REPRODUCTIVE AUTONOMY IN INDIA

Saumya Maheshwari[*]

ABSTRACT

18% of all maternal deaths in India are attributable to unsafe abortions. This disproportionately high number is a result of powerlessness over reproductive decision making, that either delays the final decision, or prompts women to seek maternal healthcare services from unqualified persons, thus increasing the likelihood of unsafe abortions. It is argued that this systematic deprivation of power is a result of a flaw in the letter of the law, and can be remedied, albeit only to a limited extent, by amending the Medical Termination of Pregnancy Act, 1971.

I. INTRODUCTION

Until 1971, termination of pregnancy in India was governed by Section 312 of the Indian Penal Code, 1860 which criminalized inducing a miscarriage other than to save the woman's life. As a consequence of the restrictive nature of this provision, the number of illegal and therefore, unsafe abortions was remarkably high. Recognizing the need for a dedicated legislation, the Parliament enacted the Medical Termination of Pregnancy Act, 1971 ("MTP Act") to check the tide of pregnancy-related deaths in the country.

[*] The author is a 5th Year B.A. LL.B. (Hons.) Student at the National Law School of India University, Bangalore.

This enactment also coincided with the Union Government's earliest campaigns promoting family planning measures aimed at controlling India's burgeoning population. Although population control was not a purported objective of the Act, it was liberal enough to allow those willing to use it for that purpose, to do so.[1] In the coming years, it was also advocated as a legitimate family planning tool.[2]

MTP Act, on the one hand, was expected to reduce maternal mortality resulting from unsafe abortions, and on the other hand, reduce the high birth rate in India.[3] While the birth rate in India has reduced as a result of greater awareness,[4] the MTP Act has not succeeded in substantially lowering the number of women who seek illegal abortions.[5] Complications from unsafe abortions account for almost 18% of maternal deaths, higher than the global average of 13%. It is estimated that about sixty-seven lakh women seek abortion services from unqualified persons in India every year. It should also be noted that this problem affects young women in the age group of 15-19

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1 Jyotsna Agnihotri Gupta, NEW REPRODUCTIVE TECHNOLOGIES, WOMEN'S HEALTH AND AUTONOMY: FREEDOM OR DEPENDENCY? 213 (2000).

2 *Id.*
Saroj Pachauri, Priority Strategies for India's Family Planning Programme, INDIAN JOURNAL OF MEDICAL RESEARCH pp. 137 – 146 (November 2014), *available at* http://icmr.nic.in/ijmr/2014/nov_supplement/1121.pdf (Last visited on February 20, 2016).

3 The birth rate in India in 1971 was 5.40, and has since consistently reduced to 2.3in 2014. *See* http://www.unicef.org/infobycountry/india_statistics.html.

4 P. Arokiasamy, *Fertility Decline: Contributions of Uneducated Women Using Contraception,* Vol. 44 (30) Economic and Political Weekly (2009).

5 Illegal abortions here means abortions sought from persons not qualified to do so under the Act. Centre for Reproductive Rights, *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change* (2008).

years disproportionately, with almost 50% of the maternal deaths in this age group resulting from unsafe abortions.[6]

It may be argued that liberalization of the legal regime does not always translate into greater access to safe and legal abortion services. Where legal medical assistance is available, the services may not be provided in sanitary surroundings. Even in areas where safe and legal medical assistance is available and affordable, access to these services is determined by a host of other factors, including the socio-economic status of a woman, and the extent of control she exercises over her reproductive choices.

The lesser the control, greater is the likelihood of her delaying her decision to seek medical help, or of seeking medical help from unqualified persons.[7] The basic premise of this paper is that a woman's bodily autonomy should supersede concerns for the competing claims of spouses or those of the foetus.[8] It is argued in this paper that family members and medical practitioners exercise greater control over reproductive decision making than women themselves, thus violating her autonomy, and furthermore resulting in a greater number of illegal and unsafe abortions.[9] It is further argued that this loss of control, while a function of several socio-legal factors, can be remedied

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6 *Id.*

7 Saseendran Pallikadavath and R. William Stones, *Maternal and Social Factors Associated with Abortion in India: A Population-Based Study*, Vol. 32 (3) INTERNATIONAL FAMILY PLANNING PERSPECTIVES (2006), p. 120-125, *available at* http://www.jstor.org/stable/4147621 (Last visited on November 15, 2015).

8 Hilarie Barnette, Introduction to Feminist Jurisprudence (1998).

9 Nirmala Sudhakaran, *Teaching Clinical Obstetrics*, Vol. 40 (18) ECONOMIC AND POLITICAL WEEKLY, p. 1867 (2005).

to a limited extent through amendments to the MTP Act and sensitisation of medical practitioners.

