Aborting Gender Justice: Legislating Abortion in Selected Countries of South Asia - A Preliminary Analysis

Dissertation submitted to the Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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CERTIFICATE

This is to certify that the dissertation titled **"Aborting Gender Justice: Legislating Abortion in Selected Countries of South Asia- A Preliminary Analysis"** submitted by **Arathi P. M.** in partial fulfilment of the requirements for the award of the degree of **Master of Philosophy** of this University is her original work according to the best of our knowledge and may be placed before the examiners for evaluation.

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Abbreviations

AAPI	:	Abortion Assessment Project of India
AGI	:	Alan Guttmacher Institute
ANMs	:	Auxiliary Nurse Midwives
BSF	:	Bangladesh Fertility Survey
CAT	:	The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment
CEDAW	:	The Convention on Elimination of all the Forms of Discrimination against Women
CEHAT	:	Centre for Enquiry into Health and Allied Themes
CERD	:	The Convention on the Elimination of all the forms of Racial Discrimination
CFPB	:	Central Family Planning Bureau
CMO	:	Chief Medical Officer
CORT	:	Centre for Operational Research and Training
CRC	:	The Convention on Rights of Child
CRLP	:	The Centre for Reproductive Law and Policy
CrPC	:	Code of Criminal Procedure
DHS	:	Director of Health Service
DLC	:	District Level Committee
FPAI	:	Family Planning Association of India
FPASL	:	Family Planning Association of Sri Lanka
FWLD	:	Forum for Women, Law and Development
GDP	:	Gross Domestic Product
GOI	:	Government of India
HW	:	Health Watch

ICCPR	:	The International Covenant on Civil and Political Rights
ICESCR	:	The International Covenant of Economic, Social and Cultura Rights
ICPD	:	International Conference on Population and Development
ICRW	:	International Centre for Research on Women
IEC	:	Information, Education, Communication
IIPS	:	International Institute for Population Services
IPC	:	Indian Penal Code
IUSSP	:	International Union for the Scientific Study in Population
MCH	:	Maternal and Child Health
MOHFW	:	Ministry of Health and Family Welfare
MRs	:	Menstrual Regulations
MTP	:	Medical Termination of Pregnancy
MTPA	:	Medical Termination of Pregnancy Act
NCMH	:	National Commission on Macroeconomics and Health
NESAC	:	Nepal South Asia Centre
NGO	:	Non-Governmental Organisation
PHC	:	Public Health Centre
PNDTA	:	Prenatal Diagnostic Technique (Regulation and Prevention o Misuse) Act
POA	:	The Cairo Programme of Action
RCH	:	Reproductive and Child Health Programme
RMP	:	Registered Medical Practitioner
UDHR	:	Universal Declaration of Human Rights
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Family Planning Association
USA	:	United States of America

USSR	:	Union of Soviet Socialist Republic
WHO	:	World Health Organisation

Introduction

Over the last more than hundred and fifty years, women in different parts of the world have launched powerful movements to reverse centuries of discrimination and injustice. Over different periods and in different countries, they have raised different issues, but overall their struggles have been against violence and oppression, demanding equal rights, greater opportunities for development, equitable law and control over their earning and bodies. The movements in the west working towards access to abortion also raised similar political concerns. The abortion debate that was originally articulated in terms of right to privacy and medical safety has of late shifted to waging a political struggle from the vantage point of women's right to control her own body. Thus the women's movements in connection with right to abortion fight for women's choice in deciding when and if to bear a child.

Feminists differ in their views on law. Some feminist groups perceive law as an instrument in the hands of ruling classes, primarily male, used to oppress and exploit women in a society with unequal power relationships. The other view is that in a democratic society law can be used as a tool for social change in order to improve the social status of women and to fight against discriminations experienced by them. Thus by using law, the political and social embeddedness of women in a patriarchal society can be altered. However, the persisting question is about whose interest being protected by the instrumentality of law in a bourgeois democratic set up. The feminist interpreters of law look at the content and the level of implementation of law critically and highlight the gender bias of the text as well as the practice of the law. This study on abortion law in selected countries of South Asia becomes relevant in this context. The gender politics of existing abortion laws in selected countries in South Asia will be analysed to understand the impact of these laws on the health status of women. The present study thus explores the gender-biased nature of these laws in the level of formation, contents and practice.

1. Statement of the Problem

The most important single determinant of abortion's impact on women's health appears to be its legal status. All the policy documents of United Nations and studies conducted by the US institutions echoed this perspective. Where abortion is legal, physicians can learn procedures from medical colleges and the equipments for

the abortion procedures can be manufactured and obtained openly. There is ample liberty to the providers and there is no need to conceal their activities and in case of complications, they can refer the cases to higher-level hospitals in order to provide better care to patients. Better accessibility is also attributed to the legality of abortion. Legality does not guarantee that every woman can obtain a procedure of good quality. The Indian situation is a typical example: here the public health system is not able to accommodate the demand for services. In sub-Saharan Africa also abortion is legal, but due to poverty enough services could not be provided in the public health system.

The World Health Organisation (WHO) uses legality as its sole criterion for classifying abortion as either safe or unsafe. The estimation of unsafe abortion is based on this classification. However, this is a generalisation with very limited scope as some illegal abortions are relatively safe. In the case of Sri Lanka and Latin American countries (until very recently) abortion is illegal unless performed to protect the life of the mother, but abortion-related mortality and morbidity is very low in these countries compared to those having liberal abortion laws. Therefore, the relationship between legality of abortion and the accessibility, availability, affordability and quality of abortion services need to be examined.

A review of the available literature on the relationship between legality and safety of abortion shows that such a linear relationship exists between legality and the safety of abortion. The studies conducted by WHO, the United Nations Family Planning Association (UNFPA), International Union for the Scientific Study in Population (IUSSP) and the Population Council establish this relationship without challenging the categorisation of WHO on legality[1]. However, all these studies are silent on other aspects of life which serve as prerequisites for the exercise of abortion rights. The studies conducted by the Alan Guttmacher Institute (AGI) also use the WHO standards and establishes the impact of legality on the health status of women[2]. All these studies have tried to establish the link between legality and abortion rates, but failed to understand the impact of legality on abortion-related

[1] WHO et al. 1999. *Health Care System in Transition in Russia.* New York: European Observation on Health Care System. http://www.who.org, accessed on 28.5.2007; WHO 2004. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion.* Geneva: WHO.

[2] Alan Guttmacher Institute 1999. *Dilemma and Decisions: Unintended Pregnancy and Abortion Worldwide.* New York; Rebecca Cook et al. 2003. *Reproductive Health and Human Right.* AGI: Washington; Ina K. Warriner and Iqbal H. Shah (eds) 2006. *Preventing Unsafe Abortion and Its Consequences.* New York: Guttmacher Institute.

mortality and morbidity rates.

The AGI categorises abortion laws worldwide as of liberal, restrictive and very restrictive nature based on the provisions contained in concerned laws and categorises countries accordingly. However, these studies do not link the impact of the nature of abortion laws on the health status of women. There are very few studies not funded and executed by international agencies and institutes and these studies visibly deviate from the mainstream discourse on abortion rights. The works of Rosalind Petchesky, for instance, look at the deeper causes of abortion seeking behaviour and how the socioeconomic inequalities contribute to it[3]. In her view, legal rights are meaningless in a society were unequal power relationships exist. For her, accessibility, availability, affordability and quality of abortion services in a patriarchal society are influenced by the larger politics of sexuality. Her research unravels the complexities of the abortion discourse and further extends the need for geopolitical studies on the issue of the legality and safety of abortion.

Unsafe abortion invokes particular concern in regions where abortion is highly restricted or where the access to safe abortion service is weak. Access to abortion in the South Asian region varies and diverse laws and policies exist in this region. Three-fourth of the total number of abortions in South Asia is legally restricted. The mortality and morbidity arising out of unsafe abortions are high in this region. Therefore it is important to enquire whether the legality of abortion has an impact on accessibility, availability, affordability and quality of abortion services in this region. The researches on abortion legislation in the South Asian context are predominantly qualitative in nature and largely draw on micro level field studies. There do not appear to be many studies available on the analysis of law across the countries of the region. The available studies are based on the human right perspective on abortion and primarily on the health status of women, especially Maternal Mortality. A perusal of these studies shows that majority of them highlight the lack of awareness of law of the public as the reason behind the failure of legal measures. These studies fail to go beyond the limit set by international agencies and institutions.

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[3] Rosalind Pollack Patchesky 1986. *Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom.* New York and London: Longman; Rosalind Pollack Patchesky and Karen Judd (eds) 2001. *Negotiating Reproductive Rights: Women's Perspective across Countries and Cultures.* London: Zed Books.

In India most of the literature on abortion has been generated by the research conducted by the Centre for Enquiry into Health and Allied Themes (CEHAT) as part of the Abortion Assessment Project of India designed in collaboration with the Ministry of Health and Family Welfare (MOHFW) and funded jointly by the Ford foundation, the Rockefeller foundation and the McArthur foundation[4]. All these studies employ the language and theoretical tools of the liberal framework and rely on the same parameters of WHO and other international agencies.

As mentioned earlier, most of the contemporary studies are micro level analyses of the perspective of the providers (healthcare institutions) and beneficiaries (women who seek abortion services). These studies analyse at micro level the socio economic background of abortion seekers and their awareness of law. All these qualitative studies consider women as objects of the study and consider them only as beneficiaries of laws and policies. These studies are totally silent on the context in which abortion laws are formulated and the influence of the politics of population control on South Asian countries and its impact on the health of the women in the region. This silence clearly indicates that the abortion discourse is governed by the politics of funding. The dearth of macro level studies on abortion is due to this factor. The attempt of the funding agencies is to hide the global politics of population control and its linkages with the regional governments in South Asia. It can be seen that macro level studies are essential to bring out these hidden connections that shapes the abortion discourse in the region.

The present study is a preliminary analysis of the abortion laws in South Asia. By examining the politics behind the formation and implementation of abortion laws, the study attempts to understand how the abortion law is used as a tool for fertility control in South Asian region and how the South Asian women turn to be victims of the population control policies as a consequence of this. As part of the understanding of the wider politics of abortion law, the study also examines the role of different actors in the legal discourse on abortion with special emphasis on international legal instruments, national governments, women's groups/NGOs and women's movements and religions.

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[4] See for example, Siddhivinayak Hirve 2004. *Abortion Policy in India: Lacunae and Future Challenges*. Mumbai: HW, CEHAT and AAPI; Swati Ghosh 2004. *'Professional' Abortion Seekers: The Sex Workers of Calcutta*. Mumbai: AAPI, HW and CEHAT; Lindsay Barnes 2004. *Abortion Option for Rural Women: Case Studies from the Village of Bokaro District, Jharkhand*. Mumbai: AAPI, HW and CEHAT.

The study views abortion legislation as a political process while situating it in the feminist discourse on legality, women's bodily autonomy and control over sexuality. The feminist debate on body, sexuality and legality is a complex one with diverse standpoints and theoretical streams. Therefore in the next section the major theoretical perspectives within the feminist discourse on body, sexuality and legality will be briefly discussed in order to emphasise the feminist standpoint the present study subscribes to.

2. Theoretical Perspectives on Right to Abortion

The campaign for abortion rights could be described as 'almost the definitive issue of contemporary feminism' in mid-1980s in the west[5]. This campaign is an ongoing one that unites feminists under the perspective that women have the right to control their own body. Different feminist groups who hold different theoretical positions varying from liberal to radical agree that abortion should be available to those women who are in need of it and who seek it. The feminist position on abortion rights has changed, widening its scope over time. The earlier perspective of 'abortion on demand' has been replaced by the broader slogan of 'reproductive rights' or 'women's right to choose', and now rejecting both these, the call for reproductive justice[6]. The theoretical disputes are based on the point whether free choice is possible in a patriarchal, capitalist society.

Liberal feminists have used liberal principles to claim reproductive rights for women on the ground that these rights make the necessary precondition for self-determination and autonomy. The liberal feminists view reproductive right as an essential prerequisite for women to compete with men in the labour market[7]. According to liberal theory, adult citizens have rights because they are intelligent beings and are capable of making rational decisions[8]. This is extended to the reproductive right argument that individuals are entitled to do what they want with their own bodies and live their lives free from unnecessary state interventions[9]. Any attempt to prevent or prohibit this, for the proponents of liberal feminism, is the violation of right to privacy and freedom. However, this position is problematic

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[5] Valerve Bryson 1999. *Feminist Debates, Issues of Theory and Political Practice*. London: McMillan.
[6] Ibid.
[7] Ibid.
[8] M.Warrenn 1991. "On the Moral and Legal Status of Abortion", in J. White (ed.). *Contemporary Moral Problems*. Minneapolis: West Publishing Company.
[9] Ibid.

because women are considered as individuals with absolute freedom and the society in which they are living is not at all a matter of concern for liberalists. Women are considered as a homogeneous group with equal opportunities and equal social status.

Socialist feminists critique the liberal feminist point of view. Socialist feminism also has demanded reproductive rights, particularly the right to abortion. However, socialists agree that women are entitled to make their own reproductive decisions. Their theoretical position is different from liberal perspective because they have placed more emphasis on the context within which rights are exercised. For them reproductive rights are embedded in the wider network of social rights and responsibilities[10]. Generally, socialist feminists argue that legal rights are meaningless if economic and social circumstances prevent women from exercising them. Rosalind Petchesky's argument is important in this regard. She contends that the access to abortion is necessary for women, which should be provided as a 'social good' along with education and health care[11].

The Disabled feminists have further argued that reproductive choice need to be exercised by all women, irrespective of their disability. The compulsory sterilisation and abortion performed on disabled women is based on the assumption that disability is an automatic ground for medical interventions in order to prevent more disabled from being born. In other words, the fascist agenda of eugenics is challenged by this group[12].

The Marxist feminists have developed the concept of social reproduction. The argument that underlies this concept is that the conditions in which people reproduce is an important part of the material basis of society[13]. According to this perspective, women are enabled to control their own fertility as part of wider human struggle to use technology to increase human freedoms. Therefore, for Marxist feminists, developments in contraceptive and reproductive technologies are potentially liberative for women. The Marxists argue that a genuine 'right to choose' will therefore only be accomplished in the context of more radical social and economic change.

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[10] S. Shaver 1993. Body Rights, Social Rights and the Liberal Welfare State. *Critical Social Policy*, 39; R. Lister, 1997. *Citizenship: Feminist Perspectives*. Basingstoke: MacMillan.
[11] Rosalind Petchesky 1990. *Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom*. Boston: Northeastern University Press.
[12] Bryson 1999, op cit.
[13] Ibid.

The Radical feminist argument links patriarchy with control of reproduction. They also reject the reduction of the concept of reproductive rights to an individualistic frame and argue that the context in which rights are exercised is important. The 'context', for radical feminists, is that of men's patriarchal control over women's bodies. Here the perspective is that the reproductive choice is not a private and individual choice but a collective demand by women that raises a basic challenge to patriarchy. Thus the radical feminism also holds the position on legal rights as of socialist feminism that legal rights are meaningless if it is isolated from wider social transformation. Radical feminists generally agree with socialist feminists that abortion must be affordable as well as legal. However all radical feminists do not hold this general view. For instance, Catherine MacKinnon argues that in a patriarchal society the increased accessibility of contraceptives and abortion ultimately serves men's interests by increasing sexual availability of women[14]. In a patriarchal society, according to some radical feminists, it is virtually impossible for women to have sexual relationship based on mutual consent and wishes. Thus the right to refuse sex is basic to the struggle for reproductive freedom[15]. The radical feminists attempt to blend the arguments of right to abortion and freedom from coercive sexuality in the context of abortion legislation.

The radical feminist view of reproductive technology rejects the idea that women's 'right to choose' can be realised by using sophisticated technologies[16]. Many of the radical feminists believe that technology is being used to control rather than to liberate women. For them, the new technologies are a masculine weapon used against women in order to maintain the patriarchal social order[17].

The Postmodern approach in feminism rejects in principle the objectivity and certainty of human knowledge and challenges the idea of absolute, unchanging and universal rights. The postmodern feminists emphasise the diversity and specificity of human experiences. As far as reproduction is concerned, the postmodernists opine that women have no general rights as there is no unified experience and needs equally applicable to all women in the world. Therefore the postmodern feminists are

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[14] Catherine MacKinnon 1989. "Sexuality, Pornography and Method: Pleasure under Patriarchy", *Ethics* 99(2): 17-26.
[15] Ibid.
[16] Jyotsna Agnihotri Gupta 2000. *New Reproductive Technologies, Women's Health and Autonomy: Freedom or Dependency?* New Delhi: Sage Publications.
[17] Bryson 1999, op cit

sceptical of the feminist approach to women's rights as a homogenous and universal category and advise feminists to take utmost care in dealing with the rights question[18]. The queer sexuality movement also is sceptical of the hetero-normative understanding of the feminists.

Despite all these contending theoretical perspectives, the public debate on legality and morality of abortion continue to be largely fixed by the 'common sense' liberal assumptions about individual rights[19]. Although different feminist schools use terms such as right to choose, reproductive autonomy etc. with specific connotations, all these differences get conflated into the liberal feminist perspective in popular parlance. The ambiguity regarding the language of abortion discourse has been reflected in or being effectively used by the international legal instruments to erase out the diversity of positions in order to legitimise the liberal argument as the sole perspective. The policy documents of UN agencies and US institutions also share the same liberal theoretical perspective.

The debate on abortion right always revolves around the moot point of women's right versus foetal rights. The ethical question being raised here is whether women have got an absolute right over her body. The language of liberal reproductive rights automatically generates counter claims by opponents of abortion that women's right to choose clashes with the claims of potential fathers and with the right to life of the foetus. In the United State this right is part of political debates and influences even the Presidential election and other political appointments. The scope of the right to abortion debate in US – which is not discussed in this dissertation – is however largely limited to pro-choice and pro-life arguments.

The theoretical understanding of the issue of abortion rights indicates the complexity of the issue. The issue of legality of abortion and its impact on the health of women cannot be resolved in isolation from other aspects of life including socio-political, economic, and cultural contexts. The present study attempts to understand the complexities of abortion discourse in the larger political framework and tries to link it with the public health understanding of the legality of abortion and its impact on women's health.

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[18] Ibid.
[19] Ibid: 160.

3. Objectives of the Study

The broad objective of the study is to analyse the role and nature of the abortion law in guaranteeing safe abortion services to women and its impact on abortion related maternal mortality and morbidity.

The specific objectives are:

1. to understand the impact of legality on accessibility, availability, affordability and quality of abortion services in India, Sri Lanka, Nepal and Bangladesh.
2. to understand the nature of abortion laws in the context of population control policies.
3. to analyse the role of religion in the formation, implementation and practice of abortion laws.
4. to examine the role of international legal instruments, UN agencies and US institutions in the formation and implementation of legislation in the countries under study.
5. to understand the role of the state and the judiciary in the shaping of abortion law in the countries under study.
6. to assess the role of women's movements and gender politics in abortion discourses globally and in the context of these countries.

4. Methodology

For a preliminary analysis of abortion legislation in South Asia, the present study examines the abortion legislation in four countries in the region. The countries selected for the study are India, Sri Lanka, Nepal and Bangladesh. The study will attempt to understand the legal provisions which allow abortion and the quality of the services available in these countries. The study also looks at how, if it does legality facilitates accessibility, affordability and availability of abortion services in these countries. These countries in South Asia have been selected due to several reasons. The nature of abortion law that exists in these countries varies significantly from restrictive to liberal. Prior to the enactment of new law or legal reforms, all these countries had almost similar provisions of law as far as abortion is concerned. India, Sri Lanka and Bangladesh were governed by IPC 1860 and Nepal by Country Code of 1853 and all these countries share a common colonial past.

In India, the abortion law was liberalised in 1971 in order to address abortion related maternal mortality and morbidity. India has a comparatively liberal abortion law. However, the impact of this law on the health status of women is negligible and abortion-related mortality and morbidity still continues as a major concern for public health. India is the largest democratic country in the world and it is secular by constitution. The role of medical fraternity in shaping the law is a unique feature of India. The abortion provisioning in India is carried out through public health system but it fails to cope with the demand for services due to lack of adequate funding in public health sector. Pertly as a result of this, the majority of abortion continued to be performed illegally. Sri Lanka is unique in terms of its high Human Development Indicators and the status of women. The country is famous for its robust Public Health System. Irrespective of the existence of a restrictive abortion law and the failure in implementing liberal legal reforms, Sri Lanka experiences less maternal mortality and morbidity as far as abortion issue is concerned. The existence of an active pro-life movement patronised by the Catholic Church in the country hinders the road to liberal legal reforms despite the Government, international agencies and women's groups together working for it. Nepal was a country with the most rigid abortion law in entire South Asia. Defined hitherto as a Hindu nation, Nepal has recently entered the path of democratisation after the ruling monarchy was brought down by the political movement led by people's parties. As part of the democratisation process, gender discriminatory provisions of the Country Code as well as abortion-related provisions have been amended. Now Nepal has abortion provisions almost similar to that of India. Prior to the enactment of the new law in 2002, women were imprisoned for seeking abortion. Now also the campaign for the release of women from the jail is part of the reproductive rights movement in the country. The existence of different ethnicities and the regional variations have a crucial impact on abortion provisioning in Nepal. Bangladesh is an Islamic country where rigid population control policies have been implemented as part of the neo-Malthusian politics of US-led institutions which consider 'population explosion' the cause of the poverty of the Third World countries. In Bangladesh, first trimester termination is allowed in the name of menstrual regulation and the Government policy documents prescribe abortion as a tool for fertility control. Bangladesh's experience is unique as far as the movement for liberalisation of abortion law is concerned, as it is the Government of a predominantly Muslim country that takes initiative for this.

The present study identifies the major stakeholders and actors in the legalisation of abortion discourse in the South Asian context: the political interest of each of them is assessed in order to understand their role in shaping the process of decision-making. The role of international legal instruments, agencies of UN, US institutions and funding agencies, women's movements and groups, NGOs, religious groups and the state governments in the process will be evaluated.

The study looks at the concerned provisions in IPC, the recommendations of the Committee which study the question of legalisation of abortion, the Medical Termination of Pregnancy Act (MTPA) 1971 and its amendments and Prenatal Diagnostic Technique (Regulation and Prevention of Misuse) Act (PNDTA) for the analysis of the Indian context. The legal documents are important to understand the characteristics and functioning of the abortion law in India. The qualitative studies conducted by Population Council, CEHAT, Health Watch and the Centre for Operational Research and Training (CORT) also have been used to understand the abortion-related ground realities in India. For abortion related statistics of India, the database of MOHFW and Registrar General of India have been relied on. In the case of Sri Lanka, the annual reports and demographic surveys undertaken by the Family Health Bureau as well as the statistics of WHO and AGI are utilised. The studies of the Centre for Reproductive Law and Policy (CRLP) and the Forum for Women, Law and Development (FWLD) are mainly depended on to understand the nature of abortion laws in Nepal as well as to understand the process of liberalisation of abortion laws in the country. The websites of different NGOs working for the cause of women's health also have been reviewed to understand the complexity of abortion issue in the context of Nepal. The websites of AGI and United Nations Development Programme (UNDP) were accessed for the relevant abortion statistics on Nepal. The constitution of Nepal is reviewed to understand the current democratisation process in the country as it is helpful in mapping the impact of the political process on the abortion law of the country. In order to capture the scenario of abortion legislation in Bangladesh, the present study looks at the demographic surveys conducted by the Bangladesh Government and the websites of legal organisations, institutions such as the UNDP, UNFPA, Population Council and WHO. To understand the status of women and the rigorous implementation of population control policies in Bangladesh, the study mainly relies on secondary literature. Personal interviews were conducted

with experts in the field of law and feminist activists who specialise on issues related to the health of women to get a clearer picture of the dynamics of abortion discourse in South Asian context.

The study mainly relied on the data from WHO. Even though we are challenging the categorisation of WHO on legality and incidence of abortion, the study relies on the same data for analysis, as no alternate database is available at macro level. The global estimation of abortion ratio and abortion rate does not apply equally to all women, because the experience of women varies in different societies. The moral stigma attached with the issue of abortion resulted in under-reporting in societies where abortion is not socially acceptable. All the countries in this study face the problem of under-reporting. Although the present study critiques the politics of the demographic surveys carried out in the third world countries, the same have been utilised for capturing the reproductive behaviour of women in the countries in this study, as alternate surveys are not available. However the present study attempts to overcome this problem by critically evaluating the data sources and surveys with the aid of secondary literature.

5. Chapterisation

The first chapter of the study looks at the global politics of abortion laws. The ongoing debate in US the Supreme Court decision in *Roe* v. *Wade*[20] and how the discourse in US shapes the decisions of funding agencies and the abortion laws in the developing countries is discussed in this chapter. The role of judiciary in interpreting abortion laws and their limited role in safeguarding the procreative autonomy of women also will be examined. This chapter presents a historical analysis of how religion influences the legality of abortion and discusses the role of Catholic Church and Islamic theology in this context. The abortion law in erstwhile Soviet Union and the socialist model of abortion law also are discussed. The role of international legal instruments and the politics of reproductive rights in the context of Cairo conference and its impact on gender justice are also discussed in the chapter.

The second chapter is on the abortion law in India. This chapter examines the provision in IPC 1860; the law existed prior to the enactment of the Medical Termination of Pregnancy Act, 1971 (MPTPA). This chapter looks at the historical

[20] 410 U.S. 113 (1973).

context in which the liberal abortion law came into existence in India and the provisions contained in the Act in detail. This is an evaluation of the Act's impact on accessibility, availability, affordability and quality of the abortion services. The chapter also deals with the role of judiciary and the state in shaping abortion rights.

The third chapter is the discussion on abortion laws in Sri Lanka, Nepal and Bangladesh. The chapter examines the role of international institutions and their nexus with the US institutions and funding agencies in the context of population policies and how this nexus intervenes in the domestic policy making of the third world countries. The role of women's groups and their NGOised nature also is discussed in this context to capture the gender politics in South Asia.

By drawing lessons from South Asia, in the 'Conclusions', certain suggestions are forwarded to strengthen Indian law in order to enable it to take into consideration the needs and experiences of women towards a gender sensitive abortion legislation.

6. Conclusion

The present study is a preliminary analysis of abortion laws and the process of legalisation in selected countries of South Asia. We are peeking into issues and problems, not delving into them with great detail. The study does not look at the experience of women in the process of terminating their pregnancy and the question of how they perceive the entire process is beyond its scope. Neither does this study go into the socio-demographic characteristics of abortion seekers. In the context of India, the study does not address the role of caste in the abortion discourse. Although we are looking at the role of international agencies and US institutions in shaping the domestic abortion laws in the South Asian region, the study does not attempt to understand the role of national elites in this regard.

The public health impact of abortion law is of contemporary significance in the South Asian context where abortion related mortality and morbidity is still an issue of concern. The present study attempts to capture the dynamics of the relationship between legality and safety of abortion. As a macro level analysis of the politics of legalisation of abortion, the present study explores the role of different actors in shaping abortion discourse in the context of public health debates.

Chapter I
Framing Abortion Laws

It is estimated that around fifty million abortions are performed each year throughout the world, of these 19 million are taken to be unsafe[1]. The World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or being carried out in an environment that lacks minimal medical standards, or both[2]. It has been estimated that 68,000 women die across the world every year as a consequence of unsafe abortions[3]. Overtime, it has become an important issue in public health discourse.

