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Navigating Abortion Laws: A Comprehensive Look at Legal Rights in India

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Abortion and legal rights in India constitute a complex and evolving landscape shaped by legislative frameworks, judicial interpretations, and socio-economic dynamics. This research paper delves into these multifaceted aspects, beginning with an introduction that outlines the historical and contemporary significance of abortion rights in India. The study then examines the Medical Termination of Pregnancy (MTP) Act of 1971[1]*, which was a landmark legislation providing a legal framework for abortion under specific circumstances. Despite the progressive intent of the MTP Act, judicial pronouncements have played a crucial role in expanding and clarifying abortion rights, ensuring broader access and protection for women's reproductive autonomy. An international overview highlights the varying legal stances on abortion across different countries, juxtaposed with World Health Organization (WHO) guidelines that advocate for safe and accessible abortion services as a component of public health and human rights.*[2] *The comparative analysis of global positions underscores the diverse approaches nations adopt based on cultural, religious, and political contexts. The paper also explores socio-economic factors that influence abortion access in India, emphasizing the pivotal role of non-governmental organizations (NGOs) in advocating for and facilitating reproductive rights. These efforts are critical in addressing the challenges faced by marginalized sections of society, including rural women, adolescents, and economically disadvantaged groups, who often encounter significant barriers to accessing safe abortion services.*

[1] Medical Termination of Pregnancy (MTP) Act 1971
[2] Abortion Care Guidelines 2022

Lastly, the paper provides recommendations and future steps for healthcare providers and lawmakers. Emphasis is placed on improving healthcare and providing legal rights. The purpose of providing recommendations is to increase accessibility and safe abortion services, thereby ensuring reproductive health. By providing an in-depth analysis of these themes, the paper seeks to advocate for policies and practices that uphold the dignity and autonomy of women in India and beyond.

Keywords: *MTP Act, judicial pronouncements, socio-economic factors, WHO.*

INTRODUCTION

An Abortion is a medical procedure to terminate a pregnancy. P. Ramanatha Aiyer, in his book 'The Law Lexicon', defines abortion as *"the premature delivery or expulsion of the human fetus, i.e., before it is capable of sustaining life. It is the emptying of the pregnant uterus before it is viable."*[3]

There are debates all over the world pertaining to whether abortions should be legally permitted or not considering the possible social repercussions of the legalization of abortions however the primary debate is between Pro-Choice and Pro-Life. Arguments in favour of choice claim that women have a right to their own bodily integrity and choice in carrying a baby and arguments in favour of life oppose abortions on the grounds that protecting the life of a foetus is paramount to the development of society.

In the case of Jacob George v State of Kerala[4], it was opined by the Supreme Court of India that a miscarriage constitutes spontaneous abortion while an abortion is a miscarriage produced by unlawful means.

The Principle and Practice of Medical Jurisprudence was referred to in the aforementioned judgment by the Apex Court since Taylor mentions that legally an abortion and miscarriage are synonymous with each other since a foetus is deemed to be human life from the moment of its fertilisation.[5] With present-day scenarios and medical advancements that have taken place, abortions can be safe as well as legal and can ensure the protection of lives. Any legal restrictions

[3] P Ramanatha Aiyar, *The Law Lexicon of British India* (Madras Law Journal Office 1940)
[4] *Dr Jacob George v State of Kerala* (1994) 3 SCC 430
[5] Alfred and Swaine Taylor, *Taylor's principles and practice of medical jurisprudence* (7th edn, J & A Churchill)

imposed on abortions at present are for social and moral reasons and will not have any medical reasoning behind them.

HISTORICAL REASONING BEHIND THE PROHIBITION OF ABORTIONS

Historically, there have been various social, medical and moral reasons behind the legal prohibition of abortion. Ancient times required the prohibition of abortions legally to ensure the protection of women and a balance in population growth as a stark contrast to how current times require that laws provide safe abortion rules in order to protect women and human life. With time it has been seen that there is a greater acceptance of these practices and the restrictions are only pushing women to adopt illegal means. In ancient times, practices like female foeticide and female infanticide were present which laid the responsibility on the law to protect human life. An example of such a step is the abolition of gender determination in India.

Social reasoning was due to prevailing practices like female foeticide. In ancient times, it was considered auspicious and financially better to have sons than having daughters in order to further the bloodline. It was assumed that the daughter does not remain a daughter and is always due to marry into another family and assume domestic and familial duties as a wife. Hence, it was a generalised assumption that having a daughter would inevitably lead to a lot of expenses on her wedding, like dowry payments, which can cause a significant dip in the family's finances. It was also assumed that a son would always remain the son of the family. Hence, it was considered a disadvantage and a burden to have a daughter. If it was determined that a daughter was to be born, people often resorted to practices like female infanticide and female foeticide to prevent the birth of a daughter. This often led to an imbalance in the population growth in many countries worldwide because there was often a disparity between the growth rate of the male and female population. Hence, in order to prevent such archaic practices and the excessive gender discrimination prevalent even before the birth of a female child, abortions had to be prohibited in many nations around the world.

Moral reasoning was the basic idea that aborting a child is wrong and against the preservation of human life. Abortions were a prevailing practice because they led to smaller family sizes which were favorable for financial and environmental reasons. Medically, abortions in ancient

times led to a loss of life and in order to protect foetal life due to improper practices and inadequate medical facilities, technological advancements had to be prohibited. In addition to foetal life, prohibition was also necessary due to the casualty rates of women undergoing the procedure.

It has been long established that the road to law reform is a long and strenuous process. Hence, there was a widely held belief that in order to ensure safe abortion practices, advocates must examine the political, health system, legal, juridical, and socio-cultural aspects related to existing laws and policies in their respective countries, and determine the type of legislation they desire (if any). The main obstacle was identifying what could realistically be accomplished, garnering widespread support, and collaborating with legal professionals, lawmakers, healthcare providers, and women themselves to amend the legislation—so that anyone seeking an abortion for an unwanted pregnancy can access it, both as early as possible and as late as necessary. The establishment of legal policies for this societal issue requires a lot of interdisciplinary studies and cannot be narrowed down to providing a legal framework on the basis of legal issues alone. Law is not a subject that can be dealt with in solace and it needs to be studied along with its related subjects in order to make policies that will accelerate social development and uplift the people. The law is meant to govern and protect the people. The only way in which law can protect the people is by being formed on the basis of prevalent societal issues.

