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ABORTION LAWS IN INDIA: THE PARAMOUNT NEED FOR CHANGE

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ABSTRACT
Abortions are an important aspect of reproductive health of women but it has for long remained a contentious issue. Abortion laws are influenced by social, moral and religious views as all laws are wont to. However, these often conflict with the medical and legal need of abortions in a society. The Medical Termination of Pregnancy Act governs all of the abortion law in India. The Act, however, was enacted nearly half a century ago and as such is not the most suitable set of provisions defining abortions in the country. This article analyzes the aforementioned Act and its lacunae from a legal and social standpoint, in an attempt to determine whether the existing legal provisions are adequate to govern abortions in the country. The Act, which defines who can terminate their pregnancy and, when and by whom, does not limit or curb abortions it deems not required. This results in unsafe alleyway abortions resulting in a great number of maternal deaths. The need for amendments to the existing laws is crucial and this article examines this taking into consideration the prevailing social conditions and mindset in the country.

Keywords: Abortion, lacunae, amendments, social standpoint, unsafe abortions

ABORTION LAWS IN INDIA: THE PARAMOUNT NEED FOR CHANGE

INTRODUCTION
The United Nations hosted the International Conference on Population and Development (ICPD), a 1994 meeting in Cairo where 179 governments adopted a revolutionary Programme of Action and called for women's reproductive health and rights to take centre stage in national and global development efforts. The Conference established that every woman has the recognized human right to decide freely and responsibly without coercion and violence the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.[1]
Access to legal and safe abortion is essential for the realization of these rights. One in four pregnancies ends in abortion. Abortions include various clinical conditions such as spontaneous and induced abortion (both viable and non-viable pregnancies), incomplete abortion and intrauterine foetal demise[2], reports the World Health Organization (WHO).

Abortion in India was illegal under Section 312 of the Indian Penal Code until it was repealed in 1971. In 1964, the Shah Committee, headed by Shantilal Shah, was constituted to form a report and give suggestions for the draft of an abortion law in India. The Committee carried out a review of

[1] U.N. International Conference on Population and Development, (Sept. 5-13, 1994).

[2] World Health Organization, *Abortion*, https://www.who.int/health-topics/abortion#tab=tab_1.

the legal, medical and socio-cultural elements of abortion and recommended the legalization of abortion. It recommended to the government liberalisation of the outdated and outlived law of miscarriage contained in Section 312 of the Code. It observed that whatever may be the moral and ethical feelings that are proposed by society as a whole on the question of induced abortion, it is an incontrovertible fact that a number of mothers are prepared to risk their lives by undergoing an illegal abortion rather than carrying that particular child to term.[3]

Thus, in 1971, the Medical Termination of Pregnancy Act[4] was passed amending the laws governing abortions in the country.

Section 3 of the MTP Act reads:

"

1) *Notwithstanding anything contained In the Indian Penal Code, a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.*

2) *Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner, —*

(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that—

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation I.*—Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave Injury to the mental health of the pregnant woman.*

Explanation II.—*Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.*

3) *In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.*

4) *(a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.*

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman. "[5]

MEDICAL TERMINATION OF PREGNANCY ACT, 1971: LACUNAE AND INADEQUACIES

Gestational Period

[3] K.D. Gaur, *Abortion and the Law in India*, 15 CULR 132 (1991).

[4] Medical Termination of Pregnancy Act, Act 34 of 1971 (hereinafter MTP Act).

[5] The Medical Termination of Pregnancy Act, § 3, 1971.

Section 3(2) of the Act, insofar as it restricts the length of pregnancy for termination to twelve and twenty weeks has no nexus with the object of the MTP Act.

In the case of **Nikhil Dattar v Union of India and Anr**[6], the petitioner argued that in view of the stride in technology, the 20th week cut off should not still be applicable considering the fact that the 20th week cut off was determined on the basis of an assessment made by the Shantilal Committee to the effect that the state of the technology available for the performance of abortions in the late 1960s and at the time of the drafting of this Act, that any abortion done after the 20th week could possibly impact on the life of the mother. During the last five decades, however, the technology has changed dramatically and it is now undisputed that abortions can be safely carried out even at the 40th week.