Some studies demonstrate the link between safety of abortion and legality. It is often seen that if there is no legal restriction, abortion services tend to be safe. In other words, where abortion laws are highly restrictive, women turn to clandestine providers with a high risk of complication[4] . But of course there is no straightforward relationship between legality and safety. There are significant exceptions to the relation between legality of abortions and safety of service provisioning[5]. The study by B. Ganatra *et al.*[6] reveals the fact that in India (where abortions were legalised in 1971), a significant number of abortions take place in unauthorised settings but abortion service is provided free of cost in government authorised clinics despite the fact that the quality of service provided by the government sector as well as problems regarding accessibility of service is forcing women to seek the aid of illegal providers.

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[1] Ahman E. Shah 2002. 'Unsafe Abortion: Worldwide Estimates for 2000', *Reproductive Health Matters*, 10 (19): 13-17. See the introduction for the definition of unsafe abortion.

[2] World Health Organisation 2004. www.who.int/reproductivehealth/publications/unsafe-abortion-estimates-04/estimates.pdf, accessed on 18.11.2006.

[3] WHO 2004. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion.* Geneva: WHO.

[4] Ina K. Warriner 2006. 'Unsafe Abortion: An Overview of Priorities and Needs', in Ina K. Warriner and Iqbal H. Shah (eds). *Preventing Unsafe Abortion and Its Consequences*, pp. 1-14, New York: Guttmacher Institute.

[5] For example, contemporary Indian context reveals that illegal abortions are not necessarily unsafe and vice-versa. For detailed discussion, see chapter 3.

[6] Ganatra B., Johnson H. B. 2002. 'Reducing Abortion-Related mortality in South-Asia: A Review of Constraints and Road Map for Change', *Journal of the American Medical Women's Associations* 57(3):159-164.

Another important outcome of restricted abortions is the emergence of private sector providers[7]. Since the economic restructuring as part of the ongoing neo-liberal reforms, the expenditure on public health is reduced starkly in the developing countries. This has had an adverse impact on abortion provisioning. The private sector providers charged more compared to public health providers. It raises the issue of affordability of such services as only women from higher income group can access the private service which is generally costly.

Thus social inequalities are an important determinant of access to safe abortion care, regardless of the legality of the procedure. There are studies conducted in Nigeria[8] and South and South-East Asia[9], revealing the causes and consequences of differential access to safe abortion. Women from marginalised populations such as poor, blacks and religious and ethnic minorities are facing additional barriers in accessing abortion care.

It is nevertheless clear that to some extent the legality and provision of safe abortion services have given woman the choice of termination of pregnancy and the right to make decisions about her own body. The human rights framework that emerged in the late 1960s played a crucial role globally in ensuring these rights and contributed immensely in liberalising the abortion laws of various countries[10]. The framework ensures the right to be free from inhuman and degrading treatment, the right to equal protection by law, the right to liberty and security of persons, and the right to health and non-discrimination on the grounds of sex and race. The scope of human right framework in the area of unsafe abortion is extensive. Rebecca J. Cook who works from within the human rights framework argues that the laws, policies or practices which are obstructing the availability or accessibility of family planning services need to be reformed to comply with human rights principles[11].

The human rights framework is the dominant and the most widely used perspective in legal paradigm. However the problem with this framework is its failure

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[7] Berer M. 2000. 'Making Abortion Safe: A Matter of Good Public Health Policy and Practice', *Bulletin of the World Health Organisation*, 78(5): 580-592.
[8] Makinwa-Aderbusoye P., Singh S. and Audam S. 1997. 'Nigerian Health Professionals' Perceptions about Abortion Practice', *International Family Planning Perspectives*, 23(4):155-161.
[9] Singh S., Wulf D. and Janes H. 1997. 'Health Professionals Perceptions about Abortion in South, Central and South-East Asia', *International Family Planning Perspectives*, 23(2):59-67.
[10] Rebecca J. Cook 2006. 'Abortion, Human Rights and International Convention on Population and Development, ICPD' in Warriner and Shah, op cit.
[11] Ibid.

in addressing the complex link between abortion rights and the social structure. By understanding these limitations, this chapter attempts to examine the abortion laws to identify how these laws, policies or practices facilitate or restrict the availability and accessibility to abortion care at the level of the health service system. The chapter will also endeavour to understand the underlying social and economic factors and processes which condition safe abortion care. In this chapter, we would be examining the nature of abortion laws in different countries with the understanding of law as a social construct[12]. Here the theoretical assumption is that law is not neutral in nature and that the existing power relationships in society crucially shape the content and working of law. The state is always uses law as a tool to control sexuality of women. And this analysis of law is based on the perspective that we live in a patriarchal society, in which control over women's body is central in maintaining the social system[13]. This chapter situates abortion politics also in the wider political context of the separation of church and the state in Europe in the seventeenth and eighteenth centuries[14]. The first part of the chapter looks at the politics of abortion laws, with an emphasis on the debates in USA. The last presidential election in US indicated that the abortion issue will continue to dominate reproductive and sexual politics worldwide. In this section the political and legal debate on abortion in USA in the light of the US Supreme Court verdict on the *Roe* v. *Wade* case will be discussed[15].

The second part of the chapter deals with the role of religion in shaping abortion laws. In the first section we will see how the abortion laws were shaped in Catholic and Islamic countries. It explores the complexities and varieties of Islamic opinion on abortion. This has been reflected in the fact that the abortion laws of predominantly Islamic nations vary considerably. The emphasis here is that there is no homogeneity exists among Islamic countries in their laws on abortion. The second section is an evaluation of the abortion laws of erstwhile socialist countries in the wake of legal reforms undertaken in these countries after the dissolution of "actually existing socialism". The contemporary status of abortion laws in these countries will also be reviewed.

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[12] Hilaire McCoubrey and Nigel D. White 1999. *Text-book on Jurisprudence*, New Delhi: Oxford University Press.

[13] Valerve Bryson 1999. 'Feminism and the Law', in idem. *Feminist Debates, Issues of Theory and Political Practice*, Bangalore: MacMillan, p. 82.

[14] Marlene Fried. 2006. 'The Politics of Abortion: A Note', *Indian Journal for Gender Studies*, 13 (12): 229-245.

[15] 410 U.S. 113 (1973).

Finally, the politics of reproductive health and the relevance of international legal instruments in terms of abortion will be discussed. This analysis is mainly based on the evolution of human rights documents on abortion, including that of the International Conference on Population and Development held at Cairo (ICPD, 1994).

1. Abortion Debate in the United States of America

> All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services.[16]

This is one of the major recommendations of the Cairo convention that establishes the responsibility of the government and non-governmental organisations in delivering abortion services and family planning services. But the Cairo Programme of Action (POA) is mild and to an extent is silent upon repressive laws that deny women's rights to seek abortion through trained and qualified practitioners in medically hygienic and safe circumstances[17].

The contemporary debates on Hyde Amendment[18] and ongoing discussion of *Roe* v. *Wade* indicates that in the US, the legality of abortion has become central to reproductive health discourse. The latest presidential election (2004) clearly indicated that the abortion issue will continue to dominate reproductive and sexual politics worldwide[19]. The core debate in the presidential election was on whether to revoke legality of abortion. As Marlene Fried observed, eighty percent of clinics that offer reproductive health services in the country have experienced violent attacks, while the emerging restrictive legislation on abortion has gone unchallenged[20]. The global tendency is towards liberalising abortion laws as a measure to improve maternal health, but the US discourse shows the opposite trend. The US Government is trying to influence international donor agencies to cut funds for research and for promotion of safe abortion services. In the name of ethical considerations, US Government

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[16] Paragraph 63 i of the *Programme of Action of ICPD*, 1994. http//:www.who.org, accessed on 18.05.2006.

[17] "In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should access to quality services for the management of complications arising from abortion". Ibid.

[18] The Hyde Amendment was passed in 1977 and is renewed every year. The amendment prohibits the use of Federal Medicaid Funds for abortion services, making it nearly impossible for thousands of low-income women to access safe abortions.

[19] Fried 2006, op cit.: 229.

[20] Ibid: 230.

slashed its funding to the UNFPA and other agencies that provide abortion services. This recommendation was introduced by Regan and it was partially revoked by Clinton and re-imposed by Bush the junior. These policy decisions of the US are driven by powerful pro-life stances and this is part of its strategic move to control the global politics of reproductive rights[21].

1.1. History of Abortion Law in US

It was only after the II World War that the restrictive laws began to be liberalised[22]. Although access to abortion had been a long-standing demand of the women's movement, the legalisation of abortion during this period was a response to wide-ranging social, economic and political movements of the period[23]. In most of the countries in the world until the nineteenth century, abortion was illegal. Since the early 1800s the religious and medical establishment together made efforts to ensure the regulation of abortion[24]. By 1868, laws restricting abortion came into force in almost all the US states. Lesley Doyal[25] and Rebecca Cook[26] perceive it as moulded by the project of imperialism; control over woman's body was part of this colonial project, along with increasing the power of imperial races[27]. Gradually the legal restrictions were imposed on other countries under colonial rule too.

In the United States, the politics of abortion has been radically shaped by the courts. The US Supreme Court's decision in 1973 to strike a balance between the protection of the health of women and protection of the potentiality of life of the foetus[28] triggered off a nation wide change in the legal status of abortion. The court's decision regarding abortion was an effort to effect social change through the exercise of judicial review. It has been argued that the Supreme Court's decision has played a major role in liberalising public attitudes. Public opinion surveys carried out just

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[21] Green, Ronald M. 2003. "U.S. Defunding of UNFPA: A Moral Analysis", *Kennedy Institute of Ethics Journal*, 13(4): 393-406.

[22] In most parts of Eastern Europe in the 1950s, in Western Europe, Canada, Australia and New Zealand in the 1960s and 1970s and in many parts of third world in the late 1970s and 1980s, laws allowing abortion on different grounds came into force.

[23] Lesley Doyal 1995. *What Makes Women Sick: Gender and the Political Economy of Health*, London: McMillan Press Ltd.

[24] The first penalties for abortion were enacted in UK in 1803 and in France through the Napoleonic code of 1810. See Ann Oakley 1986. *The Captured Womb: A History of Medieval Care of Pregnant Women*, Basil Blackwell: Oxford.

[25] Doyal 1995. Op cit.

[26] Cook 2006. Op cit.

[27] Lesley Doyal 1995, op cit. See also, David Arnold 1993. *Colonising the Body: State Medicine and Epidemic Disease in Nineteenth-Century India.* California: University of California Press.

[28] *Roe v. Wade*, 410 US 113 (1973).

before the verdict showed that public opinion had already became favourable to legal abortion[29]. In a way, the Supreme Court was reflecting social change, rather than leading it through legalisation.

1.2. Significance of *Roe v. Wade*

Roe v. *Wade*[30] was a test case for the times and registered an ongoing political struggle by women for equal rights and self-determination[31]. The right to privacy, which the court recognised in this case, no way assumes that all or even some women are genuinely free agents in sexual decisions. Therefore the court emphasised that women should have a constitutionally protected right to control the use of their own body[32]. The court concluded in *Roe* that there is a constitutional right of privacy, that the right is based on the due process clause, and that it is 'broad enough to encompass a woman's decision whether or not to terminate her pregnancy'[33]. The court asserted that women had a fundamental right to privacy to decide whether or not to bear a child. It established three things. First, it re-affirmed a pregnant women's constitutional right to pro-creative autonomy. Second, it recognised that states nevertheless do have legitimate interest in regulating abortion. Third, it constructed a detailed regime for balancing the right of the pregnant women and the interest of the state. It declared in a broad sense that the state may not forbid abortion for any reason in the first trimester of pregnancy[34]. The state can regulate abortion in the second trimester[35] only out of concern for health of the mother. Finally, the court directed that the state may not allow abortion when the foetus becomes a viable being in the third trimester of pregnancy[36]. The court in *Roe* was choosing not between alternatives of abortion and continued pregnancy, but alternative allocations of decision-making authority. The court transferred the role of decision maker from the government to the woman herself.

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[29] Lee P. R. and Mc Roy L. B. 1985. 'Abortion Politics and Public Policy' in Sachder Paul (ed.) *Perspectives on Abortion*, New Jersey: The Scarecrow Press, pp. 60-71. In USA, public opinion surveys have a crucial influence on court decisions.
[30] Hereafter *Roe*.
[31] It is profoundly ironic that 'Roe' is now a propagandist against abortion!
[32] Siegel Reva 1992. 'Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection', *Standard Law Review* 44, pp. 261-265.
[33] 410 U.S. 13 (1973), paragraph 8.
[34] That is, up to twelve weeks of pregnancy.
[35] That is, the first twenty-four weeks of pregnancy.
[36] That is, after twenty-four weeks of pregnancy.

The critiques of *Roe* shared the perspective that the ruling was based on the medical, physical and social science discourse of the period, because all these disciplines were not sensitive enough towards upholding the bodily autonomy of women. It was also critiqued that the court did not produce any significant social reform; it simply eased access to safe and legal abortion and put the abortion issue on the public agenda[37]. Luker has shown that although the Supreme Court decision had a major effect on the practice of abortion, it did very little to change the public attitudes[38]. However it was also suggested that unlike other privacy cases, *Roe* favoured the interest of woman by acknowledging her right to have control over her own body, or bodily integrity[39].

1.3. Judicial Interventions

Prior to *Roe*, anti-abortion laws were not constituently enforced against the women who could evade them by obtaining lawful abortions outside their own restrictive jurisdictions. After *Roe* v. *Wade*, different courts intervened in issues related to abortion at different levels. The discussion of important case laws is unavoidable in this context as they played significant role in shaping the politics of abortion laws. At the same time, feminist movements, mostly of the liberal tradition came to recognise the importance of abortion law reforms for women's individual freedom of choice and effective participation in the public sphere[40]. The issue of free choice in abortion appears to involve questions of change in the fundamental roles for women. This issue has generated intense moral, ethical, religious, ideological, legal and political debates in America. The case laws after *Roe*, led to the precipitation of public debate in America in favour of abortion rights of women.

There are case laws that challenged the provisions in the constitution in order to uphold the right to abortion. For example, in the year 1997, in *Maher v. Roe*[41] half the jury upheld a state regulation granting Medicaid for childbirth[42]. At the same time, they denied funding for non-therapeutic abortions[43]. The central question in this case

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[37] Luker Kristin 1984. *Abortion and the Politics of Motherhood, USA*. California: University of California Press.
[38] Ibid.
[39] Podell Janett 1990. *Abortion*. New York: H.W. Willson Co.
[40] Asoka Bandarage 1997. *Women, Population and Global Crisis: A Political Economic Analysis*. London: Zed Books.
[41] 432 U.S. 464 (1997).
[42] Medicaid is a popular healthcare insurance scheme in USA.
[43] Abortions those are not medically necessary.

is whether a regulation that impinges upon a fundamental right (right to bodily autonomy) is explicitly or implicitly protected by the constitution. In *Ouating San Antonio School Distrust v. Rodriguez*[44], again the court established the right to abortion as a fundamental right, and included a conditional clause, that nothing less than 'compelling state interest'[45] would justify difference of abortion and childbirth. Here the court tries to strike a balance between the interest of the state to protect potentiality of life and the interest of the women to terminate pregnancy. *Doe v. Bolton* [46] was a case contemporary to *Roe* and it invalidated an existing law by insisting that all first trimester abortions should be performed in a hospital. The court considered the aforementioned law as a hindrance to the exercise of right to abortion.

The court also intervened in policy matters connected with abortion funding. In the year 1980 in *Harris* v. *McRae*[47], a five to four decision of the court upheld the Hyde Amendment that prohibited the use of Federal Medicaid funds to perform abortions except where the life of the mother would be endangered if the foetus were carried to term, or except such medical procedures necessary for the victims of rape or incest. This is also a case involving the issue of funding of non-therapeutic abortions. A decision not to fund abortions is not a casual one, but a conscious attack on women's access to provisioning of abortion care. And from this viewpoint, the problem with the courts' reasoning in *Maher* and *Harris* is that it treated the pre-funding universe as the state of nature rather than a government choice to be evaluated in constitutional terms[48]. In practical terms it can be interpreted as follows: under the US constitution, Federal and State governments have no obligation to provide funds for abortion services, even though they pay for pre-natal and maternity care for poor women.

There is a spectrum of case laws connected with policies of funding. In USA, all medical procedures are funded by different medical aid schemes. So the inclusion or exclusion of certain services under these schemes is very crucial as far as the abortion provisioning is concerned. Different states, however, have shown a tendency

[44] Citation not available.
[45] Interest protecting the health of the pregnant women and protecting the potentiality of human life of the foetus.
[46] 410 U.S. 179 (1973).
[47] 448 U.S. 297 (1980).
[48] Latina Institute (NLIRH) 2006. http://www.nlirh@latinainstitute.org/hydeamnedment, accessed on 21/ 02/2007.

to make regulations in order to exclude abortion service from medical aid schemes. The validity of these laws is usually challenged in the courtrooms. For instance, when the Government refused to fund a public lecture on the relevance of abortion and maternal care, the decision was challenged in the court[49]. Here again the court took a position in favour of restricting abortion campaign and upheld the policy decisions of the Federal Government to cut down abortion funding as part of Hyde Amendment and thereby restrict the same. After *Roe*, there was no crucial change whatsoever in the attitude of the court in favour of women. Whenever there was a question of balancing the interests of women and that of the medical profession, the court tended to always support the medical establishment. In America, the medical profession is influenced by the dominant pro-life discourse. The ethical dilemma regarding abortion faced by the medical professionals always ended up in supporting the pro-life argument and the court generally supported their viewpoint. Such a professional bias of the court in favour of the medical hegemony can be traced in the cases of *Akron* v. *Akron Centre for Reproductive Health Inc.*[50] and *Thornburg* v. *American College of Obstetricians and Gynaecologists*[51]. It is clear from these cases that even after *Roe*, the attitude of the court did not change in favour of women. The nexus between judiciary and medical profession always influenced the judicial verdict. The medical practice in America prescribes counselling prior to abortion. This procedure involves communicating to patients the risk of abortion, the method used for terminating pregnancy, the contraceptive choices available in order to prevent unwanted pregnancy, the need for further medical check-ups and so on. However, in practice this has turned to be a campaign by the medical professionals on behalf of the pro-life movement. In the above-mentioned cases, the petitioner went to the court against the counselling given by the doctor restricting abortion. In both the cases, the court asserted that the government cannot interfere with a woman's right to make informed and voluntary choice by placing restrictions on doctor-patient dialogue. The history of the case laws in the US however shows that the approach of the court on the issue of abortion was not pro-women all the time.

The existing social and moral values were also challenged in the court. The issue of spousal consent was involved in *Planned Parenthood of Central Missouri* v.

[49] *Rust* v. *Sullivan*, 500 U.S. 173 (1991).
[50] 462 U.S. 416 (1983).
[51] 476 U.S. 747 (1986).

Danforth[52]. In this case the court invalidated a Missouri statute requiring prior written consent of the spouse of the women seeking an abortion. At the same time, the court again insisted on a provision which restricted access to abortion services by declaring that unless certified by a licensed physician that the abortion is necessary to preserve the life of the mother, it is illegal.

Another important area of judicial debate in abortion is regarding parental consent. A large number of cases have been battled in the courts around this issue. Court took positions in favour of un-married and teenage women in different cases and invalidated a number of state statutes. In *Danforth* [53] court also invalidated a Missouri statute prohibiting an unmarried woman under the age of eighteen from obtaining an abortion without the written consent of parent or person, unless abortion is certified by a licensed physician as necessary in order to preserve life of the mother. In *Bellotti v. Baird*[54] the court invalidated a Massachusetts statute prohibiting an unmarried woman under the age of eighteen from obtaining an abortion unless either her parents' consent or a court order that permits abortion "for good cause shown". However, in *Planned Parenthood Association of Kansas City v. Ashcroft*[55] the court upheld a parental consent requirement that contained an alternative procedure as sufficient to meet the legal standards. In *Casey v. Population Service International*[56], the court invalidated a New York statute prohibiting the distribution of contraceptives to persons under the age of sixteen. Where as in *Hodgoson v. Minnesota*[57] and *Ohio v. Akron centre for reproductive health*,[58] the court continued with the statutes regulating minor's access to abortion. In *Hodgoson*, the court invalidated a provision of a Minnesota statute that prohibited the performance of abortions of women under the age of eighteen unless at least forty-eight hours had elapsed since the time when both parents were notified[59].

There are case laws available that discuss professional regulations and challenging the existing rules that do not facilitate free access to abortion services. In

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[52] 428 U.S. 52 (1976).
[53] Ibid
[54] 443 U.S. 622 (1979), (Bellotti II).
[55] 462 U.S. 476 (1983).
[56] 431 U.S. 678 (1977).
[57] 457 U.S. 417 (1990).
[58] 457 U.S. 502 (1990).
[59] *Zabloki* v. *Redhall*, 434 U.S. 374 (1978); *Bowers* v. *Hardwicck*, 478 US 186 (1986); *Roberts* v *U.S. Jaycee*, 468 U.S. 609 (1984); and *Cruzen* v. *Director, Missouri Department of Health*, 457, U.S. 261 (1996) discussed the issue of minors' right to abortion.

the US, there are so many regulations available regarding the prescribed qualification of the medical professionals and the paramedics. However, the over-qualifications prescribed for medical practitioners turned out to be a barrier in obtaining abortion services. In *Colautti* v. *Franklin*[60], the court invalidated a Pennsylvania statute that required every person who performed an abortion first to determine that the foetus is not viable based on experience and the judgement of professional competence. In *Webster* v. *Reproductive Health Services*,[61] the court upheld several provisions of a Missouri statute regulating abortions. It has given a different interpretation to *Roe*. In *Webster*, the court explained that the statement in the abortion statute's preamble ("the life of each human being begins at conception") was not in conflict with the statement in *Roe* that "a state may not report one theory of when life begins to justify its regulations of abortion". Thus the controversy in the legalisation of abortion is rooted in the question as to when life begins.

In the year 1992 in *Planned Parenthood Association of South Eastern Pennsylvania* v. *Casey*[62] the court reversed the decision in *Roe* to an extent. In this case the court concluded that the basic decision in *Roe v. Wade* was based on a constitutional analysis, but that a woman's liberty is not unlimited. The state cannot show its concern for the life of the unborn in earlier stages of pregnancy: at a later stage of the foetal development, however, the state's interest in life has sufficient force so that the right of women to terminate the pregnancy can be restricted. It was argued that the US Supreme Court never suggested that women could make decisions about whether or not to bear a child independent of state interest. The evaluation of above mentioned case laws give us an impression that no successive evolution of '*Roe* v. *Wade*' happened in the US. The analysis of the case laws in the context of this study is for assessing the development after *Roe* v. *Wade* and thereby examining the role of judiciary in protecting procreative autonomy of women. However, a close look at the case laws indicate that there is no much progressive judicial pronouncements came after Roe in order to enhance abortion right. The judicial decisions came in response to various public debates and policies. To an extent courts failed to protect reproductive autonomy of women, even as they tried to broaden the scope of right to privacy. According to Rosalind Pollack Petchesky, "[a]lthough abortion rights have

[60] 439 U.S. 379 (1979).
[61] 425 U.S. 450 (1989).
[62] 505 U.S. 833 (1992).

been framed in terms of the 'woman's right to choose, at best such choices have always been tightly circumscribed, if not rendered meaningless"[63]. This observation is particularly true, when women are not white, moneyed, educated and assertive.

The intervention of courts in the matter of abortion right in US is always limited to the politics of *pro-choice* v. *pro-life* debate. Abortion policy remains a matter of intense debate, where there are two identifiable groups of activists: anti-abortion ("pro-life")[64] groups that advocate restrictive policies and pro-abortion ("pro-choice")[65] groups that advocate a permissive policy allowing women to choose.

1.4. Reproductive Justice: A New Movement

The pro-choice and pro-life debate has determined the historical evolution[66] as well as the contemporary debates on the Hyde Amendment. Currently, federal funding for abortion is only available in cases of life endangerment, rape or incest[67]. Consequently, without health insurance and federal funding for abortions, women consistently face reduced access to abortion services. Therefore, in the contemporary US context, overturning the Hyde Amendment and increasing public funding for reproductive health care is a necessary part of the fight for reproductive justice[68]. The reproductive justice approach is differentiated from the mainstream pro-choice politics. It is a formulation that links communities and issues, and has a greater potential to draw new constituencies to the reproductive freedom struggle. Arguing that pro-choice necessarily was a white bourgeoisie construct, reproductive justice seeks to move beyond an individualistic frame. It has been pointed out that

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[63] Rosalind Pollack Petchesky 1986. *Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom.* New York and London: Longman.

[64] For pro-life groups, abortion is equivalent to murder. They believe that human life begins at conception and right to life overrides all other rights and interests. Right to life advocates perceive any move towards liberalisation as an assault on traditional family values and gender roles. Abortion, they argue, undermines marriage, morality and motherhood, indeed the family, the nation and the American way of life.

[65] Advocates of pro-choice are inspired by secular humanism and attach moral values to the women's right to her-own body against state or societal interference. They assert that the women must be free to decide whether to continue or discontinue her pregnancy. The advocates of this position do not recognise the unborn as a person. The rights of women supersede those of foetus.

[66] In 1977, American Congress allowed federal funding for abortion only in cases of rape, incest and life endangerment. In 1978, the provision of 'severe and long lasting physical health damage' had been added. In 1979, this was removed. In 1981, provision for rape and incest also was removed by the congress. In 1983, again rape, incest and life endangerment were added as grounds for funding. In 1997, the Congress restricted the life endangerment exception to a physical disorder, physical injury or physical illness including a life endangering physical conditions arising out of pregnancy itself. This is the current version of Hyde Amendment. See Latina Institute 2006, op cit.

[67] Ibid.

[68] Ibid.

reproductive right to abort for some women came with reproductive injustice to other women, predominantly poor or women of colour. Reproductive justice, as we have seen, is part of a larger struggle for justice. As Marlene Fried[69] suggested, reproductive justice is to emphasise the link between an individual woman's ability to control her own sexual and reproductive life and her community's efforts to regulate and control itself. White feminists have framed much of their discussions of abortion rights in the context of individual choice. But for women of colour and poor women, their choice is restricted by conditions of oppression they are facing in health care institutions and in different levels in society. Women of colour and poor women are also the most frequent victims of restrictive reproductive policies because they are the most dependent on public funding of reproductive services. They are also disproportionately most likely to suffer death and injury, if abortion becomes illegal[70]. In other words, reproductive justice suggests that feminist analysis of reproductive freedom should be framed by a political perspective which is broader than individual choice. Reproductive freedom should be framed by an understanding of the need for social justice for all women, not just those who are having the privilege to make free choice[71]. Right to privacy alone probably cannot achieve such freedom, because privacy itself is largely conditioned through the structural elements of race, class and gender oppression[72].