Legal restrictions were a necessary evil in support of all the above reasoning. In the absence of legal prohibition, the occurrence of abortions was based on the social and moral beliefs of people and their belief in the medical systems. Society is formed by the people living in it. The social evils that led to the prohibition of abortion in the first place continue to persist even today making legal measures necessary to restrain such practices and declare them obsolete.

ABORTIONS IN INDIA

The Guttmacher Institute conducted a survey as part of continuous global research on unintended pregnancy and abortion, which revealed that India had around 48,500,000 pregnancies annually between 2015 and 2019. Out of this statistic, 21,500,000, nearly half, were

unintended pregnancies, resulting in a total of 16,600,000 abortions[6]. Abortion was the result of over half of the unintended pregnancies. The number of unintended pregnancies leading to abortion has increased significantly in the past few years. Out of the total deaths during pregnancy, 5-13% are caused by unsafe abortion, deaths every year.[7] The alarmingly high statistic proves that appropriate rules and regulations governing abortion are necessary to ensure the health of pregnant women. Improper abortions have led to an increasing number of casualties due to the risks associated with them. The legalization of abortions ensures that women have the legal right to exercise their choice and obtain an abortion if they want one.

The enactment of laws pertaining to social issues in India is not an easy process because it needs to address and remove social stigmas in the process of enactment. Laws need to undergo significant review before they can be enacted. Despite the practice of abortion existing since time immemorial, it is still viewed as taboo in India.

A landmark judgment that provided women with the right to abort their children in the United States of America is the case of Roe v Wade[8]. This judgment persuaded many countries across the world to provide women with the right to choose whether they want an abortion or not because they have a fundamental right to bodily integrity. The United States Supreme Court provided in this case that this right is of utmost importance and must be constitutionally protected for all women because a woman has a right to make decisions regarding her own pregnancy. It was, however, also provided that this right is not absolute and the state is permitted to make certain restrictions in order to ensure the health of the woman and the legality of the abortion process.

India enacted legislation a few months before the pronouncement of the Roe v Wade judgment. This legislation made abortions in India legal subject to certain conditions present in the Act. The Indian Parliament enacted the Medical Termination of Pregnancy (MTP) Act, 1971[9] which provided the requisite circumstances and conditions under which a woman can avail the option

[6] Elizabeth Nash et. al., 'Policy Trends in the States, 2017' (*Guttmacher*, 01 January 2018) <https://www.guttmacher.org/node/29102/printable/print> accessed 15 June 2024
[7] *Ibid*
[8] *Roe v Wade* [1973] 410 U.S. 113
[9] Medical Termination of Pregnancy Act 1971

of aborting her pregnancy. The restrictions provided by this Act are in the interest of foetal health and the prenatal health of the woman, thus ensuring they are in the overall societal interest and not detrimental to a woman's right to choice or her right to bodily integrity.

Even after the enactment, various studies show that women still do not resort to the legal methods of abortion because of the restrictions imposed on them, including, but not limited to, the gestation periods within which an abortion can be done, the legal formalities that need to be adhered to, both of which will be elaborated upon later in this paper. The standing opinion among all Indian women are that the State and their restrictive mechanisms are a blockage towards their rights even after the enactment and the legalization of the practice in the country. However, in terms of constitutional protection, abortion is considered a legal right under Article 21 of the Constitution of India[10] at present.

THE MEDICAL TERMINATION OF PREGNANCY ACT (MTP ACT) 1971

History behind the Enactment:

The implementation of the Medical Termination of Pregnancy Act occurred on 1st April 1972. Prior to the enactment of this Act, abortion was an illegal practice in India, punishable under the Indian Penal Code 1860[11] with the only exception being an abortion done in good faith with the intention of saving the life of the pregnant woman[12]. The only exception to being punished for providing an abortion was if there was no other available option in order to save the baby and the pregnant woman.

India is a country of diverse religious beliefs and sects and care needs to be taken by the Parliament and the Judiciary to avoid hurting any religious beliefs and sentiments while enacting laws and judgements, especially those pertaining to social issues. The name given to this Act was given with the intention of not explicitly providing the word 'Abortion' in it to prevent social unrest as a result of the enactment as well as to enable the acceptance of the

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[10] Constitution of India 1950, art 21

[11] Indian Penal Code 1860

[12] 'Abortion Laws In India- Explained Pointwise' (*Forum IAS,* 07 October 2023) <https://forumias.com/blog/upsc-current-affairs-news/abortion-laws-in-india-explained-pointwise/> accessed 15 June 2024

provisions of the Act without the cloud of social stigmas over it. The nomenclature was done in this manner to establish medical reasoning behind the enactment as a logical backing to it.

Due to the alarmingly high maternal mortality rates caused by improper and illegal means of terminating pregnancies, a committee known as the Shantilal Committee was set up in 1964 by the Central Family Planning Board of India. The main purpose behind the formulation of this committee was to examine whether the legalization of abortion was necessary while taking into consideration various social, ethical and medical aspects and possible repercussions of the legal step. The Committee suggested the legalization along with an enactment of a separate legislation in order to provide certain rules and regulations governing abortion practices in the country. Thus, the Medical Termination of Pregnancies Act 1971 was enacted by the Parliament and assented to by the President in order to reduce maternal mortality rates, provide a legal framework for safe abortions in India and prevent unsafe abortions by specifying that they need to be performed by registered medical practitioners.

Relevant Provisions:

The MTP Act, 1971 had 8 sections in its original form. Section 2 defines various terms as used in the Act for the purpose of understanding[13].

