum medical standards, or both. This definition evolved from the fundamental notions described in a 1992 WHO Technical Consultation.

The term "unsafe abortion" was coined to describe the scope and scope of newly developed guidelines for the management of induced abortion complications. As a result, the definition's interpretive reach is limited to that context, and this connection is critical for accurate interpretation. The terms "unsafe abortion" and "illegal abortion" are not equivalent. Illegal abortion refers to the act of terminating or attempting to terminate a pregnancy when it is prohibited by law. Illegal abortions are frequently, but not always, dangerous. Abortion is prohibited in several nations. Not every legal abortion is risk-free. Although several developing nations have liberalized their abortion regulations, women in those countries may seek abortions from medically unqualified abortionists because their health-care systems are unable to fulfill demand. Unfortunately, India is one of these countries.

ii. Prevalence in public health aspect relating to women

In India, unsafe abortion responsible for a substantial share of maternal mortality. In India, the majority of women still do not have access to safe abortion care. Because shame and fear of punishment may discourage reliable reporting, especially after illegal abortion operations, the number of fatalities and disabilities caused by unsafe abortion is likely underestimated. Furthermore, for women and their families, unsafe abortion can have significant emotional, social, and financial consequences.

[118] David HP. Born unwanted, 35 years later: the Prague study. Reproductive Health Matters, 14:181–190(2006)

Unsafe abortions are among the most common causes of maternal deaths in India. In 2015, 1.56 Crores abortions were accessed annually in India, according to a study in *The Lancet*[119]. Of these, 78% or 1.23 Crores were conducted outside health facilities. The public health system is troubled by insufficient facilities and infrastructure, misguided priorities, and insufficient and improperly used funds. Despite modest policies, most women, particularly in rural regions, still resort to unsafe abortions due to a lack of patient knowledge and government oversight. According to the National Family Health Survey2015-16, only 20% of abortions are performed in public facilities and 52% in private facilities.[120]

The wide scale study on abortions and unintended pregnancies conducted by The Lancet in 2017 said that one in three of the 48.1 million pregnancies in India end in an abortion with 15.6 million taking place in 2015. Furthermore, according to the NFHS 2015-16, "only 53% of abortions were conducted by registered medical practitioners."

According to the Ministry of Health and Family Welfare's 2019-2020 Rural Health Statistics Report, rural India, which is home to 66 percent of the country's population, has a 70 percent shortage of obstetrician-gynecologists.[121]

iii. Health consequences of unsafe abortion

Every year, over 7 million women in developing nations are admitted to hospitals due to complications from unsafe abortions.[122] Haemorrhage, infection, and damage to the vaginal tract and internal organs are the most serious life-threatening consequences of unsafe abortion Insertion of an item or substance into the uterus; dilatation and curettage performed wrongly by an unskilled physician; intake of dangerous substances; and application of external force are all examples of unsafe abortion methods. Traditional practitioners in some circumstances forcefully

[119] Ann M Moore, Chander Shekhar, Melissa Stillman, The incidence of abortion and unintended pregnancy in India, 6The lancet global health, 111-120, (2018)

[120] International Institute for Population Sciences (IIPS) and ICF,. National Family Health Survey (NFHS-4), India. Mumbai: IIPS. (2015)

[121] Government of India Ministry of Health and Family Welfare Statistics Division Rural Health Statistics, 2019-20, https://hmis.nhp.gov.in/downloadfile?filepath=publications/Rural-Health-Statistics/RHS%202019-20.pdf

[122] WHO (World Health Organization). 2017. "Preventing Unsafe Abortion." WHO Fact Sheet. http://www.who.int/mediacentre/factsheets/fs388/en/.

pummeled the woman's lower belly to disturb the pregnancy, which can cause the uterus to rupture and kill the woman.

It's difficult to quantify the number of deaths and disabilities caused by unsafe abortion. Because these deaths or problems occur as a result of a secret or illegal procedure, shame and fear of punishment prevent accurate reporting of the incidence. Data on mortality from unsafe second-trimester abortions is very difficult to come by.[123]. Furthermore, women may not attribute their symptoms to an abortion-related consequence. [124]. As a result, maternal deaths as a result of unsafe abortions are significantly underreported. For every woman seeking post-abortion care at a hospital, there are several more who have undergone an unsafe abortion but do not seek medical help, either because they believe the complication is not serious, or because they fear abuse, ill-treatment, or legal punishment.[125] Women who have an unsafe abortion pay a high price in terms of their health, finances, and emotional well-being.

iv. Mortality and morbidity

The death and disability rates associated with unsafe abortion are almost certainly underestimated. The full toll of abortion-related morbidity and mortality in a population is not reflected in facility-based data on abortion, especially in legally restrictive circumstances.[126] Every year, roughly 7 million women in developing countries are projected to be admitted to hospitals as a result of complications stemming from unsafe pregnancy termination.[127] The toll of mortality and morbidity of unsafe abortion is imperative for public health action. At the global level, between 4.7% and 13.2% of all maternal deaths can be attributed to complications due to unsafe abortion.[128] This corresponds to around 47,000 lives wasted unnecessarily each year

[123] Walker D et al. Deaths from complications of unsafe abortion: misclassified second trimester deaths. Reproductive Health Matters, , 12:27–38. (2004)
[124] Benson J. Evaluating abortion-care programs: old challenges, new directions. Studies in Family Planning, , 36:189–202. (2005)
[125] Singh S, Wulf D. Estimated levels of induced abortion in six Latin American countries. International Family Planning Perspectives, 20:4–13,(1994)
[126] Dragoman M, Sheldon WR, Qureshi Z, Blum J, Winikoff B, Ganatra B. On behalf of the WHO multicountry survey on maternal newborn health research network. Overview of abortion cases with severe maternal outcomes in the WHOmulticountry survey on maternal and newborn health: a descriptive analysis. BJOG 121(Suppl. 1)25(2014)
[127] Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. BJOG 123:1489, (2016)
[128] Say L, Chou D, Gemmill A, Tunçalp O, Moller AB, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health (2014)

among young women in their prime. Nonetheless, these figures show a steady decline in preventable fatalities.

Public health crisis of women during Pandemic

Covid-19 is a public health emergency that involves not only the virus, but also other public health issues that lead to unsafe abortions that result in the loss of lives.

Due to the ongoing COVID-19 crisis, disruptions in sexual and reproductive health services will significantly reduce access to contraceptive and safe abortion services, resulting in an increase in unwanted pregnancies, unsafe abortion, obstetric difficulties, and maternal and newborn death.[129] The COVID-19 problem is limiting access to contraceptive and safe abortion services, primarily affects the poorest and most marginalized women and girls. As the COVID-19 epidemic spreads, medical services and health systems are being pushed to their limits in some areas. The timing and scope of the revisions to the Indian abortion law are especially commendable at a time when abortion and reproductive rights are under challenge in a vast number of nations around the world, yet it is uncertain how the services would continue with the COVID 19 pandemic.

During COVID-19 emergency, the World Health Organization and the International Federation of Gynecology and Obstetrics have urged the continuation of important reproductive health services.[130] They have also passed options for simplifying care. They developed the guidelines for delivering abortion services just with the pill "misoprostol." This is intended to assist in reducing clinic visits and essential tests in order to ensure continuity of care. Pre-abortion and contraceptive information, as well as informed consent, can be delivered remotely, and legal grounds for abortion, if authorized by local rules, can be documented remotely.

According to the non-profit IPAS Development Foundation[131], 18.5 lakh women in India were unable to receive abortion services in the first three months of the pandemic. Even though out-patient facilities were closed for several months to provide Covid-only services, several hospitals

[129] Riley T, Sully E, Ahmed Z, Biddlecom A. Estimates of the potential impact of the COVID-19 pandemic on sexual and reproductive health in low- and middle-income countries. 46 Int Perspect Sex Reprod Health. 73-76 (2020). https://www.guttmacher.org/ journals/ipsrh/2020/04/estimates-potential-impact-covid-19- pandemic-sexual-and-reproductive-health.

[130] Abortion Access and Safety with COVID-19. International Federation of Gynecology and Obstetrics;(2020) https://www.figo.org/abortion-access-and-safetycovid-19.

[131] Ipas Development Foundation (IDF) is the largest Indian non-profit organization that works to prevent and manage unwanted pregnancies.

reported a larger number of abortions than in prior years. The epidemic exacerbated the already-existing obstacles that resource-poor women face: "There is no stock of drugs, the doctor is unavailable, there is no bus, and so on**." The Foundation for Reproductive Health Services, India.**[132] estimated that at least 1.18 million abortions from unplanned pregnancies would occur during the lockdown due to limited access to contraceptives.

i. Abortion during pandemic- Situation in USA

The American College of Obstetricians and Gynecologists and the American Board of Obstetrics and Gynecology, among others, concur that abortion is a life-saving, time-sensitive practice that cannot be delayed. Delaying essential care might have a "profound impact" on a person's life, health, and well-being. Patients may find it more difficult, if not impossible, to have a safe, legal abortion as a result of delays or other barriers to care.

Abortion should not be classified as a procedure that can be delayed during the COVID-19 pandemic if hospital systems or ambulatory surgical centres are categorizing procedures that can be postponed. Abortion is a necessary part of a comprehensive health-care plan. It's also a time-sensitive service, with a delay of a few weeks, or even days, potentially increasing the risks or rendering it altogether inaccessible. The repercussions of not being able to receive an abortion have a significant influence on a person's life, health, and well-being.[133]

Many people of colour, who have historically suffered systematic hurdles to health care and are especially prone to COVID-19, face grave dangers if abortion access is restricted.[134]Planned Parenthood Federation of America, the Center for Reproductive Rights and the Lawyering Project has started measures to ensure that patients can continue to access essential, time-sensitive abortion services during the COVID-19 pandemic.[135]

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[132] Impact of COVID 19 on India's Family Planning Program Policy Brief | May 2020

133 Joint Statement on Abortion Access During the COVID-19 Outbreak, , The American College of Obstetricians and Gynecologists, (Mar 18, 2020) https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak

[134] Lonnae O'Neal, March 13, 2020,the Undefeated, https://theundefeated.com/features/public-health-expert-says-african-americans-are-at-greater-risk-of-death-from-coronavirus/

135 Texas Abortion Providers File Emergency Lawsuit to Keep Essential Abortion Procedures Available During Pandemic,Center for reproductive rights, (03.25.2020), https://reproductiverights.org/texas-abortion-providers-file-emergency-lawsuit-to-keep-essential-abortion-procedures-available-during-pandemic/

A spike in the number of unsafe abortions is expected during this period given that the majority of abortions take place outside of public healthcare facilities and that most private clinics are closed.

Public health issues of abortion- Comparison of India and US

The present state of abortion access in India demonstrates that legality does not always imply availability, but a lack of availability does imply increased damage and death. In rural and underprivileged areas, women's access to contraception, particularly the most effective long-term options, remains limited. Sex education is almost non-existent. Abortion is highly stigmatized, which encourages women to seek the operation in secret rather than travelling to a local hospital, where they will be required to fill out paperwork and may run into a friend or acquaintance. Despite the hard work of community health workers, there are still a lot of misconceptions regarding birth control.

In the United States, first-trimester abortions are safer than many other routine healthcare procedures, with a very low risk of death (0.3-0.5/100,000 abortions)136, and it is predicted that only 30 women die for every 100,000 unsafe abortions due to the availability of health facilities.

India has a maternal mortality rate that is 12 times higher than the US. Unsafe abortion continues to be the cause of many of these deaths. Today's political argument in India isn't about the legality or morality of abortion; rather, it's about ensuring that women are aware of the procedure's legality and where they may obtain it securely. It's difficult to ensure that educated, competent physicians are available to serve women in need in a country with over a billion people, many of whom are illiterate and have limited access to formal health care.

Despite the fact that the United States has enough money, manpower, and infrastructure to rival much of the rest of the world, the political will in the United States is to deprive women of one of their most important sources of healthcare. It is visible by analyzing recent news of many states passing increasingly restrictive bans on abortion and some states like Texas, abortion is prohibited once a fetal heartbeat can be detected,

[136] National Academies of Sciences Engineering and Medicine. The safety and quality of abortion care in the United States.Washington, DC: National Academies Press; 2018.

Conclusion

Although India's abortion policy and law are progressive, effective translation into improved access to safe abortion care is often impeded by misguided and unnecessary practices. In India, the MTP Act, which legalised abortion in 1971, did not provide the desired results. This adds significantly to the burden of maternal illness and death. Despite the existence of moderate legislation, the majority of women continue to use hazardous abortion methods. Many nations clearly allow legal abortion throughout pregnancy in situations of foetal impairment in order to safeguard a pregnant woman's health. But in India, certain abortion regulations and vagueness in laws creates several health issues in the society. Abortion laws rarely address investments and resources because data gathering is not standardised.

In addition to the legal restrictions, other barriers to safe abortion include inability to pay, lack of social support, delays in seeking health-care, providers' negative attitudes, and poor quality of services. Young women are especially vulnerable where effective contraceptive methods are available only to married women or where the incidence of nonconsensual sexual intercourse is high. Equity and social justice in population health have long been central to public health ethics. Unsafe abortion is a glaring injustice on a worldwide scale. In nations where abortion is legal but severely limited, unequal access to safe abortion can lead to socially inequitable results.

Chapter 4- ABORTION - A REPRODUCTIVE HEALTH ISSUE

"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

INTRODUCTION

Women's reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination. Reproductive right/autonomy and right to reproductive health is not only a woman's issue, it is a family health and social issue. The ultimate aim of the right to reproduction is wellbeing of the family, woman and individuals.

The Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination against Women (CEDAW) have indicated that women's right to health includes their sexual and reproductive health. This means that States have obligations to respect, protect and fulfill the rights related to women's sexual and reproductive health. Reproductive health is not just a concern for women; it is also a family and social issue. It is the government's responsibility to provide good quality reproductive health care and to defend individual reproductive rights while remaining attentive to social and cultural issues..

The broad components of reproductive health care include:

- Accessibility to good quality family planning services, counseling to suit the reproductive needs of individuals and couples, and prevention of unwanted pregnancy
- Prevention and management of the consequences of unsafe abortion.
- Empowering adolescents by giving them reproductive and sexual health information and education in a comprehensive and sensitive way
- Ensure regular and uninterrupted availability of contraceptives, and quality family planning services, including counseling to individuals.