2. Religion and Politics of Abortion Laws

In this section we will discuss how the major religions in the world influence the abortion laws with special reference to Christianity and Islam. Worldwide, institutionalised religions are powerful forces in support of restrictive abortion laws[73]. Catholic theologians[74] for example, have always regarded abortion as a crime against

[69] Fried 2006: 242.
[70] Margaret L. Anderssen 1997. *Thinking about Women: Sociological Perspectives on Sex and Gender.* London: Allyn & Bacon.
[71] Patechsky 1986, op cit.
[72] ibid.
[73] The influence of Hinduism on abortion laws will be discussed in chapter 3 in the context of abortion law in Nepal.
[74] The current US policies and therefore the global policies on abortion have been largely influenced by the evangelical protestant fundamentalism. However, at global level the Catholic Church has been particularly influential on the issue of abortion. The discussion on Christianity and abortion is limited to Catholicism in the present chapter.

the sanctity of life[75]. In many countries interpretations of a dominant religion are relied upon to justify highly restrictive abortion laws.

2.1. Christianity and Abortion Laws

Medieval Christians condemned abortion, but did not view the termination of pregnancy to be an abortion before "ensoulment", which denotes the attribution of soul to the foetus or achievement of personhood. The concept of ensoulment was then equated with 'quickening' generally taken to mean the end of first trimester[76]. In recent public statements made by the Vatican, the position of the Catholic Church regarding abortion appears absolute and immutable. Catholic teaching on abortion is constituted by variety of beliefs and the anti-choice stance is one among them[77]. Currently, the predominantly Catholic countries such as Belgium, French and Italy also have most liberal abortion laws[78]. The current Catholic approach to abortion contradicts other long-standing teachings of the church. It is clear that through out its history, the Catholic Church did not consider abortion at early stages of pregnancy to be equivalent to the killing of the human being[79]. Catholic teaching has been historically dominated by the belief in "delayed humanisation". This is the belief that a foetus is not human until it has developed into fully human form. Since a less than human body is not capable of receiving a soul and a human does not exist without the presence of a fully human body and soul, early abortion was not considered as taking life. The Vatican's condemnation of abortion today has failed to reconcile these contradictory teachings. Catholics worldwide freely exercise their right to follow personal conscience in the face of theological uncertainty regarding nature of foetus[80].

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[75] Henry P. David 1998. *Born Unwanted: Developmental Effects Denied Abolition.* New York: Springer Publishing Company.

[76] Jodie L. Jacobson 1990. *The Global Politics of Abortion.* New York: World Watch Paper.

[77] Ibid.

[78] Centre for Reproductive Law and Policy 1999. *The World's Abortion Laws, 1999. (Wall Chart).* http://www.crlp.org.in accessed on 18-01-2007.

[79] Pope John Paul II asserted more blanket opposition to abortion in his Encyclical in 1995, *Evangelium Vitae.* See Margaret L. Andersen 1997. *Thinking about Women: Sociological Perspectives on Sex and Gender.* London: Allyn and Bacon.

[80] A study in the US reveals that US Catholic women have an abortion rate 29% higher than Protestant women. See Stanley K. Henshaw 1996. 'Abortion: Patients in 1994-95: Characteristics and Contraceptive Use', *Family Planning Perceptive* 28: 140-143. It is also noticeable that there are pro-choice movements from within the Catholic Church. 'Catholics for a Free Choice' (CFFC) is such an organisation founded in 1973 the same year Roe v. Wade verdict came. The CFFC claims that it works "as a voice for Catholics who believe that the Catholic tradition supports a woman's moral and legal right to follow her conscience in matters of sexuality and reproductive health". See http://www.catholicsforchoice.org/about/default.asp, accessed on 27.07.2007.

In Britain also the debates on abortion law was instigated by church initiatives. The Abortion Act of 1967, which contains a number of exceptions to the prohibition on abortion in the Offences against Persons Act, 1861 has been subjected to attack by the Catholic Church[81]. In Ireland even now legal abortion is prohibited. Till very recently the church managed to keep abortion illegal in most Latin American countries[82]. In Philippines, Reproductive Health Act is still pending on account of religious opposition. Abortion is a punishable offence under Penal Law of the country. Although the proposed Act does not contain a clause to amend current Penal Law on abortion the religious opposition continues to be unabated. The proposed Reproductive Health Act contains a provision for the integration of post-abortion care into the health services. It sets standards for human treatment of women with complications from unsafe abortions in public hospitals[83]. Thus the legal debate around the separation of church and state is narrowly framed and it poses more problems than solutions for women's reproductive rights.

In Muslim countries, when one makes her reproductive choice in abortion, she has to adhere to the ethical guidelines of the society. The ethical guidelines in an Islamic country are not supposed to be in contradiction with the basic instructions of Islamic Shariah[84]. However, as Gamal I. Serour pointed out, the Islamic Shariah is adaptable to and accommodative of new technological development[85]. So it is evident that the Islamic Shariah is not a static one but dynamic and flexible enough in addressing the needs of a changing world.

2.2. Islamic jurisprudence and Abortion Laws

Islamic jurisprudence is both a very important and frequently misunderstood and misrepresented view of nature and working of law[86]. Islamic law is a religious law founded upon the Qur'an revealed to the Prophet Muhammad[87]. Islam is a faith

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[81] Marie Fox 1998. "A Women's Right to Choose: A Feminist Critique". In John Hares and Soren Holm (eds). *The Future of Human Reproduction.* New York: Oxford.
[82] Centre for Reproductive Law and Policy 1999. Op cit.
[83] Carolina S. Ruiz Austria 2004. 'The Church, the State and Women's Bodies in the Context of Religious Fundamentalism in the Philippines'. *Reproductive Health Matters*, 12 (24): 96-103.
[84] Gamal I. Serour 1998. 'Reproductive Choice: A Muslim perspective'. In John Harris & Soren Holm (eds). *The Future of Human Reproduction.* New York: Oxford.
[85] Ibid: 190.
[86] McCoubrey and D. White 1999. Op cit.
[87] The matter of divine origin is fundamental to Islamic jurisprudence and the bedrock and primary source of Islamic law is the text of the Qur'an received by the prophet Muhammad between the age of 41 and 63 over a period of 22 years 2 months and 22 days.

which had over 1.225 billion adherents worldwide in the year 1990 and the population is expected to touch 2.5 billion by the year 2020[88]. Islam is a comprehensive system that regulates spiritual as well as civic aspects of individuals and communal life. It aims at producing a unique personality of the individual and a distinct culture for the community based on Islamic ideals and values. The teaching of Islam covers all the fields of human activity[89]. The instructions that regulate everyday activity are called the Shariah. There are two sources of the Shariah in Islam, called the primary sources [90]and secondary sources[91].

The complexity and variety of Islamic opinion on abortion is often obscured by the simplistic understanding that dominates public discourse[92]. All Islamic legal scholars agree that abortion is prohibited, when it involves the killing of the soul. But, as in Catholic theology, there exists considerable debate over the exact time of 'ensoulment'. This is reflected in the fact that abortion laws of predominantly Islamic nations vary considerably[93].

Islamic theology has developed into several different schools, which represent different ways of interpreting Islam. The Sunni Muslims have four main schools of law[94]. The Shiite Muslims also have several schools of interpretations[95]. The majority of jurists from the Hanafi and Zaydi schools allow abortion before 120 days because they believe that foetus is not ensouled until this period[96]. Hanabali Scholars allow abortion before 40 days. Among Shafi scholars, some allow abortion anytime before 120 days, some only until 80 days and some have a blanket prohibition[97]. Many jurists

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[88] Serour 1998. Op cit.
[89] ibid.
[90] Colon N. J. 1964. *A History of Islamic Law*. Edinburgh: Edinburgh University Press. The primary sources of Shariah in chronological order are: the holy Qur'an; the very word of god, the Sunna and the *Hadith*, which are the authentic traditions and sayings of prophet Muhammad, *Igmaah*, which is the unanimous opinion of Islamic scholars, or *Aimma*, analogy (*kias*), which is intelligent reasoning through which to rule on events the Qur'an and *Sunna* did not mention, by matching them against similar or equivalent events which have been ruled on.
[91] Ibid. The secondary sources of Shariah are: *Istihsan* which is the choice of one of several lawful options, views of the prophet companions, current local customs, if lawful, public welfare and rulings of previous divine religions if then do not contradict the primary source of Shariah.
[92] Kapil Ahmed 1995. 'Determinants of Induced Abortion in Rural Bangladesh'. Seminar paper presented in the Seminar on Socio-cultural and Political Aspects of Abortion in a Changing World, by IUSSP Committee and CDS, held at CDS, Thiruvananthapuram, from 25 to 28 March 1995.
[93] Tunisia, Turkey and several former Soviet Republics have liberal abortion laws. Bangladesh permits 'menstrual-regulation' during first eight weeks of pregnancy.
[94] Hanafi, Shafi, Maliki and Hanabali
[95] Zaydi, the Imami and the Ismaili
[96] Ahmed 1995. Op cit.
[97] ibid.

think that abortion within 120 days is acceptable[98]. In addition to these health effects, legitimate abortion has expanded in some locales to include stress, other mental health conditions and less pronounced physical symptoms[99]. Some Islamic jurists believe that economic difficulties can also be a legitimate reason to have an abortion[100]. All schools of Islam permit abortion even after ensoulment if the life of the mother is endangered by the pregnancy[101]. Thus it is clear from the grounds for abortion that Islamic law on abortion is not homogenous and varies according to the social scenario.

3. Socialist Countries: A Different Scenario[102]

The socialist countries of Central and Eastern Europe[103] do not constitute a demographic entity. There exist considerable differences in social and economic development, urbanisation, living standards, social habits, religion and so on, which shape abortion decision making. But all socialist countries shares one thing in common; the trend in abortion rates and existing regulations are highly influenced by the population policies[104]. The socialist ideology did not share the Malthusian understanding of population growth, but considered access to birth control as part of development of the nation.

After the end of Second World War, these countries shared a common social and economic system, based on industrialisation of the previously existed agricultural economies[105]. A large percentage of women entered the labour force at this juncture, resulting in significant changes in the family structure and life patterns. This was also

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[98] The reliable reasons are, i. a woman becoming pregnant while still nursing a baby, ii. A woman suffering from poor health such as a weak bladder or decease or malfunctioning of the uterus, iii. a risk of difficult labour that may require a caesarean section and iv. a woman being younger than 15.

[99] Ibid.

[100] ibid.

[101] ibid.

[102] In this section however we are not discussing the abortion laws in the socialist nations outside Europe such as China, Cuba, Vietnam and Venezuela. The economic and political transition in these countries at present is very complex and therefore it is not easy to capture the changing scenario of abortion laws at the moment.

[103] Includes erstwhile USSR, Hungary, Poland, Czech Republic, Slovakia, Romania, Bulgaria and East Germany.

[104] Henry P. David and Nancy F. Russo 1971. "Abortion and fertility regulation in the Socialist countries of central and eastern Europe" in Sidney H. Newman *et al.* (eds). *Abortion Obtained and Denied. Research Approaches*. New York: Population Council. Pp. 81-95.

[105] Rapid industrialisation resulted in internal migration and stimulated great social and occupational mobility. Ibid at 82.

reflected in the process of legalisation of abortion. The Soviet Union[106] was the first country, which provided abortion virtually on request, as a woman's right. Lenin's new government made abortion legally obtainable at free of cost[107] . The new law was justified under Lenin's principle that one of the basic rights of a citizen is that of deciding whether her child should be born[108]. After the October revolution of 1917, equality in access to education and health care and guaranteed employment were part and parcel of planned development[109]. The abortion law was also part of this social process. When this law came into force, the rate of abortion increased sharply[110]. By 1935, the problem had become so acute that Soviet government placed certain limitations on abortion. In 1936, abortion was further restricted as being provided only on inevitable medical grounds such as risk to the mother's health and serious ailment to the pregnant woman[111]. This was under the regime of Stalin, especially after the huge loss of Soviet lives in the Second World War, when the regime initiated pro-natalist measures[112]. Abortion remained illegal until 1955 in USSR. Studies revealed that women massively resorted to illegal-abortions during the period of 1936 - 55[113]. After 1955, when abortion became legal in the first trimester of pregnancy on request of the woman, the number of women having legal abortion increased to approximately seven million annually in the 1970s[114]. In 1987, the law was further liberalised[115] and the trend continued through the amendments of 1993 and 1996[116].

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[106] Soviet Union was constituted of 15 republics, namely Belarus, Moldova, Russia, Ukraine, Estonia, Latvia, Lithuania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

[107] Law came into force as an attempt to curtail the morbid consequences of Illegal abortion. A reduction of 50% of morbidity and 4% mortality allegedly reported due to this enactment.

[108] Lorimer F. 1946. *The Population of Soviet Union: History and Prospects.* Geneva: League of Nations. P. 128.

[109] William C. Cockerbam 1999. *Health and Social Change in Russia and Eastern Europe.* New York: Routledge.

[110] Available data from Moscow shows that abortion rate rose from 19 per 100 live births in 1921 to 55 in 1926 and 270 in 1934. Lorimer 1946. Op cit.

[111] James W. Brackelet 1971. "Demographic Consequences of Legal Abortion" in Sidney H. Newman *et al.* (eds) *Abortion Obtains and Denied Researcher Approaches*, pp. 81-95, New York: Population Council.

[112] By that time, increased number of population was considered as an asset for the rebuilding of the nation. So birth control measures were frozen by the state and abortions also were restricted as a result of this trend.

[113] David and Russo 1971, op cit.

[114] Ibid. Actual figures were much higher, because Soviet Union abortion statistics was not published. Instead, the demographic data was used for analysis.

[115] Permitted so called 'mini abortions', i.e. within 20 days of missed period on an out patient basis and it extended to the number of legal grounds for obtaining abortion in second trimester.

[116] Extended the number of medical and social indications in second trimester.

By this time the Russian Federation had one of the most liberal abortion laws in Europe. However, it was surprising that on average 150 women died annually from the consequence of abortions[117]. This fact has come out as part of a mortality study conducted by WHO in 2003. Taking into consideration the findings of the study, the government has reduced the number of social reasons for abortion from thirteen to only four[118]; i.e. rape, imprisonment, death or severe disability of husband, or a court decree stopping the women of her parental rights. Access to second trimester abortion is severely restricted by this measure and it could have serious consequences[119]. These efforts at restricting abortion is probably a response to the "de-population" of Russia, as birth rates have declined below replacement level and incentives for child-birth are proving ineffective.

The introduction of more modern family planning methods in Russia in the early 1990s is said to have led to a gradual decline of abortion rates[120]. It is however unclear as to whether this decline is real or caused by under-reporting, particularly in big cities where private abortion clinics have been established. The WHO study indicated that this impressive decline in abortion rate was entirely caused by improved prevention of unwanted pregnancy through better contraceptive use[121]. The outcome of the study indicated that abortion-related maternal mortality was a national problem and that it was not concentrated in some remote or rural regions only[122]. The study thus revealed that there were regional and urban-rural differences in obtaining access to legal and safe abortion services[123]. The study underscored that the most fatal cases resulted from abortion performed outside the medical institution[124]. Another issue that came into fore as a result of the study was the difficulty in obtaining second trimester abortion due to reasons such as impediments in obtaining legal abortion, shortage of second trimester abortion services, and financial barriers.

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[117] 'Abortion in Europe', *Entre Nous Mass News. The European Magazine for Sexual and Reproductive Health*, IPPF co-publisher, http//:www.who.org, accessed on 28.05.2007.
[118] ibid.
[119] Because 6 to 7% of abortions in Russia are usually performed in second trimester.
[120] The reported rate dropped from 100.3 to 50.5 between 1991 and 2000. 'Abortion in Europe', op cit.
[121] WHO *et al.* 1999. *Health Care System in Transition in Russia.* New York: European Observation on Health Care System. http://www.who.org, accessed on 28.5.2007.
[122] Ibid. As per the National Data on Health of 1999, the number of reported abortions related to mortality was 153. According to the State statistical committee it was 130. The difference caused was due to the difference in definitions.
[123] Abortion Related Maternal Mortality Rate is 6.3/100,000 known abortions.
[124] Among the 113 fatal cases, studied in depth, there were 10 cases of spontaneous abortion, 24% had an abortion inside a medical institution and 67% had an abortion outside a medical institution.

The political and economic changes of the early 1990s did not affect health care as much as other sectors in the rest of the socialist countries. The attempts to reform the health care system has built up more slowly and health services have remained primarily in the public sector[125]. However the public health sector has begun to be affected of late by the newly emerging socioeconomic and political situation in these countries. Laws and regulations have been passed since then in favour the new political system has affected the health care system. The changing regulation in Poland is an example for this[126]. The Polish Penal Code of 1932 specifically states that abortion should not be considered as an offence[127]. However, this provision was criticised in Catholic circles in the 1950s. It was argued that human life is sacred and should be protected from the moment of its conception [128]. In 1989, anti-abortionists produced a draft for new abortion act which is named as 'Act for the Protection of the Unborn Child'[129]. In Poland, over ninety per cent of the population is believers of the Catholic Church and the new draft is closely linked to the Catholic philosophy of life and Catholic morals[130].

In Romania, the fertility, abortion and pregnancy rates have starkly increased in the wake of the recent policy shift towards legalisation of abortion[131]. After Ceausescu's overthrow in 1989, the Government adopted liberalised attitude towards abortion and subsequently the abortion rate appears to be extremely high[132]. The data from Romania indicates that the total abortion rate doubled during the period of 1990-93[133].

Besides all these changes in health sector as part of the socio-political and economic transition in the former socialist countries, there is strong evidence from the socialist nations of Central and Eastern Europe that induced-abortions performed in the first trimester by qualified medical personnel in hospitals entail low risk to the life

[125] K.B. Dutta 2002. *Dynamics of Gender Planning and Population Issues and Challenges.* New Delhi: Akansha Publishing House.
[126] Law on Abortion, 1993, Poland.
[127] Dutta 2002, op cit.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] David Anderson 1998. "Abortion, Women's Health and Fertility", *Policy and Research Paper* 15, http://www.iussp.org accessed on 28.06.2007.
[132] Ibid.
[133] Ibid.

of pregnant women[134]. This indicates the accessibility, affordability and availability of service of high quality existed in the erstwhile socialist countries. The transition happened in the 1990s ruined the public health system.

4. Role of International Legal Instruments

The changing religious and moral views coupled with the realisation that illegal abortion[135] is widespread led some countries to liberalise their abortion laws and the process is still on. International legal instruments played a crucial role in catalysing this process of liberalisation of abortion laws. According to Adrienne Germain et al[136] "[t]he fundamental sexual and reproductive rights of women cannot be subordinated, against a woman's will, to the interest of partners, family members, ethnic groups, religious institutions, health providers, researchers, policy makers, the state or any other actors". The barriers to improving women's health and access to safe abortion services are often rooted in social, economic, cultural and legal conditions that infringe upon women's human rights. International legal instruments tried to overcome these barriers from within their limitations.

Human right principles acknowledge many of the interests associated with abortion dilemma. Earlier, international law placed individuals as central, but in the wake of the advent of the modern discourse on human rights in international law[137], now both national and individual rights have been given equal attention. The individuals are entitled to get right to protection by their national states and against national state, if the state infringes upon their right. The blending of public health and human rights can be situated in this context of modern international law, and right to health became one of the major concerns for human rights. This was elaborated in a celebrated essay by Jonathan Mann[138]. He observed that "human rights thinking and action have become much more closely allied to, and even integrated with public health work and in the modern world public health officials have two fundamental responsibilities to the public: to protect and promote public health and to protect and

[134] David and Russo 1971, op cit. The chances of complications arising from induced abortions in the first trimester appear to be less than the hazards of carrying a pregnancy to term.
[135] Using primitive and dangerous methods.
[136] Adrienne Germain, Sila Nowrogee and Hnin Hnin Pyne 1994. "Setting A New Agenda: Sexual And Reproductive Health Rights", in Sen, Germain and Chen. Op cit.
[137] Since Universal Declaration of Human Rights, 1948.
[138] Cook 2006, op cit.

promote human rights"[139]. The right to reproductive health has to be considered as part of the right to health. There are different international treaties which deal with rights relating to reproductive and sexual health care[140]. Sexual and reproductive health right is construed as the right to life, survival, and sexuality, right to reproductive self determination and free choice of maternity, right to health and the benefits of scientific progress and right to education, information and decision making under different treaties. In addition to this, certain legal principles have been identified as fundamental to the provision of reproductive heath services[141]. These are, informed decision-making, decision making free from any coercion, privacy, competent delivery of services and safety and efficacy of products. In order to prevent unsafe abortions, all these provisions can be invoked. However, as Mohan Rao opines in the context of ICPD, "the issues of reproduction must necessarily be linked with wider socio-economic concerns". It is noticeable that these international treaties do not take into consideration the wider socioeconomic and political inequalities in society and tend to see women as a homogenous category. The issues of accessibility, affordability, availability and quality of abortion provisioning are not being addressed comprehensively by any of these treaties.

4.1. History of Human Rights and the Issue of Abortion

The concept of basic human right emerged 200 years ago as countries debated the abolition of slavery and the treatment of prisoners of war. The concepts of human rights and equality are inherently bourgeoisie in nature as they originated during the period of the French and American revolutions.

Reproductive freedom or choice was mentioned for the first time in front of the international community in 1968, at the International Conference on Human Rights,

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[139] Mann J. M. 1997. *Medicine and Public Health, Ethics and Human Right, Hastings Centre Report*, May-June.

[140] The relevant Human Right treaties are: The International Covenant on Civil and Political Rights (ICCR), The International Covenant of Economic, Social and Cultural Rights (ICESCR), The Convention on Elimination of all the Forms of Discrimination Against Women (CEDAW), The Convention Against Torture and other Cruel, Inhuman or Degrading Treatment of Punishment (CAT), The convention on the elimination of all the forms of Racial discrimination (CERD), and The Convention on Rights of Child (CRC).

[141] Rebecca Cook, *et al.* 2003. *Reproductive Health and Human Right*, AGI: Washington.

held at Tehran[142]. The issue of reproductive right[143] has always been discussed in the context of population policies. Therefore all the international conventions on population are important landmarks in the history of reproductive rights. The World Population Plan of Action adopted at 1974 World Population Conference held in Bucharest and the Recommendations for Further Implementation of the Plan of Action, adopted at the 1984 International Conference on Population held in Mexico are two major population documents which explicitly address the issues of development, population, and the status of women[144].

The human right framework addresses a set of controversial issues in the legalisation of abortion. One of the crucial questions arising is whether the foetus can be given the status of a human being. The human right documents conspicuously state that right to life begins from the moment of birth and that foetal right cannot be considered as human right[145].

The history of negotiation as well as the text of the Universal Declaration of Human Rights declaration clearly indicates that the "right to life" can only be attributed from the moment of birth[146]. Other International human rights treaties too, by drafts or through interpretation, clearly reject the claim that human rights begin from conception or before birth[147]. These treaties also recognise that woman's right to life and other human rights are violated where restrictive abortion laws are in place. The claim for foetal rights is always being used to prevent liberalisation of abortion laws or to challenge them altogether. But the examination of UDHR, ICCPR, CRC

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[142] Tehran Resolution 18: "Parents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information in this respect". www.un.org, accessed on 18.06.2007. It is significant that this recognise the right of parents rather than of the woman. This has been further refined at the ICPD at Cairo in 1994, where the reproductive rights of a woman are addressed.

[143] The terms reproductive rights and abortion rights are being used synonymously here. It is because of the fact that the later is perceived as part of the former.

[144] Reed Boland, Sudhakar Rao, and George Zerdenstein 1994. "Honouring Human Rights in Population Policies: From Deceleration to Action", in Sen, Germain and Chen, op cit.

[145] All the following human right treaties specify that foetal right is not a human right. a. The Universal Declaration of Human Rights, b. The International Covenant on Civil and Political Right, c. Convention on the Rights of the Child and d. Convention on Elimination of all the forms of Discrimination against Women.

[146] Rhonda Copelon *et al.* 2005. "Human Rights Begin at Birth: International Law and the Claim of Foetal Rights', *Reproductive Health Matters*, 13 (26): 120-129.

[147] The opening sentence of the principles charter of the ICPD programme of Action declares: "All human beings are ***born*** free and equal in dignity and rights. Everyone is entitled to all the rights. Everyone is entitled to all the rights and freedoms set forth in the UDHR, without distinction of any kind, such as rare, colour, sex, language, religion, political or other opinion, national or social origin, properly, birth or other status. Every one has the right to life, liberty and security of person". Ibid: 120-121.

and CEDAW gives us the clear impression that right begins with the birth and foetal right claims do not have backing or legitimacy in international legal instruments[148].

4.2. The Right to Health: Reproductive Health

A landmark achievement of the **Cairo Programme of Action** was its development of the WHO Concept of health into an internationally adopted concept of reproductive health[149]. On the basis of WHO constitution, the Cairo programme states that reproductive health is,

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant[150].

The ICPD created a comprehensive approach to reproductive health and placed reproductive rights on the world agenda. The critical relationship between women's work and procreation and the development and environmental crisis came into focus when preparing for ICPD, 1994. The second preparatory committee meeting of ICPD persuaded government delegations to address explicitly the issues of reproductive heath rights, access to safe abortion, gender equity and broader socio-economic development[151].

In 1994, Cairo Programme of Action successfully promoted the concept of reproductive health, which was reinforced at the Forth International Conference on women in Beijing a year later. The concept of reproductive health skilfully integrated respect for human rights with respect for women's access to health, dignity and reproductive autonomy[152]. The Cairo Consensus underscored that democratic governments are accountable for the consequences of the laws, policies and practices

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[148]Article 1 of the UDHR opens with the following fundamental statement: "All human beings are *born* free and equal in dignity and rights". (Emphasis added). The word 'born' was used intentionally to exclude foetus or any application of human rights. ICCPR rejects the proposition that right to life protected in Article 6 (1) applies before birth. CRC does not recognise the right to life until birth. The definition of "a child" for purposes of the convention does not include a foetus. CEDAW's preamble reaffirms the UDHR that "all human beings are born free and equal in dignity and rights". See http//:www.unitednations.org, accessed on 18.12.2006.

[149]Cook 2006: 24.

[150] http://www. Law-lib. Utornto.ca/Diana, accessed on 28.02.2007.

[151] Ibid.

[152] Ibid.

that obstruct or deny access to reproductive health. The Cairo POA thus makes governments responsible to formulate public health policies in order to reduce the sufferings of unwanted pregnancy and the tragedy of unsafe abortions, and thereby ensure women's access to safe abortion service under laws respectful of women's reproductive autonomy.

The Convention on Elimination of All the Forms of Discrimination Against Women (CEDAW) is the first legally binding international treaty in which states assume the duty to eliminate all forms of discrimination against women[153]. As an international instrument prescribing normative standards, CEDAW has far-reaching implications. It covers a vast range of issues relevant to women and deals with hitherto uncovered areas of gender discrimination. The domestic sexual violence and sexual harassment at work place etc. were first dealt with internationally by the CEDAW. The CEDAW General Recommendation 12[154] on *women and health* requires that state should eliminate all forms of discrimination against women in the context of health and health care. It also ensures that women can exercise and enjoy human rights and fundamental freedoms on the basis of equality with men. The Recommendation makes clear that discrimination occurs against women, when health systems refuse or neglect to provide health service that only woman need, such as abortion services. It further argues that states are obliged to remedy this situation[155].