This paper is divided into three parts. The first part seeks to explain the concept of reproductive autonomy. The second part studies the limitations that have been imposed on the reproductive autonomy of women, both minor and adult. The final part discusses various remedial measures that can be adopted to provide greater control to women.

II. UNDERSTANDING REPRODUCTIVE AUTONOMY

Feminist theory has for long challenged biological essentialism, the belief that the unequal position of women and men in marriage, with respect to employment opportunities, discriminatory pay, is rooted in biological differences between sexes. Biological essentialism in effect attempts to scientifically justify the public-private divide, and states that women's place is in the private sphere on account of their ability to give birth.

Since pregnancy and child-birth facilitate such oppression, the women's liberation movement that arose simultaneously with the sexual liberation movement sought to transfer the control over women's bodies from men, fathers or husbands, to women, thus giving rise to the concept of reproductive rights, *viz.* rights that would enable women to control their fertility. Contraception and abortion have the possibility of allowing women

to conceptualise themselves as women, and not merely as mothers, and thus leave the private sphere.[10]

Reproductive autonomy is thus understood as the right of women to choose whether to have children or not, and if so, the right to determine the number of children they want, when and with whom; and the freedom to choose the means and methods to exercise their choices regarding fertility management.[11]Some of the most fundamental determinants of whether a legal system guarantees reproductive autonomy to women within that legal system are access to information on sexuality, access to contraceptives, access to reproductive and maternal health care, access to pregnancy termination services, and access to economic resources.[12]

The right to reproductive health is explicitly recognised in the Yogyakarta Principles, as well as in the Convention on the Rights of Persons with Disabilities ("CRPD").[13] Furthermore, the monitoring committees of various human rights treaties including the Convention on the Elimination of all Forms of Discrimination Against Women ("CEDAW"), The United Nations Convention on the Rights of the Child ("UNCRC"), the International Covenant on Civil and Political Rights ("ICCPR") and the International

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10 Lucy Irigaray, *The Power of Discourse and Subordination of the Feminine* in The Irigaray Reader (1991).

11 Agnihotri, *supra* note 3, at 26. The meaning of the word 'autonomy' here is similar to that in biomedical ethics, and is different from its usage in legal philosophy. In biomedical ethics, autonomy refers to the patient's right to choose what happens to her body, and is the cornerstone of the concept of informed consent, as reiterated in the landmark case of Montgomey v. Lanarkshire Health Board ¶. 108 [2015] UKSC 11.

12 REBECCA COOK *ET AL*, REPRODUCTIVE HEALTH AND HUMAN RIGHTS (2003).

13 Article 25, Convention on the Rights of Persons with Disabilities.

Covenant on Economic, Social and Cultural Rights ("ICESCR") have recognised the importance of the same in fully realizing all other human rights.[14] For instance, the CEDAW Committee recognises that the protection of women's right to self-determination requires states to take a holistic approach toward women's health and ensure access to safe abortion services; medically accurate information about sexual and reproductive health; and safeguards against violations of confidentiality, and quality of care.[15]

The right to reproductive autonomy has also been recognised by the Indian courts as a constitutionally guaranteed fundamental right. The judicial attitude towards the right to abort has evolved to a great extent since the 1990s, when in the case of *Jacob George v. State of Kerala*, the Apex Court refused to comment on the right of women to abort an unwanted pregnancy,[16] to the decision of the Delhi High Court in the case of *Laxmi Mandal* v. *Deen Dayal Harinagar Hospital*[17].

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14 Centre for Reproductive Rights, *Whose Right to Life? Women's Rights and Prenatal Protections under Human Rights and Comparative Law* (2014). *See also* Committee on the Elimination of Discrimination Against Women, *Concluding Observations on the combined fourth and fifth periodic reports of India*, CEDAW/C/IND/CO/4-5 (July 24, 2014).

15 *Id.*

16 Jacob George v. State of Kerala 1994 (2) SCALE 563 (Supreme Court of India).

17 Laxmi Mandal v. Deen Dayal Harinagar Hospital 172 (2010) DLT 9 (High Court of Delhi). This case was brought on behalf of Shanti Devi, who was refused admission into a government hospital even though she qualified for free services under a state-sponsored scheme. She died immediately after delivering a premature daughter at home. The Court held that the Constitution protects the right to access public health facilities, to receive a minimum standard of treatment and the enforcement of reproductive rights of women.