Inadequate reproductive health care for women leads to a high proportion of unwanted pregnancies, unsafe abortions, and unnecessary death and injury during pregnancy and childbirth. Violence against women also perpetuates inequity and keeps women from achieving their reproductive goals. Many women and their families experience mental distress as a result of abortion, especially when the procedure is accompanied by state compulsion. It cannot, however, be viewed as anything less than a fundamental right for women. Women have a right to their bodies and reproductive autonomy that they cannot give up to their families or the government. This is especially true in this country, where social norms influence childbearing and women's ability to choose when and if to have children remains a theoretical rather than a practical one. Existing abortion regulations in our country are inadequate and structured to benefit family planning programs rather than allowing women to reclaim authority over their bodies.

Women in India still do not have complete autonomy over their bodies. Most women are discouraged from taking the first step toward a clinic by social and familial pressures, and even if they do, there is a severe shortage of good medical facilities that can provide the necessary service.

Reproductive Health and Reproductive Rights

Reproductive rights can be considered as a set of rights that all persons have that allow them to receive a full range of reproductive health care. In the field of population policy, reproductive health and reproductive rights are pretty new concepts. According to a human rights statement, among these include the right to the greatest level of sexual and reproductive health, as well as the freedom to make reproductive decisions free of discrimination, coercion, and violence.[137] They are concerned with the most private and personal aspects of life, such as sexuality, sexual relations, and reproduction.

Abortion has long been regarded as a matter of reproductive rights. A feminist perspective on reproductive liberty is based on two key concepts. The first stems from the biological relationship that exists between women's bodies, sexuality, and reproduction. It is an extension of the basic premise of "bodily integrity" and "bodily self-determination" to the idea that women must have control over their bodies and reproductive capacities. The second is a historical and moral argument" based on women's social status and the requirements that this status produces.

[137] International Conference on Population and Development Para 72

Although reproductive rights have been substantially framed within **Article 21** of the Indian Constitution, namely the right to privacy, health, and dignity, essentially the rights claims be made under **Articles 14 and 15**.Women are consigned to the role of "natural" careers due to patriarchal views and thus restrictions on abortion access disproportionately affect women, particularly marginalized women. The enjoyment of basic human rights, including reproductive rights, is influenced by bigger structural health determinants such as poverty and systemic discrimination based on caste, religion, and other factors. As a result, it is critical to understand the demand for reproductive rights in its larger context..

Women's reproductive health is never solely determined by biology, but rather by biology as mediated by social and cultural structures. That is, it is not unavoidable that women take the burden of the repercussions of unexpected pregnancy and, as a result, have their sexual expression curtailed. Rather, it is the product of motherhood's socially imposed centrality in women's life.

We can see that women in various parts of the world are concerned about reproductive health. Their goal has been to empower women to control their own fertility and sexuality with maximum choice and minimal health risks by providing information and alternative services, as well as advocating for women's right to make informed fertility decisions, better services, and more appropriate technologies.

Right to abortion as an absolute right that "should be available, according to her, to any women without insolent inquisition or ruinous financial burden, for our bodies are our own"[138]. Abortion has always been and will continue to be a contentious issue in the field of reproductive health. Women's sexuality, fertility, and reproductive health are rarely deemed essential enough to be discussed in the public eye. Due to the looming impact of society's patriarchal framework, such conversations are frequently stifled. The same can be seen in the types of laws enacted in relation to women's issues.

Relevance of Reproductive Health in India

India is focusing on women's empowerment and advocating for women's reproductive health and rights. The reproductive right is one of numerous components of the empowering process. The

[138] 9 Daniel Callahan, Abortion: Law, Choice and Morality, 460 (Macmillan Publishing, New York, 1979)

number of deaths related to pregnancy and childbirth reflects the severity of women's reproductive health issues. Reproductive tract infection, sexually transmitted infections, unsafe abortion, AIDS, cervical cancer, malnutrition, and teenage pregnancy are just a few of the new health issues that Indian women are dealing with.

While the Sustainable Development Goals are universal in nature and aim to leave no one behind, inequalities based on nationality, ethnicity, gender, sexual identity and orientation, marital status, age, and other factors affect one's access to resources and ability to exercise basic rights, such as the right to sexual and reproductive health. The poorest girls and women in developing countries like India have the least control over whether or not they become pregnant. They also have the least access to high-quality prenatal and postnatal care, which frequently results in maternal death. This disparity has long-term consequences for girls' and women's health, educational opportunities, career and earning potential, as well as their contribution to their countries' development and poverty reduction. Reproductive health and reproductive rights are not just a concern for poor girls and women; they affect all of us. Women's reproductive health and rights give them control over their bodies, allowing them to decide whether, when, with whom, and how often to have children. A safe pregnancy and delivery, as well as adequate antenatal and postnatal care, as well as access to family planning counseling and a variety of modern contraceptive methods, are among the rights. Support in becoming pregnant, as well as care and counseling in the event of a miscarriage or for women suffering from post-partum depression, are all part of reproductive rights. The ability to exercise these rights also helps to prevent dangerous abortions. Sexual and reproductive health and rights have been recognized as a cornerstone of sustainable development by the international community.

Evolution of Reproductive Rights

Prior to the 1990s, reproductive health issues were primarily concerned with limiting women's fertility in order to reduce rising population. The most important entrance point was health, rather than reproductive well-being in general. Reproductive rights as human rights have gradually been recognised since the International Conference on Human Rights, which was held in Tehran in 1968 to further the principles and aims of the Universal Declaration of Human Rights (UDHR). The 1975 Declaration of Mexico on the Equality of Women and their Contribution to Development and Peace confirms the principle of equal rights within the family

and the principle of inviolability of the human body as per Principle 12, "every couple and every individual has the right to decide freely and responsibly whether or not to have children as well as to determine their number and spacing, 10 UNGA Resolution 2442 (XXIII). and to have the information, education and means to do so"[139].The Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in 1993, emphasized the "right of women, on the basis of equality with men, to access the widest range of family planning services and to have adequate health care."[140] Reproductive rights are comprehensively defined in the 1994 International Conference on Population and Development's (ICPD) Programme of Action in Cairo.[141]

The International Covenant on Economic, Social and Cultural Rights, 1996 (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women, 1979 (CEDAW) also fore-ground the focus on reproductive rights as necessary in realizing the human rights of women. The Sustainable Development Goals (SDGs) and the preceding Millennium Development Goals (MDGs) included various goals that recognised reproductive rights both directly and indirectly.

As a signatory to these covenants and conventions, India is responsible for ensuring that these objectives are met through its policies and laws. Respect for and realisation of all human rights is a necessary foundation for all people to achieve sexual and reproductive health without discrimination. Laws allowing for medical abortion, protection against coerced or sex selection, maternity benefits, and protection from domestic abuse, including sexual violence by an intimate partner, all have direct or indirect effects on women's reproductive health rights. The insufficiency of these legislation has been criticised on several occasions. The National Health Mission (NHM) (2012-2017). Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) programme, the Rashtriya Kishor Swasthya Karyakram (RKSK) strategy as well as the recent in the National Health Policy 2017, The facts and evaluations of the public healthcare system show that this is not the case. Concerns regarding a lack of interest for other

[139] UN Doc. E/CONF. 66/34.
[140] UN. General Assembly Resolution A/RES/48/121. 1993. Section 3, Para. 41.
[141] UN. UNFPA. Report of the ICPD. Doc. A/CONF.171/13. 1994.

aspects of reproductive health and rights have been raised as a result of the narrow focus on very specific aspects of maternal health and family planning..[142]

The judicial attitude towards the right to abortion has evolved to a great extent since the 1990s, when in the case of ***Jacob George v. State of Kerala***[143], the Apex Court refused to comment on the right of women to abort an unwanted pregnancy and did not explicitly recognised abortion as a part of 'reproductive rights.'. But later in the case of ***Paschim Banga Khet Majdoor Samiti v. State of West Bengal***[144] was sought to be broadened to include reproductive rights.

Analyzing the evolution of India's abortion law, we can see that the legal sanction for abortion is not based on a recognition of women's choices and rights over their bodies. It is, rather, a socially enforced outcome of the state's economic imperatives.

Human rights as a key to reproductive rights

The right to reproductive health is an inextricable aspect of human rights, which are universal, inalienable, indivisible, and interrelated, and are protected by the Indian Constitution. Access to safe and legal abortion is recognised and protected by international human rights law as necessary for protecting the entire spectrum of human rights, such as the rights to life, health, equality and non-discrimination, privacy, physical autonomy, and freedom from harsh, inhuman, and degrading treatment. These treaties and documents emphasise the state's commitment to respect, defend, promote, and fulfill reproductive health rights without discrimination, with a special focus on vulnerable and marginalised populations.

Respect for and realisation of all human rights is a necessary foundation for all people to achieve sexual and reproductive health without discrimination. Human rights violations may occur when abortion prohibitions and limitations endanger women's lives and conflict with their individual liberty. One legal perspective views abortion as one procedure within a range of services to which women should have safe access as a matter of human rights and social justice, recognising women as capable and conscientious decision makers in their own lives.[145]

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[142] Nivedita Menon, "Abortion and the Law: Questions for Feminism", 6, CJWL, 103-118 (1993).
[143] *Jacob George v. State of Kerala* (1994) SCC (3) 430
[144] *Paschim Banga Khet Majdoor Samiti v. State of West Bengal* (1996) SOL Case No. 169
[145] Cook, R. J., and Dickens, B. M,"Human Rights Dynamics of Abortion Law Reform." *Human Rights Quarterly* 25: 1–59,(2003)

Since the mid 1960's all **United Nations representative** formalized three types of reproductive rights.

(1) The freedom to decide how many children to have and when to have them.

(2) The right to have the information and means to regulate one's fertility.

(3) The right to "control one's own body".

But the third has recognized feminist discourse and not yet formalized so far as third world women are concerned. **The Convention on the Elimination of all forms of Discrimination Against women** is a significant international treaty that establishes women's freedom to make their own reproductive and sexual decisions. Policymakers, governments, and service providers must consider fertility regulation and reproductive health care as a way to empower women, not as a tool to restrict population increase, save the environment, or speed up economic development, according to this convention..

The right to make sexual and reproductive decisions, as recognised by the United Nations International Conference on Population and Development in 1994, has been expanded to include access to contraception, the right to a legal and safe abortion, and the right to make reproductive decisions without prejudice. The right to family planning was enlarged during the Fourth World Conference on Women in Beijing in 1995 to include the right to better sexual and reproductive health. The Platform of Action which was adopted by 189 delegations at the Beijing women's conference 1995, reaffirms the Cairo programmes definition of reproductive health(para 96)[146] and advances women's wider interests. In 2000, the Human Rights Committee, which monitors compliance with the ICCPR, highlighted the fact that abortion laws endanger women's lives. In General Comment No. 28 (2000), on equality of rights between men and women, the State Parties were asked to provide information on any steps taken by the State to assist women in

[146] "The Human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationship between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

preventing unwanted pregnancies and ensuring that they do not have to undertake life-threatening clandestine abortions.[147]

Locating reproductive health rights within the constitutional provisions of India

While India's Constitution does not directly recognised the right to health or reproductive rights as a fundamental right, various Supreme Court rulings have construed the right to health and the right to timely and adequate medical treatment as crucial to the right to life. "Article 21 states that no person shall be deprived of his life or personal liberty except according to procedure established by law". It guarantees the right to life, which includes the right to privacy. This assurance exerts a constraint on the government, and it is embedded in the Indian community's cultural and social consciousness. In this context, every woman has an individual right to life, liberty, and the pursuit of happiness, which includes the freedom to have an abortion. Women have reproductive characteristics and the right to make decisions about their sexual health and reproductive choices. In 2006, in ***Nand Kishore Sharma v Union of India***[148], the MTPA was challenged on the grounds that it violates the right to life and dignity of Article 21 of the Constitution. The Court, in this judgement, stated that the relevant provision of the MTPA was not unconstitutional and was in consort with Article 21.

Article 15(2) and Article 15(3) permit the State to make special provisions for women and children, ***In Parmanand Katara v Union of India***[149], which was a public interest litigation (PIL) pertaining to the provision of emergency medical treatment.

The Supreme Court in ***Suchita Srivastava and Another v Chandigarh Administration***[150] stated that "reproductive autonomy is a dimension of personal liberty as guaranteed under **Article 21."** The court opined that "Linking a woman's reproductive right to her right to life and liberty under Article 21, the Supreme Court held that reproductive rights were a dimension of a woman's liberty and her right to "privacy, dignity and bodily integrity" should be respected." woman's reproductive rights included her right to see the pregnancy to its full term.

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[147] Article 10 and 11 of General Comment 28, Equality of Rights Between Men and Women, http://hrlibrary.umn.edu/gencomm/hrcom28.htm

[148] *Nand Kishore Sharma v Union of India* (2006)AIR Raj 166

[149] *Suchita Srivastava and Another v Chandigarh Administration* (1989) AIR 2039

[150] Suchita Srivastava and Anr v Chandigarh Administration, (2009) 9 SCC 1

This Supreme Court of India in ***Bandhua Mukti Morcha v Union of India & Ors***[151] interpreted the right to health under Article 21 which guarantees the right to life. In ***State of Punjab & Ors v Mohinder Singh Chawla***[152] the apex court reaffirmed that the right to health is fundamental to the right to life and should be put on record that the government had a constitutional obligation to provide health services. In ***State of Punjab & Ors v Ram Lubhaya Bagga***[153]**,** the court went on to endorse the State's responsibility to maintain health services.

Article 47 states that "it is among the primary duties of the State to raise the level of nutrition and the standard of living of its people and to improve public health." **Article 42** states that the state must make arrangements for reasonable and humane working conditions as well as maternity leave".

Right to reproductive Health and Abortion in USA

The debate over the right to abortion began in the Western world in the 1960s, and it is linked to the demand for equality in the workplace and society. There was a concern about women's rights with a consciousness about population control, and advocates from both groups fought for abortion legislation that were more liberalized. For many women, the consequences of an undesired pregnancy have been and continue to be devastating, ranging from lost work or educational possibilities to scorn and stigmatization as a result of becoming an unwed mother. As a result, abortion became essential for women to feel in control of their lives.