The International Covenant on Economic, Social and Cultural Rights is also vocal on provisioning of health care services which includes abortion services also. The General Comment 14 of the Covenant on Right to Health of ICESCR, which explains that the right requires interrelated features[156] such as availability (heath care services have to be available in sufficient quantity), accessibility (services including information have to be physically and economically accessible to everyone without discrimination), acceptability (services have to be culturally appropriate, that is

[153] But only those states that ratify the recommendations are bound by the treaty.
[154] Article 12 of CEDAW. State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on the basis of equality of men and women, the access to health care services including those related to family planning. Notwithstanding the provision in paragraph 1 of this article, states and parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services when necessary, as well as adequate insertion during pregnancy and lactations. http://www.who.org, accessed on 18.06.2007.
[155] Resource package on *Workshop on Gender and the Law* organised by Partners for Law in development and Anweshi Women's Counselling Cell on 22-25 February 2003 at Calicut, Kerala.
[156] Ibid.

respectful of cultures of individuals, minorities and communities and sensitive to gender and life cycle requirements) and adequate quality (services have to be scientifically appropriate and of adequate quality). It is evident that laws and policies that unreasonably restrict safe abortion services would not comply with this standard[157]. This is an ideal model for a gender sensitive abortion care provisioning.

5. Conclusion

The big threat to women's reproductive health is the inability to exercise women's right to sexual non-discrimination. The aggravating human right violations explain the high prevalence of abortion mortality and morbidity. The prevalence of human right violations thus leads to severe gender discrimination; women thereby do not enjoy the same status and significance as men. Because of this, there is lack of attention to risk factors of unsafe abortion such as lack of availability of contraceptives to reduce unplanned pregnancy, lack of abortion service, sexual abuse etc., that denies women's control over sexuality. The existing power relations in society result in the patriarchal domination of the family and society by men. It is women's rights that are violated within the privacy of the household, despite the special considerations accorded to motherhood in the international instruments. Therefore in the next chapter we will discuss the evolution of abortion laws in the context of India, examining the linkages between the social structure and the legal discourse on abortion.

[157] For instance, a law or policy requiring unnecessarily high qualifications for health service providers will limit the availability of safe abortion service and thereby women's health.

Chapter 2
Abortion Law in India: Genesis and Overview

1. Introduction

From a historical perspective it is clear that the process of legalisation of abortion depends upon the socio-political conditions of the society in which it is formed. In the West the Church has largely determined the fate of abortion at different points of time. In non-Christian societies both the state and religious institutions played an active role in determining the legality of abortion. The matters related to marriage, divorce, adoption and property rights are governed by personal laws in India. All the personal laws are based on religious texts, pronouncements and customary practices, whereas the other areas of civic life are governed by uniform laws.

In India there was no ban on abortion, but stigmas were prevalent. The evidence from India shows that the state or religious denominations in India, even in the pre-British era, left abortion to civil society and regarded it as a personal matter. In India there is no historical evidence available for abortion being criminalized and considered illegal until the nineteenth century. It was only under the British colonial rule that abortion was deemed a criminal offence.[1] 'Abortion' or 'induced miscarriage' came under the purview of the Indian Penal Code of 1860 and the Code of Criminal Procedure of 1898, where it continued until 1971. Under these laws, abortion was a crime punishable for both the mother and the abortionist, except when it was induced to save the life of the mother[2]. Before the Medical Termination of Pregnancy Act came into force in 1971, there was an absolute prohibition on abortion and there was no consideration of the conditions and circumstances of women who procured abortion[3].

This chapter tries to understand the complexity of Indian abortion laws, the context influenced by religion, morals and sexual politics. In doing so, this chapter give us a better understanding of the dilemmas and conflicts between an individual

[1] Indira Jaising (ed.) 2004. *Medical Termination of Pregnancy: A User's Guide to the Law.* Lawyer's Collective and Women Right Initiative, New Delhi: Universal Law Publishing Co.
[2] Ibid.
[3] Ibid.

woman's right to decide freely on her reproductive and sexual health and the state's 'social responsibility' of population control. These dilemmas and conflicts have to be resolved not only through policy statements, enactment and amendment of law and legal research, but also through social action. For an effective liberal abortion law, political will and commitment with ample gender sensitivity is indispensable.

The first part of this chapter will review the pre-1971 abortion laws in India. This section also endeavours to trace case laws coming under the concerned provisions of IPC and discusses how the judiciary tried to intervene in this matter. The contribution of the courts to a liberal legislation by interpreting case laws will also be discussed. The recommendations of Shantilal Shah Committee Report, 1966 which deals with the issue of legalisation of abortion in India will be examined as this recommendation led to the enactment of the landmark social legislation called the Medical Termination of Pregnancy Act (MTPA), 1971. The second part of this chapter is a detailed analysis of MTPA, 1971 and its recent amendments. Here we will discuss the conflict between the Prenatal Diagnostic Techniques: Regulation and Prevention of Misuse Act (PNDT Act), 1994 and MTPA, 1971. The third section is an attempt to understand the role of state's control over women's right to abortion and the role population policies have played in this context. Problems in the implementation of the act also will be discussed here. Finally, the chapter critically examines the reality of Indian scenario; how far law could improve the availability, accessibility, affordability and quality of abortion service irrespective of social barriers.

2. Pre-1971 Abortion Laws in India

Before the MTP Act, 1971, termination of pregnancy was an offence, punishable under Indian Penal Code, 1860, under sections 312 to 316. Section 312 deals with causing miscarriage. A woman or a person who is voluntarily causing miscarriage not with good faith is punishable under this section[4]. Section 313 is about performing miscarriage without the consent of the woman. Any act with the intention of causing miscarriage resulting in the death of the woman comes under the purview of Section 314, while Section 315 describes the punishment for any act with the intention of causing death of the unborn child or causing a child to die after birth.

[4] For the relevant IPC Sections discussed here, see Annexure III.

Section 316 deals with the acts that cause the death of pregnant woman resulting i the death of the unborn child. These provisions in IPC are a replica of the English la of the time. In the English law, the rights of the unborn child were given priority ov the reproductive rights and health needs of the mother. The blind copying of Englis law in the colonial period without taking into consideration the Indian context furth contributed to the insensitivity of the legal establishment towards gender justice. detailed analysis of the IPC provisions regarding abortion through the case laws wi therefore reveal how the law undermined the interest of the pregnant woman in India context. The evolution of case laws helps us understand the limited role of judiciary i shaping a liberal law on abortion.

2.1. The Limited Role of Judiciary

While discussing case laws, the intention is not just to trace the factual detail of the cases, but trying to illustrate the *ratio decindi*[5] of the cases. Through thi analysis we are trying to capture how the judiciary interpreted various provision under the IPC regarding abortion. The judicial interpretaions are influenced by th dominant discourses of the time. The issue of abortion is always deliberated in th context of the feudal values and morals that still persist in India. The case of *Ma Sharif* v. *State of Orissa*[6] substantiates this point. The court observed in this case tha the expression "causing miscarriage" would include anything done or given t procure abortion. Precisely, the person directly responsible for causing miscarriage a well as the woman who caused herself to miscarry is liable for the offence o miscarriage under section 312 of IPC. While in *Emperor* v. *Mariam Sidi*[7], the cour took a more rigid approach towards pregnant women but gave the benefit of evidence to those who assisted the abortion. It was held that a voluntarily[8] performed miscarriage would make a woman an offender. At the same time, the court demanded additional evidence for punishing those who assisted the abortion[9]. Under Section 312

[5] *Ratio decindi* is the legal term for reasons behind the judgement and interpretations of relevant provisions.
[6] 1996 Cri LJ 2826.
[7] 19 KLR 40, 1908
[8] Section 39 of IPC 1860 defines the term 'voluntarily' as following. "A person is said to cause an effect 'voluntarily' when he causes it by means whereby he intended to cause it, or by means which, at the time of employing those means, he knew or had reason to believe to be likely to cause it".
[9] In this case, Mariam Sidi was pregnant. She went for an abortion with the help of accused no.2, who has provided her medicine and money to aid the miscarriage, which was not admitted in the court. Due to lack of evidence accused no. 2 was acquitted but Mariam Sidi was convicted.

of IPC, any doctor who performs an abortion[10] and the woman who undergoes it are equally committing a criminal offence, but the term 'miscarriage' is not defined anywhere in IPC[11]. Even now, an abortion that is not performed conforming to the specified legal grounds mentioned in MTPA will fall under Section 312 of IPC. MTPA is a social welfare legislation unlike the IPC and it does not consider woman as an offender. In MTPA, the woman who seeks abortion is a beneficiary of the law, but in IPC she is an accused. It is quite disturbing a fact that in a country with a liberal abortion law, there exists a highly reactionary legal provision that victimizes the pregnant woman.

Section 313 of IPC categorizes the crime of committing abortion into two, as abortion performed with and without the consent of the woman. In *Thulasi Devi and others* v. *State of UP*[12], the court held that any hurt caused to a pregnant woman that resulted in abortion would constitute an offence under section 313 of IPC. In this case the court convicted the accused and further observed that there was an expressed lack of consent by the woman. But IPC does not define consent under section 313 IPC. Section 90 IPC describes consent given under fear of injury or misconception as not a valid consent[13] .

Section 314 is concerned with the situation in which death has occurred in causing miscarriage. This section is applicable, even if abortion has been carried out to save the life of pregnant women. For punishing a person under this section, the court held in *Sorhab Ali* v. *State of Assam*[14] that it is immaterial whether the offender has done this act intentionally or not. By applying the same provision in *Vatehhalabai Maruti Kshirsagar* v. *State of Maharashtra*[15] the court held that the direct connection between the act of the accused and the death of the victim must be established.

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[10] According to Section 312 to of IPC, the doctor or person performing the abortion must honestly believe that the abortion is necessary to save the life of the woman.

[11] In its popular sense, miscarriage is synonymous to abortion. In legal language miscarriage is defined as the premature expulsion of the child or foetus from the mother's womb at any period of pregnancy before the term of gestation is completed. A.K.Nandi, S.K.Roy and S.P.Sengupta 2003. *Nandi's Criminal Law Ready to Reference*. Calcutta: Kamal Law House.

[12] 1996 CriLJ All.

[13] As per Section 90 IPC, "[a] consent is not such a consent as is intended by any section of this code, if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception...".

[14] 1993 Cri LJ 3525.

[15] 1993 Cri LJ 702.

Maideen Sab's case[16] reveals how this section was effectively used against quacks[17]. After the enactment of MTP Act 1971, the provisions under section 314 of IPC was incorporated in MTPA (Section 3) as a measure to control back street abortion and to punish those who indulged in such acts. This was considered as a means to protect women from unsafe abortion practices. However in practice this legal provision erases the locally available indigenous systems of practices existing in abortion care.

The unborn child is the main concern for section 315 and its objective is to protect the unborn's life. The scope of section 315 was discussed in *Leelawati* v. *State of Punjab*[18]. The application of the provision is limited to the unborn child, which means 'the period in which the child is in the womb of the mother'. The situation that the child is born alive and killed thereafter does not come under the purview of this section but under section 316 of IPC. For the application of this section, conclusive evidence is necessary to prove that the intention was to kill the child before or just after the delivery. Section 316 of IPC deals with a situation in which the unborn child is killed either as a result of torturing the pregnant woman or while performing an abortion[19]. In *Jabbar* v. *State*[20] the court clearly referred to the above-mentioned elements of Section 316. The limited scope of this Section is evident in judicial decisions like *Pappan v. State*[21]. In this case the accused was convicted under Section 302 for committing murder of his wife and the court also stated that the Section 316 has no application in this case. It shows that it is the discretionary power of the court to decide whether the act comes under the scope of Section 316 or not. It can be seen that such a discretionary power of the court indirectly shelter those criminals who resort to killing of the woman to get rid of an unwanted pregnancy. However there are instances in which court applied both the sections (IPC 316 and 302) if the accused had caused the death of both the pregnant woman and unborn child. For example, in the Madras High Court decision on *Murugan* v. *State*[22] the husband has been convicted for the murder of his pregnant wife as well as the unborn child.

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[16] *Maideen Sab* v. *State of Karnataka*, 1993 Cri LJ 1430.
[17] After the enactment of MTP Act 1971, the provisions of this section have been made subject to this act (Section 3 of MTP Act).
[18] 1982 Cri LJ 27 (P&H).
[19] The attempt to kill a person (culpable homicide) will fall under section 299 of the IPC.
[20] AIR 1966 All.590.
[21] 1953 Cri.LJ 1551.
[22] 1991 Cri.LJ 1680 (Mad).

It can be seen that the judicial contribution towards a liberal law is limited in Indian context. Under Indian Penal Code, the woman who refuses to carry the burden of their pregnancy was relegated to the status of a criminal without taking into account the trauma she passes through. The abortion was legally sanctioned only on the ground of a medical emergency associated with pregnancy and this was the only pro-women provision within IPC. It can be noticed that the attempt to create a liberal abortion law made use of this provision effectively. As Rami Chhabra and Sheel C. Nuna observed, this provision "became the peg on which liberalisation of the law could proceed later"[23]. It was only in the mid-sixties that the abortion issue came into fore as a serious concern in independent India, at a time when the British law was under review in UK[24]. The Central Family Planning Board was the first government body which considered this as an important matter to intervene. The CFPB in its meeting of August 1964 thus raised the issue of large numbers of illegal abortions "occurring in the country under insanitary conditions, affecting the health and lives of pregnant women"[25]. As a result of this, the Government of India set up an eleven-member committee to study the question of legalisation of abortion taking into consideration the legal, medical, social and ethical aspects in order to make recommendations[26].

2.2. Committee on the Legalisation of Abortion

The committee was chaired by Shri Shantilal Shah, the then Minister of Public Health, Law and Judiciary of the State of Maharashtra. The Committee consisted of five eminent woman social workers and four medical doctors. The Director of Central Family Planning Institute functioned as the member-secretary of the Committee[27]. The Shah committee took more than two years to submit its report. It considered a wide range of evidence and surveyed the prevailing laws in a number of countries[28]. The Committee particularly utilised the provisions of the draft of the new law then under revision in UK. The report was submitted by the Committee in 1966,

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[23]Rami Chhabra and Sheel C. Nuna 1994. *Abortion in India: An Overview,* New Delhi, Veerendra Printers. P.3.
[24] Ibid. In UK, the revised British Law came into force in 1967.
[25] Ibid: 5.
[26] Popularly known as Shah Committee.
[27] Ministry of Health and Family Welfare 1967. *Report of the Committee to Study the Question of Legalisation of Abortion.* New Delhi: GOI, p.3.
[28] Ibid: 53.

suggesting the broadening and rationalisation as well as the decriminalisation of the laws pertaining to abortion.

2.3. Recommendations of the Shah Committee

The Shah committee specifically denied legalisation of abortion for the purpose of population control. The Committee observed that legalisation of abortion to attain demographic goals will be counter-productive and affect the prospects of the family planning programme[29]. The Report proposed that only a qualified medical practioner acting in good faith should be permitted to terminate a pregnancy, not only for the sole purpose of saving women's life, but also due to other considerations as explained in the recommendations such as [30],

1. Serious risks to her life, or grave injury to her health -- physical or mental, before or after the birth of the child.
2. Substantial risk of the possibility of a physically or mentally handicapped child being born.
3. When the pregnancy resulted from rape or intercourse with a minor or mentally retarded girl.
4. The failure of contraception.

Further, the Committee advocated a vigorous promotion of the small family norm and contraception, sex education, marriage and expansion of easily accessible family planning services that would reduce unwanted pregnancies. It also advised doctors to recommend sterilization methods in order to prevent repeated abortions. Various recommendations were also made by the Committee regarding the conditions to be complied in connection with any treatment for termination of pregnancy[31].

The Shah Committee's recommendations were progressive on women's behalf, as far as the socio-political context of the period being considered. The Report raised woman's right issues while opining that if a woman[32] feels that a particular pregnancy is intolerable and does not desire to bear a child, she should take a decision over the question of motherhood for herself as the owner of her own body[33]. This can

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[29] S. Phadke 1998. *Pro-choice or Population Control: A Study of the Medical Termination of Pregnancy Act,* Government of India, 1971, http://www.hsph.harvard.edn/ organisations/ healthnet/ SAsia/MTPAct.html, accessed on 28.06.2006.
[30] As quoted in Indira Jaising 2004, op cit.
[31] *Report of the Committee to Study the Question of Legalisation of Abortion,* pp. 51-53.
[32] With or without concurrence of her partner.
[33] Chhabra and Nuna 1994, op cit.: 6.

be considered as one of the radical rights of Indian women[34]. The Recommendations included contraceptive failure as ground for legal abortion; this was indeed unique at the global level. In other words, failure of contraceptive was seen to induce mental trauma warranting an abortion.

It is a fact that half of the members of the committee were doctors. The rest of the members were strongly related to or influenced by the medical fraternity. This has resulted in the over-medicalisation of the Act as high medical standards were set by the Committee for the approval of termination of pregnancy in first and second trimester. The Committee did not see the matter in terms of women's rights, possibly because such language was not yet current, although the women's movement in the west had indeed framed the abortion issue in this manner. Ironically, although the members were familiar with the limitations of the existing health service system, the recommendations have been shaped without taking these very into consideration, namely, the almost total absence of a public health system to deliver these services.

2.4. Medical Termination of Pregnancy Bill (Rajya Sabha) 1969

After obtaining feedback from all the States and Union Territories on the Recommendations of the Shah Committee, the Medical Termination of Pregnancy Bill was introduced in the Rajya Sabha in 1969. The Bill in its statement of objectives and reasons pointed out that the rigid abortion law that was in existence breached the right of women to undergo abortion and forced them to approach clandestine abortion providers. The proposals of the Bill were based on the considerations of the health of women[35], a humanitarian measure providing relief where a sex crime had been committed[36], and a eugenic measure[37].

A Financial Memorandum was attached to the Bill with the intention of supporting the infrastructure development including creation of facilities in Government hospitals to meet the needs arising out of the forthcoming Act[38]. A huge sum of money was necessary for buying vacuum aspirators and increasing number of

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[34] Chabbra and Nuna 1994, op cit.
[35] The health measure was for protecting the health of women from the complexities arising out of pregnancy.
[36] The humanitarian measure was for safeguarding the victims of sexual violence from unwanted pregnancies.
[37] The eugenic measure was to avoid fetal abnormalities.
[38] S. Chandrashekar 1974: *Abortion in a Crowded World.* London: George Allen and Unwin Limited, p. 91.

beds and staff in hospitals. The Financial Memorandum contained a recurring annual expenditure of 2.4 million rupees and a non-recurring expenditure of 1.93 million[39]. However, compared to the annual estimation of abortion occurrence, this amount was insufficient. The Financial Memorandum was not discussed in both the houses of Parliament was not passed in either Houses. As S. Chandrasekhar commented, 'it simply disappeared'[40].

The Government's decision was to pass the law without opposition or resistance from pressure groups. The Government expected strong opposition from religious and conservative groups while enacting a liberal abortion law, which did not, in the event, materialise. The Act was named as 'Medical Termination of Pregnancy Act', rather than 'Abortion Act', in order to avoid the moral stigma attached to the word 'abortion'. The Bill was then forwarded to Joint Select Committee for consensus.

The Joint Select Committee introduced some major changes after interacting with various pressure groups including medical practitioners and women's groups. Throughout the process of Joint Select Committee, the interests of the medical profession were given utmost priority, as they were the most organised as a pressure group. All the amendments brought by the Joint Select Committee were to secure and safeguard women's right, but it led to further medicalisation of abortion care[41].

The evaluation of the pre-1971 laws and the context of Shantilal Shah Committee Report indicate that in India the liberalisation process of abortion was largely led by the Government, the family planning wing in particular. While major transformations in the legal discourse of abortion came into existence through pressures from the women's movements in other parts of the world, in India, women had other demands that were prioritised. These included property rights, a rethinking of the Personal Codes of different religions- all of which were gender unjust- and so

[39] Ibid.
[40] Ibid.
[41] The major amendments were the following. A) The Central government was made responsible for framing rules to carry out provision of the Act. B) Empowered Central Government to finalise rules and regulations prior to implementation of the Act in consultation with State Governments. C) Made unauthorised performance of MTP a punishable offence under IPC. D) Amended the definition of a 'registered medical practitioner'. Experience and training in Gynaecology and Obstetrics made compulsory for the RMP. E) Redefined the term 'guardian'. F) Deleted the sub clause that require a written consent of the husband of a rape victim to carry out abortion. G) Terminations in Second Trimester pregnancy required concurrence of two doctors.

on[42]. In other words, the right to abortion was never foregrounded in the India women's movements. It is therefore not surprising that several commentators have argued that this progressive legislation emanated from concerns about population explosion.

3. The Medical Termination of Pregnancy Act, 1971

The MTP Act could be considered as a landmark in the history of social legislation in India. The MTP Act permits the women to seek termination of pregnancy on well-defined grounds at recognised centres. The Act assured that the procedure of pregnancy termination would be undertaken by a qualified medical practitioner. Also, such terminations would be carried out in a hygienic place, equipped to handle any complication arising during the procedure. The proposed aim of this legislation was to reduce maternal mortality and morbidity and to remove the social stigma attached to abortion[43]. From the parliamentary debates, it is evident that the Bill was passed to liberalise the restrictions on abortion in Indian Penal Code[44]. The debates also reveal the concern of the Parliament on the substantial number of unsafe abortions that happens due to the rigid provisions of IPC. It was in the 1970s that all the social welfare legislation implemented in India, ensuring the role of State in service sector. Therefore it can be seen that the MTPA came into force as a public health measure to improve quality and accessibility of abortion care services in India.

It has been repeatedly argued that the reason behind enacting the MTPA was the State's requirement of controlling population. The evidence on this, as we have seen, is ambiguous on one hand; this aspect is not reflected in the stated objectives of the Act[45]. On the other hand, the fact that the need for this legislation emanated from the newly constituted Central Family Planning Bureau, itself constituted due to overwhelming US concern about the need to do something about over-population, lends credence to this argument. We must remember, this was at the height of population explosion arguments that shaped the population control programmes around the world. The UN, for instance had recommended that family planning be de-

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[42] Brinda Karat 2005. *Survival and Emancipation: Notes from Indian Women's Struggles.* New Delhi: Three Essays Collective.
[43] Sangeeta Batra and Sunanda Rabindranathan 2004. *Abortion Training in India: A Long Way to Go.* Health Watch, CEHAT, AAPI: Mumbai.
[44] Bela Ganatra and Leela Visaria 2005. *Informal Providers of Abortion Services: Some Exploratory Case Studies.* Mumbai: HW, IPAS, CEHAT and AAPI.
[45] Jyoti Moodbidri 1973. *Medical and Socio-economic Aspects of Abortion.* New Delhi: FPAI.

linked from MCH to enable ANMs to concentrate on family planning[46]. This was also a period when everything that could be tried was being tried to bring down birth rates[47]. It was not long before the Emergency was declared, horrendous consequences for the people: it was clear India could be a hard state when population issues were concerned.

However the agenda of the State is made explicit in this statement from the sixth Five-year plan; "the MTPA, which is in force now, is in the nature of a health measure and family planning is not one of its objectives: however the MTPA can be resorted to *as a corrective measure for failure of contraceptives*"[48]. We can see in this policy statement the silent permission of the Government to use MTPA for population control.

3.1. The Characteristics of the Act

The stated objective of the Act is to "liberalise certain existing provisions relating to the termination of pregnancy". Termination of pregnancy is allowed legally by MTPA in circumstances such as danger to the life of the pregnant women, grave injury to the physical and mental health of the pregnant women, pregnancy caused by rape, substantial risk, that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, and finally, failure of any contraceptive method or device. Thus the Act provides women the right to decide whether to continue or terminate pregnancy.

The *consent* of the woman is a crucial ingredient of the right to abortion according to MTPA. No pregnancy shall be terminated except with the consent of the pregnant woman. The written consent of her guardian is necessary if the woman is under 18 years of age and for lunatics even if they are older than 18 years[49]. The MTPA categorises women into four groups; married women, unmarried women, minors and women who are mentally ill[50]. Under MTP Act, married women are entitled to have access to maximum number of grounds to get a pregnancy

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[46]Mohan Rao 2004. *From Population Control to Reproductive Health: Malthusian Arithmetic.* New Delhi: Sage.

[47] Betsy Hartmann 1988. *Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice.* Massachusetts: South End Press.

[48] Jaising 2004, op cit.: 14. Emphasis added.

[49] Section 3(4) (a), MTPA.

[50] A mentally ill woman is defined in clause (b) of section 2 of the MTP (Amendment) Act, 2002 as "a person who is in need of treatment by reason of any mental disorder other than mental retardation".

terminated[51]. Even though rape is a ground for getting medical termination of pregnancy, marital rape does not come under the definition of rape. So a married woman cannot get an abortion on the ground that she was raped by her husband. Unmarried women are excluded from getting an abortion due to failure of contraceptive. Therefore it is obvious that under MTPA a woman does not have an *absolute right* to abortion[52]. In fact, she has to justify herself in conformity with the clauses under MTPA. The quality of services is ensured in MTPA by prescribing qualifications for the person who is performing the abortion and the conditions and standards for the spaces where abortion is to be performed. As per MTPA, only a Registered Medical Practitioner[53] having gynaecological and obstetric experience is authorised to perform an abortion. If the pregnancy exceeds 12 weeks, but not more than 20 weeks, the opinion of two RMPs is needed. Once the opinion has been formed by the required number of registered medical practitioners, the actual termination of pregnancy may be done by an RMP. The RMP is given all the privileges under the Act and the RMP is indemnified against all criminal, legal or any other action. The Act grants a monopoly to RMP in relation to the length of the pregnancy. A woman may avail an MTP only under the discretion of the RMP. At the same time, the Act is explicit in banning any termination of pregnancy, conducted by a person who is not an RMP. The abortion conducted by a person who is not an RMP is considered as an offender under the IPC. Earlier the provisions under IPC had not made a specific demarcation of medical and non-medical personnel. Thus MTPA medicalises the whole process of abortion and thereby neglects our own systems of practices prevalent in different parts of the country.

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[51] All the grounds mentioned in Section 3(2) of the MTP Act.

[52] Absolute Right implies the abortion on demand.

[53] The Act describes the qualifications as well as defines RMP succinctly in S.2 (d) MTPA, 1971. According to the Act,

a. In the case of a medical practitioner who has registered in a State Medical Register, immediately before the commencement of the Act, experience in the practice of Gynaecology and Obstetrics should be for a period not less than three years.

b. In the case of a medical practitioner who has registered in the State Medical Register after the commencement of the Act;

i. If he/she has completed six months of house surgeonship in Gynaecology and Obstetrics.

ii. If he/she has an experience at any hospital for a period of not less than one year in the practice of Obstetrics and Gynaecology.

iii. If he/she has assisted a Registered Medical Practitioner in the performance of 25 cases of medical termination of pregnancy in an established hospital or a training institution approved for this purpose by the Government.

c. In the case of medical practitioner who has been registered in State Medical Register and who holds postgraduate degree or diploma in Gynaecology and Obstetrics, the experience or training gained during the course of such degree or diploma.

The place of termination of pregnancy is specified in Section 4 of the MTPA and the rules provide that MTPs can only be conducted at a hospital established or maintained by Government or, a place approved by Government or District Level Committee[54]. The approval for a place where abortion can be performed is granted through a complex legal procedure[55]. In fact, all these legal formalities turned out to be restrictions on availing abortion services rather than facilitating it.