Various High Courts and the Supreme Court have permitted termination beyond 20 weeks on the ground of physical/mental injury to the woman and/or substantial risk of foetal abnormalities. However, as a result of the current legal framework, women in such cases are forced to approach the Courts for an immensely personal decision about their own bodies. This causes financial and social hardships, and women from rural areas and socio-economically disadvantaged backgrounds do not have the wherewithal to approach Courts.[7]

There have been a number of cases wherein the petitioner approaches the Court for permission to terminate her pregnancy after the gestational period limit but in the long drawn process of a suit and Court proceedings, gives birth to the child before the Court ever comes to a decision.

In the case of **Ms. X v. Union of India & Others,**[8] the Supreme Court of India deliberated on whether a woman terminate her pregnancy post-20 weeks where the foetus has severe abnormalities. The Court held that based on the medical board's determination that continuing the pregnancy would pose a grave threat to the woman's mental and physical health, the woman may undergo termination under Section 5 of the MTP Act.

In many cases, women do not learn of their pregnancy well into their 16th - 18th week. Any medical risks to the woman or foetal abnormalities that might arise are thus inconsequential since the law stipulates that the pregnancy cannot be terminated.

There also arises often the question of foetal abnormalities that can only be detected after certain development of the foetus which occurs after the gestational limit has expired. There is no way for women to then terminate such a pregnancy with serious foetal abnormalities that might even go on to affect their lives since the law dictates otherwise.

Medical Opinion of Woman's Health

Section 5 of the Act[9] permits termination only in cases where it is necessary to save the life of the woman is arbitrary, unreasonable,

[6] Nikhil Dattar v Union of India and Anr, Civil Appeal No. 7702 of 2014; Grounds of Challenge.

[7] A v Union of India, (2018) 14 SCC 75; Mamta Verma v Union of India, (2018) 14 SCC 289; Tapasya Umesh Pisal v Union of India (2018) 12 SCC 57; Sharmishtha Chakraborty v Union of India, (2018) 13 SCC 339, Meera Santosh Pal v Union of India, (2017) 3 SCC 462.

[8] Ms. X v. Union of India & Others, (WP(C) 593/2016).

[9] MTP *Supra* note 4.

disproportionate and violates Article 14 and 21. The Section fails to accommodate cases where medical opinion establishes that there is grave risk of injury to the physical or mental health of the pregnant woman, or where there is a substantial risk of foetal abnormalities[10]. The abovementioned Section includes the phrase "is immediately necessary to save the life of the pregnant woman" which further begs the question whether the term 'life' means only the beating of the heart or it also includes life undermined by a level of anguish and mental trauma caused by a compulsion of carrying a pregnancy to full term[11]. The Right to Life as guaranteed under Article 21[12] of the Constitution provides for a healthy, dignified life. A pregnancy which does not result in the woman's death but leaves her in a painful or anguished medical condition violates her right to health and her life cannot be said to come under the purview of Article 21.

Autonomy and abortion as a matter of right

Abortion in India is not available as a matter of right, a woman does not have the right to terminate her pregnancy simply by virtue of her desire. The legality of abortion is subject to the opinion of a medical professional determining the risk to the woman's health. Section 3(2)(a) of the Act, insofar as it requires opinions of medical practitioners certifying that continuation of pregnancy would involve risk to the life or grave injury to the physical or mental health of the pregnant woman or if there is a substantial risk of fetal abnormality, violates the fundamental right to privacy and the right to reproductive choice as have been guaranteed by the Supreme Court in the cases of **Justice (Retd.) K.S Puttaswamy v Union of India**[13] and **Suchita Srivastava v Chandigarh Administration**[14] respectively. The termination of pregnancy should not be subject to the opinion of a medical practitioner for, it snatches a woman's autonomy away from her and places it in the hand of a medical professional or Medical Board.

The Supreme Court and the High Court of Madras have respectively affirmed women's rights to choose in the context of continuing a pregnancy. In Suchita Srivastava[15], the Supreme Court clearly held that the state has an obligation to ensure a woman's reproductive rights as a component of her Article 21 rights to personal liberty, dignity, and privacy.