Section 3 of the Act provides for the requisite conditions under which a pregnancy can be terminated. Firstly, Clause 1[14] absolves a medical practitioner who performs a pregnancy termination in a legal manner of all guilt under the Indian Penal Code 1860 as well as the present legislation. Termination of pregnancy within 12 weeks is governed by Section 3(2)(a)[15] of the Act and provides for the consent of one registered medical practitioner while termination up to 20 weeks is dealt with under Section 3(2)(b)[16] wherein the approval of at least two registered medical practitioners is required. Section 3(2)(b) has two further sub-clauses- (i) and (ii) which provide for termination of pregnancy in good faith in order to protect the mental health of the pregnant woman. 3(2)(b)(i) deals with cases wherein an accidental pregnancy has occurred due

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[13] Medical Termination of Pregnancies Act 1971, s 2
[14] Medical Termination of Pregnancies Act 1971, s 3(1)
[15] Medical Termination of Pregnancies Act 1971, s 3(2)(a)
[16] Medical Termination of Pregnancies Act 1971, s 3(2)(b)

to rape and 3(2)(b)(ii) provides for a situation wherein an accidental pregnancy has occurred due to a failure of contraceptive measures that were taken[17]. Section 3(3) determines whether the continuation of a pregnancy would lead to injury to the pregnant woman or not[18]. Finally, the last sub-clause of Section 3- 3(4)(a) and 3(4)(b) provide for termination in the case of a mentally ill woman or a minor and for the consent of the pregnant woman in the aforementioned cases with the additional requisite consent of the guardian in case of the minor. [19] Section 4[20] of the Act provides for the places wherein the termination can be carried out and Section 5[21] prescribes the exceptions wherein Sections 3 and 4 will not be applicable as well as the punishments in case of an unlawful termination conducted by anyone other than a registered medical practitioner. Section 6[22] empowers the Central government to make regulations for the provisions of this Act and Section 7[23] empowers State governments to make required regulations to enforce. Section 8[24] absolves any person or any registered medical practitioner of all guilt provided the termination has been carried out in good faith.

Amendments made to the Act:

Amendment Act 2002:[25] This Amendment replaced the word 'lunatic' with the word 'mentally ill' person in all incidences of the word in the Act of 1971. Section 4 of the Act was also inserted by this amendment. Sub Sections (2) to (4) in Section 5 were also inserted by this Act.

Medical Termination of Pregnancy Rules 2003: These Rules were enacted in order to ensure the proper implementation of the provisions of the Act that could not be done by previous amendments. The guidelines specify the structure of a District committee, its members, and their respective roles, as well as the experience and qualifications required for the medical professionals participating. The Rules also specify different groups of women who are eligible

[17] Medical Termination of Pregnancies Act 1971, s 3(2)(a)
[18] Medical Termination of Pregnancies Act 1971, s 3(3)
[19] Medical Termination of Pregnancies Act 1971, s 3(4)
[20] Medical Termination of Pregnancies Act 1971, s 4
[21] Medical Termination of Pregnancies Act 1971, s 5
[22]Medical Termination of Pregnancies Act 1971, s 6
[23] Medical Termination of Pregnancies Act 1971, s 7
[24] Medical Termination of Pregnancies Act 1971, s 8
[25] Medical Termination of Pregnancy (Amendment) Act 2002

for abortion after 24 weeks[26], such as survivors of sexual assault, rape, or incest; minors; physically disabled women; those at substantial risk of fetal abnormalities; mentally challenged women; children at risk of physical or mental abnormalities if the pregnancy continues; and women pregnant during government-declared disasters, emergencies, or humanitarian situations. It further provided for a mandatory inquiry or investigation and the procedure to be followed for the same.

MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) ACT 2021

This Amendment was the most important amendment ever made to the Act due to the aspects of abortion brought under its purview. The privacy of women undergoing the procedure was protected by inserting a requirement via Section 5A[27] that the medical practitioner in charge does not disclose any details of his/her patients. Two new relevant definitions for the terms 'medical board' and 'termination of pregnancy' were inserted under Section 2. The requisite qualifications for the registered medical practitioners who can perform the procedure were provided under Section 3(2A). A condition was also added under Section 3(2B) wherein a fetus with abnormalities could be aborted even after the time limits specified under the Act. Section 3(2C) provides for the constitution of a medical board under the Act while Section 3(2D) provides for the qualifications of the members of the board.

The primary reason behind the formation of such a Board under the Act is to ensure all the formalities and provisions under the Act are adhered to in order to reaffirm the health of the pregnant woman and prevent fatalities. However, these Boards were seen as a significant drawback in practice since they served as a hindrance to women seeking to terminate their pregnancies. They were seen as an interfering organization that was restricting women from exercising their rights.

Another significant drawback of this Act is the fact that the Act specifies the categories of women who were permitted to legally terminate their pregnancies. Only the women who fall under the realm of these categories could avail of the adoption method specified in the Act. The right to

[26] Medical Termination of Pregnancy Rules 2023, s 3B
[27] Medical Termination of Pregnancies Act 1971, s 5A

terminate one's child is a legally guaranteed and intrinsic right that should be provided to all women. By distinguishing between women who can avail it or not depending on the circumstances of their pregnancy, the Act is infringing upon this fundamental right that should be available to all women. The restrictions imposed by the Act on the women who do not fall under any of the specified categories but wish to terminate their pregnancies result in these women resorting to unlawful methods of termination which is a potential risk to their health.

The social reasoning behind the enactment has not been satisfied if women still have to resort to unlawful means of obtaining abortions simply because they do not satisfy a criterion provided by the legal provisions. Differentiating between women who can exercise their choice and women who cannot is a form of discrimination in itself.

JUDICIAL PRONOUNCEMENTS RELATING TO TERMINATION OF PREGNANCIES

Common Law systems such as the judicial systems prevalent in India and the United Kingdom allow the judiciary to make laws through their interpretation and application of laws while deciding various cases before the courts. Various judgments provided by the Supreme Court of India and the High Courts of different states have been provided and analyzed to further the judicial understanding of the laws relating to the medical termination of pregnancies and the development of such laws.