3.2. Safeguards or Restrictions?

The discussion on qualification of RMP, conditions of places where MTP can be performed and the process for approval of a place expose the procedural complexities of MTP services. Thus it may be observed that these conditions, created to safeguard women, have instituted legal restrictions to accessibility of MTP services. MTP can only be performed by a medical practitioner meeting with stipulated requirements. Thus the Act totally ignored or criminalised the skills of local abortionists (*dais*). However it is contented from the purview of the modern biomedical paradigm that the service of traditional birth attendants and abortionists

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[54] Previously the Act only allowed Government approved places. But now the amended Act and rules provide registration if the District Level Committee (DLC) approves it under Section 4(b) of MTPA. A DLC consists of 3 to 5 members. One member must be a Gynaecologist/Surgeon/ Anaesthetist and other members are supposed to be from the background of medical profession, NGOs and Panchayat Raj institutions. At least one member in the committee must be female.

[55] The hospital should be equipped with several basic medical instruments. The equipment requirement varies with the kind of MTP services offered, as explained below.

1. in case of First Trimester; a) Gynaecology examination /labour table; b) Resuscitation and sterilisation equipment; c) Drugs and parental fluid d) Back up facilities for treatment of shock; and e) Facilities for transportation.
2. in case of Second Trimester; a) an operation table and instruments for performing abdominal or gynecological surgery, b) anesthetic equipment, resuscitation equipment and sterilisation equipment, c) drugs and parental fluids for emergency use, notified by Government of India from time to time.

The Procedure for Approval of a place:

1. Application- for the approval of a place, application should be made in Form A to the Chief Medical Officer (CMO) of the district.
2. Inspection and verification- CMO has been empowered to verify the content of the above-mentioned application and inspect the site in order to ensure safe and hygienic conditions under the Act. It is the duty of the owner of the place to make necessary arrangements for the inspection under this act.
3. Approval- the CMO, after satisfying by verification and inspection shall recommend the approval of the place to DLC. Then the DLC after receiving application and recommendations of the CMO approve the place and grant certificate of approval. This approval certificate is to be displayed at the place to be easily visible to persons visiting the place.
4. Monitoring and inspection- the regular inspection (within 2 months) may be done by CMO to verify whether termination of pregnancies is being performed under safe and hygienic conditions.

Again CMO has the power to seize any article, medicine, ampoule, admission register or other documents, kept or found at the place, under following conditions. a) There has been death, or injury to a pregnant woman at the place. b) The termination of pregnancy is not being done at the place under safe and hygienic conditions. The seizure by CMO has to be done with the provisions of Code of Criminal Procedure (CrPC). CMO is empowered to cancel or suspend the certificate of approval.

who rely on other systems of medicine are less reliable and unsafe. The modern medical training is considered to be ultimate, reliable and totally safe. There are proposals from the NGOs and medical associations to give training for traditional medical practitioners who perform abortions to address the unmet needs of the rural women[56]. This proposal is problematic because it perceives traditional knowledge as secondary and there is no effort from the modern medical establishment and the Government health service system to engage with the traditional system of medical knowledge and the expertise and skills of the local abortionists.

The complex formalities regarding the approval of places where abortion can be performed also affect the rural women's access to the service. There is a concentration of MTP centres in urban India. The prescribed standards and equipments are costly and it is difficult to ensure these facilities in economically backward areas[57]. It has also been revealed that women are pressurised to adopt contraceptive methods or sterilisation after abortion in public health services[58]. This coercion to undergo sterilisation stood as one reason for poor women to resort to private providers[59].

3.3. New Legislative Measures

Since 1990s, the field of abortion has subjected to crucial changes including the introduction of new medical technologies. Therefore the Act has been amended 2002 in order to incorporate these changes and to make legal abortions widely available. With the amendment, the authority for approval of registration of MTP centres has been decentralised from state to district level. In the year 2003, the Government introduced a further amendment to MTP Rules. This amendment has rationalised the criteria for physical standards of abortion facilities and fixed different criteria as appropriate for conducting first trimester and second trimester abortions[60]. The MTP Rules 2003 required a gynaecological or labour table rather than an operation table and resuscitation and sterilisation equipments but not anaesthetic

[56] Gupta M., S. Bandewar and Pisal H. 1997. 'Abortion Needs of Women in India: A Case Study of Rural Maharashtra'. *Reproductive Health Matters*, 5(9):77-81.
[57] The affordability of the services is discussed elsewhere.
[58] Ibid.
[59] Ibid.
[60] K. G. Sandhya and Salini Varma, 2004. 'Induced Abortion: The Current Scenario in India', *Regional Health Forum*, 8(2): 1-14.

equipments for centres offering first trimester abortion[61]. These rules also permitted an RMP to provide medical abortion service in the case of termination of pregnancy up to seven weeks. Under this amendment, the practitioner should also have access to the facility for offering surgical abortion in the event of failed or incomplete medical abortion[62]. The Reproductive and Child Health Programme (RCH) launched in 1971 and the National Population Policy, 2000 also have delineated a number of strategies to increase access to safe abortion at the primary health care level[63].

After 37 years of its implementation, an evaluation of MTP Act has been made and the Report was published by the National Commission on Macroeconomics and Health (NCMH), under Ministry of Health and Family Welfare. Chapter four of the Report on Maternal Health Programme enumerates the implementation of the MTPA and looks at how the Act addresses the issue of maternal mortality and morbidity[64]. The Report accepts with the contention that a large number of unsafe abortions are still taking place in India, irrespective of the fact that we have a liberal abortion law since 1971. It notes:

> Over the years number of centres where pregnancy can be terminated has increased and at present there are 11025 recognised MTP clinics in the country. However, considering the fact that large number of unsafe abortions still takes place, providing for more facilities for MTP services has been taken into consideration under the ongoing RCH programme[65].

The report clearly points out that the facilities provided for abortion care is very minimal compared to the extensive demand for abortion services. The Report further discusses the unmet needs of Indian women and what should be done in future:

> Efforts are being made to provide for the unmet need for safe abortion service and to improve utilisation of existing facilities and further expand the MTP facilities so as to make safe abortion service accessible to all women in the country including the women in rural areas. At present, Government of India under RCH programme is undertaking training of medical personnel in MTP technique and undertaking IEC activities for improving the awareness and knowledge of the community[66].

Like any other Government document, the report of NCMH has IEC (Information, Education and Communication) as the sole solution. This suggestion originates from

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[61] Ibid.
[62] Ministry of Health and Family Welfare 2003. *Notification, Medical Termination of Pregnancy Rules.* http://mohfw.nic.in/MTP/Ruleshtm, accessed on 22.5.2007.
[63] Ministry Of Health and Family Welfare (MOHFW), 2000, *National Population Policy, 2000.* New Delhi: GOI.
[64] http://www.mohfw.nic.in.report on NCMH, accessed on 25. 6.2007.
[65] Iibid: 49.
[66] Iibid: 49.

the false assumption that the public is ignorant and passive. Although the real issue of unsafe abortion could not be solved through IEC, it demands a gender sensitive political will to restructure health system as well as health service system. There is a need to make services more socially appropriate and acceptable along with increased accessibility. Therefore it is important to consider women's perspective on the nature, distribution and quality of abortion service, characteristics of and reasons for women seeking abortion service from approved as well as non-registered centres and unqualified providers, and abortion related morbidity and mortality in order to ensure a gender sensitive legislation[67]. Alka Barua, in the study of abortion care in urban slums of Ahmadabad suggests that policy makers and service providers need to work together to make the Act more realistic and easy to implement[68].

Unwanted pregnancy is an acute problem in all societies. Before the MTP Act, unwanted pregnancy was managed by resorting to clandestine abortions, infanticide or abandoning the newborn. After the implementation of the Act, the social stigma attached to abortion seeking behaviour is reduced at least to an extent. It can be noticed that patterns of sexual and reproductive behaviour have changed significantly over the years. There is remarkable mobility in society due to urbanisation, industrialisation and educational transformation. Therefore the impact of MTPA should also be judged in the context of changing social values and attitudes[69]. The changing social scenario has an impact on the abortion seeking behaviour of women. In order to cope with the emerging situation the Act needs to be revised[70].

3.4. Links between PNDT and MTPActs

The data provided by the 2001 Census was a great surprise to Government and civil society as it showed the alarming decline in the juvenile sex ratio from 971 in 1981 to 945 in 1991 and 927 in 2001. This led to the enforcement of Prenatal Diagnostic Technique (Regulation and Prevention of Misuse) Act (PNDTA) enacted in 1994 by Government of India. The Act is meant for the regulation of the use of prenatal diagnostic techniques that prevents their misuse for the purpose of prenatal sex determination and sex-selective abortion. By enacting PNDTA, the Government

[67] Alka Barua 2007. "Abortion Care in Urban Slums: The Case of Ahmedabad", in Leela Visaria and Vimala Ramachandran (eds.) *Abortion in India: Ground Realities*. New Delhi: Routledge. Pp. 27-61.
[68] Ibid.
[69] However, this investigation is out of the scope of this chapter.
[70] Ibid.

tried to ban sex selective abortion. The introduction of PNDTA created confusion as to whether the Act prohibited sex selective abortion or abortion as a whole. Although PNDTA and MTPA are two independent legislations, the study by Visaria *et al.* suggests that this distinction is hard to maintain in actual practice[71]. The widespread campaign against sex determination has improved the awareness of PNDTA among public but at the same time the awareness of legality of abortion service and MTPA is still inadequate. Most of the advertisements by the Government and NGOs are communicating mixed messages regarding the legality of abortion and sex selective abortion[72]. Therefore it is essential to communicate to the public the distinction between PNDTA and MTPA in order to avoid ambiguity regarding the subject matter of the Acts and also for the implementation of both the Acts.

4. Right to Abortion: The Role of State

The State uses women's reproductive capacities as effective instruments to control its population and the sexuality of women. The State accomplishes this through both pro-natalist and anti-natalist polices targeting different groups within society[73]. Different policies and laws of the State along with the social practices and customs helped shape and regulate women's sexuality and confined them to socially and culturally prescribed roles of wife and mother. In this section we will look at how the programmes and policies of State target women and make them further marginalised.

Health programmes for women are women targeted rather than women oriented. The use of abortion as a method of family planning with a high proportion of women seeking abortion in second-trimester indicates the lack of decision-making power of women in sexual relationship and the barriers they face in accessing the existing contraceptive methods[74]. The ways in which different methods of

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[71] Leela Visaria, Vimala Ramachandran, Bela Ganatra and Shveta Kalyanwala 2007, 'Abortion Use and Prenatal: Evidence, Challenges and Emerging Issues', in Visaria and Ramachandran, pp. 1-28. Op cit.

[72] H. Bracken H. and V. Nidadavolu 2005. 'Mixed Messages? An Analysis of Communication Materials on
Abortion and Sex Determination in Rajasthan', *Economic and Political Weekly*, 27 August: 3856-3862.

[73] Imrana Quadeer 2001. "Public Health Perspective of Reproductive Health of Women". *Vikalp-Alternatives*, 19 (1-2): 61-72.

[74] Ashoka Bandarage 1997. *Women, Population and Global Crisis: A Political Economic Analysis.* London: Zed Books.

contraceptives are tested and promoted have turned women into human guinea pigs[75]. The morbidity-load created by the use of contraceptives seems to outweigh the benefits of preventing pregnancy. The promotion of male contraceptives is deliberately neglected because it is politically counter productive.

Women's decision to abort and their experience of abortion are simultaneously controlled and mediated by larger institutions such as the state, medical institutions and patriarchal families. The structural conditions and processes like socio-economic transitions and the sexual division of labour also influence the abortion decision-making process[76]. As Petchesky argues, women's access to material resources in the form of land ownership and employment outside the domestic sphere does effectively change their conception of reproductive control[77]. The very meaning of abortion derives from the specific historical and political context in which it occurs; and circumstances like class, marital status and employment conditions of the women deeply influence it[78]. In the Indian context we can add to this the caste and regional factors. As Anandhi argues, "abortion as a women's choice or as a symbol of their reproductive freedom is always influenced by various patriarchal structures and social conditions, and it is not possible to abstract the concept of the right to choice or reproductive right from the social and material conditions under which choices are made"[79]. In developing countries like India the women's movements should be vigilant enough in using the concepts of 'right to choose' or 'reproductive autonomy', because our social conditions are totally different from the developed countries. Therefore it is the responsibility of the women's movements and organisations in India to translate these concepts into the socio-economic, political and cultural context of the country.

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[75] Rajashri Das Gupta 2004. "Quick-fix, Medical Ethics, Quinacrine Sterilization and Ethics of Contraceptive Trials", in Mohan Rao (ed.). *The Unheard Scream: Reproductive Health and Women'sLives in India*. New Delhi: Zubaan.

[76] S. Anandhi 2007. "Women, Work and Abortion Practices in Tamil Nadu", in Visaria and Ramachandran, op cit: 62-99.

[77] Rosalind Petchesky 1986. *Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom*. London: Verso.

[78] Ibid: 9.

[79] Anandhi 2007, op cit.: 63.

4.1. Abortion as a Right v. Abortion as State Policy

Usha Ramanathan contests that in the Indian context the abortion right is always in conflict with policy[80]. The lack of provisions in Maternal Benefit Act for labourers in unorganised sectors and the two-child norm adopted by the state reflects the same. She argues that the belief that 'abortion is a right' is actually a myth in the Indian context[81]. Upendra Baxi has argued that the unorganised sector is the constructive place of violation that not only denies labour rights but produces the material bases for denial of reproductive rights[82]. Therefore women from poor socio-economic condition suffer more due to denial of the right to abortion. To achieve abortion rights for marginalised and poor women would require changes in structural conditions and state policies that promote gender sensitive economic and social systems. We should not limit our endeavour into improving quality and availability of health services alone. Instead we need to change the social structure through constant political struggle.

4.2. Abortion as a Method of Family Planning

The underlying assumption in the MTPA was to make available the facility of safe abortion to Indian women. The experience with Indian women clearly shows that, apart from terminal methods such as sterilization, there has been very little change in number of users of contraceptives[83]. This observation further supports the argument that abortion law was liberalised in India as an additional means to reduce births to control the population.

A study in Tamil Nadu documented how abortion is used as a method of contraception in order to achieve desired demographic objectives[84]. In India, the population policy of the Government advocates the control of the size of the family.[85] Larger families are unacceptable. Though there is no compulsion of limiting family size, there is enough evidence that the official family planning programme 'motivates'

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[80] Usha Ramanathan, personal interview conducted on 20.11.2006.
[81] Ibid.
[82] Upendra Baxi 2000. *Gender and Reproductive Right in India: Problems and Prospects of New Millennium*, UNFPA Culture, 6 September, New Delhi.
[83] Ravi Duggal and Sandhya Barge 2004, *Abortion Service in India, Report of a Multi-centric Enquiry.* Mumbai: CEHAT, AAPI and Health Watch.
[84] Nagarj K. 2002. *Fertility Decline vs. Tamil Nadu-Social Capillarity in Action.* Chennai, Madras Institute of Development Studies.
[85] GOI. *National Population Policy (2002).* New Delhi: Ministry of Health and Family Welfare.

couples with a larger family size to undergo sterilisation[86]. It is obvious that the prevailing social attitudes that are supported by the Government make it easier to pressurise women rather than men to accept family planning[87]. Studies investigating the services repeatedly point out that the women are treated with indifference and often with disrespect[88]. It is further observed that other than women the soft targets of the Government programme are the poor and the rural population.

In this context, Sushila and Nagaraj[89] observe that vast majority of Indian women seeking MTP are adult married women with children. It is due to the lack of access to effective contraception or failure of contraception that the women resort to abortion as a measure of birth control. In India MTP is legally not advocated as a method of family planning. However, the high prevalence of abortions is a concrete proof of the Indian women's need and search for family planning measures. Even if the Shah Committee Recommendations and MTPA specifically state that this enactment should not be used as a method of birth control, it is quite evident that the reality is quite different.

4.3. Impact of MTP Act on Accessibility, Availability, Affordability and the Question of Abortion Services

Although the number of approved abortion facilities in India has increased significantly from 1877 in 1972-1976 to 11025 in 2007[90], access to safe abortion services continues to be limited for the vast majority of women in the country. In fact, some of the clauses in MTPA have in effect contributed to reducing the availability and accessibility of abortion services (provisions regarding approval certification, role of RMP, etc.). The Government has taken measures to decentralise the authority that approves MTP services through amendments. The commitment of the Government towards increasing access to abortion at primary health care level which would improve the availability of abortion facilities.

Not only are approved facilities inadequate in number, but also distributed unevenly between and within states. K.G. Sandhya and Shalini Verma's study

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[86] Ibid.
[87] Rao 2004, op cit.
[88] Anjali Radkal 2007. Abortion Among Married Women", in Leela Visaria and Vimala Ramachandran (eds). *Abortion in India: Ground Realities*. New Delhi: Routledge. Pp. 101-131.
[89] K. Sushila and K. Nagaraj 2007. "Pregnancy Wastage among Poor in Coastal Karnataka", in Visaria and Ramachandran, op cit.
[90] Ministry of Health and Family Welfare 2007. http://www.mohfw.nic.in, accessed on 17.07.2007.

provides examples from all over India in support of this[91]. In Maharashtra, a State that comprises of 10 per cent of India's population has more than one-fifth of total number of facilities in the country. But in Bihar another State of same population has only 1 per cent of the total facilities. Within each State, the approved facilities are concentrated in urban areas. This has resulted in limited access for a vast majority of women in rural areas.

4.4. Limited Public Sector Provisioning

The cuts in public funding in health sector (health sector reforms) as part of the Structural Adjustment Policies have had a negative impact on provisioning of abortion services also. The lack of trained personnel and inadequate infrastructure facilities in public sector has accentuated problems in abortion provisioning. The district level teaching institutions, sub-district hospitals and community health centres are required to provide abortion service. A situational analysis of abortion facilities in Gujarat, Maharashtra, Uttar Pradesh and Tamil Nadu shows that only about one-fourth to nearly three-fifth of Primary Health Centres (PHCs) offer abortion services[92]. The national level family survey reports that only 3 per cent of PHCs provide MTP services[93]. The survey also reports that most PHCs lack essential equipments. Only one in six primary health centres have MTP suction aspirators. According to the rules, all the PHCs are supposed to provide abortion services, but the reality is far different from this.

Several studies conducted by CEHAT as part of Abortion Assessment Project of India (AAPI)[94] and Reports of Ministry of Health and Family Welfare admit the fact that through the instrumentation of law, access to abortion service has increased. But accessibility is limited to an extent by certain provisions of the law as well as due to lack of funding and policy enactments. Legal measures are taken into consideration in order to make maximum utilisation of liberal law equally for all sections of women, irrespective of their social status. In this country, affordability or capacity to pay is

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[91] Sandhya and Verma 2004. Op cit.
[92] Ibid.
[93] International Institute for Population Services (IIPS) 2001. *Reproductive and Child Health Project: Rapid House Hold Survey (Phase I and II) 1998-99.* Mumbai: IIPS.
[94] The wide range of studies done by researchers like Bela Ganatra, Leela Visaria, Vimala Ramachandran, Alka Barua, and Shveta Kalyanwala. See http://www.cehat.org, accessed on 02.09.2006.

another important issue as far as abortion provisioning is concerned. The cost of service has got a direct impact on the health of pregnant women who need services.

4.5. Cost of Abortion Service

Economic constraints may compel many women, particularly those who belong to the lower classes to seek unhealthy and dissatisfactory services[95]. There is evidence that women are willing to pay for services that meet their needs and in accordance with their perception of quality. Whereas in public sector facilities are expected to provide services free of cost, it is reported that, women incur hidden cost in the name of medicine and bribe for staff[96]. A study in Madhya Pradesh reports that only one in ten abortions in public sector MTP centres were provided free of cost[97].

All these studies give us a picture that the cost of abortion usually varies depending upon the type of provider, the gestation period and the method used. The mortality and morbidity connected with unsafe abortions thus continues to be a major public health issue. If the cost of service is high, and it becomes a barrier for accessing the service, then it should be the role of the state to facilitate the service through free provisioning. The most disturbing fact is that MTP Act is totally silent on this issue. Even if the act gives an impression that termination of pregnancy is a *right*, there is no provision in the act, which deals with the cost of the service. There is no provision available as of now to regulate the fee structure among private sector providers. Available studies on the cost of abortion services also failed to address the issue of lack of legal provisions to regulate fee structures in private sector. In order to make abortion *on demand*, it is an important requirement that the public sector should ensure abortion service free of cost. The illegal fee levied by the public sector providers is a concrete example of exploitation.

4.6. Quality of Services

The main objective of MTPA is to provide safe abortion services. The Act emphasises safe and hygienic conditions under qualified medical personnel as a pre-requisite for legal abortion. But the available studies which have explored the quality

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[95] Parivar Seva Sanstha 1998. *Abortion Research Phase II: Final Report*. New Delhi: Parivar Seva Sanstha.

[96] Barge S. K. Mangunathan and S. Nair 1994. *Situational Analysis of MTP in Gujarat*. Vadodara: Center for Operations Research and Training (CURT).

[97] A. Malhotra *et al.* 2003. Realising Reproductive Choices and Rights: Abortion and Contraceptives in India. Washigton:International Centre for Research on Women (ICRW).

of abortion services in public and private sectors, give us evidence of poor quality of services. A national level facility survey reports that only 13 per cent of primary health centres in the country have at least one medial officer trained in MTP[98]. The situation is worse in the states of Bihar, Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh and West Bengal, when this percentage is merely 2 to 6 per cent. At the same time, the private sector providers have not obtained proper training. In public sector, training centres are getting limited number of cases, and therefore the experience of trained doctors is also limited[99]. The existing power-hierarchy in doctor-patient relationship and the morals and values lead to the judgmental attitude of providers both in public and private sectors. The use of abusive language by the medical personnel and the tendency to blame the victim are still widely prevalent[100]. This may further result in the expulsion of women from authorised services to unauthorised ones.

Studies reveal that providers often disregard the need to respect the privacy and confidentiality of women seeking abortion. The public sector service faces one more issue of coercive contraception. Several studies highlight that providers often insist on husband's consent, though the law does not give such a mandate. In a study in Rajasthan, four out of five women reported that the provider took their husbands' consent[101]. Despite the law not excluding unmarried and separated women from its scope, they could not avail certain provisions. A study in Maharashtra for instance reports that 40 per cent of providers[102] selectively refuse services to unmarried and divorced women[103].

The pre and post-abortion care service have often been given a low priority. Barua's study showed that, the providers pre-abortion services only comprise physical examination and enquiries about medical and obstetrics history. MTP regulation specifies the need of counselling before conducting abortion. Sometimes, this counselling became a morally judged one, and an exercise in victim blaming, instead

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[98] Sudhakar Morankar, Bhupali Mhaskar, Vidula Purohit, Mrudul Patil and Abhay Cubale 2007. "Community Perspectives on Abortion: An Ethnographic Exploration of Rural Pune", in Visaria and Ramachandran, op cit.

[99] Ibid.

[100] Barua 2007, op cot.

[101] Elul B. *et al.* 2003. Unintended Pregnancy and Abortion: A Community based Study in Rajasthan- Summary Report. New Delhi: Population Council.

[102] Of whom 24 per cent were legally recognised MTP centres.

[103] Ganatra B and Siddu Hievc 2002, "Induced Abortions Among adolescent women in rural Maharashtra", *Reproductive Health Matters*, 1: 39-43.

of one giving proper information regarding the possible risk of the procedure, its potential complications and their treatment, the need for a follow-up visit, and advice on post-abortion contraception with the range of contraceptive choices available to prevent repeat abortions. A multi-state study reports that less than one-half of women were informed about the possibility of infection[104]. Moreover, emergency services to deal with incomplete and life threatening post-abortion complications are totally lacking in the current service delivery system. The law has been silent on this important aspect.

4.7. Gender as a Barrier

The MTPA was poorly formulated to give women autonomy over decisions concerning their bodies. In a patriarchal society it is evident that gender roles and norms operate in many ways to limit access to safe abortion. In the process of abortion decision making, the partner, family, customs, practices, values and morals play a crucial role. Those who seek abortion are often considered as "immoral". This stigma is much more prevalent in the case of widows, divorced and unmarried women. This may lead to delays in seeking abortion and thereby jeopardise the safety of the woman in need of abortion.

4.8. Failure of Communication

Failure of communication of the legal status of abortion and the facilities where abortion services are legally provided may lead many women to seek abortion from clandestine providers. Even though abortion has been legal in India for more than three decades, only a small minority of men and women know that abortion is legal[105]. Those who are aware of the legality of abortion are not aware of the prerequisites to avail legal abortion. The Government has attempted to improving awareness through IEC. Such measures, however, are to be viewed in the context of family planning for its notorious penchant for victim blaming. Thus in a country like India in which vast majority of people are far away from all technologies of communications, we should think about new methods for better communication and thereby better understanding of the law. Surely, a better understanding of the law could accelerate better access to services.

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[104] Malhotra *et al.* 2003, op cit.

[105] Nivedita Menon, Abortion and Law: Questions from Feminism, 1993. *Canadian Journal of Women and the Law* 6: 31-38.

5. Conclusion

In democratic countries like India, law is expected to assist social change. Activists, lawyers and judges in India are trained to deliver justice to women through legal processes. Therefore, social legislation can play a significant role in initiating the process of social change. Law can assist the empowerment of women by conferring rights on them and by imposing liabilities on the State. Law can aid empowerment by strengthening the institutional infrastructure for enforcing such rights and liabilities. It can also aid empowerment by supporting, stimulating and monitoring the attitudinal and value change in society. The analysis of MTPA in this chapter is based on this understanding.

Legislation appears to be an inadequate instrument, when it comes to massive social regeneration, to a transformation of values, attitudes and the way people relate to their daily lives. Changes in legal mandates alone will not necessarily result in equality. Change in law must be accompanied by change in social attitudes in order to realise the ideal of gender equality. Change in social attitude is part of social transformation through structural changes. However, in a democratic set up, as we have seen, the law is being used as an important instrument for transforming the status of women. This is a limited interpretation of law in a society in which unequal power relations are prevailing. That is, the law can also be used as an instrument by the ruling class to exploit and oppress the marginalised sections of the society. The MTPA and its over-medicalised nature should be assessed from this understanding of the legal structure that exists in the country. Nivedita Menon observes that the progressive attitude of the Indian State to abortion is dictated by compulsion rather than commitment to women's liberation[106]. Thus the law fails to an extent to deliver justice to Indian women.

The Indian Medical Termination of Pregnancy Act came into force in 1971, in response to the high mortality and morbidity rate associated with illegal abortions. As noted by the Editorial of *The Hindu*, "Maternal Mortality Ratio (MMR) is an important indicator of the reach of clinical health service to the poor and a composite

[106] Ibid.

measure of overall quality of life"[107]. So this crisis is rooted in poverty and social inequality. Even now, India continues to spend a low percentage of GDP, i.e., less than one per cent, on public health. The ultimate impact of this is that it would become very difficult to implement law and policies to get the maximum advantage for women, as most of them would rely on the public sector for abortion services. The withdrawal of the State from public health sector is bound to affect the access to health care for women from lower *socio-economic* strata. The experience of Indian women make it clear that vast improvements in abortion law, policy and service delivery are essential for the provisioning of better abortion care in India.

[107] Editorial, *The Hindu*, dated 10.7.2007.

