**LEGALIZATION OF ABORTION**

By: -

**ARUNEESH BHARDWAJ**

**1st Yr, BBA, LL.B.**

**INDORE INSTITUTE OF LAW**

**Mob.: - 7000637690**

**E-mail aruneesh.barca5@gmail.com**



www.probono-india.in

**May 15, 2020**

**Legalization of abortion: how is abortion treated by the law and what are the moral aspects of the problem?**

Abstract: Despite the legalisation of abortion in India, morbidity and mortality continue to remain a serious problem for a majority of women undergoing abortions. A lack of reliable information, wide regional and rural-urban differences and a thin research base all make it difficult for policy-makers, administrators and women's health advocates to develop strategic interventions. Abortion, is a universal phenomenon and is defined as and has existed throughout recorded history, yet it continues to be a highly charged, controversial issue, raising extreme passions among lay people, as well as politicians, religious leaders, and health and rights advocates. Although abortion services in India were liberalized more than three decades ago, access to safe services remains limited for majority of women. This paper synthesizes recent evidence on abortion scenario in India, explores factors why women seek abortions. It highlights factors, notably unmet needs for contraception, lack of awareness of legality of abortion services, limited access to safe services, poor quality of services, leading women to seek services from untrained providers. Thus by making abortion services broadly legal, understanding size, type of unmet need, characteristics of women with unmet need, can surely help tackle this problem to some extent. But the abortion debate in India would be meaningless if it did not take into account the crucial problem of female foeticide. Liberation of women, therefore, needs to be equilibrated against the rights of the unborn child.

**INTRODUCTION**

“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.

”1-Betty Friedan.

 WOMEN AND their right to determine their sexuality, fertility and reproduction are considerations that have seldom, if ever, been taken into account in the formation of policies related to abortion.2 Abortion is one of the most controversial ethical issues because it concerns the taking of a human life. Generally, if we look at traditional arguments for and against abortion, we find legal and religious arguments guiding each respectively. When it comes to those who favor abortion, they point to the argument that abortion represents a woman’s “right to choose” whether to continue her pregnancy or terminate it. Anti-abortionists, generally make a religious argument as the spearhead of their collective opposition to abortion. Through the broad sweep of history, women have practised various forms of birth control and abortion. These practices have generated intense moral, ethical, political and legal debates since abortion is not merely a medico-technical issue but "the fulcrum of a much broader ideological struggle in which the very mean The ability of couples to plan the number, spacing and timing of births is an important fundamental human reproductive right. Women living in every country, irrespective of its development status, have been facing the problem of unintended pregnancy. Unintended pregnancy is an important public health issue in both developing and developed countries because of its negative association with the social, economic and health outcomes for both women and families [1]. Even though, globally, there is a decline in the number of unintended pregnancies, the proportion of pregnancies that are unintended remains high among the developing countries. It is estimated that nearly 40 per cent of the pregnancies in developing countries are unintended--either not wanted at all or mistimed [2]. According to 2008 global estimates nearly half (48 percent) of the unintended pregnancies will end up in abortion and most of them will be unsafe. Many of these cases end in death adding to the existing high maternal mortality ratio [3]. Unsafe abortion and unmet need for Family Planning (FP) are preventable; but remains the cause of maternal mortality and morbiditiesings of the family, the state, motherhood and young women's sexuality are contested”.

**I Abortion: a fundamental right**

One finds oneself agreeing with much of Dr. S.G. Kabra’s views on abortion in India [(1)](https://ijme.in/articles/abortion-a-fundamental-right/?galley=html#one). The Indian State’s interest in providing abortion services in the country, has as Dr. Kabra points out, been governed essentially by the exigencies of the family planning programme. The programme operates both from eugenic considerations – the perceived ‘need’ to prevent some sections of the population from reproducing themselves – and from perceived ‘national’ interests. He also rightly focuses on the indifference of the State in allowing illegal or badly performed abortions that can lead to a range of health problems for women, and in some cases, their deaths.

However, I take objection to the thrust of Dr Kabra’s argument, which suggests that the right to abortion involves the ‘fundamental rights of two individuals – the mother and the foetus’. Simultaneously, a connection is drawn between abortion and infanticide. The statement on what stage a foetus can be seen as an individual in its own right is disturbing. It tends to look at abortion at a certain stage of the pregnancy as being acceptable and unacceptable at others. The notion that the foetus is an individual in its own right infuses an emotional angle to the entire debate on abortion that in my view is unacceptable. It can, taken to its logical conclusion, lead to the perception that contraception itself is unacceptable, as it can destroy a potential life.