Nand Kishore Sharma & Ors v Union of India:[28] In this 2005 judgment, the Rajasthan High Court was petitioned to determine whether Sections 3(2)(a) and 3(2)(b) were violative of the Fundamental Right to Life and Personal Liberty under Article 21 of the Constitution of India, 1950. These sections provide for conditions of termination of pregnancy based on the gestation period passed and the conditions to be satisfied in case of 12 weeks and 20 weeks having been passed respectively. The Rajasthan High Court, while dismissing the petition in the given case, opined that the object of the MTP Act 1971 was to prevent unlawful abortions and the provisions were to be as stringent as possible to ensure their effectiveness. The provisions were not to permit any hasty decisions for termination or any blatant termination of pregnancies.

[28] *Nand Kishore Sharma & Ors v Union of India* (2006) WLC (RAJ) UC 411

Suchita Srivastava & Anr v Chandigarh Administration:[29] In the given case, the pregnant woman in question was a rape victim and was housed at a government-run orphanage. The prevalent question raised was with respect to whether a mentally ill person should avail an abortion or not. The Division Bench of the Punjab and Haryana High Court opined that the woman should undergo an abortion since she is mentally ill and it is in her best interest and they completely discarded the fact that she herself was willing to continue the pregnancy and give birth to her child. In such cases, the standard procedure followed by courts is to constitute an expert committee to analyze the facts and circumstances of the matter and provide a recommendation to the case after considering all solutions. All relevant factors need to be considered by this committee, especially medical factors.

The Apex Court was to decide if the position taken by the High Court ordering an abortion was valid or not considering her willingness to continue the pregnancy. The Supreme Court reversed the High Court's judgment by referring to Section 3 of the MTP Act[30] and Article 21[31] of the Constitution of India 1950. It was held by the court that the consent of the woman is paramount to providing her with the right to choice and she cannot be made to have an abortion on the Court's orders against her own will. This case was where it was held by the Court that a woman has a right to her own reproductive choices which includes the right to procreate and the right to abstain from procreation and the state has a reasonable say in the matter, by way of reasonable restrictions.

Devika Biswas v Union of India:[32] The given case was about the mass sterilization practices adopted by state governments and exercised upon males and females alike. The Public Interest Litigation was filed by a social activist against such sterilization due to the lapse in sanitation in the camps conducted by the governments for this purpose and the absence of consent among the people undergoing such procedures as found in many cases. The question posed before the Apex Court was whether the lack of consent was a violation of Article 21 of the Constitution of

[29] *Suchita Srivastava & Anr. v Chandigarh Administration* (2009) 9 SCC 1
[30] Medical Termination of Pregnancies Act 1971, s 3
[31] Constitution of India 1950, art 21
[32] *Devika Biswas v Union of India* (2016) 10 SCC 726

India 1950[33] or not. The Supreme Court opined that such practices were violative of Article 21 and upheld every individual's right to make their own reproductive choices within the ambit of their Right to Life and Personal Liberty under Article 21.

Meera Santhosh Pal v Union of India:[34] A 24 weeks pregnant woman petitioned the court under Article 32 of the Constitution of India, 1950 to allow her to terminate her pregnancy as her fetus was diagnosed with anencephaly, a severe congenital medical condition wherein half the brain is absent. A medical board was asked to examine the case by the court. The question posed before the Apex Court was whether the woman should be permitted to terminate her pregnancy or not after the inspection done by the medical board. The Supreme Court, relying upon the aforementioned Suchita Srivastava case, opined that the reproductive choices of a woman are a protection guaranteed under Article 21 of the Constitution of India, 1950. Emphasis was also laid upon the consent of a woman being of the essence in matters of termination and continuation of her pregnancy.

Mrs X & Ors v Union of India:[35] The petitioner herein was a 22 year old woman who was 22 weeks pregnant and she had been diagnosed with a condition known as bilateral renal agenesis and anhydramnios and by reason of this condition, the continuation of her pregnancy may endanger her life and lower the chances of survival of both the fetus and the mother. The Court allowed her petition and permitted her to exercise her right to reproductive choices and terminate her pregnancy.

Minor R The Mother H v State of NCT of Delhi & Anr:[36] The petitioner, a minor of age 14 years, petitioned the court under Article 226 of the Constitution of India 1950[37] by way of a writ of mandamus to seek the termination of her pregnancy under the MTP Act 2021. The given case was a matter pertaining to a rape victim who had crossed the 24 weeks mark in her gestation period thus enabling the medical board to deny the carrying out of her abortion.

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[33] Constitution of India 1950, art 21
[34] *Meera Santhosh Pal v Union of India* (2017) 3 SCC 462
[35] *Mrs X & Ors v Union of India* (2017) 3 SCC 458
[36] *Minor R The Mother H v State of NCT of Delhi & Anr* (2023) DHC 000570
[37] Constitution of India 1950, art 226

The High Court permitted the termination beyond 24 weeks in this case after careful consideration. Further, guidelines were issued regarding cases of rape and sexual assault leading to pregnancies. These guidelines included the conduct of a mandatory urine pregnancy test on the victim at the time of medical examination and when a major pregnant victim expresses any intent to abort her baby, it is the duty of the investigative officer to produce her before the medical board. The Court further provided for the constitution of medical boards in all government hospitals for the effective functioning of the MTP Act. Legal consent from a minor's guardian is required in case the minor is a victim who is pregnant and seeking to terminate her pregnancy.

ABC v State of Maharashtra:[38] The petitioner herein approached the court for termination of her pregnancy at 33 weeks since fetal abnormalities were found only on an ultrasound done at 29 weeks which had not been found in the ultrasound done at 14 weeks. The unborn baby was found to have microcephaly and lissencephaly. It had been stated by the constituted medical board for the case that there was no such substantial risk to the petitioner's life and hence her request for termination of her pregnancy was denied by the board. The petitioner stated that her financial status was not secure and owing to various difficulties that may arise in taking care of the child if he is born, she should be allowed to undergo an abortion. The board advised against the same thereby forcing the petitioner to seek judicial redressal from the Bombay High Court. The question posed before the Hon'ble court was pertaining to whether such abortion must be allowed or not after asking the board to look into factors like whether an infant born with such abnormalities will require extensive care, continued medical care, expenses for the same, etc and after giving the board's opinion due consideration. The Bombay High Court permitted the petitioner's termination at 33 weeks and further quashed the recommendations of the medical board, wherein the board advised not to terminate her pregnancy by reason of the length of the pregnancy.