Chapter 3
Abortion Laws in Sri Lanka, Nepal and Bangladesh

1. Introduction

As we have seen, abortion is an ethical, legal, social and medical problem of worldwide significance. Above all, it is also a deeply political issue. In developing countries, early marriage, lack of contraceptive availability, religious beliefs, social habits, the low social status of women and the lack of access to health care facilities force women to undergo unsafe abortions with tragic consequences. Women with unwanted pregnancies have always resorted to abortion. A case study revealed that non-consensual sex, sexual violence and women's inability to refuse their husbands' sexual demands seems to determine the need for abortion in both younger and older women[1]. In patriarchal societies, a majority of men apparently believe that sex within marriage is their right and that their spouses have no say on the matter. Throughout history, and even now in many countries with restrictive abortion laws, women are subjected to the danger and misery of illegal abortions.

2. South Asia: Need for serious attention

Unsafe abortion is of particular concern for public health, in regions where abortion is highly restricted through law and policies or where the implementation of safe abortion is weak. In Asia, access to abortion services varies to a great extent as different countries follow different laws and practices which are liberal to restrictive in orientation. One-half of the world's unsafe abortions occur in Asia[2]. Over three fourths of the abortions in South Asia are unsafe due to restricted legislation. This invites special attention on the South Asian scenario and detailed research on the abortion laws in the region is essential in accomplishing a gender sensitive legislation in South Asian countries. The scope of the study is limited to Sri Lanka, Nepal and Bangladesh because they are representative of the region. These countries have been selected, due to their diverse socio-political, economic and cultural contexts and the diversity in and uniqueness of their abortion laws.

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[1] T.K. Sundari Ravindran and P. Balasubrahmanian 2004. "Yes to Abortion but "No" to Sexual Rights: The Paradoxical Reality of Married Women in Tamil Nadu, India", *Reproductive Health Matters*, 12(33): 88-89.

[2] Ahman E. and Shah I. 2002. 'Unsafe Abortion: Worldwide Estimate for 2000", *Reproductive Health Matters*, 10(4):13-17.

This chapter provides an overview of abortion laws and its impact on safety, accessibility, affordability, availability and quality of abortion services in the respective countries. The chapter also analyses the available laws and policies by situating them in the historical contexts of each country and examines the involvement of different social movements, women's organisations and non-governmental organisations as pressure groups in the formation and enforcement of abortion laws. This chapter examines the role of religion in forming abortion law in different countries; in Sri Lanka the role of Buddhism, in Nepal, Hinduism and in Bangladesh, Islam. The chapter also discusses the role of international agencies in formulating abortion law and policies in respective countries.

The first part of this chapter deals with Sri Lanka. Although there have been significant improvement in the overall health and social standards within Sri Lanka, abortion is illegal except to save a woman's life. The role of Buddhism in shaping the public opinion on legalisation of abortion in the country will also be analysed. The second part discusses the abortion law in Nepal, a country where abortion was legalised only in 2002. Before that, abortion was a criminal offence in Nepal and thousands of women were punished and jailed. Women's organisations are still campaigning towards the release of these women from jail. The final section of this is on the abortion law in Bangladesh, which is an Islamic country, wherein abortion is allowed under 'menstrual regulation' during the first eight weeks of pregnancy. The reviewing of abortion laws in these countries will give us a better understanding of the relationship between legality and safety. This will strengthen our perspective on women's right to abortion and our understanding of how the rights have been formed in different social contexts. This understanding of the wider political context of abortion rights in South Asia will contribute to the endeavour to transform Indian abortion law into a more adaptable and sensitive one. This will further help the women's movement in India to debate the issue of abortion beyond the narrow context of sex selective abortion. This approach of the study will contribute to situating abortion right in the larger frame of sexual rights of women.

2.1. Abortion Law in Sri Lanka

Sri Lanka is predominantly an agricultural island consisting of people from a diverse range of ethnic and religious backgrounds. Majority of people live in rural areas. The long-standing civil war has made many parts of the country virtually

inaccessible. There have been significant improvements in the overall health and social standards in the country in recent decades. The Sri Lankan government invests heavily in the health care system and therefore the primary health care is widely accessible to the people. However there is a paucity of medical and technical staff that affects the quality of medical and diagnostic services.

Sri Lanka is traditionally a male dominated society. Women constitute 27 per cent of the labour force[3], but their contribution to the economy is largely undervalued. The women in Sri Lanka still bear the burden of domestic responsibility and thereby facing dual exploitation. The average age of first marriage is 24.4 years[4]. Women have equal property and inheritance rights.

Sri Lanka has made significant advances in terms of health of the population. The maternal mortality rate is comparatively low with 94 percent of births attended by trained personnel[5]. Oral contraceptives are available from community nurses, trained midwives and pharmacists without prescription. Condoms are widely availed through retail outlets[6]. However, it is a fact that the availability of contraception in many parts of the country is severely hampered by the political unrest. The reproductive health indicators including the availability of contraceptives in the country are very progressive in nature. At the same time, Sri Lanka has one of the most restrictive abortion laws in the world that allows abortion exclusively on medical grounds. The Family Planning Association of Sri Lanka (FPASL) and other NGOs working in the area of reproductive health are advocating the liberalization of the abortion law to include cases of rape, incest and congenital ability.

Abortion is generally illegal in Sri Lanka under the Penal Code of 1883, which was composed on the basis of Indian Penal Code. Section 303 of the Sri Lankan Penal Code provides that "anyone voluntarily causing a woman with child to miscarry is subject to up to three years imprisonment and/or payment of a fine, unless the miscarriage was caused in good faith in order to save the life of the mother[7]. The penalty is imprisonment up to seven years and payment of a fine, if the woman is

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[3] Jayawardena H. 1993. "Abortion in Sri Lanka", *Law Gazette*, 13(1):19-21.
[4] Ibid.
[5] Evaluation Unit, 2003. *Annual Report on Family Health, 2003.* Colombo, Sri Lanka: Family Health Bureau.
[6] P.C. Gunasekhara 2001. "Reducing Abortion is a Public Health Issue", *The Ceylon Medical Journal*, 46 (2): 7-10.
[7] http://www.who.org/abortion-law/srilanka, accessed on 9.11.2006.

'quick with child'"[8]. A woman who induces her own miscarriage is subject to the same penalties. Section 304 of the Penal Code provides twenty years of imprisonment and payment of fine for miscarriage caused without the consent of woman. The same penalty is imposed through Section 305, if the woman's death results from any Act carried out with an intention to cause a miscarriage; whether or not the offender knows that the act was likely to cause death[9].

In 1973, the abortion legislation of the country was studied by a Committee of Medical Legal Society of Sri Lanka. The nature and constitution of the Committee is not available. Nor do we know that what factors led to the constitution of the Committee. The Committee recommended that the law should be liberalised to allow abortions to be performed in order to prevent grave injury to the physical and mental health of the mother, in cases of pregnancy resulted from rape or incest and in case of foetal abnormalities. However, the most disturbing fact is that no legislative action resulted from these recommendations. The Ministry of Health has begun to publicise the linkage between illegal abortion and maternal mortality in order to get support for liberalisation of abortion law from the public. Yet there is not much progress in the attempts to legalise abortion in the country.

2.1.1. The Magnitude of the Abortion Issue in Sri Lanka

As in many countries, in Sri Lanka a significantly large number of women of reproductive age face unwanted pregnancies. The large number of unwanted pregnancies among women in Sri Lanka is due to lack of access to reproductive health services, non-consensual sex and rape[10]. As a result a large number of women use abortion to prevent unwanted pregnancies. It is difficult to estimate the number of induced abortions in Sri Lanka due to an obvious lack of adequate data. The available statistics estimate that approximately 150,000-200,000 induced abortions occur annually in Sri Lanka[11]. Community based surveys such as demographic and health surveys have attempted to collect information on induced abortion in Sri Lanka.

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[8] This term is not defined in the Code. It refers to an advanced stage of pregnancy, when there is perception of foetal movement. It is different from the usage of "women with child", which simply mean "being pregnant". Ibid.

[9] Ibid.

[10] Gunasekhara 2001, op cit.

[11] This estimation is derived by using daily average attendance in known abortion clinics. Family Health Bureau 1993. *Demographic and Health Survey 1993*. Colombo: Ministry of Health.

However the surveys are not successful in colleting accurate data on abortions due to legal, social and cultural stigma associated with induced abortions.

2.1.2. Use of Contraceptives and Abortion

The Demographic and Health Survey of 1993 reported that in Sri Lanka about 40 percent of the current users of contraception among married women relied on traditional methods[12]. The expert committee of CEDAW in Sri Lanka is of the opinion that the improved use of contraceptives can reduce the number of unwanted pregnancy. The failure in providing good quality family planning services to all segments of Sri Lankan society pushes the current annual abortion incidence to higher levels[13]. Partner's opposition to modern methods, poor access and fear of side effects are some of the reasons for not obtaining contraceptive services. In those societies where there is no proper use of contraceptive, abortion is sometimes relied on as a method of family planning. This is made explicit in the study of De Silva I. *et al.*, which reveals the reasons for abortion seeking. According to the study, one third of abortions are for spacing pregnancies. Economic difficulty and unstable marriages are also referred to as inducing abortion-seeking behaviour. However, the majority of the abortion seekers use abortion as an alternative for contraceptives. This has obviously a deep impact on the health of women in the country[14]. The practice of menstrual regulation is widely used as a method of termination of pregnancy in Sri Lanka. However, menstrual regulation is conducted only in the first trimester of pregnancy, mostly with the intention of family planning. Like any other patriarchal societies, in Sri Lanka also the burden of family planning became predominantly a women's responsibility.

2.1.3. Necessity of the Law

The law concerning abortion in Sri Lanka was enacted in 1883 and abortions are restricted through penal provisions. While 61 per cent of the humanity lives in countries where termination of pregnancy is legal and generally available, Sri Lanka is one among the 21 per cent of countries where termination of pregnancy is legal

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[12] Ibid.

[13] http://www.who.org/abortion law in Sri lanka/cedawrecommendations, accessed on 9.11.2006

[14] De Silva I., Rankapuge, L. and Perera R. 2000. "Induced Abortion in Sri Lanka: Who Goes to Providers for Pregnancy Termination?" In Department of Demography. *Demography of Sri Lanka, Issues and Challenges*. Sri Lanka: University of Colombo. Pp. 182-196.

only to save the life of the mother[15]. Because of the restrictive abortion law in Sri Lanka, doctors are usually unwilling to provide abortion services. Even if the service is provided, the cost in private facilities is very high and abortions are performed in unsatisfactory settings[16]. The mortality and morbidity in terms of abortion depend on the facilities available: the skill of abortionist, the methods used, the gestation period and the availability of treatment facilities for complication[17]. Abortion and their complications account for about 5-6 per cent of maternal deaths in Sri Lanka[18]. This is a tragic situation as the maternal deaths due to abortion are the easiest to prevent through minimal medical attention. This situation highlights the need for a law which facilitates the termination of pregnancy.

An attempt to reform the restrictive abortion laws to permit termination of foetal malformation and pregnancy followed by rape or incest failed when the proposed Penal Code Amendment of 1995 was withdrawn. The proposed 1995 Penal Code Amendment had been advocated by professional organisations (including medical professionals and NGO's working on women's cause) for liberalisation of the restrictive abortion law, but these amendments were not realized due to the opposition mainly from the Catholic members of the legislature[19]. 'Right to life' arguments and other justifications based on tradition were articulated in parliamentary debates in the context of the proposed amendment[20]. At present there is an ongoing attempt to revamp the amendment and deliberations are going on over the issue of abortion in Sri Lanka. The main thrust of the negotiations is the wide disagreement that persists among the stakeholders on whether abortion should be legalized or not. In stark contrast to the progressive policies and enactments in other matters, the issue of abortion is still struggling to get out of the clutches of conservativism. As a major force that maintains the status quo of society by intervening in the mundane life of the people, it is important to look at how the religion approaches the issue of legalisation of abortion.

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[15] Alan Guttmacher Institute 1999. *Dilemma and Decisions: Unintended Pregnancy and Abortion Worldwide*. New York.
[16] Gunasekhara 12001, op cit.
[17] Ibid.
[18] Evaluation Unit 2000. *Annual Report on Family Health 2000*. Colombo, Sri Lanka: Family Health Bureau.
[19] http://www.policyproject.com, accessed on 9.11.2006.
[20] The parliament debate is not available. This is quoted from *Hansad* of 19th September 1995, pp. 89-128. Cited in Gunasekhara 2001, op cit.

2.1.4. Religion and the Abortion Law

Buddhism is the official State religion of Sri Lanka. Christianity and Hinduism also have influence in the country. The Catholic Church has a wide presence in Sri Lanka.

Buddhist teachings give rise to a variety of interpretations regarding the permissibility of abortion. This is quite obvious while analysing the abortion laws in Buddhist countries. Countries such as Bhutan, Sri Lanka and Thailand have restrictive laws. Cambodia permits abortion at women's request during the first 12 weeks of pregnancy. In Japan, a predominantly Buddhist state, abortion is acceptable both legally and socially[21]. Like other religions, in Buddhism also there is debate on the personhood status of the unborn foetus. There are diverse opinions in Buddhism regarding the conditions under which abortion could be justified. It is noted that Buddhism is more or less silent on the issue of regulation of abortion and the choice is left to the individual conscience of the pregnant women[22]. Therefore it can be noticed that in Sri Lanka, Buddhism has not contributed much in shaping public opinion on the legalisation of abortion. It was Catholicism that took a leading role in the abortion debate, precisely due to the silence of Buddhism on the matter[23].

Catholic theology plays a crucial role in determining the nature of abortion legislation in the country. In Sri Lanka, 69.1 per cent of the population follows Buddhism and the rest is shared by the Islam (7.6 per cent), Hinduism (7.1) and Christianity (6.2) in which majority are Catholics[24]. Among the minority religions, Christianity is more organised and vocal in the context of Sri Lanka. Based on the pro-life perspective, the Catholicism tried to undermine the bodily autonomy of women and thereby control sexuality of women in Sri Lanka. The efforts for liberal abortion legislation (Penal Code Amendment, 1995) also have been attacked by the Catholic Church. However the Government in cooperation with NGOs attempts to counter this anti women move.

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[21] James H. Horhughes and Damien Keown 1995. 'Buddhism and Medical Ethics: A Bibliographic Introduction', *Journal of Buddhist Ethics*, 2: 16-24.
[22] Ibid.
[23] Ibid.
[24] http://www.careinternational.org.uk/Sri+Lanka+Statistics+3552.twl, accessed on 27.07.2007.

2.1.5. Abortion Movement in Sri Lanka

The ongoing struggle for a liberal abortion law in Sri Lanka is jointly led by the Government and NGOs. Decriminalisation of abortion is perceived by the concerned NGOs and social activists as a means to achieve social justice. The NGOs are working in collaboration with international agencies like UNFPA and WHO. The NGO sector plays a supportive role in the initiative of the Government to improve family planning services[25]. The outlook of these NGOs is based on their commitment to women's health and for them the issue of unsafe abortion is a major public health concern.

Despite the call of reproductive health and rights as the International Conference on Population and Development (ICPD), the population control lobby views the issue of abortion only in the limited context of its impact on the health of the women. According to their perspective, abortion issue could be addressed effectively by implementing proper family planning programmes, through the increased availability of contraceptives and of sterilisation. Here the assumption is that by improving family planning services unwanted pregnancy can be prevented and accordingly the complications arising out of unsafe abortions too. Thus the politics of population control is limited in the sense that here the wider politics of sexuality is not taken into consideration. In a patriarchal society, the decision-making capacity of women is limited in matters concerning the use of contraceptives and sterilisation. She is an object of the imperatives of family and society. Therefore, to address abortion issue, it is essential to change the role of women in marital relationship, family and society. Unfortunately the Government and NGOs are holding the same politics of population control in Sri Lanka. The general standpoint of the abortion movement in Sri Lanka is that by improving family planning services, and through decriminalizing abortion, the issue of unsafe abortion can be tackled. The necessary initiative in Sri Lanka should be for a new law, which ensures the quality, availability, affordability and accessibility of abortion services.

The example of Sri Lanka in the context of a study of abortion law is important because, in spite of the recent steady rise in human development indicators,

[25] The NGOs namely FPASL, Sarvodaya, World View Sri Lanka, SALVSC, CDS, Vinivida Federation of Community Based Organisations and Sumithrayo are mainly functioning in this area. They are involved in programmes related to education, training and counselling. Ibid.

a rigid abortion law still persists in the country. This is a paradox that has to be probed further.

2.2. Nepal: From Ban to Legalisation

Laws that criminalise abortion deny women's fullest enjoyment of basic human rights. The criminal law prevents women from exercising human rights such as the right to life and health, right to equality and self-determination. The human rights of Nepali women were breached by the law criminalising abortion till 2002. The awareness of the impact of unsafe abortion on public health along with the emergence of women's movements in Nepal led to the reformation of the abortion law in the country. It was also related to the commitments made at Cairo. The political movement that aimed at the democratisation of Nepal also contributed to the formation of a liberal law. The new law is a radical one in nature. Before 2002, abortion was banned completely and illegal abortion was a criminal act.

2.2.1. Status of Women in Nepal

Centuries of patriarchy and feudalism have resulted in unequal treatment of women in all spheres of life. Women are considered to be 'second class citizens' and they continue to be marginalised and oppressed[26]. However, the constitution adopted in 1993 as part of the political process of democratisation guarantees women the right to equality. The study conducted by the CRLP and FWLD observe that the women of Nepal do not constitute a homogenous group[27]. Therefore the degrees of discrimination vary by caste and ethnicity in the country[28]. Women belonging to indigenous groups enjoy more liberty in matters of health and sexuality in the private domain than women belonging to higher castes. However the situation is diametrically opposite as far as the public domain is concerned. Indigenous women face greater economic and political disadvantage than women belonging to higher castes.

Women in Nepal experience extreme forms of gender discrimination. The extent of gender discrimination is visible in son preference, female sex-selective abortion, low rate of enrolment of girl students in schools, early marriages and so on.

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[26] http://www.cedpa.org, accessed on 18.02.2007

[27] The Centre for Reproductive Law and Policy (CRLP) and Forum for Women Law and Development (FWLD). 2002 *Abortion in Nepal: Women Imprisoned.* Katmandu.

[28] Ibid.

The health of women in general and the reproductive health in particular have to be addressed in this context. The maternal mortality rate is 740 per 100,000 live births; this is extraordinarily high even by South Asian standards[29]. The birth attended by skilled personnel is 15 per cent in 1996 - 2004 and this is an indication of the lack of importance given to women's health. Half of the maternal mortality rate arises out of unsafe abortions. The problems associated with the absence of safe and legal abortion services and the lack of contraceptive methods are the major reasons for the huge load of maternal mortality.

2.2.2. Nepal and Hinduism

Nepal held the distinction being the world's only Hindu Royal kingdom until the new democratic Government came in to power in 2006. Although the constitution of 1990 envisioned a secular state governed by secular principles, in reality the society continued with a majority of the population following Hinduism and largely the Hindu religious values and norms shaped the social fabric[30]. The status of women was determined by the ideology of patriarchy blended with the religious morals and values. The social norms and values were products of this nexus between religion and patriarchy. The sexuality of women was controlled by the social norms and values in order to maintain the status quo. The norms, values and customary practices are being considered as the main sources of law. Therefore, it is important to examine the context of abortion law and the reforms in reference to the complexities of Hinduism. However, the sacred texts of Hinduism are silent on the issue of abortion. Along with religion, the economic development hampered by political instability and social unrest in the country also operated as influential on banning abortion. Nepal is one of the poorest countries in the world. The life expectancy, infant mortality, literacy, access to health care and income levels vary greatly across geographic regions, caste, ethnicity and social groups in Nepal[31].

2.2.3. Demographic Background

The total population of Nepal is almost 25 million. Nepal is predominantly rural where approximately 88 per cent of the total population living in rural areas[32].

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[29]http://www.panasiaorg sg/nepalnet/abortion law, accessed on 02.06.2007.
[30] *Nepal Constitution, Preamble*. Government of Nepal, 2006.
[31] Nepal South Asia Centre (NESAC) for United Nations Development Programme (UNDP). *Nepal Human Development Report 1998*. http://www.undp.org accessed on 18.06.2007.
[32] Ibid.

Women constitute 49.3 per cent of the total population. Half of the population lives below the poverty line. The primary source of income is agriculture and nearly 80 per cent of the total population relies on agriculture as a source of income. Several attempts at land reforms were made in Nepal at different points of time, but all of them turned to be unsuccessful. Life expectancy along with other social and economic indicators varies across the country but is generally low. The complexity of the demographic profile of Nepal indicates that the issue of abortion care and provisioning in the country also is a complex one.

2.2.4. Pre 2002 law on abortion

The restrictive abortion law which existed till 2002 in Nepal banned abortion and punished the women who underwent termination of pregnancy. Therefore it is important to look at the pre-2002 abortion law in Nepal, in order to understand the problems associated with the banning of abortion that criminalised the process of abortion seeking.

To understand the broader legal context in which abortion was interpreted and enforced in Nepal, it is necessary to examine the country's major sources of law. Both domestic and international sources of law contributed to shape a liberal abortion law. The domestic sources include the Constitution (1990), the Country Code (1963) and judicial decisions of the Supreme Court as a binding precedent[33].

The 1990 Constitution is the domestic law of highest authority. The enactment of this constitution was part of the process of democratization of the country. The preamble of the constitution assures "basic human right to every citizen of Nepal"[34]. The Directive Principle of the constitution protects equality and the stated objective includes "establishing a just system in all aspects of national life and eliminating all types of economic and social inequalities" as a means to establish and develop healthy social life[35].

Mulki Ain 2020 or the Country Code of 1963 was the first written law in Nepal that had been introduced in the year of 1853. It was dictated by Hindu religious principles and beliefs. This was the main source which sanctioned caste-based and gender-based discriminations in Nepal. It was revised in 1963 and many caste-based

[33] CRLP 2002, op cit: 36.
[34] Ibid: 37.
[35] Ibid.

provisions were removed. However, gender-based discriminatory provisions were not removed. The code contained substantive legal provisions relating to marriage, divorce, inheritance and rape, but many of these provisions discriminated against women. The legal provision on abortion was provided in the chapter on homicide in the Country Code[36].

Precedents are another source of law. The judicial decisions of the Supreme Court are binding and considered as law. The binding nature of Supreme Court decisions is called Precedents. The decision of the Supreme Court should be followed by other Courts in the country. Thus precedents are considered to be equivalent to law. In a few notable occasions, the Supreme Court has broadly interpreted fundamental rights guaranteed in the constitution in favour of women[37]. Thereby, the apex court functions as an important vehicle for the promotion and protection of women's rights[38].

International Sources are the major international treaties ratified by Nepal. These treaties include International Covenant On Civil And Political Rights, International Covenant on Economic, Social and Cultural Rights, the Convention on Elimination of all the Forms of Discrimination Against Women, The Convention on Rights of the Child, International Convention for the Elimination of All Forms of Racial Discrimination and The Convention Against Torture and Other Cruel Inhuman Or Degrading Treatment Or Punishment.[39] There is a legal provision in Nepal (Section 9 of the Treaty Act 1990) which emphasizes that national laws and polices in the country should comply with ratified international treaties[40]. This legal provision is used in Nepal to liberalise abortion laws, as the international documents assert the need for liberalisation of abortion laws to improve accessibility of such services. The international legal instruments took affirmative steps to protect and fulfil basic human rights, although the abortion law that existed in Nepal abused the basic principles of human rights. The translated version of Section 28 of Chapter 10 of the Country Code makes it clear that how discriminative the law was. The Section describes that "[e]xcept while doing something for the purpose of welfare, if a pregnancy is

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[36] FWLD 2000. *Discriminating Laws in Nepal and Their Impact on Women: A Review of The Current Situation and Proposals for Change, Vol. I &II.* Katmandu.
[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.

terminated, the person who terminates the pregnancy or the person who helps in the termination of a pregnancy shall be guilty of the offence"[41]. The one and only exception available for obtaining abortion was, therefore, the purpose of 'welfare'. However, it is not clearly stated in the Section that who is the beneficiary and under what circumstances the Section can be invoked. The term welfare is not defined anywhere in the Code[42].

It is interesting to note that the Nepal Medical Council Rules of 1967 (containing medical ethics for health care providers) did allow abortions on medical grounds, but the Country Code was so established that doctors were not ready to provide abortion services[43]. Therefore, it is evident from the evaluation of sources of law that the ban on abortion that existed in Nepal was in contradiction with international legal instruments.

As we discussed in earlier chapters, the accessibility of services depends on the legality of abortion to an extent and Nepal was a concrete example for the impact of legality on limited accessibility. The abortion law in Nepal not only restricted accessibility of abortion services but also penalised those who sought abortion. The criminalisation of abortion undermined women's right to privacy, physical integrity and reproductive decision-making. It is important to note that the process of criminalisation was deeply rooted in a social context in which women's capacity for self-determination was already weakened by their low status within families and in society. The criminalisation of abortion worsened the situation of women in Nepal and made them more vulnerable.

The socio-political situations in the country along with the pressures from different women's groups and international agencies paved the way for a new legislation on abortion that came into force in March 2002. The Guttmacher Report on policy observes the "the new law is a radical departure from past policy". The report noted that the Nepal Government was committed to release the 65 women who were imprisoned in Nepal in 2002 under the Country Code for violating the ban on

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[41] CRLP 2002, op cit.
[42] Ibid: 38.
[43] Matrika Champagain 2006. "Conjugal Power Relations and Couple's Participation in Reproductive Health Decision-Making: Exploring the Links in Nepal". *Gender Technology and Development*, 10 (2):159-189.

abortion[44]. The exact numbers of women who are still in jail are not available. *The Deccan Herald* of 06 January 2006 reported that in Nepal 21 women are still behind the bars for aborting their pregnancies. The organisations advocating for the release of women from jail are pressurising Government to intervene in this matter through policy enactments. The issue of imprisonment of women can be addressed by giving retrospective effect to the eleventh Amendment Bill of 2002.

2.2.5. Decriminalising Abortion: Law Reform in Nepal

After years of struggles and advocacy by different women's groups, Nepalese Parliament passed a bill, legalising abortion. According to the Eleventh Amendment Bill, abortion is legal on request during the first 12 weeks of pregnancy[45]. The abortion can be legally availed on the grounds of risk to life or health of a woman and in case of rape, incest and foetal impairment. International agencies consider this as the first step toward ensuring the Nepali women's reproductive rights. Prior to the enactment of the new legal reform, a series of efforts from different women's groups was noticeable. As part of their efforts, a bill was introduced in 1996 to legalise abortion and regulate access to abortion. The bill generated much debate in parliament as well as among public, but it lapsed before being placed in the Parliament for voting. At that time Nepal was discussing women's right to property and it was the major political agenda of all political parties in Nepal. As a result of this political process the Government of Nepal decided to amend the Country Code. The Mulki Ain Eleventh Amendment Bill of 1997 proposed to amend some of the discriminatory provisions against women, including prohibition of abortion[46].