In landmark ruling in ***Roe v. Wade***,[154], The Supreme Court declared that the right to abortion is a basic liberty guaranteed by the Constitution's Fourteenth Amendment. In this case, the Supreme Court declared abortion to be a constitutionally protected right as part of the right to privacy, stating that the right to privacy is broad enough to include a woman's right to choose whether or not to abort, and that it shall not be subject to government regulation unless the state has a compelling interest.. In ***Griswold v. Connecticut***[155], the Court struck down a ban on the use or

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[151] *Bandhua Mukti Morcha v Union of India & Ors* (1997) 10 SCC 549
[152] *State of Punjab & Ors v Mohinder Singh Chawla* (1997) 2 SCC 83
[153]*State of Punjab & Ors v Ram Lubhaya Bagga* (1998) 4 SCC 117
[154] *Roe v. Wade,*[154], (1973)410 U.S. 113
[155] *Griswold v. Connecticut* (1965)381 U.S. 479

sale of contraceptives to married couples because it violated the constitutional right to privacy. In another case, ***Eisenstadt v. Baird***[156], the Court extended this fundamental right to contraception to unmarried people also. Eisenstadt gave further definition on the right to privacy as "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Three key cases define the constitutional protection for a woman's right to abortion: *Roe*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, and *Whole Woman's Health v. Hellerstedt*.

Planned Parenthood v. Casey[157], Court elaborated that abortion "involve the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy" and is "central to the liberty protected by the Fourteenth Amendment." Although the Court upheld Roe v. Wade's ruling that states cannot restrict abortion before viability, the joint majority deviated from strict scrutiny and used the "undue burden" criterion to decide whether limitations were unlawful. Thus, the undue burden standard sought to provide "real substance" to "the compelling claims of the woman to maintain ultimate control over her fate and her body."

Whole Woman's Health was successful in preserving abortion access for thousands of Texas women and signaling that rules similar to those challenged in that case are unlawful. Furthermore, the test published in Whole Woman's Health is applicable to a wide range of abortion restrictions, not just those challenged in Texas or similar laws. The Constitution of US protects not just a woman's right to abortion, but also that it affords robust protection to that right.

Reproductive rights of mentally retarded women

Legally, the MTP Act does not address access to abortion for women with mental retardation, and it incorrectly distinguishes between women with mental retardation and women with mental illness, leaving the former out entirely. Also, the Act fails to recognised that both of these types of women are more likely than not to be penniless, which complicates guardianship. This case demonstrates clearly that the Indian legal structure needs to be significantly upgraded in order to

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[156] *Eisenstadt v. Baird* (1972)405 U.S. 438

[157] *Planned Parenthood v. Casey* (1992)505 U.S. 833, 856

bring it into compliance with international law. It also raises the question of whether our government structures are secure enough to safeguard women, particularly disabled persons.

Abortion & reproductive autonomy

Reproductive autonomy is defined as a woman's right to choose whether or not to have children, and if so, the right to decide how many children she wants, when and with whom, as well as the freedom to pick the means and methods by which she exercises her fertility management choices. Access to sexuality information, access to contraception, Some of the most essential factors of whether a legal system ensures reproductive autonomy to women within that legal system include access to reproductive and maternal health care, access to pregnancy termination services, and access to economic resources..[158] Reproductive autonomy, defined as the ability to be self-determining and act on one's own values and wishes in making reproductive decisions, is a significant factor in law and policy.

Reproductive autonomy is a concept that developed in the West as a result of the women's movement's demand for the freedom to make decisions about one's own body. The MTP Act of 1971 in India grants Indian women a form of reproductive autonomy. Despite the existence of an abortion law in India, women do not have complete control over their bodies. Most women are discouraged from taking the first step toward a clinic by societal and familial pressures, and even if she does, there is a severe shortage of good medical facilities that provide the essential service.

A reproductive autonomy model that prioritizes women's autonomy and bodily integrity requires women to have access to safe, legal abortion.[159] This indicates that the state must not only legalize abortion but also make arrangements for regulation, which is typically accomplished by requiring clinics to register with the state if they perform abortion services.

Reproductive autonomy is a necessity in today's culture, both in terms of human rights and women's health. To persuade legislators, the most informed kind of advocacy and education is required.

[158] Rebecca cook etal, reproductive health and human rights (2003).
[159] Asit K. Bose, "Abortion in India: A Legal Study, 16(4) JILI 535-548 (1974)

Barriers to securing reproductive rights in India

Gender inequalities are among the most widespread, though deceptively subtle, forms of inequality worldwide. Indian women in general face significant pressure to confirm to the domestic duties of wife and mother, and they are vulnerable to religious doctrine that places a major emphasis on female inferiority. Arranged marriages, the dowry system, and the position of widows all contribute to women's social and economic reliance. The fact that the region's sex ratio is very patriarchal functions as a timely reminder that women are often regarded in low esteem.

Despite their motivation, most women still preferred home births with untrained traditional birth attendants. The main reasons for noncompliance were poverty, a lack of adequate transportation, inability to leave household responsibilities, social taboos, and fear of hospitals and unfamiliar medical personnel. Illiteracy is also another hurdle to utilisation of the existing health facilities.

While the MTP legislation makes it legal to acquire consent from a pregnant woman, it does not go so far as to emphasise the woman's right to choose whether or not to continue the pregnancy. As a result, the claim that the MTP Act "is restricted to the liberalization of conditions under which women may have access to abortion services provided by approved medical practitioners" is valid.

Reproductive rights and autonomy under India's current legal framework for abortion

The MTP Act, which controls women's access to pregnancy termination services, has a significant influence on women's reproductive autonomy within the Indian legal system. The laws do not allow a woman to choose her own pregnancy, but instead place her in a limited set of conditions where doctors and medical boards make the decision for her. The MTP Act of 1971 was a defining moment for the healthcare sector and its users. It did not grant women the right to abortion. It broadened the list of acceptable reasons for abortion in India, making it lawful if certain conditions are met. Abortion for reasons other than those authorized in the law is a crime punishable by the Indian Penal Code.

Sections 3 and 5 of MTP act which deals with when a pregnancy can be aborted, evidently infringe women's rights to make reproductive choices, which the bench affirmed as parts of the right to privacy. A woman cannot choose to have an abortion on her own throughout a

pregnancy, which prohibits women from exercising their right to physical integrity and making free decisions about their bodies. Abortions are doctor-led, with doctors having complete control over a woman's body and decision at all stages of her pregnancy. Even when a court intervenes in a woman's favour, the judgement is reached after a long judicial process that concludes in a decision made on her behalf, but not by her.

The constitution of medical boards and other additional layers of authorization for obtaining legal termination of pregnancy creates barriers to women's exercise of reproductive autonomy**.** These Boards are unlawful and infringe on the fundamental rights of pregnant women by exposing them to several invasive exams and prolonging the abortion process. While the MTP Act's poor implementation prevents many women from enjoying their reproductive rights, it fails to recognised the rights of particular groups of women, such as minor girls and mentally ill women. Further, the law recognizes only medical risks and contraceptive failures as grounds for an abortion, delegitimizing all other reasons why a woman may seek to terminate her pregnancy. When a woman is compelled to carry a pregnancy, her reproductive health is jeopardized. The legislation does not take into account the financial costs of raising a kid, the impact on job choices, or any other personal factors.

Our laws raise privacy concerns, and even the 2020 amendment to the MTP Act does not adequately address all privacy concerns with the act's abortion restrictions. Despite the fact that the amendment enables abortions up to 24 weeks, women must still establish that the pregnancy was unintended or that contraception failed, which severely limits their ability to exercise choice in this subject. To have an abortion, the amendment still needs to be proven that either the foetus or the mother is in danger.

Women's decision-making power over their own bodies should be emphasised in India's legal system. For instance, several European countries, have abortion legislation that include specific wording about women's rights to dignity and the capacity to make free and autonomous decisions while seeking abortion services. The Netherlands, for example, puts the final decision in the hands of the woman, noting that an abortion is permissible “if the woman believes there is no other way to end her distressing situation” and the physician is satisfied that she made the

decision of her own free will.[160] The abortion legislation in Norway places a great emphasis on women's autonomy and active participation throughout the abortion process. The woman "must personally take a final choice to terminate the pregnancy," according to Norwegian law.[161]

Role of Judiciary in protecting Reproductive health and Autonomy of women

Indian Courts have established through a series of case laws that the right to abortion is a fundamental right of a woman and includes the right to equality and nondiscrimination, bodily autonomy, health, dignity and choice. Women's reproductive rights have been recognised by Indian courts as part of the "inalienable survival rights" implicitly guaranteed under the fundamental right to life. The courts have acknowledged reproductive rights as critical to women's equality and have asked for women's autonomy and decision-making in pregnancy to be respected.

In a landmark nine-judge bench of the Supreme Court of India ***in K.S. Puttaswamy v. Union of India***[162] Under Article 21 of the Constitution, the exercise of reproductive choices is unequivocally founded in a constitutionally protected right to life and personal liberty. Justice Chandrachud, writing for the majority, noted that a woman's statutory right under the MTP Act to decide whether or not to consent to a pregnancy termination is related to her constitutional right to make reproductive choices. The idea of decisional autonomy, which is intrinsically tied to the rights to privacy and self-determination, was discussed further by Justice Chandrachud, who stated that "family, marriage, procreation, and sexual orientation are all integral to the dignity of the individual." His third point was that decisional autonomy encompasses such sensitive personal issues as reproduction and the power to make decisions about one's sexual or procreative nature. Similarly, Justice Chelameshwar in his opinion unequivocally stated that a "woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy"."

[160] Netherlands, Law No. 50 of 13 on the Termination of Pregnancy, 1975, Sec. 5.
[161] Norway, Law on Interruption of Pregnancy, 1975, Sec. 2.
[162] K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1

In 2018, the Supreme Court has relied on the concept of substantive equality in two significant decisions -***Joseph Shine v. Union of India***"[163] and ***Navtej Johar v. Union of India***[164]. The Court stated in both decisions that discrimination based on patriarchal concepts and assumptions about gender roles is unlawful under the Constitution's Equality Code.

Suchita Srivastava v. Chandigarh Admn[165] the Court held that the right to make reproductive choices is a dimension of 'personal liberty' guaranteed by Article 21 and further, that "reproductive choices can be exercised to procreate as well as to abstain from procreating". It further stated that a woman's reproductive rights include the right to bring a pregnancy to term, give birth, and raise children; and that these rights are part of a woman's right to privacy, dignity, and bodily integrity.

In ***High Court On Its Own Motion vs The State Of Maharashtra***[166]Bombay High Court stated that a "woman alone should have the right to control her body, fertility and motherhood choices." The court also addressed the status of the legitimate state interest in protecting "potential life." It stated that since pregnancy takes place within a woman's body and profoundly affects her health, mental well-being and life, an unborn foetus cannot be put on a higher pedestal than the rights of a living woman." The court further stated that a woman's decision to terminate a pregnancy is not frivolous .Abortion is often the only way out of a very difficult situation for a woman,'' The court said the law "bestows a very precious right to a pregnant woman to say no to motherhood''.

In ***Devika Biswas v. Union of India,***[167] The Court once again ruled that the right to life and personal liberty guaranteed by Article 21 includes reproductive rights. It emphasised that this includes the right to "access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour."[168]

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[163] Joseph Shine v. Union of India, (2019) 3 SCC 39.
[164] Navtej Singh Johar v. Union of India, (2018) 10 SCC 1.
[165] Suchita Srivastava v. Chandigarh Admn., (2009) 9 SCC 1.
[166] *High Court On Its Own Motion vs The State Of Maharashtra* (2016) SCC Online Born 8426.
[167] *Devika Biswas v. Union of India* (2016) 10 SCC 726
[168] Ibid.

In the case of ***High Court on its Own Motion v. State of Maharashtra,*** ('Suo Motu PIL') a significant judgment through a suo motu PIL employed similar reasoning to guarantee access to abortion services for incarcerated women.[169] The Court held that an unborn foetus is not an entity with human rights; it is vested with rights only at birth." On the contrary, a pregnant woman's fundamental rights, particularly her right to life and liberty, are gravely harmed if she is compelled to carry "unwanted" pregnancy. The Court stated unequivocally that women have complete control over their bodies, and that their health should take precedence over that of a foetus. The emotional trauma a woman experiences as a result of being forced to carry on with an unwanted pregnancy must exceed any concerns about potential foetal rights. The Court also recognized the special harm that only women and girls are subjected to under the current interpretation of the statute. Women alone have a say in how they choose to cope with pregnancies, according to the report, and they have the "right to autonomy and to decide what to do with their own bodies." Suo Moto was one of the first instances to acknowledge abortion limitations as a form of gender discrimination and to remedy the gender injustice that emerges from bringing unwanted pregnancies to term.

Judiciary's view towards reproductive autonomy

Our current legal framework requires the woman's consent before a medical abortion is performed. The requirement for the spouse's consent is not mentioned anywhere. Women appear to have some control over their reproductive autonomy as a result of this. According to the written word of the law, the wife should make the decisions regarding when and how many children to have. All of these parts of our legislation relate with the state's provision of reproductive autonomy to women. This, however, is shown to be incorrect when we examine the outcomes of specific divorce cases. In ***Deepak Kumar Arora v. Sampuran Arora***[170] it was held that, if a wife undergoes abortion with a view to spite her husband then it may in certain circumstances be contended that the abortion resulted in cruelty to the husband. Later in ***Kalpana Srivastava v. Surendra Nath Srivastava***,[171] the Court held that refusal to prepare tea coupled with lodging of false F.I.R. and termination of pregnancy without consent of the husband were

[169] High Court on its Own Motion v. State of Maharashtra, (2016)SCC Online Born 8426
[170] *Deepak Kumar Arora v. Sampuran Arora* (1983) 1 DMC 182
[171] *Kalpana Srivastava v. Surendra Nath Srivastava* AIR 1985 All 253

acts constituting mental cruelty by wife to the husband. Again in ***Sushil Kumar Verma v. Usha***,[172] a single Judge of the Delhi High Court held that the wife's aborting fetus in her first pregnancy without the consent of the husband would amount to cruelty within the meaning of Section 13(1)(a) of the Hindu Marriage Act, 1955. In the face of such decisions it is hard to assert that an Indian woman is the master of her own body.