INTERNATIONAL OVERVIEW

World Health Organisation Guidelines toward Safe Abortions:

[38] *ABC v State of Maharashtra* (2023) Writ Petition (ST) No 1357/2023

The main purpose behind the formation of the World Health Organisation was to promote health, keep the world safe and protect vulnerable groups of society. WHO is known for prescribing various guidelines with regard to health issues that need to be addressed at a global level. The guidelines provided by the organization ideally need to be adhered to by all member states.

WHO defines health as "*a state of complete physical, mental and social well-being and not just the absence of disease of infirmity.*" The aim is to progress towards basic human rights and the provision of health care to all by increasing accessibility. Comprehensive abortion care services are prescribed by WHO which includes within its sphere, information and management of abortions as well as post-abortion care. Lack of access to appropriate safe methods of abortion can damage all aspects- physical, mental and social well-being of the woman undergoing the procedure. As per a statistic provided by WHO, every year almost half of the pregnancies that occur, which is about 121 million worldwide, are unwanted and unplanned pregnancies. Out of all unintended pregnancies, 6 out of 10 results in abortion while out of the total number of pregnancies in general, 3 out of 10 results in abortions.

The Sustainable Development Goals (SDGs) also prescribe goals such as good health and well-being (SDG3) and gender equality (SDG5). The attainment of these goals is paramount for the United Nations and by extension, the World Health Organisation. The provision of appropriate methods of abortion is also a step towards the attainment of these global objectives. WHO advocates for well-functioning health systems, an adequate amount of information and its accessibility to all, and the appropriate amount of weightage being given to human rights frameworks as prescribed under law.

Some preliminary guidelines provided by the Organisation are:

- Different types of healthcare workers in adequate numbers are available within reach for women;
- Improvement in delivery mechanisms of safe abortion care services including those methods that are self-administered;
- Ensuring abortion care does not result in significant financial dips for women;

- Removal of all laws and policies that act as a source of restriction on abortion practices and criminalize them since restrictions are proven to have led women and girls to adopt unsafe procedures. It has been found that in countries where abortion is a restricted practice, only 1 in 4 abortions are safe compared to a statistic of nearly 9 in 10 abortions being safe in countries where the practice is legal;
- Ensuring adequate amount of sensitivity and legal training are given to healthcare workers to enable them to view the legal policies in the light of human rights frameworks;
- Ensuring access to abortion is not reduced due to the non-administration by healthcare workers on account of their personal beliefs being contradictory to the practice;
- Providing people with access to accurate and unbiased information to prevent unintended pregnancies and enable them to make autonomous and sound decisions about abortion.

In addition, the WHO has issued guidelines on several basic interventions at the primary care level that enhance the standard of abortion care offered to women and girls. These interventions include, but are not limited to, delegating tasks to a broader spectrum of healthcare professionals, guaranteeing the availability of medical abortion pills to enable more women to access safe abortion services, and ensuring accurate care information is accessible to all who require it. In its 2022 guidelines, the Organisation included suggestions for utilizing telemedicine when suitable, which assisted in ensuring access to abortion and family planning services during the COVID-19 pandemic, thus making them flexible to current social circumstances.

Positions of Various Nations on Abortion Rights:

Many countries across the world include in their legislations, laws that criminalize the practice of abortion. In the United Kingdom, Sections 58[39] and 59[40] of the Offences Against the Person Act 1861 criminalized the practice. However, the 1967 Abortion Act[41] allowed the practice under pre-described conditions acting as an exception to the Act of 1861. The Sections that criminalized

[39] Offences Against the Person Act 1861, s 58
[40] Offences Against the Person Act 1861, s 59
[41] Abortion Act 1967

the practice have still not been repealed since they are used as grounds to punish illegal abortions.[42] By the end of the twentieth century, 98% of the world's countries allowed abortion to save the life of a woman. In terms of other grounds for abortion, 63% of countries permitted it to preserve the woman's physical health, 62% for mental health, 43% in cases of rape, sexual abuse, or incest, 39% for fetal anomaly or impairment, 33% for economic or social reasons, and 27% allowed abortion on request.[43]

In 2002, the number of countries permitting abortion for each of these grounds varied significantly by region. For instance, 65% of developed countries allowed abortion upon request, while only 14% of developing countries did so. Additionally, abortion for economic and social reasons was permitted in 75% of developed countries but only 19% of developing countries.[44] In some countries, additional reasons for abortion are allowed, such as if the woman is HIV positive, is younger than 16 or older than 40, is unmarried, or already has many children. In a few cases, abortion is permitted to protect existing children or due to contraceptive failure.[45]

The percentages mentioned were published in 2002 and may be outdated, but they have remained relatively stable. In late 2017, new research updating global abortion laws and incorporating additional information about related policies, conducted by the Department of Reproductive Health and Research/Human Reproductive Programme at WHO, will be added to the United Nations Population Division's website.[46] Reed Boland discovered that in some countries, especially those with strict abortion laws, there is often a lack of clarity between laws and regulations governing abortion, and in some cases, no regulations have been issued at all. As a result, uncertainty exists regarding when abortion is permitted and when it is not, potentially hindering safe and open access to abortion services.[47]

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[42] Marge Berer, 'Abortion Law and Policy Around the World: In Search of Decriminalization' (2017) 19(1) Health and Human Rights <https://pubmed.ncbi.nlm.nih.gov/28630538/> accessed 17 June 2024

[43] Department of Economic and Public Affairs, *Abortion policies: A global review* (Vol 3, United Nations 2002)

[44] 'Un Population Division Issues Updated Study On Abortion Policies' (*United Nations,* 14 June 2002) <https://www.un.org/en/development/desa/population/publications/pdf/abortion/pop830.pdf> accessed 17 June 2024

[45] Department of Economic and Public Affairs (n 43)

[46] Berer (n 42)

[47] Reed Boland, 'Second-trimester abortion laws globally: actuality, trends and recommendations' (2010) 18(36) Reproductive Health Matters <https://www.jstor.org/stable/25767363> accessed 17 June 2024