In its original form the Amendment Bill proposed legalisation of abortion on limited grounds[47]. With the active participation and campaign of civil society groups and women's groups the original bill was significantly revised and its scope was broadened by the Law, Justice and Parliamentary Affairs Committee. The most notable changes were the removal of marital distinction and removal of the clause for spousal consent. By these revisions, unmarried, widows and divorcees also could

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[44] *Guttmacher Report on Public Policy*, 5 (2), May 2002.
[45] Ibid.
[46] http://www.crlp.org/pub bo nepal.html,accessed on 17.4.2007.
[47] It sought to create the right to legal and safe abortion for married women, with their husband's consent within the first 12 weeks of pregnancy and on the ground of rape and incest within 18 weeks, to save the life of the woman or where the woman's health is in danger at anytime during pregnancy and where there is evidence of foetal abnormality. Ibid.

avail the progressive provisions. The removal of the spousal consent widened the ambit of the law and tried to protect bodily autonomy of the women in Nepal. The Bill also prohibits sex selective abortion. There is no retrospective effect for the new law; hence the release of the imprisoned women is out of the scope of the new reform. The demand for release of women imprisoned for 'abortion crime' is part of the political agenda of all reproductive health advocates in Nepal[48].

The recent legal amendment regarding abortion brought in Nepal is an NGO driven one. The leadership of the movement was vested on organisations like the Centre for Reproductive Law and Policy and the Forum for Women, Law and Development. These organisations perceive women as beneficiaries of law and policies. All these organisations are working as agencies to international institutions of UN such as UNDP, UNFPA and WHO. Segregating the issue of abortion from the socio-political processes of the country and fixing them in the limited framework of Human Right principles is nevertheless problematic. The Nepali abortion liberalisation movement is also facing this limitation in their understanding of the complexities of legalisation of abortion. The negotiations and advocacy done by these groups highlighted the issue of ban on abortion as a violation of women's human right, without talking into consideration the nature of the then Hindu State and how patriarchy works through regulating women's sexuality. The abortion movement approached the issue of the ban on abortion simply as violation of human rights such as right to life, right to health, right to equality and non-discrimination, and right to reproductive self-determination as emphasised by CEDAW. However, this perspective on reproductive right is not ready to go beyond an extent. The free and absolute exercise of these rights and the political prerequisites are totally neglected. In a country like Nepal, the legalisation of abortion is a progressive one. For the realisation of the right to abortion and to avail the benefit of the legal reform throughout the country irrespective of social and geographical differences, the structural change of the society has to be accomplished through a political process. The new democratic government in Nepal and the ongoing political process of democratization of the country is a positive sign in this context.

[48] Ibid.

2.3. Bangladesh: Demand for Legalisation

Historically, a society's view on abortion has been shaped by the changing perceptions of State, medical profession and the changing role of women. Legalisation of abortion is a follow-up process of this perceptional change. In Bangladesh, abortion is restricted but allowed only for saving the life of the pregnant women. However, the perceptional change that is visible in the medical profession recently has reflected in Government policies. As a result of these perceptional changes, Bangladesh is now allowing abortion in the name of Menstrual Regulation in the first trimester of pregnancy. However, the changing attitude towards a liberalised abortion law in Bangladesh is initiated by the state as part of its wider objective of population control. The religious leadership in Bangladesh has given a silent sanction for the new initiative of the Government.

Bangladesh is one of the densely populated countries in the world. Bangladesh is a country that went through much hardship, political instability and natural disasters since its formation in 1972. The majority of the people live in poverty. The total population of Bangladesh is 119.3 million, of which 78 per cent live in absolute poverty (1992), 71 per cent of them in rural areas[49]. 52 per cent of the population lives without access to health care services (1985-93). Safe water accessibility is limited to 15 per cent of the total population and sanitation facilities are accessible for 65 per cent[50]. Life expectancy at birth (1995) is 55 years[51]. The issue of induced abortion cannot be discussed without considering these factors related to the health status of women. The general statistics indicates that there is poor access to social welfare services and the life expectancy in the country is very low. Therefore it is obvious that the data on women is worse due to the gender discrimination prevailing in Bangladesh.

2.3.1. Abortion law in Bangladesh and the issue of induced abortion

The abortion law in Bangladesh is based on the British Penal Code of 1860. The Penal Code prohibits abortion except to save the life of the woman. Nevertheless, the Bangladesh Government has allowed menstrual regulation[52] which is performed in

[49] http:// www.webster.edu/~woolflm/bangladesh/html, accessed on 12.7.2007.
[50] Ibid.
[51] Ibid.
[52] Menstrual regulation means termination of pregnancy up to 12 weeks of gestation.

both private and Government health centres[53]. However, this liberal view of the Government of Bangladesh is largely due to its recognition of abortion as an effective method to control population growth[54].

The study of Rosenberg *et al.* reveals that no physician has ever been prosecuted for performing an abortion in Bangladesh and the survey conducted as part of the study reports that 98.9 per cent of rural physicians in Bangladesh support the use of abortion in one or more circumstances approved by the law[55]. The study of Measham A.R. reveals the magnitude of the problem of induced abortion in Bangladesh[56]. Although the latter study was conducted in 1981, the issue is unlikely to have changed radically. Induced abortion is illegal, but is quite common in Bangladesh. There were 1590 reported cases of complicated abortions, as revealed by the study, of which 31.3 per cent were fatal and 42 per cent of abortions were performed by traditional birth-attenders (*dais*) and 18.1 per cent by traditional abortion practitioners[57]. The study further goes into the details of unsafe abortions and reports that in Bangladesh medically approved procedures for terminating pregnancy were very limited. According to the study, only 4.9 per cent of the total abortions in Bangladesh were medically approved. Most of the non-medical terminations of pregnancies were caused by inserting foreign objects like cylindrical items, cow dung and carbon from used dry cells[58]. The aforementioned study estimated that in 1978 there were 7, 80,000 abortions performed in Bangladesh, causing 7,800 deaths[59].

Another study observes that the provision for menstrual regulation is used in the Government Family Planning Programme as an instrument to control population[60]. At the same time, menstrual regulation services are not widely available in rural areas. This has reflected in the estimation of hospital admission for abortion-

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[53] Michael J. Rosenberg, Royee W. Rochat, Suraiya Jabeen, Anthony M. Measham, M. Obaidullah and Atiqur R. Khan 1981. "Attitudes of Rural Bangladesh Physicians towards Abortion", *Studies in Family Planning* 12(8/9): 318-321.
[54] Ibid: 318.
[55] Ibid.
[56] A. R. Measham., M. Obaidullah, M. J. Rosenberg, R.W. Rochat, A.R. Khan and S. Jabeen 1981 'Complications from Induced Abortion in Bangladesh Related to types of Practitioners and Methods and Impact on Mortality", *Lancet*, January 24, (8213):199-202.
[57] Ibid.
[58] Ibid.
[59] Ibid.
[60] Atiqur Rahman Khan, Royee W. Rochat, Farida Akhtar Jahan and Sayeda Feroza Begum 1986. "Induced Abortion in A Rural Area of Bangladesh", *Studies in Family Planning*, 17(2): 95-99.

related complications, which amounts to approximately half of the total obstetric cases reported in Bangladesh a year[61].

2.3.2. Legal procedure for menstrual regulation

As mentioned earlier, abortion law in Bangladesh is governed by section 312 to 316 of IPC 1860[62]. This law was temporarily waived in 1972 for the victims of rape during the War of Independence[63]. The Government of Bangladesh approved first trimester abortion in order to help the rape victims of the War[64]. This is the first time the Bangladesh Government legally sanctioned abortion on social grounds. In order to regulate this provision, the Government enacted certain conditions and clauses in order to prevent the complications arising out of unsafe abortions performed in clandestine conditions[65]. According to the clauses concerned with menstrual regulations, it must be performed by a qualified physician in a hospital and also by a trained paramedic[66]. The training in menstrual regulation services is provided by the government[67].

2.3.3. The issue of under-reporting

The issue of under-reporting of incidents of abortion has had a negative impact on the process of legalisation of abortion in Bangladesh. In 1995-96, there were 3.8 legal abortions and 28 illegal abortions per 1,000 women in the age group of 15-44[68]. Among the unintended pregnancies due to failure of contraceptive methods or devices, 31 per cent undergo Menstrual Regulation (legal abortion) and 4.9 per cent seek induced abortion[69]. The incidence of abortion contributes to one quarter of the total number of maternal deaths in Bangladesh[70]. Thus in Bangladesh severe economic hardship and poor access to health care services govern abortion-seeking

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[61] Ibid.
[62] All the punishment provisions are same as that of mentioned in IPC, as discussed in chapter 2. See the annexure for concerned provisions of IPC.
[63] The War of Independence led to the separation of East and West Pakistan, followed by the creation of Bangladesh in 1972.
[64] Rosenberg *et al.* 1981, op cit.
[65] http://www.bnwla.org, accessed on 18.6.2007
[66] http://www.cddc.vt.edu/ferminism/ban html, accessed on 20.6.2007.
[67] Ibid. However, studies are not available to understand the quality of these services.
[68] Henshaw S. K., Singh S. and Hass T. 1999. 'The Incidence of Abortion Worldwide", *International Family Planning Perspectives*, 25 (supplement): 30-38.
[69] Akhtar H. H. 1997. *Scope of Emergency Contraception in Bangladesh. Proceedings of Emergency Contraception Workshop*. December. Dhaka, Bangladesh: Population Council.
[70] Chowdhuri, T.A. 1997. *Emergency Contraception: Service Providers' Concern and Consideration: Proceedings of Emergency Contraception Workshop*. December. Dhaka, Bangladesh: Population Council.

behaviour, whereas religious teaching has not directly interfered in the practice of menstrual regulation[71]. The researchers who study the nature of abortions in Bangladesh face a dearth of adequate data on the number of terminations performed in Bangladesh, either through legal or traditional means. According to Amin *et al.*, the Government service statistics captured only 29 per cent of the total MRs[72]. It is believed that many of the induced abortions are under-reported due to social, cultural and legal reasons. In a country where the day-to-day life of women is governed by religious denominations and patriarchal values, it is not surprisingly difficult to procure exact statistics on abortions. The decision-making of women regarding contraceptive choice and abortion seeking is widely influenced by patriarchal norms like permission of husband and family[73]. The moral and religious values attached with abortion seeking behaviour hinder women from being vocal and thus the under-reporting.

2.3.4. The family planning programmes in Bangladesh

The issue of legalisation was always connected with the family planning programmes in Bangladesh. The perception of Bangladesh Government on poverty is governed by the neo-Malthusian understanding of population explosion, which connects the proportional relationship between population growth and the use of resources. Since Bangladesh was considered an international 'basked case', international agencies have invested heavily in the population control programme, indeed directing it and shaping it. Thus measures have been taken to control population in order to eradicate poverty. In Bangladesh, as part of rigorous family planning drive, abortion is used as a means to control population and thereby to eradicate poverty. It can be seen that the state's agenda to use abortion as a mode of population control and its endeavour to achieve poverty eradication through this neo-Malthusian method. In Bangladesh the process of family planning had been initiated by international finance agencies and US institutions. The initial attempts of population control in Bangladesh began with the Private Family Planning

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[71] Piet-Pelon N.J. 1998. Menstrual Regulation: Past, Present and Future Challenges, *Policy Dialogue,* 9 June, Bangladesh: Population Council.

[72] Amin R. Kamal, G. M. Begum, SF and Kamal H. 1989. "Menstrual Regulation Training and Service Programmes in Bangladesh: Result from a National Survey", *Studies in Family Planning,* 20(2): 102-106.

[73] Muhammad Amirul Islam 2005. "Evaluation of Reported Induced Abortion in Bangladesh: Evidence from the Recent DHS", Paper presented at the IUSSP International Population Conference, Tours (France), 18-23, July.

Associations in the 1950s[74]. The Population Council intervened in this matter in 1960s and the 1980s witnessed active participation of World Bank, AID and UNFPA in population control drive[75].One of the methods they had adopted for promotion of family planning was giving incentives to those who underwent sterilisation. The successive five-year plans, starting from the first five-year plan (1973-78) attempted to bridge family planning with health services and the promotion of sterilisation. However, the implementation of family planning programmes did not succeed in poverty eradication in the country. The implementation of family planning in a poor country like Bangladesh caused mass sterilisation, as the poor people succumbed to it for getting the incentives provided to those who undergo sterilisation, due to their poverty[76]. Compulsory sterilisation was a common phenomenon during 1980s and 90s also[77].

All the Government programmes and policies in terms of family planning in Bangladesh are based on the demographic surveys conducted by various international agencies. The recent study of Saul Halfon explains the politics of these demographic surveys[78]. These surveys are not only linked to different elements of population politics, but also connected the bodies of women in third world with the US institutions and also, the third world governments with the reproductive right activists of the first world. The agenda of population control has been implemented through this process and the third world women's body is effectively used as a space for experimentations. The Western activists and US institutions have used several methodologies in conducting surveys and implemented policies that suit the vested interests of US institutions. The policy enactments of the Third World Governments are based on the results of aforementioned demographic surveys. The methodologies used in these surveys are politically challenged by academics like Saul Halfon based on the Bangladesh Fertility Survey (BSF), conducted in 1975[79]. He cites the example of the politics of the term 'the unmet needs', a usage, according to him, is the basic

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[74] Dorothy Stein 1995. *People who Count Population Policies, Women and Children.* London: Earth Scan.
[75] Ibid.
[76] Ibid.
[77] Ibid.
[78] Saul Halfon 2007. *The Cairo Consensus: Demographic Surveys, Women's Empowerment and Regime Change in Population Policy.* Lanham: Lexington Books.
[79] Bangladesh had an 'unmet need' of married women. By 2004, 54 per cent of married women were using contraceptives (DHS) and this is in contradiction with the BSF 1975, which estimated simply 10 per cent of contraceptive use. The government policies of the country are still based on BSF.

concept upon which the logic of population control is founded[80]. The 'unmet need' is always used in the context of contraceptives or family planning services, denoting the lack of availability and accessibility of the people compared to their demands for such services. The term is not considered as a direct measure of women's subjective state (influenced by individual women's status, circumstances etc.) but exclusively as an objective measure calculated for each country[81]. Nevertheless the question of 'unmet needs' has never been asked directly in the demographic surveys. The quantification of the need for family planning services is highly problematic, because it varies qualitatively with respect to different individuals and circumstances.

A close watch of abortion politics in Bangladesh thus reveals that the attempt to legalise abortion in Bangladesh is executed as a state agenda in the political context of the involvement of international lending agencies and the international population control establishment. What is missing in the picture is the voice of women, who lack autonomy through out the process of decision-making on their bodies.

2.3.5. Right to Abortion: A complex issue

In the context of Bangladesh, unlike Sri Lanka and Nepal, there are no women's movements demanding legalisation of abortion and it was the Government that took *suo moto* a positive stance towards legalising abortion. As we have seen earlier, abortion is considered as a means to family planning and population control by the Bangladesh Government. In an Islamic country like Bangladesh, control over women's reproductive decisions is very conservative in nature[82] and therefore it is amazing to see that the Government itself is standing for legalisation of abortion. Using abortion as a method of family planning has got deep impact on the health of the women because of the repeated abortions. The poor health status of the Bangladeshi women increases the gravity of the issue. Bangladesh is in need of a new movement to raise the issue of gender-based discrimination faced by the women and to situate their rights in the political context of rigid population control policies of the State. The right to abortion needs to be placed outside the scope of family planning and has to be linked to the wider context of the politics of sexuality. The linking of abortion right with right to bodily autonomy, right to self determination and right to

[80] Ibid: 140.
[81] Ibid.
[82] The Islamic theology and the issue of abortion legalisation vary in different circumstances. The opinion of Islamic theology on abortion is not a homogenous one as discussed in first chapter.

life per se is politically important in the context of Bangladesh. The rigorous imposition of population policies promoted by international agencies is part of the larger global politics of blaming poor countries such as Bangladesh for population growth.

3. Conclusion

By reviewing the process of legalisation of abortion, its history and contemporary issues and prospects, this chapter attempted to portray the diversified context of South Asia. The countries have been selected here based on the diversity in abortion laws and related characteristics and the case studies help us capture the South Asian context of legal discourses on abortion[83]. These four countries vary in terms of their socio-political, economic, cultural and ethnic contexts. However in all the countries under study except Nepal it was the IPC 1860 in force due to the colonial past these countries shared. In Nepal it was the Country Code which was in practice, and it was somewhat similar in nature to IPC 1860. In Sri Lanka and Bangladesh the provisions contained in IPC 1860 still prevail, whereas independent India brought in legislative reforms in 1970 to address the issue of mortality and morbidity associated with unsafe abortions. In Nepal the new amendment came into force in 2002.

The endeavour to legalise abortion in Sri Lanka is under the joint leadership of NGOS and the Government. In India, it was a Government led initiative in communication with the medical fraternity. The Bangladesh Government is trying to incorporate the agenda of liberalisation of abortion law in its policies in order to enforce population control. The basic issue with all these initiatives is their understanding of reproductive rights in a limited framework of the violation of human rights. This is applicable to the entire South Asia region, as the legalisation of abortion is considered as an assurance of human rights. Unlike western countries, the issue of abortion is not a serious concern for the women's movements in South Asia. In Sri Lanka, the debate on abortion is completely hijacked by NGOs who are working as agents of international organisations and funding agencies. In India it is the medical fraternity that crucially shaped the abortion laws and the role of women's movements is limited to debates on sex selective abortion. The current discourse on abortion in India is also led by NGOs standing for women's cause and it is not in the

[83] The selection criteria of the four countries have been explained in detail in the introduction.

agenda of political movements in the country. As in Sri Lanka, in Nepal also the women's groups which stand for decriminalisation of abortion and liberalisation of abortion law are controlled by national and international funding agencies, whereas in Bangladesh such groups are passive. In South Asia, the right to abortion is not debated by political movements but limited to discussions and advocacies of the NGOs. The impact of this limitation is that the debate is curtailed to the initiation of rights and silent on the enforcement of such rights through the political will of the Government. Thus the effectiveness of the law in protecting and promoting the availability, accessibility and affordability of services is not debated anywhere. The contentions of the monitoring committees of international legal instruments simply rest on policy documents rather than political discourse.

In Bangladesh, the religious movements are silent on the issue of liberalisation of abortion law. In Nepal also the new law did not face much religious opposition. In India when the new Act came into force, there was not much resistance from religious circles. The Government was triumphant in convincing the religious groups in India that a liberal abortion law was a prerequisite for the economic development of the country. In Sri Lanka, unlike other countries, the pro-life movement is vocal. The Catholic Church subverted the attempts to initiate legal reforms towards a liberalised abortion law in Sri Lanka. In contemporary Sri Lanka the role of pro-life movement led by the Catholic Church is crucial in determining the course of negotiations regarding abortion.

The nature of abortion laws in these countries today clearly indicates that there exists no uniformity. India has a comparatively liberal law which allows abortion on social and medical grounds including failure of contraceptives. Nepal is now closer to India and allows abortion other than the ground of contraceptive failure. Abortion is strictly restricted to medical grounds in Sri Lanka, whereas in Bangladesh, menstrual regulation is permissible in the first trimester.

This analysis is not trying to compare the four countries under study, but to see what generalisation can be possible in the south Asian context. The main problem being addressed in this process is the availability of data on incidence of abortion, availability of abortion services, cost of services in private sectors and the role of traditional abortionists. The availability of exact data on abortion-related matters largely depends on the social values and morals attached to abortion. Because of the

social stigma regarding abortion practices, the real experiences of women are not captured by statistics and their by leading to under-reporting or non-availability of data. The non-availability of data from the same period in different countries' contexts also is a serious drawback. Although generalisation of the South Asian context is not possible on the basis of the available data, certain common characteristics shared by these countries can be understood by looking at the processes of legalisation in different national contexts as well as the movements involved in the process and the inherent nature of laws on abortion.

The abortion laws in different countries in South Asia range from restrictive to liberal. However, irrespective of the nature of the law, all the liberal laws are formed in the context of population policies. The attempts for the liberalisation of abortion laws are also being influenced by the politics of population policies. The hidden demographic goal of these laws and the intention to use the process of abortion as a means of birth control are explicit. It can be seen that the international legal instruments are playing a crucial role in initiating a liberal law in all countries which lack such legislation at present. These international agencies work in tandem with national Governments and women's groups in order to instigate the process.

The role of women's movement is nominal in the abortion debate. The women's movements are setting their political agenda by prioritising eradication of poverty and political participation. Unlike their western counterparts, reproductive rights are not in the political agenda of women's movements in South Asia. However, the international agencies are trying to insert reproductive rights in the manifestos of third world women's movements of late, in order to further their vested interests. This attempt should be viewed in the global political context of pushing the agenda of reproductive rights into the feminist discourses since the Cairo consensus. Although the abortion discourse brings into picture the question of bodily autonomy and sexual rights of women in a limited sense, the agenda of liberalisation of abortion law is largely part of the wider politics of international agencies. The massive funding available in the area leads to the mushrooming of NGOs in the third world. This phenomenon erases out women's movements and their political forums and therefore appears to be anti-feminist in its politics.

The role of religion is limited in Islamic and Hindu countries as far as legalisation of abortion is concerned. However, it is debatable whether the situation in

other Islamic countries could be equated with that of Bangladesh. Legalisation of abortion is presented as part of economic imperatives of the state and the religious institutions seem to be compromising in this regard. However, the role of religion is still influential in the issue of accessibility to abortion. The morals and values being constituted as part of the conservative agenda of religion stands as a barrier in accessing abortion services in all South Asian countries, irrespective of the nature of religion.

The issue of abortion is rooted in the prevailing social structure and the abortion laws currently existing in South Asia are not capable of addressing it. The lack of gender sensitivity is a major trait of all abortion laws in south Asia. The perception of national Governments is largely influenced by the politics of US institutions and UN agencies. Abortion issue is considered as a public health issue to be addressed through policy enactments. The language used in the international legal documents of US and UN agencies present themselves as radical in their approach to women's liberation, but never make any serious attempt to understand the structural inequalities and gender based discriminations existing in these countries. The policy documents are equally silent on the issue of the lack of political will of the national governments in implementing the right to abortion by upholding gender justice. The influence of law on the accessibility, availability and affordability of abortion services must be evaluated in the context of each country in South Asia in order to make possible a better gender sensitive abortion legislation.

Conclusions

The issue of abortion is a troubling one, deeply rooted in the social context of unequal power relationships and exploitation of women. The early debates on abortion revolved around the axis of right to privacy and medical safety, but of late the emphasis has shifted to the question of reproductive autonomy and reproductive rights of women. A study on abortion law in selected countries of South Asia becomes significant in this context. A close look at the gender dynamics of the existing abortion laws in the selected countries in South Asia (India, Sri Lanka, Nepal and Bangladesh) helped us understand not just the strengths and weaknesses of the laws, but above all perhaps what constellation of factors moulded them. This study thus attempted to explore the gender-biased nature of the formation, contents and practice of abortion laws in these countries. As a part of this, the relationship between legality of abortion and the accessibility, availability, affordability and quality of abortion services have been examined in the socio-political context of each country. These indicators of the abortion services in a patriarchal society are determined by the politics of sexuality.

Unsafe abortion as a social problem demands utmost attention in regions where abortion is morally and legally restricted and where poor abortion services prevail. In the South Asian region access to abortion varies from country to country and there is diversity in the characteristics of laws and policies. It is noted that most of the available literature on abortion legislation in the context of South Asia is based on micro-level analysis of the socio-demographic features of abortion seekers and the situational analysis of health care providers like hospitals and traditional healers. Many of these studies blame the public for their passivity and lack of awareness regarding the abortion services and fail to situate the problem in the larger socio-political context of the region. The women seeking abortions are perceived by these studies as mere objects and beneficiaries of abortion-related laws and policies. The politics of gender and sexuality and of population control policies in shaping abortion laws in the South Asian region is not at all captured in the existing literature. The abortion discourse in South Asia is deeply intertwined with the geopolitics of the contemporary world and the politics of funding. Therefore it is essential to bring out the hidden linkages between the national governments, funding agencies, US institutions and international legal instruments that shape the abortion discourse in the

region. The micro-level analysis of the social factors behind the issue of abortion has to be therefore complemented with macro level studies that bring out these larger global and regional factors. This study is a small preliminary step in this regard.

The present study provides a preliminary analysis of the regional dynamics of abortion discourse by focusing on the legislative process in the South Asia. By examining the politics behind the formation and implementation of abortion laws, the study attempted to demonstrate how abortion law was used as a tool for fertility control in the region and how South Asian women were victimised by the rigid implementation of the policies of population control. The study also assessed the role of international legal instruments, national governments, women's groups/NGOs, women's movements and religious groups in shaping abortion laws in the region. Thus the complexity of the problem was acknowledged in the present study and attempt was made to link the abortion legislation in the region with the public health understanding of the legality of abortion and its impact on women's health. The objective of the study was to examine the role and nature of the abortion law in guaranteeing safe abortion services to women and its impact on abortion related maternal mortality and morbidity.

It is noted in the present study that social inequalities are important determinants of access to safe abortion care, regardless of the legality of the procedure. The socio-economic background of the women influences the exercise of legal rights. In the context of US, the reproductive rights are always understood in terms of 'choice' under the questionable assumption that 'choice' is independent of socioeconomic factors. However, social reality in the US clearly indicates the explicit linkage between choice –or its lack – and the socioeconomic factors. For instance, the reproductive choice for the women of colour and poor women is restricted by conditions of oppression they face health care institutions and at all levels of society, from schooling to job and income. Thus to focus on choice, to the exclusion of these other factors, marginalising them in society is to reify the concept of choice. In the US, public funding on abortion is restricted through judicial interventions as well as through policy enactments. Women of colour and poor women are the most frequent victims of restrictive reproductive policies in the country as they are the most dependent on public funding for reproductive services. This indicates that the feminist analysis of reproductive freedom has to be positioned in a political perspective which

goes beyond the liberal understanding of individual choice. Reproductive freedom should be framed by an understanding of the need for social justice for all women, not just those who are having the privilege to make free choices. In the US, the debate on abortion right is located in the framework of right to privacy and pregnancy is considered as a private matter of women. The role of state in regulating procreative autonomy of women is often challenged by women in the court by invoking the right to privacy. However, it can be seen that the right to privacy alone cannot ensure reproductive freedom, because privacy itself is largely conditioned by structural factors like race, class and gender oppression.

On the other hand, the erstwhile Soviet Union had a different experience as far as abortion related mortality and morbidity is concerned. The well-established public sector service provisioning and socioeconomic conditions that prevailed in the USSR contributed to a low mortality and morbidity rate. This points to the fact that accessibility, affordability and availability of service of high quality had prevailed in the former socialist countries. The economic reforms of the 1990s led by World Bank and IMF nonetheless facilitated the collapse of the social security system and the health system of these countries.

The woman's interests in the abortion decision-making process often contradict with the cultural context when her choice does not enjoy the approval or support of the family or society in which she lives. Indeed, in any country in the world, it might often conflict with her spouse's wishes or interests. Who then has the right to decide over the woman's body? The husband? The community? The state? Religious leaders? The process of decision-making in a patriarchal society is thus often framed not by the woman concerned but the cultural values attached with abortion seeking. The family, religion and media radically contribute to the decision-making process. The medical, legal and educational institutions also have crucial role in it.

In this context, the emerging concern is whether law can intervene in changing the cultural aspects associated with the abortion decision-making. As mentioned earlier, the law itself is influenced by the cultural practices, values and norms of the society and hence the role of law is limited in the process of cultural transformation. However, in the context of the US Supreme Court decision in *Roe* v. *Wade* the

controversial question on whether the law is influenced by changing cultural values or vice versa still persists.