Need for decriminalisation of abortion for the protection of Reproductive health and autonomy

The criminalization of abortion harms women, girls, and people of all genders in a variety of ways. First, it is a major legal barrier to safe abortion access. It has long been shown that prohibiting or restricting abortion does not diminish demand; rather, it restricts access to safe abortions.[173] Criminalizing abortion drives women and girls underground, forcing them to seek out unlawful treatments in less than ideal conditions. As long as the medical treatment is shrouded in secrecy and crime, stigma will flourish. The taboos around abortion have a substantial impact on women's health and influence their decisions about whether to have a safe or unsafe abortion, as well as whether or not to reveal the abortion to others.[174] This has a chilling effect on the exercise of reproductive autonomy when taken together. The misalignment of the MTP and PCPNDT Acts results in denial of services due to fear of punishment, and, as a result, abortion access is hampered. This compounding impact encourages women to seek judicial authorization for abortion services. Pregnant women who do not want to go through such judicial hoops owing to stigma or a lack of resources are left with two options: not receive an abortion or get an unauthorized treatment. Unlicensed operations may have a higher risk of serious injury. Because practitioners are less supervised, and women who are harmed are less likely to report for fear of facing criminal charges. As a result, India faces a complex web of barriers that prevent medically safe, accessible, and affordable abortion services. This has a chilling effect on the availability of safe abortions.

If abortion were to be fully decriminalised in India, there would be no need for the MTP Act, which presently provides registered medical practitioners who terminate pregnancies with

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[172] *Sushil Kumar Verma v. Usha* AIR 1987 Del 86

[173] Michelle Oberman, The Consequences of El Salvador's Abortion Ban, January 11, 2018, available at https://www.guernicamag.com/consequences-el-salvador

[174] Ayodeji Oginni et al., Correlates of individual-level abortion stigma among women seeking elective abortion in Nigeria, 10 International Journal of Women's Health, 361-366 (2018).

immunity from criminal prosecution. Abortion could be considered as a healthcare issue in the absence of particular legislation regulating the termination of pregnancy, enabling a woman to make the ultimate decision in collaboration with her doctor. The Supreme Court purports to endorse reproductive autonomy based on the preceding cases, yet women have no meaningful authority over abortions. Despite the fact that the most recent Supreme Court ruling may be a sign of progress.

Conclusion

Access to safe, high-quality abortion services, such as information, counselling, and post-abortion care, is extremely limited in our country. Early marriage, as well as its harmful consequences for reproductive health and rights, has been a neglected topic. Within government, reproductive morbidities are largely ignored. A well-developed public health system capable of providing comprehensive, high-quality health care services that are available to all, free at the point of access, and, above all, accountable to people is required to ensure the realisation of reproductive rights. Unfortunately, India's public health system is plagued by plenty of issues, including a lack of public investment, inadequate infrastructure, including medical and diagnostic facilities, and under-skilled human resources. In addition, there has been an increase in the privatisation and corporatization of health care in recent decades, as well as a lack of rigorous regulation. This has resulted in a significant decline in the accessibility, affordability, and quality of health care, leading in increased social, economic, and geographical barriers to health care, particularly for girls, women, and marginalised communities.

The protection of women's human rights requires the protection of reproductive rights and the provision of sexual and reproductive health care. This has a chilling effect on the availability of safe abortions. Indian jurisprudence has already prepared the road for this by recognising decisional autonomy as inextricably linked to the right to equality. Without an absolute right to abortion, pregnant women confront an impossible choice and have a potentially risky, unlicensed abortion or lose decision-making control over their own bodies, with the State's interests taking precedence over the right to decisional autonomy. It's past time for us to have a framework for abortion that is based on gender justice and equality.

Chapter- 5

Access to safe abortion care- Role of state and medical boards in safeguarding the health of woman

"The states are not free, under the guise of protecting maternal health or potential life, to intimidate women into continuing pregnancies."

- Harry Blackmun,

Justice of U S Supreme Court,

Author of the Court's opinion in Roe v. Wade

Introduction

In India, Medical Termination of Pregnancy Act, 1971 provides legal framework for access to abortion, by regulating the conditions under which a pregnancy may be aborted. The legal framework of India has provisions for providing access to affordable abortion services. Section 3 of the Act lays down the basic rules and conditions regarding abortion. But India is one of the countries with most number of unsafe abortions due to lack of access to safe abortion services. This is because, despite the existence of a legislative framework for legal abortions, wider access to safe abortion facilities has not been achieved. Even when such facilities are accessible, women rarely have the choice to decide whether or not to terminate their pregnancy. Access to such services is hampered by a variety of socioeconomic problems and other factors.

Abortion has long been a contentious issue in both developed and underdeveloped countries. Recently, wealthier countries recognized it as a reproductive rights issue in international conventions. It is commonly known that safe abortion services have the potential to reduce major mortality and morbidity. While abortion is still prohibited in many developing countries, it became legal in India in 1972. However, legalization has not assured Indian women's access to safe abortion services.

There are significant barrios faced by women in our country under our legal framework while accessing safe abortion services. Some of them are following restrictive laws

- poor availability of services
- high cost
- stigma
- the conscientious objection of health-care providers and
- unnecessary requirements, such as mandatory waiting periods, mandatory counselling,
- provision of misleading information,
- third-party authorization, and
- Medically unnecessary tests that delay care. etc.

Denial of healthcare services violates Article 21 of the Constitution's fundamental right to life and liberty. The Supreme Court of India's jurisprudence has ruled that access to emergency care is a fundamental right,[175] and that a duty of care is the foremost obligation of the medical profession.[176]

Need of access to safe abortion

"There is need for increasing access of women to legal and safe abortion services in order to reduce maternal mortality and morbidity caused by unsafe abortions," said health minister Harsh Vardhan during the Rajya Sabha debate on March 16, 2020[177]. Where abortion is not illegal, access to abortion may be hampered by legally imposed procedural barriers such as mandatory and biased counseling requirements, waiting periods, third-party consent and notification requirements, restrictions on the range of permissible abortion methods, and restrictions on public funding. Unsafe abortions are one of the primary causes of maternal death in India. According to a research published in The L*ancet*.[178], 1.56 crores abortions were performed in

[175] Parmanand Katarav. Union of India, (1989) 4 SCC 286

[176] Edward P. Pinto, The jurisprudence of emergency medical care in India: an ethics perspective, 2Indian Journal of Medical Ethics 4 (2017)

[177] http://164.100.47.7/newdebate/253/16032021/Fullday.pdf

[178] The Guttmacher Institute, New York, International Institute for Population Sciences (IIPS), Mumbai and Population Council, New Delhi conducted the first study in India to estimate the incidence of abortion. The results from this study were published in Lancet Global Health journal in December 2017 in the form of a paper titled 'The incidence of abortion and unintended pregnancy in India, 2015'

India in 2015. Of these, 78% or 1.23 crores were conducted outside health facilities. Access to timely and affordable abortion services is crucial, particularly for marginalized people.

"The legal status of abortion has no effect on a woman's need for an abortion, but it dramatically affects her access to safe abortion"[179] When women are denied access to legal, safe abortion services, they frequently resort to unsafe abortions, and in many cases, they suffer the consequences. So, because abortion is such a serious issue, the medical boards and the state have a great deal of responsibility for it. There is an ethical obligation to provide safe abortion services within the legal framework. Conscientious objection is permissible, but it should not be exploited to conceal the stigma connected with abortion.

In US ,over the decades of various decisions, i.e., since the Court first held in ***Roe v. Wade*** that the Constitution encompasses protection for the right to abortion, including its most recent decision, ***Whole Woman's Health v. Hellerstedt***[180], recognized that without access to abortion, the right is meaningless.

In 1994 the Programme of Action of the United Nations International Conference on Population and Development stated that in "circumstances where abortion is not against the law, such abortion should be safe"[181] i.e., "in circumstances where abortion is not illegal, health-care practitioners should be trained and equipped, and other measures should be taken to guarantee that such abortion is safe and accessible."[182].

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[179] WHO (World Health Organization). 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd ed. (Geneva: WHO). http://who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.

[180] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016),

[181]UNFPA (United Nations Population Fund). 1994. Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5–13 September (1994). https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.

[182] UNFPA (United Nations Population Fund). 1999. "Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development." Adopted at the Twenty-first Special Session of the UN General Assembly, New York, 1999. http://www.unfpa.org/sites/default/files/resource-pdf/key_actions.pdf.

The doctors' inability to discharge their duties in accordance with the MTP Act put the woman's health and life in jeopardy. The hospital, on the other hand, maintained that the delay and denial of abortion were in accordance with the MTPA's provisions. This exposes the prevalent practice of restrictive and subjective interpretation of the MTPA, which is a grave violation of the reproductive autonomy of women seeking abortion care.

i. Global Examples

Global examples show that increased abortion access promotes women to seek pregnancy termination in the early stages of pregnancy, resulting in better-managed abortions. Sweden, for example, has one of the most permissive abortion regulations in the world, making MTP available on demand up to 18 weeks. The majority of abortions in Sweden are performed around the 12-week gestation point, usually using the two-pill combination procedure, which is favored in first-trimester abortions and simulates a natural miscarriage. Canada was the first country to decriminalise abortion in 1988, and it has recorded a decrease in the gestational age at abortion without an increase in the abortion rate. It has managed enhanced abortion equity across socioeconomic and geographical backgrounds by making abortion a state-funded treatment and allowing telemedicine facility for medical termination via pills.

ii. Restricting access to abortion does not reduce the number of abortions

Whether abortion is legally restricted or available on demand, a woman's chances of becoming pregnant unintentionally and seeking an induced abortion are roughly the same.[183] However, due to legal restrictions and other impediments, many women choose to perform their own abortions or seek abortions from untrained practitioners. The legal status of abortion has little effect on a woman's desire for an abortion, but it does have a significant impact on her ability to obtain a safe abortion. When abortion is legal under broad conditions, the rate of unsafe abortion and its complications is often lower than when abortion is legally restricted. Abortion that is unsafe, as well as the related morbidity and mortality in women, can be avoided. As a result, all women should have access to safe abortion services to the full extent of the law. Many women are forced to seek care in other countries, from inexperienced providers, or in unhygienic settings as a result

[183] Sedgh G, et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. Lancet, 379,625–632,(2012)

of the legal restrictions, putting them at danger of death or disability. According to the World Health Organization, countries with more restrictive abortion regulations have a thrice higher maternal death rate than countries with less restrictive abortion laws. The relaxation of abortion restrictions leads to a decrease in maternal mortality due to unsafe abortion and, as a result, a decrease in overall maternal mortality.

Barriers to accessing safe abortion

A number of barriers continue to obstruct complete access to legal abortion services, forcing some women to rely on inexperienced informal-sector practitioners. Barriers to access include a lack of facilities offering abortion services, a shortage of licensed staff, a lack of equipment and supplies, failures to protect privacy and confidentiality, a lack of awareness among women that abortion is legal, and stigma associated with seeking abortion-related care. They also experience delays as a result of a lack of knowledge about their legal rights, societal shame, and legal ambiguity.[184]. In Bihar, upto 75% of women are unaware that abortion is legal.[185] Misconceptions about the law also contribute to the delay in obtaining abortion, such as the spousal consent demanded by providers despite the fact that it is not required by law, and the courts' necessity to prove the rape claim before authorizing access to abortion. Addressing sex-selective abortion while ensuring access to legal abortion remains a challenge. The Government of India's strict enforcement of the Pre-Conception and Pre-Natal Diagnostics Techniques (PCPNDT) Act of 2003, which prohibits the misuse of prenatal diagnostic tests for the purpose of sex determination, as well as the intense public focus on this issue in recent years, has made it difficult to obtain and provide safe abortion and post-abortion care. For example, a rising number of qualified providers are hesitant to provide pregnancy termination services due to both real and perceived restrictions imposed by authorities aiming to limit sex-selective abortions. These impediments also caused delays in access to abortion. by women and young girls.

Because access to safe, legal abortion services has been limited, women have routinely purchased medication abortion from pharmacists, chemists, and informal vendors, and the information they receive on how to take the medications and recommended gestational

[184] Government of India, Framework for Implementation: National Health Mission 2012-2017 2, 32 (2014)
[185] Stillman M et al., *Unintended Pregnancy, Abortion and Post abortion Care in Bihar, India2015*, New York: Guttmacher Institute, (2018)

limitations is frequently erroneous or non-existent.[186] Surgical abortion procedures are still available in health care facilities, and some women continue to use risky means to self-induce abortion.[187]

International Human Rights Standards on Access to abortion

Access to safe and legal abortion is recognized and protected by international human rights law as essential to ensuring the full range of human rights, including the rights to life, health, equality and non-discrimination, privacy, bodily autonomy, and freedom from cruel, inhuman, and degrading treatment. Abortion bans in the United States blatantly contradict basic human rights standards.

The impact of severe legal restrictions, barriers, and stigma on abortion access has been a source of concern for UN human rights mechanisms in recent years. They have urged governments to reform legislation to legalize abortion, remove barriers, eliminate criminal penalties, and prevent stigmatization of abortion-seeking women and girls in order to ensure effective access to safe, legal abortion services.[188]

UN human rights treaty monitoring bodies have clearly established that while abortion is permitted under domestic law, it must be available, accessible, affordable, accepted, and of high quality.[189] States are advised to eliminate procedural impediments to abortion services, such as third-party authorization restrictions, mandated waiting periods, and biased counseling.[190] They've also urged countries to provide financial assistance to those who can't afford abortions, to ensure the availability of skilled health-care providers who can provide safe

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[186] Jejeebhoy S Zavier AJF Acharya R Kalyanwala Increasing access to safe abortion in rural Maharashtra: outcomes of a comprehensive abortion care model. Population Council, New Delhi2011

[187] Powell-Jackson, Timothy et al. "Delivering medical abortion at scale: a study of the retail market for medical abortion in Madhya Pradesh, India." *PloS one* vol. 10,3 e0120637. 30 Mar. 2015, doi:10.1371/journal.pone.0120637

[188] Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights, Ctr. for Reprod. Rights (2018), https://www.reproductiverights.org/sites/crr.civicactions.net/files/doc

[189] Committee on Economic, Social and Cultural Rights (CESCR), Gen. Comment No. 22: on the right to sexual and reproductive health , 11-21, U.N. Doc. E/C.12/GC/22 (2016); CESCR, Gen. Comment No. 14 (2000)

[190] CESCR, Gen. Comment No. 14 (2000) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), Para. 12, U.N. Doc. E/C.12/2000/4 (2000)

abortions, and to ensure that provider refusals based on religion or conscience don't obstruct women's access to services.[191]

They have also recognized that laws prohibiting abortion, forcing women to choose between continuing a pregnancy and traveling to another country to obtain legal abortion services, can cause anguish and suffering, noting the financial, social, and health-related burdens and hardships placed on women in such situations.[192] Denials of abortion services have been ruled to be infringement of the rights to life, health, privacy, nondiscrimination, and freedom from harsh, inhuman, and degrading treatment on several occasions.[193]

The UN Committee on the Elimination of Discrimination Against Women (CEDAW) has framed the right to abortion as a component of women's autonomy,[194] emphasizing that a state's inability or unwillingness to offer reproductive health care constitutes gender discrimination.[195]

The United Nations Human Rights Committee, which oversees the implementation of the International Covenant on Civil and Political Rights (ICCPR), a treaty ratified by the US, clarified in 2018 that the right to life includes the right to safe and legal abortion.[196] The committee declared that States may not erect new barriers to abortion, but they should eliminate existing restrictions that prevent women and girls from having safe and legal abortions. States should also work to avoid stigmatizing women and girls who seek abortions.

The World Health Organization understands that induced abortion rates are high in countries with restrictive abortion legislation that the majority of abortions are unsafe, and that women's

[191] CEDAW Committee, Concluding Observations on Austria, Para. 38-39, U.N. Doc. CEDAW/C/AUT/CO/7-8. 2013 (2013)

[192] Amanda Jane Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, Para. 7.8, 7.10-7.11, 8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016).

[193] K.L. v. Peru, Human Rights Committee, Comment No. 1153/2003, Para. 7, U.N. Doc. CCPR/C/85/D/1153/2003 (2005)

[194] CEDAW Committee, Concluding Observations on New Zealand, Para. 35(a), U.N. Doc. CEDAW/C/NZL/CO/7 (2012)

[195] CEDAW Committee, Gen. Recommendation No. 24: Article 12 of the Convention (women and health), at 360, Para. 11 U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008)

[196] HRC, Gen. Comment 36 on the Right to Life, Para. 8, U.N. Doc. CCPR/C/GC/36 (2018).

health and lives are frequently jeopardized. Abortion restrictions do not result in fewer abortions. Rather, they force women to put their lives and health at risk by seeking unsafe abortion procedures.

The Committee on Economic, Social, and Cultural Rights has emphasized the significance of avoiding regressive actions in the domain of sexual and reproductive health and rights, such as imposing barriers to accessing sexual and reproductive health information, commodities, and services.[197]

UN human rights experts have published numerous findings and recommendations in recent years regarding the right to abortion in the United States, in particular. The United Nations **Working Group on Discrimination against Women in Law and Practice,** for example, has recommended that the United States ensure that women can exercise their constitutional right to abortion under Roe v. Wade, repeal the Hyde Amendment, and combat the stigma associated with reproductive and sexual health care.[198] Low-income women in the United States confront legal and practical barriers to exercising their constitutional, privacy-derived right to abortion services, according to the UN Special Rapporteur on Extreme Poverty, and this lack of access to abortion services traps many women in poverty cycles.[199]

Recently, a group of UN human rights experts, including the **Working Group on Discrimination against Women and Girls**, expressed alarm over state governments' attempts to restrict abortion access during the COVID-19 pandemic. Restrictions on access to complete reproductive health information and services, including abortion, "constitute human rights violations and can inflict irreversible harm, particularly to low-income women, racial minorities, and immigrant communities," according to the Working Group.[200] These restrictions were the

[197] CESCR, Gen. Comment No. 22: on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), Para. 38, U.N. Doc. E/C.12/GC/22 (2016).
[198] U.N. Working Group on Discrimination Against Women in Law and Practice, Report of the Mission to the United States of America, Para. 90(vii; x; xvi), U.N. Doc. A/HRC/32/44/Add.2 (2016)
[199] Special Rapporteur on extreme poverty and human rights, Report of the Mission to the United States of America, Para. 56, U.N. Doc. A/HRC/38/33/Add.1 (2018)
[200] UN Office of the High Commissioner for Human Rights, "United States: Authorities manipulating COVID-19 crisis to restrict access to abortion, say UN experts,(2020)
https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25907&LangID=E

most recent in a long line of restrictions and regressive steps in access to legal abortion care across the country.

Abortion Access in USA- Duty of the State

In the United States, there is statutory protection for abortion, which includes state constitutional protections, such as a declaration from the state's highest court affirming that the state constitution protects the right to abortion, separate and apart from the existence of any federal constitutional right.

In the United States, the health and life of mothers is given first priority, as it is a fundamental right to life and liberty, and the government cannot intervene unless it has a compelling state interest. The state has a legitimate interest in maintaining and protecting the health of pregnant women, as well as another legitimate interest in safeguarding human potential. The United States respects a woman's freedom to choose whether or not to have an abortion, which falls within her right to privacy. Only after the stage of viability does the state have an interest in protecting the unborn child.

The state has duty in providing various aspects of abortion services such as:

i. **Public funding**- States are mandated to offer public funding for abortion services warranted by life endangerment, rape, or incest through the state Medicaid program. States can also set aside state-only funds to cover all or the majority of medically required abortion services for Medicaid recipients.
ii. **Private insurance requirements**- States have the authority to require that state-regulated commercial health-insurance plans include particular benefits, such as abortion coverage.
iii. **Clinic safety and access**- Laws prohibiting physical obstruction of clinics, threats to providers or patients, trespassing, and telephone harassment of clinics, as well as establishing a protected zone around the clinic.
iv. **Abortion Provider Qualifications**- State legislatures and licensing boards govern the scope of practice for health-care practitioners. In most cases, state legislation does not specify which medical services are within or outside of a practitioner's scope of practice.

> By repealing physician-only laws or expressly authorising physician assistants, certified nurse midwives, nurse practitioners, and other qualified medical professionals to provide abortion care through legislation, regulations, or attorney general opinions, many states have taken a different approach to abortion. Other states have taken aggressive steps to develop the sorts of professionals who are legally permitted to perform abortions.[201]

Changes in federal and state policies are made in response to the needs of women in order to ensure safe access to abortion services. For example, for U.S military woman the federal policy used to prohibit abortion provision at military treatment facilities and military insurance coverage of abortion, except in cases of rape, incest, or a life-endangering pregnancy. Abortion access for service members is restricted by such limitations, especially during deployment. U.S. servicewomen are frequently stationed in countries where abortion is prohibited, and federal policy in the United States restricts abortion services at medical treatment centers. As a result, federal limitations on the provision and coverage of abortion care have been lifted, and better education about current regulations may increase access to timely abortion care and, in certain situations, allow servicewomen who want to get an abortion to stay in the military.[202].

Judicial decisions on providing access of abortion

The access to MTP has developed as a rights issue world-over and the same has been recognised through various judgements in India. The ***High Court On Its Own Motion v. The State Of* Maharashtra** [203] which is a *suo motu* public interest litigation on the condition of a prison inmate, The Court issued guidelines to make it easier for women prisoners to access health care, including the right to medical abortion, and stated that denying a woman the opportunity to terminate her pregnancy is equivalent to injuring her mental health. The Court went on to say that pregnancy occurs within a woman's body and has a significant impact on her health,

[201] Rev. Stat. Ann. tit. 22, § 1598(1). Law was amended to allow physician assistants and advanced practice nurses to also perform abortions. See H.P. 922, 129th Leg., 1st Reg. Sess. (Me. 2019); Wash. Rev. Code § 9.02.110; Wash. Att'y Gen. Op 2004 No. 1 (2004); Wash. Att'y Gen. Op 2019 No. 1 (2019).

202 Grindlay K.Grossman D.Unintended pregnancy among active-duty women in the United States military,.*Obstetrics & Gynecology.* 2013; 121: 241-246(2008)

[203] High Court on its Own Motion v. State of Maharashtra, (2016) SCC Online Born 8426.

emotional well-being, and life. The HC a set of directions for jails to follow in order to ensure that women detainees are not stymied by bureaucracy and miss a legal deadline under the Medical Termination of Pregnancy Act (MTP Act).

In the 2008 case of In ***Dr Nikhil Dhattar v Union of India***[204] the patient Nikita Mehta, the case of severe foetal abnormalities which posed a risk to the survival of the foetus were detected in her 22nd week of pregnancy, and the abnormalities were confirmed by medical diagnosis in the 24th week of pregnancy. She tried to abort the pregnancy, but she was unable to do so due to the statutory limit of twenty weeks, despite medical advice to the contrary. The Court refused to allow the pregnancy to be terminated, citing the the limitation under Section 5 and the lack of a conclusive medical opinion that the child, if born, would suffer from significant mental and physical disabilities. It further found that interpreting Section 5 to include the circumstances set forth in Section 3(2) (b) (ii) amounted to legislating on the Act, which was unlawful. Nikita Mehta, who was denied permission to abort her pregnancy, miscarried a few days after the case was decided.

In other cases, the Supreme Court has allowed termination of pregnancies beyond the statutory twenty week limit**. *X v. Union of India***[205], the Supreme Court held, on the basis of a report submitted by the medical board directed to be constituted, Even though the petitioner's current pregnancy was only about 24 weeks old, the life of the unborn outside the womb was in risk, so the Supreme Court allowed the woman to have a medical abortion under the MTP Act's provisions. The Court determined that the case fell under Section 5 of the MTPA. **In *Meera Santosh Pal v. Union of India***[206], woman who was in the 24th week of her pregnancy filed a petition before the Supreme Court with the plea to undergo a medical termination of pregnancy. The Supreme Court ordered the formation of a medical board, which determined that continuing the pregnancy would not only harm the woman's physical and mental health, but also that the foetus would not be able to survive "extra-uterine life" due to abnormalities, and thus the Supreme Court ordered that the woman be allowed to have a medical termination of pregnancy.

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[204] *Dr Nikhil Dhattar v Union of India* SLP (C) 5334 of 2009)
[205] *X v. Union of India* (2017) 3 SCC 458
[206] *Santosh Pal v. Union of India* (2017) 3 SCC 462

Similarly, in ***Sarmishtha Chakrabortty v. Union of India***[207], A woman went to the Supreme Court to ask for permission to have a medical termination of pregnancy The Supreme Court ordered that a medical board be established, and the medical board determined that it was a case for abortion because the woman was at risk of severe mental injury if the pregnancy was continued, and if the child were born alive, he or she would require complex cardiac corrective surgery stage by stage after birth, with high mortality and morbidity at each stage. As a result, the Supreme Court granted the petition's requests, allowing the woman to have her pregnancy terminated medically.

However, in certain cases, the Supreme Court has rejected a woman's plea to undergo medical termination. In ***Savita Sachin Patil v. Union of India***[208]**,** a woman in her 26th week of pregnancy approached the Supreme Court in order to seek permission to undergo a medical termination. The Supreme Court established set up a medical board, and the medical board submitted a report stating that there is no health risk to the mother of continuing or terminating the pregnancy, and that if the baby is born with "Trisomy 21," it is "likely" to have mental and physical issues. The Supreme Court ruled that because the medical report does not state that this particular foetus will face severe mental and physical challenges, but only that it is "likely" to face these challenges, and because the woman's life is not in danger, the request for medical termination should be denied.

Similarly, in ***Sheetal Shankar Salvi v. Union of India***[209]**,** On the basis of the medical board's report, the Supreme Court denied a woman's request for medical termination on the grounds that the Medical Board was unable to determine the period of time for which the baby is likely to survive, that there is no danger to the mother's life, and that there was a chance that "the baby may be born alive."

6.1 Towards rape victims and minors

In the case of ***Hallo Bi v. State of Madhya Pradesh and Other***[210]**s,** the High Court of Madhya Pradesh emphasized the need of allowing rape victims to have abortions without the need for judicial approval, stating "we cannot force a victim of violent rape/forced sex to give birth to a

[207] *Sarmishtha Chakrabortty v. Union of India* (2018) 13 SCC 339

[208] *Savita Sachin Patil v. Union of India* (2017) 13 SCC 436

[209] *Sheetal Shankar Salvi v. Union of India* (2018) 11 SCC 606

[210] *Hallo Bi v. State of Madhya Pradesh and Other* (2013) (1) MPHT 451

child of a rapist. The anguish and the humiliation which the petitioner is suffering daily, will certainly cause a grave injury to her mental health."[211]

In the case of ***R v. State of Haryana***[212], Delays in post-rape medical exams were considered as a result of medical authorities' negligence.

Courts have repeated the MTP Act's previous acknowledgment of the "grave anguish" that pregnancies resulting from rape might bring in cases involving rape victims' requests for MTP beyond 20 weeks. like the supreme court decision on ***X v. Govt of NCT of Delhi***[213]. In the case of ***Murugan Kayakkar v. Union of India & Ors***[214], The Supreme Court relied heavily on mental health suffering in reaching its judgement to allow a 13-year-old girl to abort her pregnancy at 32 weeks. But still in certain case like ***Ashaben w/o. Dineshbhai Jasubhai Talsaniya v. State of Gujarat,***[215] despite the court's recognition of the pain, psychological suffering, and social isolation that can arise from forcing a rape survivor to carry an undesired pregnancy to term, petitioners' MTPs were rejected.

In ***Ms Z v. The State of Bihar and Others***[216], the Supreme Court of India denied a medical termination of pregnancy (MTP) to Z, a 35-year old woman from Patna, Bihar living with HIV who became pregnant as a result of rape. Although Indian legislation allows MTP until 20 weeks for a variety of reasons, including rape and threats to the pregnant woman's health, Z.'s request for an abortion was denied by a government hospital that wrongly requested spousal and parental approval. Despite the fact that the Supreme Court acknowledged that Z.'s rights had been violated as a result of inappropriate requirements imposed on her, she was denied an abortion since she was nearly 26 weeks pregnant by the time she could file the appeal.

Justice Dipak Misra expressed:

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[211] Human Rights Law Network (HRLN), The High Court of Madhya Pradesh allowed a pregnant female prisoner to exercise her reproductive rights under the Medical Termination of Pregnancy Act (2013).
[212] *R v. State of Haryana* W.P.(C), 6733 of 2016
[213] *X v. Govt of NCT of Delhi* W.P.(CRL) 18262 of 2013
[214] *Murugan Kayakkar v. Union of India & Ors* W.P.(C) 749 of 2017
[215] *Ashaben w/o. Dineshbhai Jasubhai Talsaniya v. State of Gujarat* S.C.A.(Q) 1919 of 2015
[216] *Ms Z v. The State of Bihar and Others* (2018) 11 SCC 572

In a condition of anguish, the victim may even consider suicide or living with a horrific experience that may be compared to having a life heavily miserable. It is because the authorities failed to carry out the duty imposed on them by the Medical Termination of Pregnancy Act of 1971, and this failure has resulted in a disaster; a prolonged anguish.

First, the hospital turned down her request, which was illegal because she was an adult who was less than twenty weeks pregnant. Second, the high court upheld her dismissal. Finally, it was more than twenty-six weeks into her pregnancy that the Supreme Court recognized that she had been violated. Her request for an abortion was also denied due to the fact that she was past the legal gestation limit. Therefore, there is a dire need to fast-track these petitions, giving a petitioner a fair chance to abort safely.

Criticism on judicial authorization on authorizing access to abortion

To permit or deny abortion, different courts have relied on different standards. For example, the viability of the foetus has been considered in some circumstances, which is a deviation from the original standard that considered the impact of a pregnancy on a woman's mental or physical health." Even in cases when rape survivors have requested abortions, the courts have relied on medical boards' advice, which has been based on inconsistent various criteria.[217] The possibility of having to seek court's authorization is intimidating, and for some women, this deters them from seeking the option at all, causing them to resort to unsafe abortion procedures. It is important to understand that countries normally do not require judicial authorization for abortion in circumstances of health risks and in India, it is a critical step that women must follow suit.

Courts usually deal with these matters on a case-by-case approach, and women must go to court to have their condition assessed by a government-appointed medical board. This has resulted in an extra-legal requirement for third-party authorisation, which disempowers women and girls by causing unnecessary delays, denials, and anomalies in the application of the legislation, as well as a giving a chilling impact on access to MTPs even at early stages of pregnancy. One of the main concerns that impede the MTP Act's implementation is the legal response to pregnancy

[217] Pratigya Campaign, supra note 14, 17.

termination. The slowness with which administrative and judicial authorities respond has frequently resulted in delays that are beyond repair.

Hundreds of women have filed writ petitions in India's Supreme Court and High Courts to have their pregnancies medically terminated. While each instance stems from traumatic events such as rape, life-threatening situations, mental health risks, or foetal abnormalities, the outcomes are different and unpredictable. Inconsistencies like these taint the credibility of law that impacts women's lives and bodies. It also causes women to lose faith in the legal system and its ability to recognize women's autonomy over their bodies.

Providers have continued to refer women and girls to the courts due to the judiciary's case-by-case approach. Only those women and girls with financial and legal resources have the option of going via the legal system; others are left with no choice except to continue an unwanted pregnancy or endanger their lives by going to an unsafe provider. Even those who are able to file petitions face public scrutiny and shame, as well as invasive and frequently repetitive medical inspections by medical boards and grief from the uncertainty of their rights during an already difficult time.

Duty of state for providing proper abortion care

Effective contraceptive services, provision of safe and legal induced abortion, prompt management of complications, and provision of post-abortion care are all possible steps toward averting nearly every death and disability caused by unsafe abortion.[218]

Providing quality reproductive health services allows women to balance safe childbearing with other elements of their lives. It also assists them in avoiding health hazards and facilitating social involvement, including work. Women's health is a human right, and the state government and authorities have a social and ethical responsibility to stand beside and support them. Various steps, such as mobilizing human, financial, and material resources to support safe abortion practices, as well as increasing the number of trained individuals and well-equipped abortion clinics, are required.

[218] WHO (World Health Organization). "Preventing Unsafe Abortion." WHO Fact Sheet(2017). http://www.who.int/mediacentre/factsheets/fs388/en/.

Furthermore, growing investment in public utilities, streamlining registration procedures, and other measures contribute to the development of the public health side of abortion.

A. Planning and managing safe abortion care

A number of health system challenges must be considered while planning and managing safe, legal abortion care. These difficulties apply to all types of services, whether they are public, private, or non-profit. Establishing and improving existing services should be based on meticulous planning that includes the principles and recommendations.

According to WHO, certain standards and measures were needed to be taken for managing safe abortion care.

i. **Establishment of national standards and guidelines:** ensuring complete legal access to and provision of safe abortion treatment. Standards and guidelines should address the following topics: types of abortion services, where they can be provided, and by whom; essential equipment, instruments, medications, supplies, and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality, and privacy, with special attention to the needs of adolescents; special provisions for rape victims.

ii. **Financing:** Staffs, training programs, equipment, drugs, supplies, and capital costs should all be included in health-care budgets. It's also important to find ways of making services more affordable for women who need them. When compared to the costs of unsafe abortion to the health system and the benefits to women's health, the costs of adding safe abortion services to current health services are expected to be minimal.[219]

iii. **Ensuring health-care provider skills and performance through**: Monitoring, evaluation, and other quality-improvement processes; training; supportive and facilitative supervision; monitoring, evaluation, and other quality-improvement processes Competency-based training should address health-care provider attitudes and ethical challenges surrounding the provision of safe, induced abortions. The gathering of routine service statistics and safe abortion indicators are examples of monitoring and assessment.

[219] (http:// screening.iarc.fr/doc/policybrief1.pdf).

iv. **A systematic approach to policy and programme development**: This entails developing and executing policies and programs with the goal of improving women's health and human rights as a result.[220]

B. Family planning

Unwanted pregnancies are reduced, and abortions are avoided, thanks to family planning programmes. In order to minimize undesired pregnancies, the state has a responsibility to promote family planning services., while also acknowledging the necessity of providing safe, affordable, accessible, and accepted abortion services to women who need to end an unwanted pregnancy. Strong government backing, well-trained service providers who are sensitive to cultural contexts, listen to clients' needs, and are friendly and compassionate are all part of family planning. Services are reasonable, and a variety of contraceptive techniques are accessible. Counseling ensures informed consent in contraceptive choice, as well as privacy and confidentiality. Facilities are comfortable and clean, and service is rapid. The government of India has made facilities for home contraceptive delivery by ASHAs, an enhanced compensation scheme, a National Family Planning Indemnity Scheme, and a focus on postpartum and post-abortion family planning services.

C. Providing abortion and post-abortion care

Abortion is a major public health concern. Working to provide reproductive health services, policymakers and health-care management should always ensure that safe abortion care is readily available and available to the full extent of the law. Induced abortions have been performed by women in every country. All women's health and human rights, especially adolescents', should be protected by stat legislation and services. They should not put women and teenagers in situations that encourage them to seek unsafe abortions. In fact, most countries have one or more legislative provisions allowing for safe abortion.

"Post abortion care" is a term used to describe this type of treatment. Quality health services should enable safe abortion procedures and effective post-abortion care in situations where abortion is legal. This would considerably lower maternal mortality rates. While emergency

[220] (http:// www.who.int/reproductivehealth/publications/ strategic approach/9789241500319/en/index. html).

care of abortion complications is necessary to limit the number of deaths and injuries caused by unsafe abortion, it cannot replace the protection of women's health and human rights provided by safe, legal induced abortion.

D. Involvement of men in reproductive health programs

More males participating in reproductive health decisions will offer women more power, not less. The well-being of all family members is the common goal. By preserving their partner's health and supporting their choices, men may help advance gender equality and increase their family's well-being.

E. Providing access to rural areas

The access to safe abortion and facilities are very limited particularly in rural areas and women from back word classes. The state authority has a responsibility to make sure that necessary facilities are provided in such areas and no other malpractices are conducting for the same. Not only are doctors and hospitals few, but many people in rural areas are unaware that abortion is permitted. It is not enough for the government to pass a law; it is also the government's responsibility to educate the public about that law, especially if the law is for social progress.

F. Introducing new policies in accordance with technological advancements

Technology in medical science has advanced significantly since the MTP Act was enacted in 1971, and this was not recognized until the Medical Termination of Pregnancy (Amendment) Act 2020. Medicines like mifepristone and misoprostol have made it possible to execute abortions in a simple and efficient manner. Various modern and practical methods of providing abortion treatment, such as telemedicine, which is already in use in countries such as Australia and the United Kingdom, have not been used here. Telemedicine offers a way to protect women and meet their important health care demands during the COVID-19 pandemic. The Departments of Health in England and Wales have indicated that they will make the necessary changes to allow women to take both sets of pills required for an early medical abortion in the privacy of their own homes, rather than having to travel to a hospital or clinic. Our law, on the other hand, does not make the necessary updates, resulting in a clumsy implementation and a stuck-up approach.

G. Recent Initiatives taken by government of India

Initiatives for safe and comprehensive abortion care (CAC) services under the National Health Mission (NHM) are stated to be offered through the reproductive, maternity, neonatal, child, and adolescent health (RMNCH+A) program. The NHM is expected to assist states in implementing CAC guidelines, improving access to comprehensive abortion care, including post-abortion contraceptive counseling and services, and expanding the network of facilities that provide Medical Termination of Pregnancy (MTP) at the First Referral Unit (FRU) level[221]. It also includes providing funds to states for the effective implementation of health-care services, such as the procurement of equipment and drugs for medicated abortion, as well as training of health-care providers, such as medical officers, in safe abortion techniques, as well as ANMs and ASHAs (Accredited Social Health Activists) to provide information and counseling, including for posing[222]. While these government initiatives are commendable, they must be closely monitored in order to assess their implementation and success in the various states.

H. Community Mobilization for RMNCHA activities

Indian Government has established Community health workers for Reproductive Maternal Newborn Child Health + Adolescent Health activities. Accredited Social Health Activists (ASHA) play an important role in providing information about health services, building links between and health facilities, and enabling women to access their entitlements at public health facilities, including CAC. ASHA training modules created by the Ministry of Health and Human Services and the National Health Systems Resource Centre are a vital component of the National Health Mission, providing information on pertinent themes to ASHAs. Three of the seven modules contain information about CAC and associated issues.

I. Communication on CAC

Comprehensive abortion care (CAC) is an important part of the National Health Mission's maternal health treatments. Despite the fact that some people are aware of their legal rights to

[221]" Activities under National Health Mission. "Delhi Government. http://delhi.gov.in/wps/wcm/connect/doitdceastupdated/DC of East Delhi Updated/Home/District Health Society/

[222] Government of India. Ministry of Health and Family Welfare. "Abortions." News release, January 5, 2018. Press Information Bureau

abortion, they are unaware of where they can obtain abortion services. Abortion services are largely unavailable due to moral and political reasons. Women also do not have easy access to information about abortion services or the choice of having an abortion unless they are in an emergency or the baby is ill.

Issues in the functions of state while providing legal termination of pregnancy

A. Unlawful denial of abortion

Access to services is hampered by the law's implementation and the health system's focus on providing abortion treatment. For example, even in the case of minors, the legislation does not require spousal, relative, or third-party consent for pregnancy abortion. Medical practitioners, on the other hand, frequently demand such consent, claiming that it is necessary to avoid any socio-legal complications that may arise as a result of the abortion, infantilizing women seeking abortions on the one hand while thrusting child rearing responsibility on her on the other. They should implement programs aimed at providing legal and safe abortions, preventing the need for abortion through family planning, managing abortion complications, and providing post-abortion care.

Denial of services is a violation of the right to privacy and the right to health. In light of the ***Justice K. S. Puttaswamy (Retd.) and Anr. v. Union Of India And Ors***[223] judgment on privacy, which stated that "a woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy", To ensure that no woman resorts to dangerous means and techniques to terminate a pregnancy because she is unable to access safe abortion services, a multi-pronged strategy must be taken. At the policy level, the Medical Termination of Pregnancy Act, 1971, which must be altered to allow women to have abortions on demand, potentially increasing access to safe abortion treatment.

Denial of abortion services has also been reported due to the lack of an Aadhar identity, which is illegal under the MTPA. A domestic worker was denied abortion care at a government hospital in Chandigarh in 2017 because she could not present her Aadhar card, according to media

[223] *Justice K. S. Puttaswamy (Retd.) and Anr. v. Union Of India And Ors* (2017) 10 SCC 1

reports. She eventually sought an abortion from an unqualified local physician, but the procedure did not go well, and she was rushed to the hospital with significant bleeding and a blood transfusion.[224] Insisting on the Aadhar card for provision of health services by hospitals is a gross violation, and highly arbitrary. So state must consider all these aspects to avoids such unnecessary denials in abortion.

B. Insufficient number of trained medical personnel

In comparison to our population, India lacks a significant quantity of skilled medical workers. Due to a lack of medical practitioners and services, women are frequently forced to resort to unsafe methods of abortion, which encourages quackery. One solution to this problem would be to train more service providers. Increased staffing, simplified abortion procedures, increased public awareness, and legislation that keeps up with technology could all help.

C. Inequity in access to healthcare

State governments sometimes leave large portions of the health budget unspent, resulting in crumbling healthcare facilities, particularly in rural areas, exacerbating inequity in access to healthcare.[225] As a result, women without family support or who live in poverty face highly disproportionate barriers to abortion services, as they lack the financial means to get both legal and illegal abortions.

D. Lack of access for rape victims and minors

Due to stigma and personal risks, many rape victims wait until their pregnancy is discovered by medical testing or made public before seeking an abortion, either directly or through their parents. Because they are unaware of the potential of becoming pregnant from rape or the indications of pregnancy, minors are unaware they are pregnant. These delays in discovering pregnancy may be exacerbated if state officials fail to appropriately respond to and investigate rape complaints; fail to provide rape victims with pregnancy testing kits as required by national guidelines; or dispute petitioners' rape allegations. Several petitioners in abortion cases have highlighted the psychological anguish and suffering, including suicidal ideation, that they have had as a result of being forced to continue their pregnancy. The substantial physical and mental health concerns that pregnancy poses to women and girls have been recognized by Indian courts.

[224] Duggal R. The political economy of abortion in India: cost and expenditure patterns. Reproductive]Health Matters.2004

[225] Human Rights Watch, supra note 65.

As a result, state authorities have a responsibility to give rape and children a higher priority and responsibility.

Required changes that our government should undertake

• Ensure comprehensive maternal health services in the public sector, including access to abortion services. Ensure the safety of deliveries, both at home and in institutions.

• Assign specific cadres of health care workers to disadvantaged communities, if necessary, to ensure that even home births are safe.

• Create a well-managed and adequate public health workforce by increasing the number of jobs available and ensuring that all public health workers receive the necessary training on topics relating to mental health and violence against women.

• Require that updates and amendments to laws, rules, and other regulations be included into medical curricula, textbooks, continuing medical education programs, and other training programs to guarantee that skill-based, unbiased, and ethical health care is provided.

• Reorient medical, paramedical, and affiliated curriculum to better prepare health care practitioners to comprehend and deal sensitively with reproductive health issues such as abortion.

Role of Medical Boards in protecting health of women by providing access to safe abortion

Courts appoint a medical board to evaluate the medical condition woman and render an opinion on whether the pregnancy whether the termination would be safe and constitutes any risk to the pregnant person's life. When an abortion is requested because of a foetal anomaly, the boards determine whether the defect is serious enough to warrant termination. A gynecologist, one radiologist or sonologist, one pediatrician, and additional members selected by the state or union territory make up the Medical Board in each state and territory.

Medical boards focus on the facts of the case, but personal beliefs may influence the board's decision, which is one of the most difficult aspects of getting a third-party opinion on such a personal matter.

Medical board members rely on scientific information, but not all doctors would be pro-choice. As a result, there's a chance that some personal bias will sneak in. Doctors will bring their own biases, personal moralities, and values to the table, and they may refuse even if the procedure is only 20-24 weeks long. The medical board indicated there was a considerable risk to the mother's life undergoing abortion, thus the Calcutta High Court denied permission to a 30-week pregnant woman.

When evaluating whether a pregnancy should be continued or not, the law places a premium on a woman's experience and health. It recognizes that an unwanted pregnancy can cause "grave injury" to the mental health of a woman.

Draw backs of Medical boards and other additional layers of authorization

A. Creating Additional layers of authorisation

Additional layers of authorisation create barriers to women's exercise of reproductive autonomy. Unwanted pregnancy is linked to poor maternal mental health and can have harmful repercussions for any children who are already born.[226] Unwanted pregnancy has also been linked to lower mental health outcomes later in life, according to studies.[227] When women are forced to endure an undesired pregnancy owing to time spent in litigation, their physical and emotional health is threatened.

The necessity for a second layer of clearance, from the court and then the medical board, is superfluous, especially because the decision to terminate is ultimately based on the opinions of

[226] Diana Greene Foster et al., Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children, 205 The Journal of Pediatrics (2019).

[227] Pamela Herd et al., The Implications of Unintended Pregnancies for Mental Health in Later Life 106 AJPH Perspectives 3 (2016)

qualified medical practitioners. In the case of ***Murugan Nayakkar v. Union of India***,[228] The Supreme Court granted a 13-year-old rape survivor's request to abort her pregnancy due to her trauma. The Medical Board's recommendation that the pregnancy be terminated was the only basis for the Court's decision. High Courts have also permitted termination after the twenty-week mark, such as in ***Bhavikaben v. State of Gujarat,***[229] and ***Shaikh Ayesha Khatoon v. Union of India***.[230]

In ***R v. State of Haryana***,[231] The Punjab and Haryana High Court noted that the pregnant lady had been referred to various medical boards, each of which had different opinions, causing the case to be delayed until the pregnancy had progressed past twenty-four weeks and could no longer be terminated. The Court underlined that doctors who terminate a pregnancy in good faith to save a woman's life or avoid harm to her mental or physical health would not be punished needlessly.

B. Create shortages in access to safe abortion services

In every state and territory, a Medical Board is established to decide on the termination of a pregnancy after 24 weeks in cases of foetal abnormalities. A gynecologist, one radiologist or sonologist, one pediatrician, and other members appointed by the state or union territory will make up each Board.

Most states and UTs have a shortage of over 80% of obstetricians and gynecologists. Many states, including Tamil Nadu, Arunachal Pradesh, and Gujarat, have reported a near-total lack of some specialists, particularly in rural areas. Pediatricians are in limited supply in states like Arunachal Pradesh, Meghalaya, Mizoram, and Sikkim.

Due to a data shortage in Primary Health Centres, the research relies on data from Secondary Health Centres (SHCs) (PHCs). In most parts of the country, forming boards with a panel of experts will be almost difficult. Furthermore, the bureaucratic process will cause the abortion to

[228] Murugan Nayakkar v. Union of India, (2017) SCC Online SC 1902.
[229] Bhavikaben v. State of Gujarat, (2016) SCC Online Guj 9142
[230] Sk. Ayesha Khatoonv. Union of India, (2018) SCC Online Bom 11
[231] Rv. State of Haryana, (2016) SCC Online P&H 18369.

be delayed, and the expenditures required by the pregnant woman to travel to the Board may result in financial hardship.

C. Causes unnecessary delays

Due to the establishments of medical boards, women are frequently approaching the courts to obtain authorization to terminate unwanted pregnancies. Pregnant women are frequently advised by doctors to obtain a court order authorizing them to terminate the pregnancy. Women have been obliged to approach the court for authorization to abort as a result of this denial of assistance. Furthermore, doctors have required women to go to court even for pregnancies of less than twenty weeks.[232]

D. Privacy clashes

The third party authorization and constitution of medical boards in our current legislation contradicts with the Supreme Court's 2017 privacy judgement in ***Justice KS Puttaswamy V. Union of India and others***[233], which ruled that a woman's right to make reproductive choices is a dimension of personal liberty as understood under Article 21 of the Constitution. ..

International scenario of third party authorization on abortion

At the international stage, the UN Human Rights Committee in LMR v. Argentina[234] stated that the decision to terminate a pregnancy should be made by the pregnant woman/girl and her doctor, and that including the court in this decision would be a violation of the right to privacy.[235] In its General Comment No. 22, the Committee on Economic, Social, and Cultural Rights mandates States to "remove and refrain from enacting laws that create barriers in access to sexual and reproductive health services," including third-party authorisations for accessing abortion services.[236] The World Health Organization has also stated that third-party authorisation restrictions limit women's autonomy. As a result, the unwritten history of forcing pregnant

[232] Pratigya Campaign, Assessing the Judiciary's Role in Access to Safe Abortion, (2019) https://pratigyacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-tosafe-abortion.pdf,
[233] *Justice KS Puttaswamy V. Union of India and others* (2017) 10 SCC 1
[234] IHRL 157 (UNHRC 2011)
[235] LMR v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).
[236] Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the Right to sexual and reproductive health E/C.12/GC/22, https://www.escr-net.org/

women to seek judicial authorization for abortion services produces unnecessary anxiety and harassment. The dread is heightened by the legal ambiguity surrounding sex-selective abortion.

Several countries have rejected the requirement of medical board authorizations for abortion. The Supreme Court of Canada, for example, overturned abortion regulations that required women seeking abortions to gain approval from a hospital's therapeutic abortion committee, citing that such limitations caused delays and unequal access, and so violated women's right to personal security.[237] In Italy, if a pathological condition poses a major threat to a pregnant woman's mental health, she has the option of terminating the pregnancy after a physician diagnoses and certifies the disease.[238] Medical boards, on the other hand, have been established as appeals mechanisms for requests that have been denied. In Slovakia, a pregnant woman's choice of physician determines if the conditions for abortion are met; if the physician finds that the conditions are not met, the woman may request a re-assessment by the health facility's director.[239] In contrast to the MTP Act, these numerous rules from around the world affirm that women should have the final say in whether or not to terminate a pregnancy and emphasize that the law is meant to protect the pregnant woman, not just the practitioner delivering the service.[240] Furthermore, these regulations ensure that a woman and her physician make the decision to have an abortion, not third parties.

Conclusion

Access to abortion is a key component of women's comprehensive health care. Women's economic prosperity, educational accomplishment, and overall health and well-being are all tied to their ability to choose whether, when, and how to give birth. A variety of difficulties confront India's public health system, including limited public investment, poor infrastructure, including drugs and diagnostics, and a lack of competent human resources, to name a few. In addition, there has been an increase in the privatization and corporatization of health care in recent decades, as well as a lack of rigorous regulation. All of this has resulted in a decline in the accessibility, affordability, and quality of healthcare, particularly for reproductive health

[237] R v. Morgentaler, (1988) 1 S.C.R. 30, 32-33 (Can.)

[238] Italy, Law No. 194 of 22, 1978, Sec.6(b)

[239] 5 Slovakia, Act No. 73/1986 Coll. On Artificial Interruption of Pregnancy, as amended, 1986, Sec. 8

[240] South Africa, Choice on Termination of Pregnancy Act, 1996 (fetal impairment); Czech Republic, Law on Abortion, 1986 (fetal impairment); Germany, Criminal Code, 1998 (health, fetal impairment, rape/incest exception)

requirements, widening social, economic, and geographic gaps, mostly affecting girls, women, and marginalized communities. In India, there exist disparities in access to reproductive healthcare and health outcomes for vulnerable groups, as well as between and within states. Even in states where general averages are improving, marginalized communities and lower-income quintiles of the population, particularly women and girls, continue to suffer.

In cases where a woman or girl faces denials or barriers to accessing an abortion, medical boards can play an important role as an appeals mechanism. However, requiring judicial or medical board authorizations in all cases violates the state's constitutional and human rights obligations to create a legal and procedural framework that respects reproductive autonomy.To address the problem of healthcare availability in the pandemic, enhanced self-management of medical abortion with medical abortion pills, maybe with remote monitoring, has been proposed. They had requested better abortion self-management in the first trimester even before the pandemic, as well as the requirement of only one MTP provider's opinion instead of two for terminations between 20 and 24 weeks of pregnancy. Other demands included more mid-level healthcare workers being trained to perform abortions.

Chapter 6- Conclusion and suggestions

The great Tamil Saint Thiruvalluvar said, "The touch of children is the delight of the body; the delight of the ear is the hearing of their speech". It is a mother's natural duty to provide the best for her children. However, she occasionally engages in activities that are harmful to the foetus. It might happen due to a lack of knowledge, incompetence, or even purposeful acts. Abortion raises a number of social, ethical, and financial concerns. As a result, it shall be a mother's right to terminate a pregnancy.

Women living in every country, irrespective of its developed or underdeveloped, are vulnerable to the complication of unintended pregnancy. Abortion as a contentious right has been debated in national and international platforms across the globe. While abortion is forbidden by several religions, there are additional issues that raise serious moral dilemmas, such as infanticide, ethics, and women's rights.

Since the Medical Termination of Pregnancy (MTP) Act of 1971, which created an exception to the offence of abortion under the Indian Penal Code, 1860, abortion has been permitted in restricted circumstances in India. Meanwhile the abortion law in the United States has remained controversial and contested, and it differs from state to state.

When comparing India's current legal framework for abortion to that of the United States, we can see a recent trend in the U.S, of enacting legislation significantly restricting women's access to safe abortion, including by imposing criminal penalties on both women and abortion service providers. Several states in the United States have approved legislation this year aimed at limiting or prohibiting access to abortion services. Texas, for example, has established the country's strictest anti-abortion legislation . But eventhough the limitations are stiffer the number of maternal mortality and morbidity rate and deaths due to unsafe abortion are significantly smaller than that of India because of superior healthcare facilities and good execution of international norms. Access to effective post-abortion care improves when general health care improves and national governments prioritize implementing World Health Organization (WHO) guidelines. As a result of these developments and safer procedures, fewer women are dying as a result of unsafe abortions. Abortions that are unsafe are more common in developing

countries where countries with stringent abortion laws are concentrated. However, even in countries where abortion is broadly legal, a lack of affordable services can limit access to safe abortions, as is the case in India. Furthermore, prolonged stigma can influence doctors' willingness to perform abortions and drive women to prioritize secrecy over safety.

Despite the fact that induced abortion has been lawful in India since 1971 on broad grounds, representative data on access to abortion services and abortion rates has remained sparse. Because abortion is a critical component of both indicators, the lack of comprehensive data of abortion incidence has limited accurate assessment of total pregnancy and unwanted pregnancy rates. The creation and implementation of clinical guidelines and standards is believed to have aided in the provision of safe abortion.

Women must go to court to have their specific circumstance assessed by a government-established medical board. This has resulted in an extra-legal requirement for third-party authorisation, which disempowers women and girls by causing unnecessary delays, denials, and discrepancies in the application of the laws, as well as a chilling impact on access to MTPs even at early stages of pregnancy. According to our research we identifies that the establishment of medical boards does not always provide necessary support in ensuring safe abortion access. Instead, it creates numerous barriers to access by adding unnecessary authorization layers. The Illegality of termination of pregnancy has a direct impact on the right of gender equality under constitutional right of equality. Countries with less restrictive legislation, efforts are made to resolve demands of women. Yet such need of restriction free abortion needs to available to women efforts to meet women's need for abortion without limits need to be realized.

A substantial barrier women encounter in accessing abortion services is due to limited registered health care practitioners and paucity of fully equipped facilities to execute the procedure. They also encounter delays owing to lack of understanding about their legal rights, societal stigma and confusion regarding legality[241]. In Bihar, upto 75% of women are unaware that abortion is legal. The misconceptions concerning the law also influence delay in accessing to abortion, including the spousal consent required by providers despite not mandated under the law and the courts necessity to prove the rape allegation before permitting to obtain abortion.

[241] Government of India, Framework for Implementation: National Health Mission 2012-2017 2, 32 (2014)

States in USA implements abortion regulations of waiting periods to delay women led to shutting of abortion facilities. Imposition of Limit to abortion service providers serving as a de facto prohibition. US supreme court ruling of closing half of all existing state abortion facilities operational. Law approved by state's Legislature in 2013 in Texas had decreased from 41 clinics to 20. Implementation of entirely upheld then only 9-10 clinics will maintain ongoing operation. Many states restrict access through tactics ranging from rules targeting abortion providers to mandated delays. Some jurisdictions are passing increasingly draconian bans, including pre-viability bans, which are the subject of current litigation. Many are in court. If Roe v. Wade is diminished, abortion rights would be guaranteed in less than half of the US states and none of the US territories.

"Even if women are educated, they lack sex education," said Dr. Ajay Pal Singh Solanki, a doctor completing safe-abortion training via the non-profit organisation Ipas, an international reproductive health and rights organisation. "They are lacking in fundamental knowledge. In contemporary society," there are several myths about abortion and contraception.

It is strange that in the United States, where people want to defund Planned Parenthood, one of the country's leading providers of preventative health care, sex education, and contraception. In a state where a recent law shuttered more than half of the abortion facilities, and in a country where abortion is a woman's constitutional right, it's unusual to read a recent research by the University of Texas indicating that more than 100,000 Texas women have sought to self-induce their own abortions. And if the organization closed each and every one of its facilities tomorrow, abortion would exist they would just be tougher for women to acquire. And they would be, by extension, less safe. We've already seen this in portions of the United States: In Texas's Rio Grande Valley, where draconian abortion legislation shuttered the sole surviving abortion clinic, women report buying abortion drugs at flea markets, crossing the Mexico border for operations, or douching with Pepsi in an effort to miscarry.

India's new amendment has a limited capacity to solve several health issues and defend several rights of women. When comparing the existing situation U.S, India's move comes at a time when the historic Roe v. Wade is under investigation. A landmark piece of legislation, it acted as a light of hope for women around the world. Roe v. Wade is already trembling at its roots as a conservative US Supreme Court wants doctors performing abortions to acquire admitting

credentials from a neighboring hospital. American women understandably worry that the government could ring fence their alternatives. A ruling is not expected until later this year and stakes are high. The European Court of Human Rights has never weighed publicly on the topic of abortion and whether or not it should be legalised. In fact, Ireland, a member of the European Council, legalised abortion only in 2018.

The new amendment in MTP authorizes the termination upto 24 weeks which supposedly proves the ability of proving safe abortions even after such a protracted duration of pregnancy. It is also obvious that abortion might be achieved with the administration of single pill and even self-administration is possible. But if the technique of termination of a pregnancy is safe and appropriate at 24 weeks for certain people then why not extend it for all persons? Why continue to consider abortion as a reward that can be handed only to someone who has been victimized in some way and thus 'deserves' it? This clearly reveals the attitude of policy makers and how the societal standards wherever certain women are not permitted to choose to continue while other cannot choose to terminate. It is simpler to express pity to a woman who was compelled to have sex. Society is unwilling to forgive a woman who chooses to have sex. Especially the 'wrong' kind of sex. This is the woman who is to face societal punishment by being compelled to continue or to perish trying to terminate.[242]

The most central question that we really need to raise at this point is, why we need the MTP Act in the first place, when all other medical procedures are performed based on the doctor's clinical judgment. The MTP Act is required because sections 312-316 of the Indian Penal Code, which is a mostly unchanged law from the British penal code of 1860 ,punish miscarriage.

We should consider decriminalizing it first, and then enacting legislation that protects women's and pregnant people's right to their bodies by ensuring that they have access to free and high-quality safe abortion services (surgical and medical) at all public health-care facilities, free of coercion for contraception, and at private-sector facilities without extortion.

What we need from a good law is for it to ensure that no pregnant woman is turned away or forced to have an unsafe abortion or to carry on with an undesirable pregnancy. The present

[242] A quote fromManisha Gupte, a well-known figure in the sex determination and safe abortion rights work in India.

changes do not address this, and they do not make the government or public health institutions responsible in any manner for ensuring any of this.

We still do not have abortion as a right in our country, 50 years after the MTP Act of 1971. It is regrettable that the Amendments, which took more than 20 years to become law, are still insufficient, not far-reaching or visionary enough, and provide no relief to those who truly need it because they continue to hold the public sector accountable for providing a full range of sensitive and quality services, and they do not shift the power balance in decision-making from the provider to the pregnant woman. While it is critical to communicate knowledge about the tiny steps forward taken so far, we must also regroup and work toward the reforms that are still required.

The long journey of legalizing access to safe abortion that began in 1971 will finally come to an end only when India decriminalizes abortion. Meanwhile, a rights-based legislative framework on abortion is needed, one that is consistent with India's constitutional principles and international human rights law commitments. The fight goes on for a law that protects people's rights to equality, autonomy, bodily integrity, and privacy, as well as for a law that can change the environment in which individuals can exercise their entire range of reproductive rights, including their decisional autonomy to seek abortions.

Inconsistent jurisprudence is another factor contributing to women's health issues. Inconsistent rulings add to the general lack of clarity surrounding the conditions in which a woman may legitimately terminate her pregnancy. Women are also made to face the weight of administrative delays. Women are prevented from having an abortion after the time limit had expired, despite the fact that she had made her abortion request a long time before. The attitude of the judiciary toward abortion is more worrying than the statute itself. When it comes to abortion and reproductive autonomy, the law and the mindset of the public, particularly judges, must be revised. The revulsion that is linked with abortion and the process of enacting abortion laws must be eradicated.

The right of a woman to abort has been upheld by US courts. Conferring a person other than the pregnant lady is not the same as conferring a person other than the pregnant woman. The husband's genuine interests in participation allow him to have a say in the outcome. As a result,

the United States judiciary has erred in regard to the husband's legitimate rights in the propagation of his unborn child's future life. It may take a long time for American courts to strike a balance between a pregnant woman's right and her spouse's interests.

The current legal framework on abortion in India is not sufficient enough in curtailing public health issues relating to termination of pregnancy with respect to women. There are various barrios affecting proper access to safe and affordable access of abortion for women in India. Besides socio economic cultural barrios, various other barriers due to our existing legislature are affecting the patients. Lack of proper concern given by the government in providing facilities and regressive and outdated system of authorization are weighing over this issue. Even though the new amendment has made some changes in the situation, it is still not sufficient enough to contain majority of the problems faced by women, particularly from economic and socially backward sectors. Our government should give more focus on protecting the reproductive autonomy and rights of women by dealing with the matter of medical termination of pregnancy.

Suggestions

1. Telemedicine

Telemedicine is a safe and discreet option to have an abortion in early pregnancy without having to go to a clinic, which is important for people who are self-isolated due to pandemic, as well as those who live in distant regions or who are unable to leave the house due to childcare commitments. Telemedicine offers a way to protect women and meet their important health care demands during the COVID-19 pandemicAustralia is already using this cutting-edge and practical method of providing abortion treatment. Telemedicine is also used in the United Kingdom to consult with doctors via the internet and get medicine from afar.

2. Self-managed abortions

Allowing self-abortion is quite helpful in alleviating several concerns related to abortion availability. Self-managed abortion, or abortion outside of a medical environment, is a generally safe and effective technique to end a pregnancy.

Given the current situation in India and the United States, where severe anti-abortion legislation are on the rise, it has become increasingly difficult to obtain safe and legal abortion services. Increased interest in self-induced or self-managed abortions, primarily using drugs obtained outside of the medical context, is one response to this unfriendly environment for reproductive care access.

The two most significant concerns about the safety of self-managed abortion, when compared to clinic-based treatment, are that patients seeking abortion may mistakenly self-identify as eligible candidates and that they will not know or be able to receive medical care if necessary. As a result, there is a growing need for medical clinicians to learn about, and researchers to evaluate, the incidence, safety, and efficacy of abortion self-management. As a result, reproductive law specialists must continue to establish and educate on legal frameworks that protect and decriminalize both people seeking self-managed abortion and their care providers. A lasting answer for the development of this approach would be to provide a legal foundation for terminating pregnancy at any gestational stage.

3. Need for autonomy

In the absence of medical complications, the decision to have or not have a child should be made solely by the pregnant woman. Unwanted pregnancies can compel women to seek out unsafe abortions, which can result in serious physical and mental harm, if not death. State interventions should be limited to ensuring access to comprehensive and safe abortion treatment, as well as other sexual and reproductive health services. Furthermore, any interference in matters of choice is not only contrary to equality ideals, but also an invasion of women's fundamental right to privacy.. A shift in the law from restrictive to permissive will prepare the way for a way to show women that the moral ban on abortion has been lifted, and that those who want abortion for any reason have the permission and support of society as a whole. This will assist to alleviate the social pressure and shame associated with abortion. It's important to remember that not every mother wants to abort her fetus. However, they must be offered the choice freely because the outcome of a pregnancy determines their future path. The first step in this procedure would be to eliminate the need for judicial and medical board approvals for abortions. Abortion remains a conditional provision, not an absolute right, under our laws. A real transfer in power from the

doctor to the person seeking an abortion is required. It is necessary to revise the MTP Act using a rights-based approach that is women centric in nature.

4. Changes needed in other laws

There is a lot of grey area or overlap between MTP and other laws. the Protection of Children from Sexual Offences Act and the Drugs and Cosmetics Act, 1940. The modified MTP statute, on the other hand, substantially protects the privacy of those participating in abortion. As a result, it is necessary to amend Section 19(1) of the Protection of Children from Sexual Offenses Act to ensure that pregnant teenagers have access to abortion facilities without fear of confidentially being compromised, as required by the act's mandatory clause.

It conflicts with the provisions of PCPNDT Act of 1994, and officials conducting extensive inspections to prevent sex determination by the PNDT frequently targeting MTP centers and gynecologists legally licensed to perform abortions.

Medical abortion pills are also categorized as Schedule H drugs, which require a pharmacist to keep a sales record under the Drugs and Cosmetics Act. This goes against the MTP Act 2021's promise of confidentiality. Such laws should be amended in order for our laws to function properly.

5. Reducing the Need for Abortion

The need for abortion can be reduced by making contraceptive information and services available, accessible, and inexpensive. The availability and appropriate use of economical, effective, and safe contraception has been linked to a decrease in the number of abortions in the United States. In areas like Eastern Europe and Central Asia, where induced abortion was historically the most common technique of controlling fertility, data shows that as the use of modern contraceptive methods grew, induced abortion dropped. Contraception reduces the frequency of unplanned pregnancies, but it does not eliminate the need for safe abortion access..

6. Building awareness and good health facilities

Efforts should be made to raise awareness and educate women and the general public about their sexual and reproductive health and rights (SRHR), including their right to safe abortion

treatment. More significantly, we must educate our healthcare providers and law enforcers about a woman's right to reproductive choice, privacy, and dignity, as well as the importance of providing services free of bias and judgment.

Health care facilities can play a bigger role in providing abortion services and quality care, including post-abortion contraception. Better equipping existing facilities, maintaining appropriate and consistent supply of medication abortion drugs, and expanding the number of qualified doctors are all needed to increase access to abortion services. Education, particularly sex education, was critical in encouraging women to use contraception and lowering the abortion rate. It was also important to make sure that well-trained practitioners were available in hospitals around the country.

7. Need of more women participation in policy making

Women must be included at all levels of policy-making and program implementation because they are the primary users of reproductive health services. Policymakers must think about how their actions affect men and women, as well as how gender norms help or hinder initiatives and progress toward gender equality. Reproductive health care should have the following components: strong government support for family planning, service professionals that are properly trained, sensitive to cultural contexts, listen to clients' needs, and are friendly and compassionate, Services are affordable, and there is a variety of contraceptive options to choose from. Counseling that ensures informed consent in contraceptive choice, privacy and secrecy, comfortable and clean facilities, and timely service are all provided.

All individuals and groups from various socioeconomic backgrounds must be heard and taken into account.[243] Only by hearing from marginalized people about their experiences with barriers to abortion and reproductive healthcare will we be able to grasp the subtleties and complexities of this issue.

8. Decriminalization of Abortion

[243] RashmiLuthra, Toward a Reconceptualization of "Choice": Challenges by Women at the Margins, Feminist Issues (1993).

Criminalizing abortions, unless in certain circumstances and within particular gestational restrictions, is a significant impediment to women's reproductive choice. Decriminalizing abortion services by not requiring pregnant women to meet restricted criteria for abortion access will remove these barriers and is consistent with constitutional principles of human dignity and bodily autonomy. Forcing women to continue with unwanted pregnancies is a major gender injustice due to the disproportionate load placed on women as child bearers and caretakers. To overcome this, and to further ensure that structural barriers to abortion access are eliminated, an approach to abortion rights based on equality and non-discrimination is required.

Abortion was decriminalized on limited grounds in Canada in 1969. In **R v Morgentaler**, the Supreme Court of Canada ruled in 1988 that forcing a woman to carry a baby to term violates on her right to life, liberty, and the security of her person, as provided by section 7 of the Canadian Charter of Rights and Freedom.[244] In Canada, abortion is enshrined in the healthcare system, and the decision is left to a woman and her doctor; the state is not required to intervene unless it is to ensure that everyone has access to safe and affordable reproductive healthcare. Abortion is not governed by any criminal statute or other legal framework; decisions are made "in the same manner as vasectomy or treatment for a ruptured appendix or an ectopic pregnancy."[245] As a result, abortion is regarded like any other medical treatment, with the same scrutiny and safety precautions. Existing law from Nepal and Canada emphasizes the necessity of ensuring that women have the ability to exercise their reproductive autonomy. New South Wales, Australia's largest state, has decriminalized abortion, overturning a 119-year-old law. In Vietnam, abortion has been available on demand since the 1960s, and the Law on Public Health Protection, which was passed in 1989, recognizes women's right to abortion and does not impose any gestational limits.[246] The Termination of Pregnancy Act of 1974 in Singapore allows for abortion up to twenty-four weeks after conception.[247]

Decriminalizing both consensual and self-induced abortions would improve everyone's access to safe abortion services. In India, the legal framework is very explicit on when abortions can be

[244] Henry Morgentalerv. R., 1988 SCC OnLine Can SC 4
[245] W.V. Norman & J. Downie, Abortion care in Canada is decided between a woman and her doctor, without recourse to criminal law, The BMJ (2017)
[246] 2 Centre for Reproductive Rights, Vietnam's Abortion Provisions, available at https://reproductiverights.org/world-abortion-laws/vietnams-abortion-provisions (2019).
[247] The Termination of Pregnancy Act, 1974 (Singapore).

performed. As a result, amend the Indian Penal Code to legalize abortion in order to reduce the social stigma associated with the practice while also increasing access to safe, legal procedures.

9. Other changes required

Reform is told to eliminate the delays and denials caused by a lack of licensed abortion providers, women's lack of awareness of the law, providers' fear of punishment, insufficient guidance on how to safely conduct abortions, and a lack of clear guidelines for doctors on relevant clinical factors for opinions in abortion cases. Despite the procedure's legality, many women seeking an MTP are stopped by procedural impediments and a lack of clear standards and guidelines.

Amee Yajnik, Member of Parliament in the Rajya Sabha said[248], specialists required for the medical boards that are supposed to sanction post-24 week abortions, gynecologist, pediatrician, radiologist or sonologist are in short supply. As a result, another critical issue that the government must address is the lack of medical professionals and workers. Otherwise, no matter what legislation is in place, it will be ineffective without proper access.

Given how many women rely on self-administration of pharmaceutical abortion medications, interventions are required to provide women with appropriate information about these treatments, as well as follow-up care as needed. There is a need for research to test interventions that improve knowledge and practice in providing medication abortions, The Indian government, both at the national and state levels, must prioritize improving policies and practice to increase access to comprehensive abortion care and high-quality contraceptive services to prevent unintended pregnancy. The public sector's role in delivering high-quality health care to poor and vulnerable women should be reviewed and assessed to see if an expanded role in providing abortion care is necessary. Unintended pregnancies and abortion rates in India are consistent with women's unmet contraception needs, highlighting the need for further investment to satisfy women's and couples' contraceptive needs and assure access to safe abortion services.

[248] http://164.100.47.7/newdebate/253/16032021/Fullday.pdf

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