Abortion causes emotional turmoil for many women and their families, especially when accompanied with coercion by the state. However, it cannot be seen as anything less than an unalienable right for women. Women have a right over their bodies and their reproduction, that cannot be transferred to their families or the state. This is more relevant in this country where childbearing is modified by social mores; and women’s right to decide when and if they want to bear children remains a theoretical rather than a practical right. The existing laws on abortion are inadequate and designed to serve the interests of the family planning programme, rather than to allow women to regain control over their bodies.

The Medical Termination of Pregnancy Act (henceforth MTP Act) was passed in 1971. [(2)](https://ijme.in/articles/abortion-a-fundamental-right/?galley=html#two). Under this act, women have a restricted right to abortion. The declared objects of the Act are to help women who become pregnant as a result of rape, married women who are pregnant due to contraceptive failure, or to reduce the ‘risk’ of severely handicapped children being born. As with the family planning programme, the right to contraception is seen as applicable only to married women, marital sexuality alone being seen as legitimate.

Under the MTP Act, regulations on record maintenance require the doctor performing the operation to maintain records on each abortion which include the reasons for the abortion — legally, the woman cannot avoid giving an explanation. This register is a secret document, to be destroyed by the doctor at the end of five years since the date of the last entry.

There is much scope for misuse. Many married women undergo abortions without the knowledge of their family members, including, at times, their husbands. For single women, the need for secrecy is even more pressing. Not only do they face a greater degree of social control; the abortion may well be out of the purview of the MTP Act. Given this, the register can easily become a tool for blackmail in the hands of unscrupulous medical practitioners and medical staff.

Besides, the insistence that woman explain their reasons for an abortion, and denying the clause of contraceptive failure to single women, demonstrate the not so hidden moral agenda of law makers. At a more general level, this makes a mockery of women’s right to abortion, and in an extended understanding, women’s rights over their bodies

**II Abortion as human right**

The Preamble of the Universal Declaration of Human Rights describes the Declaration as, “a common standard of achievement for all peoples and nations” and states that “the peoples of the United Nations have . . . reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person, and in the equal rights of men and women.” The second article stresses further that these rights and freedoms belong to everyone, without discrimination, by virtue of being a human being: “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind.” In the third article, explains the first of the rights belonging to everyone, “Everyone has the right to life.” The right to life is the foundation of all other human rights. Though the declaration states the understanding of the international community regarding human rights, it does not create legal obligations. International Covenant on Civil and Political Rights (ICCPR) echoes and enforces the right to life of the declaration. The Covenant proclaims, “Every human being has the inherent right to life. Law shall protect this right. No one shall be arbitrarily deprived of his life.”Notably, the covenant articulates the right as applying to every human being. Unlike the word “person” that, through judicial interpretation in the United States (US), has left the unborn outside a sphere of protection, “human being” is a scientific term for a living human organism. Thus, one view lies that the basic human-rights documents are against abortion; they certainly do not create a right for abortion.Some jurists have asserted that the historical understanding is that the right to life, as protected by the international bill of rights, begins when a human being is born. This interpretation is supported by the negotiation history of international human rights treaties. During the negotiation processes leading up to the adoption of several international and regional human rights documents, a small number of governments proposed adding language to the provisions on the right to life, that would have protected the right to life from the moment of conception. In the vast majority of cases, these proposals have been rejected.9Article 1of ICCPR, declares that, ‘every human being’ has the inherent right to life, while in respect to other rights the expressions used are ‘everyone’ and ‘every person’. This use of different terminology raises the question whether ‘every human being’ has a wider connotation than ‘everyone’ and could therefore be understood to include the unborn child. There is an absence of authoritative literature on the above contention however it is a well understood fact that the criminalization of abortion can have implications regarding the right to life. This can be backed by the instances of suicides, which young females commit as a result of failure to perform an abortion due to its criminalisation by the state which is a direct violation of right to life. Failure to prevent unnecessary deaths due to anti-abortion laws would raise issues pertaining to the obligation to ensure that everyone enjoys the right to life. Another interpretation can be drawn from article 12 of the CEDAW Convention that provides that, “States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

**III Abortion and the Constitution of India**

While establishing the democratic setup, our Constitution framers were vigilant and inculcated the sprit that people must be protected against misuse of power by the government and its officials. They, therefore, provided for the fundamental rights in part-III of the Constitution. The article 21 of Indian constitution provide right to life which includes within its ambit the right to privacy. Right to life and personal liberty is the most sacrosanct, precious, inalienable and fundamental of all the fundamental rights of citizens. This guarantee imposes a restraint on the government and it is part of the cultural and social consciousness of thecommunity in India. In this context, every woman owe an individual right, right to her life, to her liberty, and to the pursuit of her happiness, that sanctions her right to have an abortion. The women have reproductive features and have right to decide about her sexual health and shape her reproductive choices. To ensure availability of human rights to women and to advance the development, the international community acknowledged reproductive rights of the woman. In order to follow the international mandate, governments from all over the world have recognized and accredited reproductive rights to women to an unprecedented heights. To fulfill its commitment government enacted formal laws and policies that are prime indicators in promoting reproductive rights. Thus it can be reiterated that all over the World each and every woman has an unconditional right to have control over her own body and.

**IV Medical Termination of Pregnancy Act, 197**1

After the Roe v. Wade10 case, European and American countries started to legalise abortion. During the last thirty years, since 1970s many countries have liberalized their abortion laws. Roe case has been subsequently modified by the US Supreme Court in Planned Parenthood v. Casey11 where the legality of the abortion law is now linked to the viability of the foetus rather than the rigid third trimester test laid down in Roe case. In India, the Central Family Planning Board on August 25, 1964 recommended the Ministry of Health to constitute a committee to study the need of legislation on abortion. The recommendation was adopted in the later half of 1964 constituting a committee which consisted of members from various Indian public and private agencies. The committee – called Shantilal Shah Committee. After analysing a vast expanse of statistical data available at that time, this committee issued its report on December 30, 1966. On the basis of this report, the government passed the Medical Termination of Pregnancy Act, 1971 (MTP Act of 1971) and liberalised abortion laws in India. The committee acknowledged that there did not exist and would not exist in the predictable future either the doctors or the medical facilities to support an extensive abortion programme. It also specifically denied that its intention was to force down for the legislation of abortion only for the population control in India. The committee further pointed out. It is felt, that legalising abortions with a view of obtaining demographic results is unpractical and may even defeat the constructive and positive practice of family planning through contraception. It is noteworthy that the MTP Act was implemented in the month of April, 1972 and again revised in the year of 1975 to eliminate time consuming procedures for the approval of the place and to make services more readily available. This Act was amended in the year 2002 and again in 2005. 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”. The Act, consisting of just 8 sections, deals with the various aspects like the time, place and circumstances in which a pregnancy may be terminated by a registered medical practitioner. It legalizes abortion in case where there is a failure of contraceptives or where the pregnancy will adversely affect the physical or mental termination of pregnancy, consent of the pregnant woman is a must unless she is a minor or lunatic when her guardian’s consent is required.15The Act permits abortion only in certain circumstances. It Act allows medical termination of pregnancy up to Twenty weeks’ gestation. Though the Act talks about the written consent of the pregnant mother before the technique is administered to her, the law fails to recognise the social reality that a woman cannot make a free choice. Thus, it is evident that the Act fails to achieve a equilibrium between the right of the unborn to be born and the right of the woman, who bears, gives birth and rears the child, to decide whether she wants the child or wants to abort the foetus. In Nikhil D. Dattar v. Union of India, section 3 and 5 of MTP Act was challenged on the ground of non-inclusion of eventualities vires of the Act. In this case the foetus was diagnosed for complete heart block thus the Petitioner, in her twenty sixth week of pregnancy, had sought termination of pregnancy. The petitioner contended that section 5(1) of the MTP Act should be read down to include the eventualities in section 3 and consequently, a direction should be issued to the respondents to allow the petitioner to terminate the pregnancy. The court held that the courts are not empowered to legislate upon a statute. Sections 3 and 5 provide for right to terminate pregnancy only under the specified circumstances. And the remedy under section 5 can only be available when the non-termination of pregnancy would be dangerous to the life of pregnant woman. While dismissing the petition the court further held that since twenty six weeks of pregnancy has already passed the court could not pass any direction for exercise of right under section 3. This case further reiterated that the physical and mental trauma which may be experienced by women in such circumstances. It also highlighted the ethical issue faced by the doctors in similar situations.

**V Socio- ethical issues**

Abortion touches social, religious, economic and political aspects. Its impact on the society seen can be looked at both in a positive and a negative manner. In the earlier years of forming abortion policy, the Western civilisations disapproved the practice. By the nineteenth century many nations passed laws banning abortion. It wasn’t until late in the twentieth century when the women rights were given importance and after many awareness movements that some nations, including the US, began to legalise abortion. In India, which is a country with immense social baggage supplemented by societal evils such as illiteracy and poverty, the impact of the MTP Act should be judged in the context of changing social circumstances, values and attitudes. The social implications of MTP Act, in its very raw form can be segregated into abortion in unmarried girls versus abortion in married woman. These two have completely different connotations. In MTP Act married woman is not considered as a social stigma, whereas unmarried girls are not easily accepted. The fact that it is unaccepted creates hindrances in safe abortions, sometimes defeating the very purpose of abortion i.e., health of the woman undergoing abortion. In villages where there is in access to medical facilities, girls are taken to other distant places for MTP Act in the name of preserving the girl's future and keeping image in the society intact. The legalising of MTP Act has obviously had a positive stimulus upon the omen in need of MTP and has shown reduced incidence of suicide and betterment of health and safety. The acceptance of the family planning methods has also witnessed wider acceptance.18There are however, certain undesirable implications of the MTP and these lie in the inconsistency in following prescribed standards. This problem is rampant especially in rural areas due the lack of awareness of the patients and the lack of surveillance by the government. The effectiveness and safety of these medical procedures still lie in dim light. The lack of proper cleanliness, staff and facilities sometimes results in such as infertility, menstrual disturbances and pelvic inflammatory diseases. In a few cases, this results in death as well.19The real problem lies in the implementation of the laws and existing framework. It is the responsibility of the government to ensure that MTP Act is done by qualified surgeons in registered clinics or hospitals. The concerned authorities need to deal with another major challenge and that is of the genuineness of reasons behind requesting termination of pregnancy. There have been cases reported where in MTP Act is performed flimsy ground such as examinations, family weddings, tours etc. such abortions are conducted by the medical practioners for financial gains and go unchecked on most occasions due to fabricated reports. Such abortions have both long term and short term consequences. It is also unfortunate that abortion often is used as an alternative to regular methods of family planning.20 Such issues can only be addressed by government initiatives and awareness programs. It is the social responsibility of doctors to counsel all patients coming for termination of pregnancy about the use of some contraception. It should be emphasised that contraception use is much safer than termination of pregnancy. To mitigate the ill effects on society, the balancing of the negative and positive aspects of this social legislation needs to be taken up. The ethical debate about the legal stance of prevention of unwanted pregnancies has been continuing for many years throughout the world, and this established the idea of enacting a legislation that would balance the ethical and legal perspective. In India, in spite of legislative and judicial control, ethical controversies surrounding medical termination of pregnancy still continues. Though many people believe that medical termination of pregnancy is immoral but today it is a right that cannot be taken away from the women. In relation to social stigma a Supreme Court bench comprising Thakker and D.K. Jain JJ held in Suman Kapur v. Sudhir Kapur 21 that an abortion by a woman without her husband’s consent would amount to mental cruelty and a ground for divorce. To quote the bench:22 Mental cruelty is a state of mind. The feeling of deep anguish, disappointment, frustration in one spouse caused by the conduct of the other for a long time may lead to mental cruelty. A sustained course of abusive and humiliating treatment calculated to torture, discommode or render life miserable for the spouse. In the light of such judgements, it can be said that Constitution does not guarantee right to abortion to the women in India and the MTP Act, 1971 itself limited sphere of this right and provides for the ‘termination of pregnancy’ in certain cases only. In a expansion that may have far-reaching consequences, the Supreme Court of India have decided that severe foetal abnormality can be a valid ground for the medical termination of pregnancy, even if the foetus is more than twenty weeks old. The Supreme Court granted a twenty four week pregnant woman and rape survivor the permission to go for an abortion in Ms. X v. Union of India.23Here it is pertinent to specify that the International Federation of Gynecology and Obstetrics (FIGO) recognises an ethical obligation to allow women to terminate a severely malformed fetus.24 FIGO emphasises that in such cases, “[t]he decision to terminate a pregnancy should rest primarily with the parents.”25 It is evident that many countries permit the legal abortion procedure throughout pregnancy in cases of fetal impairment to protect a pregnant woman’s health.

**VI Psychosocial aspects**

The famous birth control activist Margeret Sanger once said that “No woman can call herself free until she can choose consciously whether she will or will not be a mother”. Women have however now come a long way since those days where in abortion was illegal and medical termination of pregnancy was socially unacceptable. The crucial consequence that followed this attitude towards abortion was the psychological implications upon the pregnant woman

amily. These persons were faced with distress of an uncertain future. In today’s time however, it is legally available in most countries of the world and due to this the physiological trauma and social isolation have reduced. Psychologically it gives them a sense of control upon one’s own future and the power to make choices. However, in the favorable social circumstances following legalised abortion, the patient’s relief of getting rid of the unwanted pregnancy out shadows and feeling of guilt that either used to accompany an illegal and socially unsanctioned procedure. In a minority of patients, one sees psychological disturbances in the form of major psychoses or depression.26It was not yet recognised as a justification for abortion that the women’s health would be endangered if the pregnancy is carried to the full term. That step has not been taken but perceptibly it constitutes a greater inroad in the sanctity of life of the fetus than a provision intended to guard against danger to the women’s life. But each person has a right to bodily sovereignty and human rights and various international instruments protect such rights. Thus it becomes important to secure the right to abortion to every woman.27Those who are pro-life are against abortion and believe that since life begins at conception, abortion is parallel to murder as it is the act of taking human life. Abortion is in direct disobedience of the idea of the sanctity of human life and that no civilized society permits any human to harm or take the life of another human. Their answer to an unwanted child is adoption and they believe that with millions of child less parents wanting to adopt a child. In the instance of rape and incest, etc., they believe that abortion punishes the unborn child who committed no crime; instead. Their basic premise is that for women who demand complete control of their body, control should include preventing the risk of unwanted pregnancy through the responsible use of contraception or, if that is not possible, through self-restraint. In short, it can be said that abortion should not be used as another form of contraception.28 On the other hand, those who are pro-choice support abortion and believe that since the fetus cannot be regarded as a different entity in the first trimester as a fetus cannot exist independent of the mother.Attached to the mother by the placenta and umbilical cord and its health is dependent on her health, and cannot be regarded as a separate entity as it cannot exist outside her womb.29 Another contention that they out forwards is that the concept of human life is totally different from the concept of personhood. At the time of conception human life occurs, but fertilized eggs that used for in vitro fertilisation, in many times, are not implanted and are routinely thrown away and it is not considered as murder, then how would abortion be considered as murder? They also believe that the concept of adoption is not an alternative remedy to abortion. Even in the case of rape or incest, etc., often a woman is unaware that she is pregnant or is too afraid to talk about, thus the contraceptive pills are ineffective in these situations. This group of persons believes that although abortion should not be used as a form of contraception but even with responsible contraceptive use pregnancy can take place.30 Another aspect that they rest their case on is that teenagers who become mothers have harsh prospects for the future such as leaving the school, health issues, inadequate prenatal care combined with social stigma. Thus they believe it to be against the very fundamental concept of civil rights and right to make choices.

**Outcomes of unintended pregnancy**

A recent estimation found that 183,400 fewer women died in 2008 than in the year 1980 [19]. However, India alone accounted for 19 percent of all maternal deaths in 2008. India country overview of World Bank mentions that there were 68,000 maternal deaths in the country in 2008 [2]. About a quarter or more of maternal and child mortality in the world takes place in India [20, 21]. There are variations in the country level in the risk for maternal and infant mortality. Despite a declining Maternal Mortality Ratio (MMR), huge disparities are visible between different states, and between districts in the same state. This disparity is due to differential levels of socioeconomic development. Various factors like access to skilled birth attendance, emergency obstetric care, overall status of women, female literacy, maternal health, and anemia are factors that were seen to be attenuating it [22].While looking at the trends of maternal mortality ratio in the focused states, it was found that even though there is a decline in MMR in the focused states the ratio is comparatively higher than the national average. Among the three focused states, Madhya Pradesh showed highest maternal mortality ratio throughout the period and Bihar is not far behind. Another analysis of the maternal deaths in the country found that Odisha is accounting for most of the maternal deaths in the country. The other states with high MMR are Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttaranchal, and Assam. These states had weak infrastructure which in some way is correlated to poor development indicators and poor health outcomes [22]. A hypothetical exercise using data from Sweden for years 1911 and 2005 (because maternal deaths were rare in 2005) highlighted the role of fertility decline in reducing maternal deaths. Estimations revealed that more than 30,000 maternal deaths would occur if the TFR and MMR were both at 1911 levels. Changing both measures to their 2005 values reduced the number of deaths to 104. Fertility decline alone halved the number of maternal deaths, to fewer than 15,000. For example, the maternal mortality rate for the youngest women (15-19 years), who face a higher risk for adverse outcomes, fell by two-thirds (69%) [23].In 2010, there were 52·8 million deaths globally. At the most aggregate level, communicable, maternal, neonatal, and nutritional causes were 24·9% of deaths worldwide in 2010, down from 15·9 million (34·1%) of 46·5 million in 1990. This decrease was largely due to decreases in mortality from diarrhoeal disease (from 2·5 to 1·4 million), lower respiratory infections (from 3·4 to 2·8 million), neonatal disorders (from 3·1 to 2·2 million), measles (from 0·63 to 0·13 million), and tetanus (from 0·27 to 0·06 million) [24]. For every woman who succumbs to maternal death, many more suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications. Globally, it is estimated that for every maternal death, about thirty women suffer disability or injury due to pregnancy complications, childbirth or abortion. In 2010, 35% of global disability adjusted life years was from communicable, maternal, neonatal and maternal disorders. About half of all deaths from unsafe abortion are in Asia, with most of the remainder (44%) in Africa.

**Abortion laws and policies**

Voluntarily causing miscarriage to a woman with child other than in good faith for the purpose of saving her life is a crime under section 312 of the Indian Penal Code (IPC) punishable by simple rigorous imprisonment and/or fine. Induced abortion was legalized in India in 1971 to curb maternal mortality and morbidity stemming from illegal abortions. Medical Termination of Pregnancy Act 1971 was hailed as a progressive act when it was passed, which was expected to decrease existing high mortality and morbidity of women by reducing illegal abortions. The term “Medical Termination of Pregnancy” (MTP) was used to reduce opposition from socio-religious groups [48]. Unlike many developed countries which permitted abortion if there was fetal

15malformations, danger to mother’s health or it was resulting from rape; abortion can be sought in India on all grounds—physical and mental health and environmental considerations. No spousal consent was required and only if women were under age 18 years, parental consent was mentioned. Indian Penal Code 1862 found women seeking abortion as well as abortionist guilty and were imprisoned. The new act was seen as pro women and pro life with its base on human rights. Despite this, women continued to seek unsafe abortions [48, 49]. Three decades after the introduction of the MTP act, only 9% of the 2400 women surveyed in Madhya Pradesh knew that abortion was legal. Nearly half considered induced abortion to be illegal [50]. Likewise, poor knowledge of the rights under the MTP act was reported from other states too [51-56]. MTP act has recognized the implications of second trimester abortions (thanks to the involvement of the medical community in pushing for the act) and while allowing the same within the act, infrastructural requirements are very well elaborated [48]. In the year 2008, India saw 6.41 lakh abortions across 12, 510 institutions approved to carry out medical termination of pregnancy (MTP) [57]. The number will be much higher if unreported abortions are also counted. This statistics is disquieting because unreported abortions tend to be unsafe abortions. A study in Gujarat showed that majority of women coming for 2nd trimester abortion had tried to abort the fetus unsuccessfully in the first trimester. Even married women go for clandestine abortions when the pregnancy is from contraceptive failure and they fear their husband will suspect them of infidelity or they are worried about the increasing number of children and lack of care to them while husbands are least bothered about the issue [49]. In a study, of the 549 unmarried women age 15-24 years surveyed from Bihar and Jharkhand; one in six women mentioned that non-consensual sex had resulted in pregnancy. Eighty-four percent decided before the end of the first trimester to have an abortion, but only 75% obtained one in this period. Women who were older or who had more schooling had a decreased likelihood of having a second-trimester abortion whereas those who lived in rural areas, those who did not receive full support from their partners and those who reported a forced encounter had an increased likelihood of having a late abortion[56]. For every identified case coming to hospital with post abortion complications; there will be many who did not suffer worrying complications and so had not sought treatment. Despite a well-defined law, there is a lack of regulation of abortion services or providers, and the cost to women is determined by supply side economics [58].Since 1991, 80 percent of districts in India have recorded a declining sex ratio with the state of Punjab being the worst. Preconception and Prenatal Diagnostic Techniques (prohibition of sex selection) Act (PCPNDT) 1994 was passed to curb the increasing sex selective abortion leading to the skewed sex ratio [59]. Sex selective abortions are mostly second trimester abortions. Dealing with fetal sex determination and sex selective abortion as business and money making opportunity by unethical medical professionals led to the modification of the PCPNDT act in 2003 to target the medical profession —the ‘supply side’ of the practice of sex selection. However, the envisaged effect could not be achieved since the implementers and the judges did not know the act and its requirements in detail. Despite many complaints and cases, number of convictions is few, making the act ineffective in achieving its objective [60-64]. This situation is discussed in detail while discussing the two acts together. One of the abortion service providers in India is of the opinion that women are not seeking abortion in second trimester for sex selection [65]. “Girls are often seen as a burden by their families, particularly in poor rural areas” [66]. However, sex selective abortion especially if the first born is a girl is higher in urban areas and in educated and wealthier families. The conditional sex ratio for second-order births when the firstborn was a girl fell from 906 per 1000 boys (99% CI 798–1013) in 1990 to 836 (733–939) in 2005; an annual decline of 0·52% (p for trend=0∙002). No significant declines were noticed if first born was a boy[77]. Trend in reported abortions increased after MTP Act in 1971. The number of approved institutions providing MTP has increased every year. Despite this trend, safe abortion services are still negligible in rural areas.

The recent census data highlighted the increase in sexual disparity at birth and the disappearing girl children. The news papers and other media focused on this issue with numerous articles. This has had its negative effects on the provisions in the MTP act [67, 68]. FOGSI narrated that despite having committed persons and NGOs working for promotion of safe abortion; fear is ruling the provision of services in Maharashtra. Pharmacists do not stock medical abortion pills, doctors do not apply for registering their clinics as an abortion service provider. Tabling the amendment to the CAC guidelines in the parliament was delayed since the focus soon after the census 2011 data was released was its highlight of the disappearing girls in many states. There was an increasing consensus at the one day meeting held in Delhi by FOGSI and PSI that the clinicians who are not well versed with the law and the maintenance of the forms and registers get easily caught and punished by the inspectors who themselves are not sure of their roles and powers [68]. Thus despite the presence of MTP act that allows induced abortion for all reasons, women are unable to access safe abortion [59, 60].To understand this dichotomy, the two laws in India—MTP and PCPNDT—need to be discussed here to highlight how the laws tend to help as well as restrict safe abortion. MTP act hadmade abortion legal. Technology; ultrasound made it possible for couples to find out the sex of the fetus. Son preference of the Indian society thus gave an easy way to abort the female foetuses and also promoted a business by some medical professionals. To thwart this trend, PCPNDT act was passed in 1994. This has made disclosure of the sex of the child a punishable offence. The existence of MTP and PCPNDT acts one focusing on the right of the women and the other looking at punishable things have led to confusion among the common people on what is allowed by law and what is restricted. MTP is based on the right of the woman and so there is a tendency of health professionals to feel that sex-selective abortion is a right of the woman. Communities are also not able to differentiate between the restriction in PCPNDT act and the allowances in the MTP act [56]. Many feel that integrating MTP and PCPNDT into a single act is necessary for its successful implementation. The difficulty of one act covering the components of the two acts is difficult because of the differing focus and basic theme in the two acts. The safe abortion lobby in the country is against merging the two acts because the protection of women’s health with the MTP act will get compromised. Hence the lobby’s efforts are in the direction of rejuvenating the lack of interest among providers in providing abortion services. The study carried out by CYDA and UNFPA further found that appropriate authority (AA) who are responsible to monitor the implementation of the PCPNDT act are dysfunctional in most districts of the selected states. Even where it was operational, clarity is lacking among the officials about their roles and actions they should implement. Sometimes political interference prevents the officials from implementation of the provisions in the act. The lack of proper knowledge on the maintenance of forms by the doctors and by the AA on what procedures they need to document and poor knowledge of the act among the judges have all come in the way of convictions as well as unjust jailing of the medical officers. CMO is the chair of the AA, which is cited by few as a conflict of interest (doctors checking on doctors) [62].Situation analysis of MTP services in Bihar and Jharkhand carried out by IPAS found that district level committee(DLC) with chief medical officer (CMO) as the chairperson required to be formed within the MTP act was not formed in many districts. The nine districts that reported ever having a DLCIn Biharat the time of the survey were Bhojpur, Patna, Muzaffarpur,Darbhanga, Madhepur, Vaishali, Supaul,Bhagalpur, and Kishanganj. Of these, DLC in 7 districts were active and had periodic meetings. A total of 334 health facilities were reported providing MTP services at the time of the survey. An overwhelming majority of these health facilities (79%, 265 of 334) were from the private sector [63]. The Bihar state government launched ‘Yukti’, scheme in2011 to provide comprehensive abortion care The Bihar state government launched ‘Yukti’, scheme in2011 to provide comprehensive abortion care

17services to women across the state. The scheme has been launched in association with Ipas, a Non-government Organization. Additionally, 2011 was declared as safe motherhood year and high focus was given to safe delivery and abortion. To bring down the MMR, the government has taken measures like increasing institutional deliveries (IDs), appointment of women health workers such as Mamta in government hospitals across the state for better care of mother and child, and launching of ‘Yukti Yojana’ for providing accreditation to private institutions to provide proper facilities for monitoring of pregnancy and ensuring safe delivery [70, 71]. The dialogue around the changes needed to MTP act is ongoing. Ministry had requested Ipas to review the act and they have submitted their recommendations to the government

**VII Conclusion**

 Before concluding and drawing an inference, it would be relevant to understand the basic aim behind legislating with regards to abortion. One can deduce that the foremost objective is to provide all women with quality abortion care, which is sensitive to their needs by increasing aspects such as easy accessibility and affordability to safe abortion services. This may be done by mobilising human, financial and material resources for provision of care and safety in abortion procedure and increasing the number of trained persons and equipped abortion centers. In addition to this by efficiency is increased and ambit is broadened by integrating abortion services into primary and community health centers, increasing investment in public amenities, broaden the base of abortion providers by training paramedics to do first trimester abortions, simplifying registration procedures, link policy with up-to-date technology, addressing the need for appropriate post-abortion care etc. In India, legalising abortion through the MTP Act, which was done in 1971 has not yielded the expected outcomes. Despite the existence of moderate policies, the majority of women still resort to unsafe abortion. This contributes substantially to the burden of maternal morbidity and

mortality. The MTP Act currently contains explanations to section 3 stating that terminations for rape and contraceptive failure are permissible because the anguish caused by each constitutes a “grave injury to her physical or mental health.” The MTP Act needs to be recognised that a diagnosis of fetal impairment could likely to produce distress constituting a severe injury to mental health and that such an exception must be existed during entire pregnancy period, since certain fetal anomalies cannot be detected within the stipulated 20th week period of pregnancy. 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 natural duty of the mother to provide the best to her children. However, sometimes she involves in such activities that affect the fetus injuriously. It may occur due to lack of knowledge, negligence or sometimes due to willful acts. Abortion includes various social, ethical and financial issues. Thus it can be concluded that mother’s right is limited to have a termination of pregnancy.31 It is on the shoulders of the law to take care of the independence and freedom of the mother as well as the life of unborn. The medical community and society needs to offer love and support to women with unplanned pregnancies and to assist them in finding empathetic alternatives to abortion.

**REFERENCES:**

1.Gipson JD, Koenig MA and Hindin MJ. The effects of unintended pregnancy on infant, child and parental health: A review of the literature. Studies in Family Planning2008; 39: 18-38.

2.Singh S, Sedgh G and Hussain R. Unintended pregnancy: Worldwide levels, trends and outcome. Studies in Family Planning 2010; 41: 241-250

3.World Health Organisation (WHO). Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, sixth ed., Geneva: WHO, 2011.

4.Bongaarts J, Cleland J, Townsend JW, Bertrand JT, and Gupta MD. Family planning programs for the 21stcentuary: Rationale and desigen.New York:Population Council, 2012

.5.Population council. Fact sheet on scaling up access to quality family planning and safe abortion services, July 2012

.6.World Health Organization (WHO). Engaging men and boys in changing gender based inequity in health: Evidence from programming interventions, Geneva: WHO, 2007.

7.World Health Organization (WHO). The prevention and management of unsafe abortion. Report of a technical working group. Geneva: WHO, 1992

**ABOUT THE AUTHOR**

Aruneesh Bhardwaj is a first year BBA,LLB student at Indore institute of law, Indore, He has keen interest both in fields of corporate law and JAG ( Judge Advocate General) and intends to pursue career in the following. He is working as an campus ambassador at Legalbites. Other than academics he is also a semi-professional footballer at Royal Vikings FC Indore.