The Constitution and Penal Code of Uganda contradict each other, by constitutionally permitting abortions while simultaneously penalising people under the Penal Code when they conduct abortions causing confusion and a lack of awareness about the legality of abortion for the protection of women's health and life. Additionally, although Uganda has a national reproductive health policy, it is not legally supported and is not put into practice. To address this issue in 2015, the minister of health and other stakeholders created Standards and Evidence-based Guidelines on the Prevention of Unsafe Abortion, outlining who can perform abortions, where and how they can be done, and defining health service responsibilities, including the level of care and post-abortion care. Unfortunately, these guidelines were withdrawn in January 2016 due to opposition from religious and political groups.[48]

In Tanzania, there is uncertainty about the legality of abortion under the 1981 Revised Penal Code, particularly in cases where it is necessary to protect a woman's physical or mental health or her life. Unsafe abortions still account for 16% of maternal deaths in the country[49]. Despite efforts by the government to improve access to post-abortion care, a study in 2015 revealed that there were still significant gaps in the care provided to women in need.

In early 2016, the newly appointed prime minister and the president issued warnings about the consequences, including possible dismissal and imprisonment, for doctors found performing illegal abortions. This came after reports of doctors in both public and private hospitals accepting payments for performing abortions and an increase in complications from these procedures.[50] The abortion law in Morocco dates back to 1920 during the time when Morocco was under French control. In May 2015, the king initiated a reform process to expand legal protections following a public debate sparked by reports of women dying from unsafe abortions. The Moroccan Family Planning Association notes that there is a consensus that abortion should be allowed within the first three months if the woman's physical and mental health is at risk, as well as in cases of rape, incest, or congenital malformation. However,

[48] Amanda Cleeve et. al., 'Time to act-comprehensive abortion care in east Africa' (2016) 4(9) The Lancet Global health <https://pubmed.ncbi.nlm.nih.gov/27539801/> accessed 17 June 2024

[49] Sarah C. Keogh et. al., 'Incidence of Induced Abortion and Post-Abortion Care in Tanzania' (2015) 10(9) PLOS ONE <https://doi.org/10.1371%2Fjournal.pone.0133933> accessed 17 June 2024

[50] *Ibid*

unmarried women would not be eligible for abortion as it is illegal to engage in sexual activity outside of marriage.[51]

Hence, it is seen that different countries have different legal frameworks in place with respect to abortion legislation and uniform guidelines like those provided by the World Health Organisation can help streamline the perspectives of different countries by providing a certain uniform standard that needs to be adhered to other than the respective individual national guidelines.

SOCIO-ECONOMIC FACTORS AND ADVOCACY EFFORTS IN INDIA

Role of NGOs and Advocacy Groups in Advancing Abortion Rights:

According to a study carried out in 2020, 73.2% of individuals are of the opinion that Non-Governmental Organizations (NGOs) have a crucial and essential role in advancing abortion rights in India by raising awareness about them.[52] NGOs assist in reaching a wider audience across all societal segments and involving them by offering education on their rights and how to access them. Similarly, NGOs play a crucial role in reaching out to women from all backgrounds and educating them about safe abortion practices. They provide comprehensive information about abortion procedures and available methods, thereby raising awareness. By ensuring that the information they provide is well-researched and accurate, NGOs help in dispelling misinformation and offer trustworthy guidance to individuals.

One example of an NGO with a primary focus on advocating for women's reproductive rights in India is the national-level organization IPAS (Individual Personal Assistance Service Development Foundation). The organization is headquartered in Delhi and operates across 12 states in India with the main goal of advocating for women's reproductive choices. According to reports, there are 10 well-known NGOs in India that specifically focus on protecting abortion

[51] Moroccan Family Planning Association, *Religious Fundamentalism and Access to Safe Abortion Services in Morocco* (2015)

[52] Kritika Seth and Sakshi Kothari, 'Abortion Laws: Role of NGO's in Strengthening Communities and Providing Related Services' (2021) 3(1) International Journal of Legal Science and Innovation <https://ijlsi.com/36-abortion-laws-role-of-ngos-in-strengthening-communities-and-providing-related-services/> accessed 17 June 2024

rights in the country. With an estimated 15.6 million abortions occurring in India, it is crucial to establish more organizations that can offer safe and easily accessible abortion services to women in the country.[53]

During a workshop involving ObGyn Societies, which consist of medical professionals, it was collectively agreed by these experts that advocating for broader recognition of the importance of safe abortion should be a priority. This should be accompanied by efforts to improve the availability of services, trained providers, and necessary supplies. The development, implementation, and sharing of national guidelines are essential, as is the engagement of young people, traditional and religious leaders. Furthermore, it is crucial to raise awareness about the law among healthcare providers, policymakers, and the public.[54]

The availability of advocacy opportunities for safe abortion varies from one country to another and is influenced by factors such as existing legal structures, the extent of public discourse on abortion, and the involvement of key stakeholders. In nations with strict laws, advocacy efforts may centre on pushing for a relaxation of the legislation. The primary aim of ObGyn societies was not necessarily to liberalize the law, especially in countries with already liberal or semi-liberal legal frameworks. Therefore, advocacy groups should realign their focus based on societal needs, and in India, there is a need for more NGOs to ensure broader outreach and accessibility of services to marginalized and vulnerable segments of the population.

Challenges faced by Marginalized Communities in Accessing Abortion Services:

Legal groups and medical organizations both encounter the ongoing challenge of insufficient access to safe abortion services, especially in rural areas, due to the uneven availability of facilities and providers as well as barriers related to service provision. For instance, a survey conducted in 2009-10 found that there were 0.85 certified abortion facilities per 100,000

[53] *Ibid*

[54] Irene de Vries et. al., 'Advocating safe abortion: outcomes of a multi-country needs assessment on the potential role of national societies of obstetrics and gynecology' (2020) 148(3) International Journal of Gynaecology and Obstetrics <https://doi.org/10.1002/ijgo.13092> accessed 17 June 2024

population in rural areas of all 33 districts of Rajasthan, compared to 3.65 in urban areas[55]. In 2002, the use of mifepristone and misoprostol for medical abortion was approved for terminating pregnancies up to 49 days of gestation[56]. Subsequently, in 2006, the Drug Controller of India sanctioned the use of a combipack of the same drugs for pregnancies up to 9 weeks of gestation[57]. However, medical abortion drugs remain largely unavailable in most primary care facilities. The provision of medical abortion can be offered at primary care facilities without the need for staff skilled in surgical evacuation procedures.

Women face multiple barriers to accessing safe abortion services, including lack of confidentiality and unnecessary requirements for the husband's or relative's consent, despite such requirements not being legally mandated. Some public health facilities only offer abortion services if women agree to undergo sterilization or receive a copper IUD[58] afterwards. Additionally, the cost of abortion services at private facilities is beyond the means of many women.[59] Finally, certain facilities do not provide women with a choice of abortion methods, and others prefer to utilize dilation and curettage[60], which come with their own risks and admission requirements. As a result, women seeking medical abortion pills tend to steer clear of such facilities.

Women in Rajasthan face social disadvantages that hinder their ability to access services from a remote urban facility. Only 48% of women are literate[61], and 62% are married before the age of 18. They have limited autonomy in terms of mobility - data from 2005-06 shows that only 32% of women were permitted to go alone to the market, the health facility, and places outside the

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[55] Kirti Iyengar and Sharad D. Iyengar, 'Improving access to safe abortion in a rural primary care setting in India: experience of a service delivery intervention' (2016) 13(1) Reproductive health <https://doi.org/10.1186%2Fs12978-016-0157-5> accessed 17 June 2024
[56] Drug and Cosmetics Act and Rules 2003
[57] Vinod Kumar Paul et. al., 'Reproductive health, and child health and nutrition in India: meeting the challenge' (2011) 377(9762) THE LANCET <https://doi.org/10.1016%2FS0140-6736(10)61492-4> accessed 17 June 2024
[58] Iyengar (n 55)
[59] Ravi Duggal, 'The Political Economy of Abortion in India: Cost and Expenditure Patterns' (2004) 14(24) Reproductive Health Matters <https://www.jstor.org/stable/3776124> accessed 17 June 2024
[60] *Ibid*
[61] Government of India, 'Census Tables' (*Census India*) <https://censusindia.gov.in/census.website/data/census-tables> accessed 17 June 2024

village or community[62]. Despite women bearing a significant work burden, much of their labour involves unpaid agricultural or household duties. The state's maternal mortality ratio exceeds the national average, standing at 254 per 100,000 live births, with 10% of these deaths attributed to unsafe abortion[63].

Action Research and Training for Health (ARTH), a non-governmental organization focused on public health in India, carries out a rural field service initiative covering 50 remote villages with a total population of approximately 70,000, with nearly half belonging to an underprivileged tribal community. Within this area, three rural health centres offer various primary healthcare services, including antenatal care, 24-hour delivery and newborn care, first-trimester abortions, and reversible contraception methods. Abortion services in the first trimester utilize manual vacuum aspiration (MVA) and medical abortion (MA). MVA has been offered since 1999, and medical abortion was added in 2003.[64]

Hence it can be deduced that the major challenge faced by marginalized communities in terms of accessing their own reproductive rights is the lack of access to these rights and lack of information about what is actually legally required of them. There is an absence of knowledge among people regarding the law and their own legal rights and duties. Awareness needs to be spread regarding abortions in both a medical as well as a legal perspective.

Influence of Cultural and Religious Beliefs on Perceptions of Abortion:

Abortion is not a practice that exists in solidarity with legal enforcement alone. It needs to be analyzed in view of social, cultural, religious practices and other questions of ethics need to be answered while enacting a law pertaining to abortion since it is a highly sensitive issue socially. Abortion has implications for social, religious, economic, and political spheres, and its influence on society can be perceived in both positive and negative light. In the early stages of abortion policy formation, Western civilizations looked down upon the practice, leading to the passage of laws prohibiting abortion in many nations by the nineteenth century. It was only in the late

[62] National Family Health Survey, *National Family Health Survey (NFHS-3) 2005–06* (vol 1, International Institute for Population Sciences 2007)
[63] Registrar General of India, *Sample Registration System Statistical Report* (2010)
[64] Iyengar (n 55)

twentieth century, following significant women's rights movements and increased awareness, that certain nations, including the United States, began to legalize abortion. In the case of India, a country burdened by deep-seated social issues such as illiteracy and poverty, the impact of the MTP Act should be assessed in the context of evolving social conditions, values, and perspectives.

The social implications of the MTP Act can be categorized into the differences between abortion in unmarried girls and abortion in married women. These two scenarios carry distinct implications. Under the MTP Act, abortion in married women is not viewed as a social stigma, while it is not easily accepted for unmarried girls. The lack of acceptance creates barriers to safe abortions, sometimes undermining the primary purpose of abortion, which is the health of the woman undergoing the procedure. In rural areas with limited access to medical facilities, girls are taken to distant locations for MTP Act procedures in order to protect the girl's future and maintain the family's image in society. The legalization of the MTP Act has clearly had a beneficial impact on women requiring MTP, resulting in a decrease in suicide rates and improved health and safety. Family planning methods have also seen increased acceptance.

In a survey carried out in Assam and Madhya Pradesh in 2018, it was found that almost 62% of the 500 young women participants considered abortion to be a 'sin'.[65] Additionally, one-third of the respondents thought that discussing abortion was unacceptable and stated that they would end friendships with those seeking an abortion. The foundation of medical jurisprudence textbooks rests on patriarchal assumptions regarding the sexual and reproductive behaviour of women, perpetuating the stigma surrounding abortion. The interviews conducted by the authors of the report revealed the presence of stigma among medical practitioners. According to a leading gynaecologist in Chennai, she believes that abortions are not recommended from an ethical standpoint. A doctor in Pune expressed the view that a woman does not have the right to demand an abortion because the fetus does not belong solely to the woman. Additionally, the report highlights that some doctors caution women by mentioning that '*God is watching and that they will suffer for the rest of their lives if they get an abortion.*'

[65] Seth (n 52)

Hence, it is evident that if a medical practitioner's opinion on the procedure can be influenced by factors such as religious and cultural stigma against it, then it is only reasonable to assume that common people are also sufficiently convinced that abortion is a practice that is not socially and culturally advisable. Common people cannot be expected to treat the practice as normal and remove the stigma from it in their minds when medical practitioners themselves are unable to segregate the biological practice from religious myths and existing social stigma.

FUTURE DIRECTIVES AND RECOMMENDATIONS FOR REFORMS

Recommendations to Healthcare Providers:

Considering the implications on the healthcare industry with the provision of safe abortion services, the healthcare sector and its constituents can play a pivotal role in advocacy. Healthcare professionals and institutions have a vital role to play alongside activist movements in advancing the development of legal frameworks for safe abortion. The form and time of involvement varies depending on individual and contextual factors. Healthcare provider's and organizations' voices, testimonies, and narratives are relevant across countries as they hold influence in public and political spheres. Their narratives bring scientific evidence and credibility to national discussions, given that healthcare providers are trusted as technical, professional, and independent voices separate from political actors or activist groups. Additionally, their day-to-day service provision testimonies have the potential to amplify the diversity of women's experiences, linking the discussions on safe abortion to the reality of the general population.

The perspectives of healthcare providers are essential in legislative processes due to their ability to combine scientific arguments with real stories of women who have sought or undergone an abortion. This is crucial for effectively countering false, biased, or inconsistent arguments and myths surrounding abortion, especially in highly polarized contexts where they can reach groups with ambivalent or undeveloped opinions on proposed legal reforms. However, it is

recognized that the political and social controversy surrounding abortion may impede the involvement of healthcare providers and organizations in political and legislative processes.[66]

Healthcare providers may be concerned about facing negative responses, personal criticism, and being stigmatized due to their involvement. Public actions taken by health professionals, which are often emphasized as influential in making laws, like speaking out during parliamentary discussions or joining public initiatives, involve being in the public eye. As a result, individual healthcare providers with experience as health advocates or leaders often also engaged in these activities in the study.

Despite the possible negative repercussions that can occur, healthcare providers need to understand the role they can play in bringing more recognition to abortion practices. Spreading awareness can result in removing social stigma because the practice will attain more of a normalized stature in society. Ensuring safe abortions is the responsibility of the healthcare providers. It may not be their responsibility to hold the law accountable and penalize unsafe abortions but their duties do include the provision of services in such a manner that they guarantee the safety of the woman undergoing the procedure. Making healthcare accessible is one of the primary roles of providers. Social and economic factors should not infringe on matters of health. Adequate knowledge needs to be provided to young doctors along with sensitivity training to equip them to deal with patients in an appropriate manner. Therefore, healthcare providers need to play an active role in making abortions safer and more accessible to weaker sections of society while spreading awareness about the practices that can be adopted.

Proposed Reforms to Improve Access to Safe Abortion Services:

Different countries require different social reforms based on their individual problems. In India, the primary problems seen are in terms of lack of accessibility to safe abortion measures, the laws serving as more of a barrier or restriction to safe abortions and inadequate awareness about what is actually required of people under the law.

[66] Gloria Maira et. al., 'Abortion in Chile: The Long Road to Legalization and its Slow Implementation' (2019) 21(2) Health and Human Rights <https://pubmed.ncbi.nlm.nih.gov/31885442/> accessed 18 June 2024

Improving accessibility in both rural and urban areas is crucial. Legislators and policymakers need to address the issues posed by the laws in place by reforming laws wherever necessary and understanding public opinions to comprehend the issues faced by the people at the grassroots due to the laws in place. The laws are in place to protect the people however in case of abortions, it is seen that the laws are pushing people towards unsafe and illegal practices because of the compliances that need to be ensured.

Social taboo is a major factor in India that needs to be addressed. Since the practice is considered immoral and unethical due to various religious and cultural beliefs, it is more of a taboo than an accepted practice. More discussion in rural areas can help the cause. Additionally, NGOs and other welfare organisations can enable the spreading of knowledge of safe practices. To ensure comfort in the accuracy of the information, medical professionals can provide sexual education. Camps can be conducted in various areas of the country to provide safe access to abortion services. The practice needs to be normalized which can be done using policies. If the law is restrictive of practice, it justifies the social taboo behind it. The restrictions at present in India are only catering to social and ethical issues and are not backed by medical reasoning since with the development of medical science, medical reasoning is now invalid and cannot support legal restrictions behind the practice.

Internationally, the following WHO guidelines can help countries make abortions safer and more accessible to people and can help normalize the practice. The normalization of abortions needs to start with the laws in order to remove the social stigma behind it. Efforts to advocate for legal reforms can have a significant impact only if they receive support from powerful social movements. The bright prospect of a robust intersectional movement in the future gives us hope, as it will question the punitive stance on abortion and promote an anti-caste feminist viewpoint on reproductive justice.

CONCLUSION

The findings of the paper show that laws need to be updated regularly in order to remove social stigmas wherever necessary. The simplicity and irrefutability of what makes abortion safe is its availability upon the woman's request and universal affordability and accessibility. Looking at

it from this angle, existing laws hardly serve their purpose but instead just reiterate various restrictions in every possible way.

The aim of this paper was not to provide a simple outline of the policies in India but to highlight the shortcomings and areas of improvement for policymakers and healthcare providers. By comparing international policies and guidelines given by WHO, the intention is to provide a brief outline to understand where the policies are lacking both internationally and nationally.

Regarding abortion, recognizing it as essential healthcare represents significant progress. When it comes to national regulations, advocates may consider creating a straightforward and supportive law that prioritizes first-trimester abortion care at the primary and community level, guarantees second-trimester services, involves mid-level providers, raises awareness among women about available services and the law, strives for universal access, incorporates WHO-approved methods, and works to address social attitudes in order to decrease opposition.

In order to achieve these goals, or something close to them, it takes a strong and active national coalition, a critical mass of support, and a strong, integrated, united front because it not only requires the amendment of laws but the removal of social stigma, cultural and religious barriers is also paramount to attaining true acceptance of the practice and ensuring the normalization of the practice.