The abortion discourse is crucially influenced by the religious institutions and leaders. The abortion movement all over the world confront religious groups in the process of legalisation of abortion. In the South Asia in different societal contexts different religious groups intervene in the debate in totally dissimilar ways. At the same time it can be noticed that different religious groups broadly take a pro-life stance in the discourse. In the South Asian context Islamic, Christian, Buddhist and Hindu religious groups participated in the abortion discourse. The contemporary South Asian scenario reveals that religious groups are compromising with the pro-natalist position of national governments and keeping strategic silence on the legalisation process of abortion. The non-opposition from the Hindu religious groups to the liberalisation of abortion laws in Nepal and the silent sanction of the governmental attempt to liberalise abortion laws from the Islamic groups in Bangladesh are examples for this. In India also while the legalisation process was on debate, not much religious oppositions was forthcoming. In Sri Lanka, Buddhist groups are silent on the issue of abortion legislation, whereas the pro-life movement patronised by the Catholic Church is vocal.

The role of judiciary is limited in the discourse of legalisation of abortion in the South Asian region. The judicial interpretations of abortion law are always complementary to the positions of the state. The contribution of judiciary is marginal in the process of liberalisation of abortion law or attempts to strengthen the present legislation on abortion in South Asia. Unlike the western practices of law, the abortion issue is not much debated in the courtrooms in South Asia.

The international legal instruments played a crucial role in catalysing the process of liberalisation of abortion laws. The liberalisation process in Nepal was initiated by CEDAW. In Sri Lanka, the effort for a liberal law is an ongoing process under the aegis of the same international legal instrument. The international legal instruments hold the liberal feminist standpoint on the issue of abortion. The language of the international legal documents is radical in appearance, but these documents do not address the social context in which rights are demanded, actualised and experienced. International legal documents subscribe to the problematic human right framework that treats women as a homogeneous group. The experience of women in

South Asia is diverse within and across the countries. Hence these international legal instruments are inadequate to trace and address the abortion related issues in the South Asian context.

The population policies of the state are a means to control the sexuality of women. Different policies and laws of the State along with the social practices and customs help regulate women's sexuality and thereby confine women to the stereotypical roles prescribed to them. In a bourgeois democratic state, the law is being used as an instrument to oppress marginalised sections of the society. In the South Asian countries the role of the state in enhancing patriarchy and thereby controlling bodily autonomy of women is obvious. The facilitation of accessibility, availability, affordability and quality of abortion service by the government is a political process. The larger context of economic reforms and structural adjustments has an impact on all the preconditions that ensure abortion as an absolute right. The regional governments in South Asia in the 1990s promoted health sector reforms as part of the Structural Adjustment Policies. Most of the women in third world countries like India, Nepal and Bangladesh largely relied on public health sector. The withdrawal of the state from the provisioning of abortion services under public sector had reflected in the abortion-related mortality and morbidity. There is no data to substantiate this argument and this is mainly due to the nature of researches undertaken in the area of abortion provisioning.

The data available in the South Asian context is drawn from micro-level studies funded by international donor agencies like the Ford Foundation, the Rockefeller Foundation, the McArthur Foundation and so on. The same agencies at one point, pushed Third World governments to pursue neo-Malthusian population control policies; in the mean time they managed to convince much of the middle classes of the world that the primary problem in the world was the "population bomb". They did not reflect on who is consuming global resources. Today, the same agencies have apparently undergone a "paradigm shift" at Cairo and uphold the concept of reproductive rights. While progressive, this is not enough. It still does not question the global structure of the majority of populations of the world. Thus it is not surprising that the studies funded by them do not explore the impact of the neo-liberal policies on accessibility, availability, affordability and quality of abortion services. The US institutions which are acting as funding agencies to UN organs like UNFPA

are controlled by the same politics of neo-liberalism as well as the pro-life principle. For instance, recently the US funding to the UNFPA's campaign on medical termination of pregnancy in China has been withdrawn on the basis of ethical considerations emanating from the pro-life principle[1].

The role of women's movement is nominal in the abortion discourse in the South Asian context; although the abortion legalisation campaign was the biggest ever campaign undertaken by the western women's movement since the suffrage movement. The political agenda of the women's movement in South Asia is radically different from that of west. Unlike their western counterparts, reproductive rights are not in the political agenda of women's movements in South Asia. The issue of abortion and reproductive rights of women are not addressed by the women's movements in the region as the issue of poverty and similar concerns populate their priority list due to the unique socioeconomic and political characteristics of the region. However, the international agencies are now trying to insert reproductive rights into the charter of demands of the third world women's movements. This attempt should be viewed in the global political context of pushing the agenda of reproductive rights into the feminist discourses since the Cairo consensus.

The issue of abortion is rooted in the prevailing social structure and the abortion laws currently existing in South Asia are not capable of addressing this issue. The lack of gender sensitivity is a major feature of all abortion laws that exist in the region. The impact of abortion law on the health status of women is a complex issue. The complex web of patriarchal values, the cultural context, religion, state, judiciary, international legal instruments, the US and its funding agencies and the women's groups determine the health impact of abortion legislation in South Asia. This invites new research to understand the dynamics of the complex interplay of these factors in shaping abortion discourse in South Asia.

[1] Ronald M. Green 2003. "U.S. Defunding of UNFPA: A Moral Analysis", *Kennedy Institute of Ethics Journal*, 13(4): 393-406.

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Annexure

Annexure I

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

(34 of 1971)

[*10th August, 1971*]

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto.

BE it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:—

1. Short title, extent and commencement.—(1) This Act may be called the Medical Termination of Pregnancy Act, 1971.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions.—In this Act, unless the context otherwise requires,—

(a) "guardian" means a person having the care of the person of a minor or a [1][mentally ill person];

[2][(b) "mentally ill person" means a person who is in need for treatment by reason of any mental disorder other than mental retardation;]

(c) "minor" means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority;

(d) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined inclause (h) of section 2 of the Indian Medical Council Act, 1956(102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act.

3. When pregnancies may be terminated by registered medical practitioners.—(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), 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,—

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1. Subs. by Act 64 of 2002, sec. 2, for "lunatic" (w.e.f. 18-6-2003).
2. Subs. by Act 64 of 2002, sec. 2, for clause (b) "lunatic" has the meaning assigned to it in section 3 of the Indian Lunacy Act, 1912 (4 of 1912)' (w.e.f. 18-6-2003).

(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 1.—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 2.—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 to the pregnant woman's actual or reasonable 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 [1][mentally ill person], 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.

[2][4. Place where pregnancy may be terminated.—No termination of pregnancy shall be made in accordance with this Act at any place other than—

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government or a District Level Committee constituted by that Government with the Chief Medical Officer or District Health Officer as the Chairperson of the said Committee.

Provided that the District Level Committee shall consist of not less than three and not more than five members including the Chairperson, as the Government may specify from time to time.]

5. Sections 3 and 4 when not to apply.—(1) The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed

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1. Subs. by Act 64 of 2002, sec. 3, for "lunatic" (w.e.f. 18-6-2003).

2. Subs. by Act 64 of 2002, sec. 4, for section "4. *Place where a pregnancy may be terminated.*—No termination of pregnancy shall be made in accordance with this Act at any place other than—

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government" (w.e.f. 18-6-2003).

in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

[1][(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of pregnancy by a person who is not a registered medical practitioner shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years under that Code, and that Code shall, to this extent, stand modified.

(3) Whoever terminates any pregnancy in a place other than that mentioned in section 4, shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.

(4) Any person being owner of a place which is not approved under clause (b) of section 4 shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.

Explanation I.—For the purposes of this section, the expression "owner" in relation to a place means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act.

Explanation 2.—For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.]

6. Power to make rules.—(1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely:—

(a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act; and

(b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

7. Power to make regulations.—(1) The State Government may, by regulations,—

(a) require any such opinion as is referred to in sub-section (2) of section 3 to be certified by a registered medical practitioner or practitioners concerned, in such form and at

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1. Subs. by Act 64 of 2002, sec. 5, for "(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation.—For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply" (w.e.f. 18-6-2003).

such time as may be specified in such regulations, and the preservation or disposal of such certificates;

(b) require any registered medical practitioner, who terminates a pregnancy, to give intimation of such termination and such other information relating to the termination as may be specified in such regulations;

(c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(2) The intimation given and the information furnished in pursuance of regulations made by virtue of clause (b) of sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine which may extend to one thousand rupees.

8. **Protection of action taken in good faith.**—No suit or other legal proceedings shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act.

Annexure II

THE MEDICAL TERMINATION OF PREGNANCY RULES, 2003[1]

In exercise of powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely:—

1. Short title and commencement.—(1) These rules may be called the Medical Termination of Pregnancy Rules, 2003.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions—In these rules, unless the context otherwise requires,—

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);

(b) "Chief Medical Officer" means the Chief Medical Officer of a District, by whatever name called;

(c) "Form" means a form appended to these rules;

(d) "owner", in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act.

(e) "Committee" means a committee constituted at the district level under the proviso to clause (b) of section 4 read with rule 3.

3. Composition and tenure of District level Committee.—(1) One member of the District level Committee shall be the Gynaecologist/Surgeon/Anesthetist and other members from the local medical profession, non-governmental organizations, and Panchayati Raj Institution of the district:

Provided that one of the members of the Committee shall be a woman.

(2) Tenure of the Committee shall be for two calendar years and the tenure of the non-Government members shall not be more than two terms.

4. Experience and training under clause (d) of section 2.—For the purpose of clause (d) of section (2), a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely:—

(a) in the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;

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1. *Vide* G.S.R. 485(E) dated 13th June, 2003, published in the Gazette of India, Extra., Pt. II, Sec. 3(i) dated 13th June, 2003

(b) in the case of a medical practitioner, who is registered in a State Medical Register:—

(i) if he has completed six months of house surgency in gynaecology and obstetrics, or

(ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or

(c) if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy of which at least five have been performed independently, in a hospital established or maintained, or a training institute approved for this purpose by the Government.

(i) This training would enable the Registered Medical Practitioner (RMP) to do only Ist Trimester terminations (up to 12 weeks of gestation).

(ii) For terminations up to twenty weeks the experience or training as prescribed under sub-rules (a), (b) and (d) shall apply.

(d) in case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

5. Approval of a place.—(1) No place shall be approved under clause (b) of section 4,—

(i) unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

(ii) unless the following facilities are provided therein, namely:—

in case of first trimester, that is, up to 12 weeks of pregnancy:—

a gynaecology examination/labour table, resuscitation and sterilization equipment, drugs and parental fluid, back up facilities for treatment of shock and facilities for transportation; and

in case of second trimester, that is up to 20 weeks of pregnancy:—

(a) an operation table and instruments for performing abdominal or gynaecological surgery;

(b) anaesthetic equipment, resuscitation equipment and sterilization equipment;

(c) drugs and parental fluids for emergency use, notified by Government of India from time to time.

Explanation.—In the case of termination of early pregnancy up to seven weeks using RU-486 with Misoprostol, the same may be prescribed by a Registered Medical Practitioner (RMP) as defined under clause (d) of section 2 of the Act and section 4 of MTP Rules, at his clinic, provided such a Registered Medical Practitioner has access to a place approved under Section 4 of the MTP Act, 1971 read with MTP (Amendment) Act, 2002 and rule 5 of the MTP Rules. For the purpose of access, the RMP should display a Certificate to this effect from the owner of the approved place.

(2) Every application for the approval of a place shall be in Form A and shall be addressed to the Chief Medical Officer of the District.

(3) On receipt of an application under sub-rule (2), the Chief Medical Officer of the District may verify any information contained, in any such application or inspect any such place with a

view to satisfying himself that the facilities referred to in sub-rule (1) are provided, and that termination of pregnancies may be made under safe and hygienic conditions.

(4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.

(5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommend the approval of such place to the Committee.

(6) The Committee may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.

(7) The certificate of approval issued by the Committee shall be conspicuously displaced at the place to be easily visible to persons visiting the place.

(8) The place shall be inspected within 2 months of receiving the application and certificate of approval may be issued within the next 2 months, or in case any deficiency has been noted, within 2 months of the deficiency having been rectified by the applicant.

(9) On the commencement of these rules, a place approved in accordance with the Medical Termination of Pregnancy Rules, 1975 shall be deemed to have been approved under these rules.

6. **Inspection of a place.**—(1) A place approved under rule 5 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe and hygienic conditions.

(2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampoule, admission register or other document, maintained, kept or found at the place.

(3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure, so far as it may, apply to seizure made under sub-rule (2).

7. **Cancellation or suspension of certificate of approval.**—(1) If, after inspection of any place approved under rule 5, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 5 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Committee giving the detail of the deficiencies or defects found at the place and the committee may, if it is satisfied, suspend or cancel the approval provided that the Committee shall give an opportunity of making representation to the owner of the place before the certificate issued under rule 5 is cancelled.

(2) Where a certificate issued under rule 5 is cancelled, the owner of the place may make such additions or improvements in the place and thereafter, he may make an application to the Committee for grant of approval under rule 5.

(3) In the event of suspension of a certificate of approval, the place shall not be deemed to be an approved place during the suspension for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

8. Review.—(1) The owner of a place, who is aggrieved by an order made under rule 7, may make .an application for review of the order to the Government within a period of sixty days from the date of such order:

Provided that the Government may condone any delay in case it is satisfied that applicant was prevented by sufficient cause to make application within time.

(2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

9. Form of consent.—The consent referred to in sub-section (4) of section 3 shall be given in Form C.

10. Repeal and saving.—The Medical Termination of Pregnancy Rules, 1975, are hereby repealed except as respects things done or omitted to be done before such repeal.

FORM A

(*See* sub-rule (2) of rule 5)

FORM OF APPLICATION FOR THE APPROVAL OF A PLACE UNDER CLAUSE (B) OF SECTION 4

Category of approved place:

A Pregnancy can be terminated upto 12 weeks

B Pregnancy can be terminated upto 20 weeks

1. Name of the place (in capital letters)
2. Address in full
3. Non-Governmental/Private/Nursing Home/Other Institutions
4. State, if the following facilities are available at the place

Category A

(i) Gynaecological examination/labour table.
(ii) Resuscitation equipment.
(iii) Sterilization equipment.
(iv) Facilities for treatment of shock, including emergency drugs.
(v) Facilities for transportation, if required.

Category B

(ii) An operation table and instruments for performing abdominal or gynaecological surgery.
(iii) Drugs and parental fluid in sufficient supply for emergency cases.
(iv) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place..... Signature of the owner of the place

Date.....

FORM B

(*See* sub-rule (6) of rule 5)

CERTIFICATE OF APPROVAL

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

AS READ WITHIN UPTO.....WEEKS

Name of the Place

Address and other descriptions

Name of the owner

Place.....

Date.....

To the Government of the.....

FORM C

(*See* rule 9)

I.....daughter/wife of.....aged about..... years.....

(here state the permanent address)

at present residing at.....

do hereby give my consent to termination of my pregnancy at.....

.....

(State the name of place where the pregnancy is to be terminated)

Place..... Signature

Date.....

(To be filled in by guardian where the woman is a mentally ill person or minor)

I.....son/daughter/wife of.....aged about..... years of.....at present residing at (permanent address) .....do hereby give my consent to the termination of the pregnancy of my ward.....who is a minor/lunatic at.....

(place of termination of my pregnancy)

Place..... Signature

Date.....

FORM II

[*See* Regulation 4(5)]

1. Name of the State
2. Name of the Hospital/approved place
3. Duration of pregnancy (give total No. only)
   (a) Up to 12 weeks.
   (b) Between 12 - 20 weeks
4. Religion of woman
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) Others
   (e) Total
5. Termination with acceptance of contraception.
   (a) Sterlisation.
   (b) I.U.D.
6. Reasons for termination:
   (give total number under each sub-head)
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method.

Signature of the Officer Incharge with Date

FORM III

(*See* Regulation 5)

ADMISSION REGISTER

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

1	2	3	4	5	6	7
S.No.	Name of Admission	Name of the Patient	Wife/Daugbter of	Age	Religion	Address

8	9	10	11	12	13	14
Duration of Pregnancy	Reasons on which Pregnancy is terminated	Date of termination of Pregnancy	Date of discharge of patient	Result and Remarks	Name of Registered MedicaL Practitioner (s) by whom the opinion is formed	Name of Registered Medical Practitioner (s) by whom Pregnancy is terminated

Provided that the person conducting ultrasonography on a pregnant woman shal keep complete record thereof in the clinic in such manner, as may be prescribed, and any deficiency or inaccuracy found therein shall amount to contravention of the provisions of section 5 or section 6 unless contrary is proved by the person conducting such ultrasonography;

(4) no person including a relative or husband of the pregnant woman shall seek or encourage the conduct of any pre-natal diagnostic techniques on her except for the purposes specified in clause (2);

(5) no person including a relative or husband of a woman shall seek or encourage the conduct of any sex-selection technique on her or him or both.

CHAPTER V

APPROPRIATE AUTHORITY AND ADVISORY COMMITTEE

17. Appropriate Authority and Advisory Committee.—(1) The Central Government shall appoint, by notification in the Official Gazette, one or more Appropriate Authorities for each of the Union territories for the purposes of this Act.

(2) The State Government shall appoint, by notification in the Official Gazette, one or more Appropriate Authorities for the whole or part of the State for the purposes of this Act having regard to the intensity of the problem of pre-natal sex determination leading to female foeticide.

(3) The officers appointed as Appropriate Authorities under sub-section (1) or sub-section (2) shall be,—

(a) when appointed for the whole of the State or the Union territory, consisting of the following three members:—

(i) an officer of or above the rank of the Joint Director of Health and Family Welfare—Chairperson;

(ii) an eminent woman representing women's organisation; and

(iii) an officer of Law Department of the State or the Union territory concerned:

Provided that it shall be the duty of the State or the Union territory concerned to constitute multi-member State or Union territory level Appropriate Authority within three months of the coming into force of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002:

Provided further that any vacancy occurring therein shall be filled within three months of the occurrence;

(b) when appointed for any part of the State or the Union territory, of such other rank as the State Government or the Central Government, as the case may be, may deem fit.

(4) the Appropriate Authority shall have the following functions, namely:—

(a) to grant, suspend or cancel registration of a Genetic Counselling Cent e, Genetic Laboratory or Genetic Clinic;

(b) to enforce standards prescribed for the Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic;

(c) to investigate complaints of breach of the provisions of this Act or the rules made thereunder and take immediate action;

(d) to seek and consider the advice of the Advisory Committee, constituted under sub-section (5), on application for registration and on complaints for suspension or cancellation of registration;

(e) to take appropriate legal action against the use of any sex selection technique by any person at any place, *suo motu* or brought to its notice and also to initiate independent investigations in such matter;

(f) to create public awareness against the practice of sex selection or pre-natal determination of sex;

(g) to supervise the implementation of the provisions of the Act and rules;

(h) to recommend to the Board and State Boards modifications required in the rules in accordance with changes in technology or social conditions;

(i) to take action on the recommendations of the Advisory Committee made after investigation of complaint for suspension or cancellation of registration.

(5) The Central Government or the State Government, as the case may be, shall constitute an Advisory Committee for each Appropriate Authority to aid and advise the Appropriate Authority in the discharge of its functions, and shall appoint one of the members of the Advisory Committee to be its Chairman.

(6) The Advisory Committee shall consist of—

(a) three medical experts from amongest gynaecologists, obstericians, paediatricians and medical geneticists;

(b) one legal expert;

(c) one officer to represent the department dealing with information and publicity of the State Government or the Union Territory, as the case may be;

(d) three eminent social workers of whom not less than one shall be from amongst representatives of women's organisations.

(7) No person who has been associated with the use or promotion of pre-natal diagnostic techniques for determination of sex or sex selection shall be appointed as a member of the Advisory Committee.

(8) The Advisory Committee may meet as and when it thinks fit or on the request of the Appropriate Authority for consideration of any application for registration or any complaint for suspension or cancellation of registration and to give advice thereon:

Provided that the period intervening between any two meetings shall not exceed the prescribed period.

(9) The terms and conditions subject to which a person may be appointed to the Advisory Committee and the procedure to be followed by such Committee in the discharge of its functions shall be such as may be prescribed.

17A. Powers of Appropriate Authorities.—The Appropriate Authority shall have the powers in respect of the following matters, namely:—

(a) summoning of any person who is in possession of any information relating to violation of the provisions of this Act or the rules made thereunder;

(b) production of any document or material object relating to clause (a);

(c) issuing search warrant for any place suspected to be indulging in sex selection techniques or pre-natal sex determination; and

(d) any other matter which may be prescribed.

CHAPTER VIII

MISCELLANEOUS

29. Maintenance of records.—(1) All records, charts, forms, reports, consent letters and all ıe documents required to be maintained under this Act and the rules shall be preserved for a eriod of two years or for such period as may be prescribed:

Provided that, if any criminal or other proceedings are instituted against any Genetic ounselling Centre, Genetic Laboratory or Genetic Clinic, the records and all other documents of ıch Centre, Laboratory or Clinic shall be preserved till the final disposal of such proceedings.

(2) All such records shall, at all reasonable times, be made available for inspection to the ɔpropriate Authority or to any other person authorised by the Appropriate Authority in this half.

Annexure III

THE MEDICAL TERMINATION OF PREGNANCY REGULATIONS, 2003[1]

In exercise of powers conferred by section 7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following regulations, namely:—

1. Short title, extent and commencement.—(1) These regulations may be called the Medical Termination of Pregnancy Regulations, 2003.

(2) They extend to all the Union territories.

(3) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions.—In these regulations, unless the context otherwise requires,—

(a) "Act" means the Medical Termination of Pregnancy Act; 1971 (34 of 1971);

(b) "Admission Register" means the register maintained under regulation 5;

(c) "Chief Medical Officer" means the Chief Medical Officer of a District by whatever name called.

(d) "Form" means a form appended to these regulations;

(e) "hospital" means a hospital established or maintained by the Central Government or the Government of Union territory;

(f) "section" means a section of the Act.

3. Form of certifying opinion or opinions.—(1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of section 3 or 5, he or she shall certify such opinion in Form 1.

(2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

4. Custody of forms.—(1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant

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1. *Vide* G.S.R. 486(E), dated 13th June, 2003, published in the Gazette of India, Extra., Pt. II, Sec. 3(i) dated 13th June, 2003

woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, in Form II a monthly statement of cases where medical termination of pregnancy has been done.

(6) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 5, there shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelope shall be marked "SECRET".

Explanation.—The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under section 5.

(7) Where the Pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the next working day following the day on which the pregnancy was terminated:

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

5. **Maintenance of Admission Register.**—(1) Every head of the hospital or owner of the approved place shall maintain a register in Form III for recording therein the details of the admissions of women for the termination of their pregnancies and keep such register for a period of five years from the end of the calendar year it relates to.

(2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

6. **Admission Register not to be open to inspection.**—The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorized by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open for inspection by any person except under the authority of law:

Provided that the registered medical practitioner on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer:

Provided further that any such employer shall not disclose this information to any other person.

7. **Entries in registers maintained in hospital or approved place.**—No entry shall be made in any case-sheet, operation theater register, follow-up card or any other document or register other than the admission Register maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to the woman in the Admission Register.

FORM I

[*See* Regulation 3]

I.....

(Name and qualifications of the Registered Medical Practitioner in block letters)

.....

(Full address of the Registered Medical Practitioner)

I.....

(Name and qualifications of the Registered Medical Practitioner in block letters)

.....

(Full address of the Registered Medical Practitioner) hereby certify that *I/we am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of.....

.....

(Full name of pregnant woman in block letters) resident of.....

..... (Full address of pregnant woman in block letters) for the reasons given below**.

* I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial No. .....in the Admission Register of the hospital/approved place.

Place..... Signature of the Registered Medical Practitioner

Date..... Signature of the Registered Medical Practitioners

Strike out whichever is not applicable,

**of the reasons specified items (i) to (v) write the one which is appropriate:—

(i) in order to save the life of the pregnant woman,

(ii) in order to prevent grave injury to the physical and mental health of the pregnant woman,

(iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,

(iv) as the pregnancy is alleged by pregnant woman to have been caused by rape,

(v) as the pregnancy has occurred as result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children

Note.—Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place..... Signature of the Registered Medical Practitioner/Practitioners

Date.....

FORM II

[*See* Regulation 4(5)]

1. Name of the State
2. Name of the Hospital/approved place
3. Duration of pregnancy (give total No. only)
   (a) Up to 12 weeks.
   (b) Between 12 - 20 weeks
4. Religion of woman
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) Others
   (e) Total
5. Termination with acceptance of contraception.
   (a) Sterlisation
   (b) I.U.D.
6. Reasons for termination:

   (give total number under each sub-head)
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or men abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method.

Signature of the Officer Incharge with Da

Annexure IV

THE INDIAN PENAL CODE, 1860

(RELEVANT PROVISIONS)

312. Causing miscarriage.—Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Explanation.—A woman who causes herself to miscarry, is within the meaning of this section.

313. Causing miscarriage without woman's consent.—Whoever commits the offence defined in the last preceding section without the consent of the woman, whether the woman is quick with child or not, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

314. Death caused by act done with intent to cause miscarriage.—Whoever, with intent to cause the miscarriage of a woman with child, does any act which causes the death of such woman, shall be punished with imprisonment of either description for a term may extend to ten years, and shall also be liable to fine;

If act done without woman's consent.—And if the act is done without the consent of the woman, shall be punished either with imprisonment for life, or with the punishment above mentioned.

Explanation.—It is not essential to this offence that the offender should know that the act is likely to cause death.

315. Act done with intent to prevent child being born alive or to cause it to die after birth.—Whoever before the birth of any child does any act with the intention of thereby preventing that child from being born alive or causing it to die after its birth, and does by such act prevent that child from being born alive, or causes it to die after its birth, shall, if such act be not caused in good faith for the purpose of saving the life of the mother, be punished with imprisonment of either description for a term which may extend to ten years, or with fine, or with both.

316. Causing death of quick unborn child by act amounting to culpable homicide.—Whoever does any act under such circumstances, that if he thereby caused death he would be guilty of culpable homicide, and does by such act cause the death of a quick unborn child, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

Annexure V

THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 1994

(RELEVANT PROVISIONS)

CHAPTER III

REGULATION OF PRE-NATAL DIAGNOSTIC TECHNIQUES

4. Regulation of pre-natal diagnostic techniques.—On and from the commencement of this Act,—

(1) no place including a registered Genetic Counselling Centre or Genetic Laboratory or Genetic Clinic shall be used or caused to be used by any person for conducting pre-natal diagnostic techniques except for the purposes specified in clause (2) and after satisfying any of the conditions specified in clause (3);

(2) no pre-natal diagnostic techniques shall be conducted except for the purposes of detection of any of the following abnormalities, namely:—

(i) chromosomal abnormalities;

(ii) genetic metabolic diseases;

(iii) haemoglobinopathies;

(iv) sex-linked genetic diseases;

(v) congenital anomalies;

(vi) any other abnormalities or diseases as may be specified by the Central Supervisory Board;

(3) no pre-natal diagnostic techniques shall be used or conducted unless the person qualified to do so is satisfied for reasons to be recorded in writing that any of the following conditions are fulfilled, namely:—

(i) age of the pregnant woman is above thirty-five years;

(ii) the pregnant woman has undergone two or more spontaneous abortions or foetal loss;

(iii) the pregnant woman had been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals;

(iv) the pregnant woman or her spouse has a family history of mental retardation or physical deformities such as, spasticity or any other genetic disease;

(v) any other condition as may be specified by the Board: