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LEGALIZATION OF ABORTION: HOW IS ABORTION TREATED BY LAW?

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ABSTRACT

In a country like India, where people fight for reservation rights and the Right to equality every day, there is one right that needs the fight or movement is Abortion Rights under Article 21. This Right can change the economic, social, and psychological status of every woman in this country. In India it is only the married women who are given abortion rights under the Medical termination of Pregnancy Act, 1971 but that too under certain conditions which are mentioned under Section 3 of the MTP Act. This article provides a detailed review of the MTP Act and its amendments with the availability of new technologies for safe abortion. It also determines the right of a mother to abort unwanted pregnancy and the rights of the unborn child.

Keywords: - *Abortion, Medical Termination of Pregnancy Act, Pre-conception, and Pre-natal Diagnostic Techniques Act, Mother's right.*

INTRODUCTION

Globally, induced abortion—safe or unsafe, legal, or illegal—is a reproductive health service that is part of the lives of women, couples, and communities in both developed and developing countries. When faced with unintended pregnancies, especially in contexts in which women lack access to effective family planning, induced abortion is an important part of women's reproductive health care. Ensuring the safety and availability of abortion services is critical to women's health, and creating a supportive legal environment is one step in that process. In India, the second-most populous country in the world, abortion has been legal on a broad range of grounds since 1971.

WHAT IS ABORTION OR TERMINATION OF PREGNANCY?

According to the Merriam-Webster dictionary, an abortion is, "the termination of a pregnancy after followed by the death of the embryo or fetus, as the expulsion of a human fetus during the first twelve weeks of gestation-miscarriage."

Abortion or miscarriage means the spontaneous or induced termination of pregnancy before the fetus is independently viable, which is usually taken as occurring after the 28th week of conception. Children born a few days before the 28th week are known to have survived with modern care. Medically, abortion means the expulsion of the ovum within the first three months of pregnancy; miscarriage, the expulsion of the fetus from 4th to 7th month; and premature delivery, the delivery of a baby after 7 months of pregnancy and before full term.

Legally, miscarriage, abortion, and premature labor are now accepted as synonymous terms, indicating any termination of pregnancy at any stage before

confinement.[1] Abortion may be classified into various categories depending upon nature and circumstances under which it occurs. For instance, it may be either, (i) natural; (ii) accidental; (iii) spontaneous; (iv) artificial or induced abortion. Abortions falling under the first three categories are not punishable, while induced abortion is criminal unless exempted under the law.[2]

ABORTION LAWS ACROSS THE WORLD

Abortion laws vary across the world, and about 60 countries prescribe gestational limits. 52 % of the countries in the world including France, the UK, Austria, Ethiopia, Italy, Spain, Iceland, Finland, Sweden, Norway, Switzerland, and even Nepal, allow for termination beyond 20 weeks on the diagnosis of fetal abnormalities. Some countries go beyond these limits with laws. In 23 countries—Canada, Germany, Vietnam, Denmark, Ghana, and Zambia—allow abortion at any time during the pregnancy at the request of the mother.[3] The reasons could be either social or evidence of fetal abnormalities. In the United Kingdom, abortions are allowed at up to 24 weeks, with abortion guidelines formulated by the Royal College of Obstetricians and Gynecologists including procedures for termination of pregnancies older than 20 weeks. It states that, in pregnancy older than 21 weeks and 6 days, an injection to cause fetal death is given before the fetus is evacuated.[4] Many other countries follow the same procedure for late-term abortions. The UK guidelines also take into consideration doctors who have an objection to abortion based on their religious or moral beliefs: While a doctor can refuse to perform an abortion, he is required to inform the woman of her right to see another doctor.

MEDICAL TERMINATION OF PREGNANCY ACT

The Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971 to regulate and ensure access to safe abortion. As of this writing, this law permits only registered allopathic 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 for the abortion is not required from the woman's husband or other family members, however, a guardian's consent is required if the woman seeking an abortion is either younger than 18 or is mentally ill. The act allows an unintended pregnancy to be terminated up to 20 weeks' gestation; however, if the pregnancy is beyond twelve weeks, a second doctor's approval is required. There are exceptions to this rule: If the provider believes that abortion is immediately necessary to save a woman's life, the gestational age limit does not apply

[1] K. Mathiharan & Amrit K. Patnaik (eds.), Modi's Medical Jurisprudence & Toxicology 1013 (Lexis Nexis Butterworth, New Delhi, 23rd ed., 2006).

[2] K. D. Gaur, Criminal Law & Criminology 209 (Deep & Deep Publication, New Delhi, 2002).

[3] Boland R. Second trimester abortion laws globally: actuality, trends and recommendations. *Report Health Matters.* 2010 Nov;18(36):67-89.

[4] Royal College of Obstetricians and Gynaecologists. The care of women requesting abortion. Evidence-based Clinical Guideline No 7. London: RCOG; 2011 Nov [cited 2018 Sep 6] Available from: **https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf**

and the second opinion is not required. Under the current abortion policy, Providers of Legal Abortion Services under the MTP Act, health care workers who are not allopathic physicians are excluded from being trained as abortion providers or legally providing abortions. Only obstetrician-gynecologists and other allopathic physicians who have completed a bachelor of medicine/bachelor of surgery degree have undergone specific government-approved training in abortion provision and have received certification are permitted to legally provide abortion. To meet the government criteria, a training center must perform a minimum of 600 procedures per year and have all the necessary equipment. The recommended duration of training for surgical abortion is two weeks, and each trainee must observe at least 10 abortion procedures, assist with five, perform at least five under the supervision, and perform another five independently.

Abortion provision is allowed at all public hospitals, as long as the provider is certified in abortion provision. The MTP Act mandates that each state provide abortion services at tertiary-level health care centers (medical colleges) and secondary-level health care centers (district hospitals and first referral units) up to 20 weeks' gestation. Private-sector facilities are permitted to provide first- and second-trimester abortion services after receiving government approval as a registered abortion facility. The Medical Termination of Pregnancy Rules and Regulations of 1975, which operationalized the MTP Act, define the criteria and procedures for approval of an abortion facility, which applies exclusively to private sector facilities. In addition to outlining the procedures for consent and confidentiality requirements, record-keeping and reporting is also necessary

Amendments to the MTP Act

Since 1971, the government of India has taken steps to increase access to legal and safe abortion services by implementing policies designed to expand the number of legal abortion providers. Despite the legality of abortion provision in the public health sector, the actual provision at lower level public facilities (such as primary health centers) was scarce before 2000. In 2000, the National Population Policy officially recommended expanding the provision of abortion up to eight weeks' gestation to all public health care facilities, including primary health centers. A decade later, community health centers continue to be the main providers of abortions up to eight weeks' gestation, and provision at the lower level remains a challenge because most primary health centers are not staffed with certified abortion providers. Additional amendments to the MTP Act and Rules and Regulations were made in 2002 and 2003 to streamline registration of private doctors as abortion providers and thereby further expand access to safe abortion services. The 2002 amendment to the MTP Act decentralized the regulation of abortion facilities from the state level to District Level Committees and the subsequent amended Rules streamlined the facility registration process by creating facility inspection deadlines to which the district-level committees must adhere—policy changes that were expected to speed up the process of certifying private facilities. The Rules also changed the physical standards for facilities providing first-trimester abortion services: Facilities are no longer required to have the onsite capability for managing emergency

complications but must have personnel trained to recognize complications and be able to refer patients to another facility for emergency care if necessary. After the decentralization of the registration and certification processes, local governments became empowered to regulate abortion services. Operationally, however, implementation has been uneven because many District Level Committees are nonfunctional; also, the devolution to the local level implies there may be differences in regulations across states.

Policies on Provision of Medical Abortion

Another result of the 2002 amendment was the approval of medical abortion using a combined mifepristone-misoprostol regimen as a legal method for the termination of early pregnancy. The amendment allowed for registered medical practitioners to provide medical abortion up to seven weeks' gestation in a facility approved to provide abortion. In 2003, an amendment to the MTP Rules and Regulations was passed to enable certified abortion providers to prescribe medical abortion drugs outside a registered setting, as long as emergency facilities are available to them. In 2010, the national training and service delivery guidelines of comprehensive abortion care were issued and included both surgical and medical guidelines. These guidelines mention (as a footnote) that medical abortion with mifepristone and misoprostol may be provided up to 63 days' (nine weeks') gestation; however, this protocol has not yet been incorporated in a modification to the MTP Act amendment.

Proposed 2014 Amendment to the MTP Act

For several years, sections of India's medical community, advocacy groups, and government officials have been discussing an amendment to the MTP Act, which was officially proposed by the Ministries of Health and Law in 2014 and is now pending approval by Parliament. The 2014 draft amendment, which includes changes that would potentially improve access to legal abortion, proposes

- expanding abortion provision to nurses, auxiliary nurse midwives and practitioners trained in the Indian System of Medicine with recognized qualifications in Ayurveda, Unani, Siddha or homeopathy;
- allowing abortion at a woman's request up to 12 weeks' gestation and increasing the gestational age limit for abortion to 24 weeks;
- clarifying the use of prenatal diagnostic technology by stating that the gestational age limit does not apply if the termination of pregnancy is necessitated by the diagnosis of a substantial fetal abnormality;
- replacing the term "married women" with "all women" and the word "husband" with "partner" in the contraceptive failure clause, in an attempt to clarify that abortion is legal for all women, not only those who are married; and
- mandating that the name and other particulars of a woman having an abortion remain confidential.

PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES ACT

Discriminatory practices against females in India are widespread and broadly rooted in cultural norms that value men over women. Sons are perceived as contributing to family income and bringing in dowry, while daughters are viewed as obligating families to pay for a dowry and other marriage expenses and are considered less likely to

help their parents in old age. Although the average family size has decreased over time, the pressure to bear at least one son remains. The introduction of technologies in 1980 that allowed parents to determine the sex of the fetus before 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. To address this issue, the government passed a law in 1994 to eliminate prenatal sex determination and associated sex-selective abortions and arrest the declining sex ratio in India. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, amended in 2003, prohibits the misuse of antenatal diagnostic tests for sex determination. The Act also prohibits the advertisement of such tests, requires registration of all the facilities that use them, and prohibits in conducting the tests that reveal the sex of the fetus to the expectant parents.

Guidelines for Abortion and Post-abortion Care

In India, abortion guidelines have not always translated into practice. Despite the 2001 guidelines recommended that primary care providers use Manual Vacuum Aspiration (MVA) for abortions up to eight weeks' gestation, whereas studies have found that providers commonly use more invasive Dilation and Curettage (D&C) procedures. In a government effort to improve access to quality services at the facility level, priority was placed on ensuring the availability of MVA technologies at all community health centers and first referral units and at least half of all primary health centers, which operate 24 hours per day, and seven days a week. New national training and service delivery guidelines for comprehensive abortion care were introduced in 2010 which included many elements from the 2003 World Health Organization (WHO) technical and policy guidelines for safe abortion. For instance, the new guidelines stipulate that pre-abortion counseling should include discussion of choices of termination method, contraceptive counseling and, services, should provide care after the abortion procedure, and follow-up visits, should reinforce the use of contraceptive and ensure the procedure's successful completion. The national guidelines also advocate the use of Electric Vacuum Aspiration (EVA) and MVA up to 12 weeks' gestation and mention that WHO recommends eliminating the use of D&C. The guidelines follow WHO recommendations for dosages and oral administration of mifepristone (200mg) and misoprostol (400mcg), including using mifepristone with repeated doses of misoprostol for second-trimester abortions; however this protocol is not approved by the MTP Act amendment. Instead, the legally approved medical method for second-trimester abortion uses ethacridine lactate (which is in short supply and not recommended by WHO); dilation and evacuation (D&E) is the approved surgical method. While laws, policies, and guidelines on abortion have generally moved in the direction of increasing access to safe abortion services, many providers lack in-depth knowledge of these guidelines for abortion and post-abortion care. Lack of awareness among women and deep-seated social, economic, and health system constraints have also had a dampening effect and act as barriers for many women who may need quality abortion-related information and

services. Consequently, many women receive poor-quality abortion services from untrained or uncertified providers and experience negative health outcomes as a result.

SOCIAL ETHICAL ISSUES

Abortion touches social, religious, economic, and political aspects. Its impact on society can be s looked at both positively and negatively. In the earlier years of forming an abortion policy, the Western civilizations disapproved of the practice. By the nineteenth century many nations passed laws banning abortion. It wasn't until late in the twentieth century when the women's rights were given importance and abortions were made legal and safe.

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 legalizing of the MTP Act has had a positive stimulus upon the women in need of MTP and has shown a reduced incidence of suicide and betterment of health and safety. The acceptance of family planning methods has also witnessed wider acceptance.[5]

There 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 to 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, infertility, menstrual disturbances, and pelvic inflammatory diseases. In a few cases, this results in death as well.[6]

The real problem lies in the implementation of the laws in the existing frameworks. It is the responsibility of the government to ensure that the MTP is done by qualified surgeons in registered clinics or hospitals. The concerned authorities need to deal with a major challenge and the genuine reason behind requesting termination of pregnancy. There have been cases reported wherein MTP Act is performed on a flimsy ground such as examinations, family weddings, holidays and tours, etc. such abortions are conducted by the medical practitioners 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 is often used as an alternative to regular methods of family planning.[7]

Issues such as this 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 emphasized that contraception use is much safer than the

[5] Government of India, Report of Ministry of Health and Family Welfare on Rural Health Care System in India (MHFW, 2005).

[6] Government of India, Annual Report, 2000–2001, Government of India Press (Ministry of Health and Family Welfare, 2001).

[7] Ministry of Statistics and Programme Implementation, NSSO 60th Round, Report No. 507 on Morbidity, Health Care and the Condition of the Aged, (National Sample Survey Organisation, 2004).

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.

In India, despite legislative and judicial control, ethical controversies surrounding medical termination of pregnancy continue. Though many people believe that medical termination of pregnancy is immoral but today it is a right of a woman that cannot be taken away.

EFFECTS OF ABORTION

Abortion can affect each woman differently. Emotional and psychological effects following abortion are more common than physical side effects and can range from mild regret to more serious complications such as depression.

Many believe that abortion should be legalized only for extreme cases, like pregnancy due to rape and incest. If a child is a product of violence, there is no need to protect his/her life while trying to heal the pain of the woman. This only guarantees further emotional stress for the victimized woman in the future.

MOTHER'S RIGHTS TO ABORT

'Abortion' is a woman's individual choice; therefore, it must be a legal part of today's society. Individual rights have an outstanding role in this controversial topic. The individual rights for abortion show rights of life, liberty, and pursuit of happiness. Women should be able to have the choice to choose to have an abortion or not to abort, for several important reasons. The right to make these decisions should lie in the hands of the "mother" as it concerns her own body.

Bringing unwanted children into this world, with no means of proper care and love, is restraining the pursuit of happiness in these children. If we as humans can't give a child a healthy life; then the point to bring it into this world is not useful and causes lots more problems that should have never erupted in the first place. Should an individual have the obligation to go through a nine-month pregnancy, and childbirth, or the mental stress of raising or giving away the child? The individual rights a woman is not only for herself but also for the child relying on her to live. One of the woman's most basic freedom is the right to control her own body and to determine if she wants to bear a child or not. She and only she can determine whether she is emotionally, physically, and economically ready at any given time to have and raise a child.[8]

Raising a child is not an easy task. It requires social & emotional commitment coupled with financial resources. As such if a woman feels that she is not ready for a child, it means the pregnancy is unwanted and resultant allowing a fetus to grow into a child is worse than abortion since the resultant child will grow in a non-conducive & destructive environment without the love, care and stability that a child needs to grow as a socially acceptable person.

Every woman has the right to do whatever she wants with their body aka Bodily Autonomy. As it is illegal to take organs from the deceased who have not signed off permission, it should also be unfair to let grow a fetus inside the body of a woman

[8] Chicago Women's Liberation Union

without her permission. If we continue with the right afterlife, why do we strip it from a pregnant woman? Why would we grant a dead person a right that we wouldn't give to someone alive?

ABORTION: LEGAL OE ILLEGAL

A fetus is not legally or scientifically a person or human being, so abortion cannot be equated to murder or taking a life since the fetus is not a person. It is without a cerebral cortex and cannot think or feel.

We get right to life, liberty & pursuit of happiness only when we are born. The fetus does not have these rights until it is born. So abortion is not murder. It does not go against the rights of a fetus since it does not have any rights until and unless it is born literally.

If someone needs to donate something that he does not own, he cannot do it legally. This parallels to pregnancies because a fetus needs resources to grow and develop, but the mother is not legally obligated to keep giving her resources to the fetus. Secondly denying to give someone a part of one's own body is not illegal, so terminating a pregnancy should not be illegal.

Thus, abortion should be legal but discouraged. Legally because it is a choice, and what grows inside the body of a woman is hers. But discouraged because there are other more effective ways to prevent pregnancy than abortion like - contraception.

RIGHT TO ABORTION VS. RIGHT TO LIFE OF THE UNBORN

The validity of the abortion laws has been questioned on the ground of constitutionality of 'right to life of an unborn' vis-a-vis right of the mother to bear or not to bear a child. The Mother, therefore, has become a subject of debate among advocacy groups belonging to one of two camps. Those who are against legal restrictions on abortion describe themselves as pro-choice while those who are in favor of prohibition of abortion are considered pro-life advocates. Pro-life individuals generally believe that human life should be valued either from fertilization or implantation until natural death.[9] They advocate that it is God who is the giver of 'life and death" and not the parents. On the other hand "pro-choice" individuals believe that everyone has unlimited autonomy for their reproductive system as long as they do not breach the autonomy of others.[10] Pro-choice individuals accept that women should have complete control over fertility and pregnancy. It is the personal choice of a woman to have children as it affects her body, personal health, and future. These are two extreme views. One view opposes abortion and another gives freedom to the expectant mother to terminate her pregnancy even after the viability of the fetus. After making a careful study of the pros and cons of the entire issue and taking a pragmatic view of the socio-economic and legal problems involved in the case, it may be argued that a pregnant woman should have "personal liberty" to destroy any fetus of her own if she finds it "intolerable". To force a woman to continue an unwanted pregnancy is to impose a kind of slavery upon her, or at least to infringe her sense of self-respect and dignity. The fetus may have a right to life, but not a

[9] Available at: http://en.wikipedia.org/wiki/Pro-life.

[10] Tom Head, "Civil Liberties, Pro-life vs Pro-Choice", available at: http://www.about.com Guide.

right to be kept inside a woman's body against her will.[11] After all, the fetus is a parasite and has less claim to live, than the host i.e. the mother. Hence the fetus in utero is not in the ordinary sense another person, distinct from its mother. Even if the fetus is a person, it might be argued that the pregnant woman has the right to use self-defense to protect herself from the physical invasion of unwanted pregnancy.[12] It is submitted that it is the mother next to God who provides the maximum and the best possible care to her child without any reciprocal favor. If she opts for abortion there may be some reason either due to ignorance, carelessness, or acts done willfully. Abortion is an issue best left to the decision of the mother. It is further argued that if there is no possibility of begetting a living child with all human potential it is better to prevent such a child to be born and thereby saving the child from earthly miseries.[13]

CONCLUSION

Contrary to expectations, the legalization of abortion has not been associated with an increase in the demand for abortion. In developed countries, medical abortion offers women an alternative to surgical abortion. In underdeveloped countries, even where abortion is legal, surgical abortion may not be an option because physicians may be unwilling or inadequately trained to perform the procedure.

In India, legalizing 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 (the mother) physical or mental health." The MTP Act needs to be recognized that a diagnosis of fetal impairment could likely produce distress constituting a severe injury to mental health and that such an exception must exist during the entire pregnancy period since certain fetal anomalies cannot be detected within the stipulated 24th week period of pregnancy.

It is natural for a 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 in India. Thus it can be concluded that the mother's right is limited to have a termination of pregnancy.[14] 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 need to offer love and support to women with unplanned pregnancies and to assist them in finding empathetic alternatives to abortion.

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[11] S.N. Parikh, "Right to Life and Unborn Person" 11 (3) IBR 295 (1984).

[12] Judith Jarvis Thomson, "A Defence of Abortion" 1 Philosophy and Public Affairs 47 (1971).

[13] G.V. Ramiah, "Right to Conceive vis-a-vis Right to Birth" AIR Jour 139-140 (1996).

[14] Patchesky Rosalind Pollack, Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom 13 (Northeastern University Press, 1st edn., 1991).