In the landmark judgement of **Joesph Shine v Union of India**[16], the Hon'ble Supreme Court while decriminalizing adultery under Section 497 of the Indian Penal Code[17] has upheld the absolute sexual autonomy of a woman. Denial of the right to decide on the number of children and the termination of pregnancy on the basis of the not uncommon argument that 'prevention is better than cure' and it is the woman's fault for conceiving an unwanted pregnancy, inevitably stains the sexual autonomy of the woman.

[10] Swati Agarwal and Ors v Union of India, Writ Petition (Civil) No. 825 of 2019.
[11] *Id.*
[12] INDIAN CONST. art 21.
[13] Justice (Retd.) K.S Puttaswamy v Union of India, (2017) 10 SCC 1.
[14] Suchita Srivastava v Chandigarh Administration, (2009) 9 SCC 1.
[15] *Id.*
[16] Joesph Shine v Union of India, 018 SCC OnLine SC 1676.
[17] Indian Penal Code, 1860, § 497.

Social Stigma

Abortion related stigma, which cuts across all contexts, continues to negatively affect women's health and well- being. Stigma is also an important reason why data on induced abortion are so scarce and unreliable: For fear of being shamed or judged, women worldwide underreport their abortions in data collection efforts.[18]

A 2004 U.S. study, for example, found that 72% of women reported at least three reasons for why they had had an abortion.[19]

Socioeconomic concerns is the most frequently cited type of reason, followed by wanting to stop childbearing and wanting to postpone or space a birth. Other main reasons include partner- and health-related issues, which vary widely in prevalence by country. The established statistical reasons include financial, maturity, age, health, violence and relationship concerns.

Not all pregnant women can afford childcare and all the costs that come with raising a child. Unintended pregnancies cause great financial strain and it is one of the leading reasons behind abortions.

Teenage pregnancies are especially difficult because the women are dependent on their parents for financial reasons and lack the maturity and emotional stability required to give birth and raise a child.

In India, specifically, the social stigma and disgrace attached to being an unmarried pregnant women is a huge factor in abortion numbers. Unmarried mothers face great difficulties in every sphere due to a preconceived notion about their so perceived state of disgrace.

According to a study in Nigeria, lack of partner support for the abortion decision has been linked to both relatively late (second-trimester) abortions and the use of untrained providers.[20] To this end, designing intervention to reduce the stigma has become a priority, as has eveloping the research tools to measure stigma – from both providers'[21] and women's[22] perspectives.

Rape

The MTP Act[23] provides that in pregnancies caused by rape, the woman will be presumed to be under great mental anguish and injury. While this provision allows women who are rape victims to get their pregnancy terminated within the stipulated gestational limits, it does not cater to women further along in their pregnancy. In such cases, women have to approach Courts for a discretionary decision about the termination of their pregnancy. They are also subject to the opinion of medical practitioners, often

[18] Astbury-Ward E, Parry O and Carnwell R, *Stigma, abortion, and disclosure—findings from a qualitative study*, Journal of Sexual Medicine, 2012, 9(12):3137–3147; Jones RK and Kost K, *Underreporting of induced and spontaneous abortion in the United States: an analysis of the 2002 National Survey of Family Growth*, Studies in Family Planning, 2007, 38(3):187–197.

[19] Finer LB et al., *Reasons U.S. women have abortions: quantitative and qualitative perspectives*, Perspectives on Sexual and Reproductive Health, 2005, 37(3):110–118.

[20] Bankole A et al., *Abortion-seeking behaviour among Nigerian women*, Journal of Biosocial Science, 2008, 40(2):247–268.

[21] Martin LA et al., *Measuring stigma among abortion providers: assessing the Abortion Provider Stigma Survey instrument*, Women & Health, 54(7):641–661 (2014).

[22] Shellenberg KM, Hessini L and Levandowski BA, *Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: results from Ghana and Zambia*, Women & Health, 54(7):599–616 (2014).

[23] MTP, *Supra* note 4.

having to carry their pregnancy to full term, suffering great mental anguish all the while.

In the case of **V. Krishnan v. Rajan Alias Madipu Rajan & Another**[24], the Madras High Court held that a minor rape survivor has the right to decide whether to continue a pregnancy or not. The Court said, *"We cannot force a victim of violent rape/forced sex to give birth to a child of a rapist."*

However, in **D. Rajeswari v. State of Tamil Nadu & Others**[25], the Madras High Court upheld that a minor rape survivor who satisfies the requirements of Section 3 of the MTP Act can obtain a termination of pregnancy.

In the case of **Chandrakant Jayantilal Suthar & Another v. State of Gujarat**[26], the Supreme Court of India while deciding whether a minor rape survivor who is 24 weeks' pregnant access medical termination of pregnancy, reviewed the medical opinion and allowed for termination if the girl consented. However, the Court noted that this was a particularly difficult decision because "*Whatever be the circumstances in which the child was conceived, whatever the trauma of the young mother, the fact remains that the child is also not to blame for being conceived*."

"A rape victim shall not be further traumatized by putting through a needless process of approaching courts for taking permission.''

In the **Bhavikaben v. The State of Gujarat**[27] case, the High Court of Gujarat debated if an adult rape survivor undergo medical termination of pregnancy when she is more than 20 weeks pregnant. The Court applied the survivor's best interests test in Chandrakant, and found that where medical experts agree that the woman's mental or physical health will be severely impacted by the pregnancy, she has a right to terminate.

In the case of **Registrar (Judicial), Madurai Bench of Madras High Court v Union of India**[28], a Division Bench of the Court presided by Justice N. Kirunakaran, on the basis of a news report, took suo moto cognizance of the high rate of maternal mortality and the barriers to access abortion after the 20 week gestational limit. Pursuant to his research, Justice Kirunakaran directed the registration of a writ petition calling upon the Central Government to remove gestational limits in the case of rape, among other directions.

His order noted: "*in India, thousands of women and children are raped every year and the number of rapes are shockingly increasing. In 2016, about 38, 947 women were raped whereas the number was only 18, 233in 2004. In case of rape victims, there is a chance for getting conceived and those unwanted foetus can be terminated if abortion window period is extended for 24 weeks, so that, the birth of unwanted children with stigma which are result of the rapes and forced relationships, against the wishes of the victims, can be avoided. In the interest of women, children and future generation, the amendment is necessary*."

[24] *V. Krishnan v. Rajan Alias Madipu Rajan & Another, H.C.M.P.No. 264 of 1993/H.C.P.No. 1450 of 1993.*

[25] D. Rajeswari v. State of Tamil Nadu & Others, (Crl.O.P. No. 1862/1996).

[26] Chandrakant Jayantilal Suthar & Another v. State of Gujarat, Special Leave Crm. 6013/2015.

[27] Bhavikaben v. The State of Gujarat, Special Crim App 1155/2016.

[28] Registrar (Judicial), Madurai Bench of Madras High Court v Union of India, Suo Moto WP (MD) No. 9910 of 2019.

Personal Law and State Interference

There ought not to be any legal impediments at all to a woman's right to an abortion and the State's interference with such a fundamental personal decision by way of legislation is disputable. The question that arises is whether the State is capable of understanding the complex situation that arises in the context of pregnancies when bound by legislation and, whether the State may at all legislate in a domain which is essentially personal.

This debate, however, not unlike many other issues and legislations enters into the age long debate of State pervasive personal laws. What really constitutes the personal sphere when the State frames legislations to govern all aspects. The recently decriminalized law of adultery[29], for example, allowed the State to peer into one's bedroom. The law pertaining to conjugal rights (under the Hindu Marriage Act, 1955)[30] give the State the power to, in a sense, dictate the marital physical relationship between a husband and wife.

Discrimination against unmarried women

Explanation 2 to Section 3(2) of the Act[31], insofar as it is limited to contraceptive failure only for married women, discriminates against unmarried and single women and is thus violative of Article 14. The classification based on marital status is not tenable as it has no nexus with the object of terminating an unwanted pregnancy. An unwanted pregnancy in the case of single women also causes anguish and has far greater mental and socio-economic consequences. The provision also adversely affects the sexual autonomy of unmarried and single women.

In **Amit Sahni v Union of India and Ors**[32], a Public Interest Litigation filed before the Delhi High Court, the petitioner raises the crucial issue that there exist a myriad of situations in which women find themselves unable to carry through with a pregnancy. There are financial, emotional, social and many other situations, such as death of spouse or partner and marital discord, where a woman is in no position at all to carry on and seeks an abortion.

MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL, 2014

The Medical Termination of Pregnancy (Amendment) Bill, 2014 was introduced in October 2014 and hoped to bring about great changes in the existing abortion law in the country and to finally shift the discourse from medical professionals to women. Such a shift decreases the vulnerability of women within the clinical setting and frees them from subjective interpretations of abortion law.

The 1971 MTP Act does not recognise the ability of women to act as autonomous agents within the clinical setting. It primarily offers protection to all doctors carrying out abortions in good faith and within the limits stipulated by the law, empowering them to make the final decision on abortion. This focus on the medical profession rather than women This focus on the medical profession rather than women is partly the result of the fact that the Indian abortion law stemmed from national concern about the growing population and about the high maternal

[29] Penal Code, *Supra* note 17.
[30] Hindu Marriage Act, § 9 (1955).
[31] MTP, *Supra* note 4.
[32] Amit Sahni v Union of India and Ors, Writ Petition (Criminal) No. 1612 of 2019.

mortality from unsafe abortion. In India, therefore, abortion is located within discourses on family planning and public health, which justifies the 1971 MTP Act's emphasis on the providers of the service.[33]

The Bill suggested several major changes:

1. The term 'medical practitioners' was replaced by 'health care providers'. This was done to include other fields of medicine into the purview. The term health care providers included medical qualifications of Ayurveda, Unani, Siddha, Homeopathy and nurses or auxiliary nurse midwives.
2. The Bill aimed to extend the gestational period during which a pregnancy could be terminated, from twenty weeks to twenty four weeks.
3. It also granted women autonomy for terminations under twelve weeks of pregnancy. This meant that women pregnant for twelve weeks or under no longer needed the opinion of a medical professional to get an abortion and could do so on request.
4. The Bill included a provision under which the length of the pregnancy would not apply where the termination was necessitated by diagnosis of any of the substantial foetal abnormalities as may be prescribed.
5. It included a provision for the protection of the privacy of women whose pregnancy has been terminated under the Act.
6. The Explanation to Section 3(2) was amended to include all women and their partners and not just married women under the protection of failure of contraceptive or device.

The inclusion of other fields of medicine was hotly debated and argued over. It was said to dilute the safety of medical procedures and would result in unsafe and careless abortions. On the other hand, it would be more inclusive not just in the medical field but would also cater to women to whom hospitals are not easily accessible, especially in rural areas. Reports from the World Health Organization also show that nurses and midwives successfully and smoothly perform a large percentage of abortions over the world.

The Bill was a huge step forward towards achieving legal recognizance of women's autonomy over their bodies and, safe and healthy abortions.

The Bill, however, was not passed in the past six years and neither was it deliberated upon. A draft Bill was introduced and suggestions from the public and all stakeholders were invited, however, no changes were ever deliberated or introduced to the Bill.
Several petitions were filed in Courts, asking for the passage and implementation of the 2014 Bill and the Ministry of Health and Family Welfare was asked to prepare reports and deliberations multiple times.[34]

MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL, 2020

The Amendment Bill was introduced on February 13th, 2020 and was passed by the Lok Sabha (Lower House) on March 17th, 2020. The Bill was built on the base provided by the MTP Amendment Bill, 2014 and apart from recognizing a need for better, more technologically advanced provisions, also acknowledges in its Statement of Objects and Reasons, that several Writ Petitions have been filed before the Supreme Court and

[33] Shweta Krishnan, *MTP Amendment Bill, 2014: towards re-imagining abortion care*, Indian Journal of Medical Ethics, Vol XII No. 1, January-March 2015.

[34] *See* Amit Sahni v Union of India and Ors, Writ Petition (Criminal) No. 1612 of, 2019.

various High Courts seeking permission for aborting pregnancies at gestational age beyond the present permissible limit on the grounds of foetal abnormalities or pregnancies due to sexual violence faced by women.

Among the changes introduced by this Bill were some that were suggested in the 2014 Amendment Bill and a handful of new ones:
The Bill included the provisions for the termination as when necessitated by diagnosis of any of the substantial foetal abnormalities, privacy of the woman and contraceptive failure extending to unmarried women. However, the contested provision for medical practitioners to be amended to health care providers was left out. It also established constitution and establishment of Medical Boards for the purposes of safe and regulated pregnancy terminations.
The gestational period for the termination of a pregnancy was extended from twelve and twenty weeks to twenty and twenty four weeks. However, the autonomy that would've been given to women under the 2014 Bill was not included. The gestation period was increased subject to the conditions and evaluations of medical practitioners as under the MTP Act, 1971.

This Bill, is one step forwards in the right direction. An extended period will allow more risks to both the pregnant women and the foetus to be detected and prevented. The bill does not, however, make abortion a matter of choice or right, the medical practitioner's opinion is still the focal point. There are several reasons beyond medical, as discussed above, that govern a woman's decision to terminate her pregnancy and the Bill does not cater to such needs.
The need for such a provision is imminent but given the current situation, passage of the Bill in its present state might also be considered a positive thing.

INTERNATIONAL CONVENTIONS AND LAWS

Right to life and personal liberty is the heart and soul of the wider field of law called the '*human rights*.' Reproductive rights were not explicitly enumerated but were provided protection under the umbrella of the 'right to life and liberty' until the coming into existence of various international and legal instruments (regardless of their justiciability) like the Proclamation of Tehran (1968), Cairo Program of Action (1994), Beijing Platform (1995), Yogyakarta Principles (2006), Article 12 of European Convention on the Protection of Human Rights and Fundamental Freedoms, African Commission on Human and Peoples' Rights and Inter-American Commission.[35]

The International Covenant on Civil and Political Rights (**ICCPR**), the International Covenant on Economic, Social and Cultural Rights (**ICESCR**) and the Convention on Elimination of all forms of Discrimination Against Women (**CEDAW**), specifically General Recommendation 24, all support that the right to reproductive healthcare and the right to reproductive autonomy are basic rights and that the State has a positive obligation to fulfill these rights.
Article 1 of the American Declaration of Rights and Duties of Man and the Inter American Commission of Human Rights say

[35] *Legal dynamism comes to rescue when sanskars, human rights, ideals of liberty clash*, https://www.youthkiawaaz.com/2019/05/legal-dynamism-comes-to-rescue-when-sanskars-human-rights-ideals-of-liberty-clash/

that abortion is legalized until the end of First trimester[36].

Article 16(e) of the Convention on Elimination of all forms of Discrimination Against Women reads: "The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;"[37].

In the landmark judgement of **Roe v Wade**[38], the U.S. Supreme Court on January 22, 1973, ruled (7–2) that unduly restrictive state regulation of abortion is unconstitutional. Justice Harry A. Blackmun, the court held that a set of statutes criminalizing abortion in most instances violated a woman's constitutional right of privacy, which it found to be implicit in the liberty guarantee of the due process clause of the Fourteenth Amendment (*"...nor shall any state deprive any person of life, liberty, or property, without due process of law"*).

In his opinion, Blackmun noted that only a "compelling state interest" justifies regulations limiting "fundamental rights" such as privacy and that legislators must therefore draw statutes narrowly "to express only the legitimate state interests at stake." The court then attempted to balance the state's distinct compelling interests in the health of pregnant women and in the potential life of foetuses. It placed the point after which a state's compelling interest in the pregnant woman's health would allow it to regulate abortion "at approximately the end of the first trimester" of pregnancy. With regard to the foetus, the court located that point at "capability of meaningful life outside the mother's womb," or viability.

In the judgement of **Ayotte v Planned Parenthood of Northern New England**[39], the U.S. Supreme Court issued its opinion, upholding the plaintiffs' ability to challenge the law's constitutionality pre-enforcement, and affirming that the states may not enact abortion restrictions that fail to protect women's health and safety.

In **Planned Parenthood of Southeastern Pennsylvania v Casey**[40], the fundamental right of a pregnant woman to obtain a lawful abortion without government imposition of an undue burden on that right was argued. the decision restated that the source of the privacy right that undergirds women's right to choose abortion derives from the due process clause of the Fourteenth Amendment to the U.S. Constitution, placing individual decisions about abortion, family planning, marriage, and education within "a realm of personal liberty which the government may not enter." The judgment also revised the test that courts use to scrutinize laws relating to abortion, moving to an "undue burden" standard: a law is invalid if its "purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the foetus attains viability."

In the cases of **Singleton v Wulff**[41] and **Northwestern Memorial Hospital v Asheroft**[42], a U.S Court upheld that a

[36] lnter-Am. Comm'n H.R, art 1.

[37] Convention on Elimination of all forms of Discrimination Against Women, art 16(e), Dec. 18, 1979.

[38] Roe v Wade, 410 U.S. 113.

[39] Ayotte v Planned Parenthood of Northern New England, 546 U.S. 320.

[40] Planned Parenthood of Southeastern Pennsylvania v Casey, 505 U.S. 833.

[41] Singleton v Wulff , 428 U.S. 106.

[42] Northwestern Memorial Hospital v Asheroft , 362 F. 3d 923 (7th Cir. 2004).

physician had standing to assert rights of patients seeking abortions and, patient "may be chilled from such assertion by the desire to protect the very privacy of her decision from the publicity of a court suit."

In **K.L. v Peru**[43], it was held by the United Nations Human Rights Committee (UNHRC) that a forced continuation of pregnancy and denial of access to legal abortion constitutes cruel, inhumane and degrading treatment (Article 7, ICCPR) and violation of privacy (Article 17, ICCPR) among other things.

In the face of recent threats of Roe v Wade[44] being overruled in the U.S., both by state and people action, pro-reproductive health care law and policy makers have stepped up and ensured safe and legal access to abortions in their states, in cases even expanding access.
One such law is New York's Reproductive Health Act. When passed in January 2019, it was hailed as one of the strongest protections for abortion access in any state in any country. The Act ensures that if Roe v. Wade were ever overturned, abortion would remain a legal health procedure in New York – and patients and doctors would not go to jail. It also expands access to abortion later in pregnancy if the pregnancy cannot survive. The Reproductive Health Act is about making sure that at every point in a pregnancy, a patient's health (not a politician's ideology) drives medical decisions.
Illinois, New Mexico and Rhode Island have introduced similar Reproductive Health Acts, which would codify in law what we already know: abortion is not a crime. These bills would safeguard residents' right to access abortion safely and legally, no matter what might happen at the U.S. Supreme Court.[45]

STATISTICS

According to the first national study of the incidence of abortion and unintended pregnancy in India, an estimated 15.6 million abortions were performed in the country in 2015 which translates to an abortion rate of 47 per 1,000 women aged 15–49. The study was conducted jointly by researchers at the International Institute for Population Sciences (IIPS), Mumbai; the Population Council, New Delhi; and the New York–based Guttmacher Institute.[46]
The study also estimated the incidence of unintended pregnancy in India and found that out of the total 48.1 million pregnancies in 2015, about half were unintended—meaning they were wanted later or not at all. The estimated unintended pregnancy rate was 70 per 1,000 women aged 15–49 in 2015.[47]
Currently, slightly fewer than one in four abortions are provided in health facilities. The public sector—which is the main source of health care for rural and poor women—accounts for only one-quarter of facility-based abortion provision, in part because many public facilities do not offer abortion services.[48]
Laws fall along a continuum from outright prohibition to allowing abortion without restriction as to reason. As of 2017, 42% of women of reproductive age live in the 125 countries where abortion is highly restricted

[43] K.L. v Peru, CCPR/C/85/D/1153/2003.
[44] Roe, *Supra* note 38.
[45] Planned Parenthood, *Roe v Wade*, https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade.
[46] Susheela Singh et al, *The Incidence of Abortion and Unintended Pregnancy in India, 2015*, The Lancet Global Health, 2017.
[47] *Id.*
[48] *Id.*

(prohibited altogether, or allowed only to save a woman's life or protect her health).
The vast majority (93%) of countries with such highly restrictive laws are in developing regions. In contrast, broadly liberal laws are found in nearly all countries in Europe and Northern America, as well as in several countries in Asia.[49]

An Order in **Registrar (Judicial), Madurai Bench of Madras High Court v Union of India**[50], noted the prevalence of unsafe abortions and high rate of foetal abnormalities, "*About 1.6 crore abortions are done in India and 81% of the abortions are don e at homes and 13 women die every day due to unsafe abortions. Moreover, it has been reported by WHO – MOD (March of Dimes) about 2,70,00,000 children are born every year in India and the children born with birth defects are 1.7 million viz., 17 lakh children and foetal abnormalities are found out in the foetal itself. The doctors are finding it very difficult to diagnose the abnormalities in the foetus within 20 weeks as the cases are reported very late, especially, in the rural areas. The birth of children with defects to the tune of 17 lakh every year could be avoided*."

UNSAFE ABORTIONS

The World Health Organization defines that an unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. Unsafe abortion procedures may involve the insertion of an object or substance (root, twig, or catheter or traditional concoction) into the uterus; dilatation and curettage performed incorrectly by an unskilled provider; ingestion of harmful substances; and application of external force. In some settings, traditional practitioners vigorously pummel the woman's lower abdomen to disrupt the pregnancy, which can cause the uterus to rupture, killing the woman. Women, including adolescents, with unwanted pregnancies, often resort to unsafe abortion when they cannot access safe abortion.[51]

The Guttmacher Institute report[52] mentions the challenges faced by women in India trying to obtain abortion care, including the limited availability of abortion services in public health facilities. "Our findings suggest that a shortage of trained staff and inadequate supplies and equipment are the primary reasons many public facilities don't provide abortion care."

The steps that can be taken to improve availability and quality of abortion services extend to training and certifying a greater number of doctors and permitting nurses, auxiliary nurse midwives and practitioners of indigenous medicine to provide medication induced abortions and MMA.

Ensuring that public health facilities have the equipment and drug supplies necessary to provide surgical abortion care and MMA is imminent.

The study also recommends improving the quality of contraceptive services, including by offering a wide range of contraceptive

[49] "*Abortion Worldwide: Uneven Progress and Unequal Access",* Guttmacher Institute, March 2018.
[50] Registrar, *Supra* note 28.
[51] World Health Organization, *Abortion*, https://www.who.int/health-topics/abortion#tab=tab_1.
[52] Guttmacher, *Supra* note 49.

methods and providing counselling to help individuals prevent the pregnancies they do not want and achieve their reproductive goals.[53]

Inadequate abortion laws will not curb the number of abortions, rather increase the number of abortions done illegally and unsafely.

CONCLUSION

Induced abortion is common across the globe. The vast majority of abortions occur in response to unintended pregnancies, which typically result from ineffective use or non-usage of contraceptives. Other factors are also important drivers of unintended pregnancy and the decision to have an abortion. Some unintended pregnancies result from rape and incest. Other pregnancies become unwanted after changes in life circumstances or because taking a pregnancy to term would have negative consequences on the woman's health and well-being. As a result, abortion continues to be part of how women and couples in all contexts manage their fertility and their lives, regardless of the laws in their country.[54] This calls for laws that can successfully and effectively hep women access abortions, establishing their autonomy and rights under reproductive health care.

Law reform can be achieved in many ways, and usually a combination of strategies is used. For example, advocacy often integrates efforts from legal, medical, research and women's associations and organizations to collectively present the benefits gained from reforming the law. In addition, global and regional treaties, agreements and conventions can provide the basis for urging signatory countries to change their abortion law to be in compliance with the provisions of such agreements. [55]

But abortions do not automatically become safe with legalization.

As the preference for small families and the desire to control the timing of births continue to increase, so will the motivation to postpone motherhood, achieve healthy spacing between births and limit family size to the number of children desired. National governments and donors need to continue to invest in providing high-quality, comprehensive contraceptive services that women and couples need to achieve their desired family size and preferred timing of their births. Ensuring personal choice is essential to a woman's ability to use whichever method best suits her specific needs. Yet, because of human error or method failure, some pregnancies will be unintended despite contraceptive use. [56]

In addition, all women need contraceptive care that is non-judgmental, supportive and confidential; this is especially important for single sexually active women in settings where taboos against sex and childbearing outside of union remain strong. It is crucial to

[53] Guttmacher Institute, *National Estimate-Abortion India*, https://www.guttmacher.org/news-release/2017/national-estimate-abortion-india-released.

[54] S, Singh et al. "*Abortion Worldwide: Uneven Progress and Unequal Access*", Guttmacher Institute, March 2018.

[55] *Id.*

[56] *Id.*

expand modern contraceptive services to all subgroups of women who want them.[57]

Policies and programs to protect women's health through reducing unsafe abortion have had some success, but they must be strengthened and sustained.

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[57] *Id.*