In the above case, the right to health as defined in the case of *Paschim Banga Khet Majdoor Samiti* v. *State of West Bengal*[18] was sought to be broadened to include reproductive rights. However, the decision in *Laxmi Mandal* was in the context of denial of maternal healthcare services, and did not explicitly recognise abortion as a part of 'reproductive rights.' Mere legal recognition is not sufficient to ensure the enforcement of reproductive rights. A legal framework that enables women to exercise them needs to be built, in order to fulfil India's obligations under the abovementioned international instruments.[19]

III. GUARANTEES UNDER THE MTP ACT

As the MTP Act governs women's access to pregnancy termination services, it has a key impact on the reproductive autonomy of women within the Indian legal system. Under this Act, women have the right to undergo an abortion within twenty weeks, on the grounds that there is grave risk of physical or mental injury to the mother, or that the child is likely to be born seriously handicapped.[20] The right to abort a pregnancy is available to the pregnant woman throughout the duration of the pregnancy for the purpose

[18] Paschim Banga Khet Mazdoor Samiti v. State of West Bengal 1996 (4) SCC 37 (Supreme Court of India). In this case, it was held that failure of the Government to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.

[19] India acceded to ICCPR and ICESCR in 1979, signed CEDAW in 1980 and ratified it in 1993, and signed and ratified UNCRC in 1992.

[20] Sec. 3, MTP Act.

of saving her life.[21] The MTP Act legalizes medical and surgical forms of terminating pregnancy.

It allows abortions on socio-economic grounds, and permits consideration of a woman's economic resources, her age, her marital status, and the number of her children for the purpose of determining whether non-termination of the pregnancy will result in injury to her mental health.[22] Despite there being an enabling law for safe abortions, statistics suggest that a large number of Indian women who die due to pregnancy related causes, die as a result of unsafe abortions.[23]

This is because even though there is a legal framework for legal abortions, the same has not translated into greater access to safe abortion facilities. Even where such facilities are available, women rarely have the ability to determine whether the pregnancy should be terminated or not. Socio-economic factors such as lack of agency generate the harrowing statistics stated above. This lack of agency, and its causes, has been studied in the next section.

A. Who Decides?

Section 3(4) of the MTP Act states that,

21 Sec. 5. MTP Act.
22 Centre for Reproductive Rights, *World's Abortion Laws* (2008).
23 CRR, *supra* note 6.

> "*(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 mentally ill person, shall be terminated except with the consent in writing of her guardian.*
>
> *(b) Save as otherwise provided in C1.(a), no pregnancy shall be terminated except with the consent of the pregnant woman.*"

The pregnancy of a sound adult woman cannot be terminated unless she consents to the same. Moreover, her consent is sufficient to terminate the pregnancy. For the termination of the pregnancy of a minor or a mentally ill person, the registered medical practitioner is required to obtain the consent of her guardian. Clause (b) of sub-section (4) of section 3 can also states that the consent of a woman who is either a minor or mentally unsound need not be obtained before her pregnancy is terminated.

B. Losing Control over Bodily Autonomy

Section 3(4) gives rise to a number of questions on the issue of consent, and the different ways in which it deprives women of control over their own bodies. For the purpose of understanding the same, women can be classified into the following broad categories – minor women, minor married women, adult married women, and adult unmarried women.[24]

[24] This classification has been made on the basis of the treatment of women of different age groups by the law, and is solely for the purpose of analysis in this paper. It does not take into account differences of class, caste, region, religion, etc.

1. Adult Married Women and the Need for Spousal Consent

The MTP Act was hailed as a revolutionary legislation for its time, not only because of the wide range of grounds that it prescribed for termination of pregnancy, but also because in the 1970s itself, when the western world was grappling with the idea of abortion and the right of fathers to be equal parties in the decision-making,[25] the Indian legislature recognised the need to give married women complete control over their bodies by eliminating the need for spousal consent for termination of pregnancy.

Section 3(4) has been read to mean that a married woman's consent is *enough* for terminating her pregnancy, and the registered medical practitioner *need not* obtain the consent of her husband for the same. To that extent, the Act recognises that a woman has complete control over her body, and legally, her husband has no stake in the foetus' survival or termination, until the baby is delivered. This view has been endorsed by the Federation of Obstetric and Gynaecological Societies of India ("FOGSI"), which in its Guidelines for good clinical practice states that,

> "*An adult woman who is not mentally ill can undergo MTP with only her own consent as provided under the MTP Act. This section seeks to emphasize certain important but not always appreciated aspects of the MTP act of India. ... It is emphasized that spousal consent or consent of*

[25] HILARIE BARNETTE, INTRODUCTION TO FEMINIST JURISPRUDENCE (1998).

> *partner is not required in case a major woman who has no mental illness desires to terminate an unwanted pregnancy.*"[26]

Given that the brunt of pregnancy, physical, economic and social, is largely borne by the woman carrying the foetus,[27] women alone should have control over the decision whether the pregnancy should be carried to term or not. Moreover, in a societal set-up where women have little say in family planning and carry almost complete responsibility of birth control,[28] a spousal consent requirement could pose a significant obstacle to undergoing an abortion for most women.[29] In a societal set-up like ours, where a male child is preferred over a female child,[30] married women are often compelled to reproduce until a male heir is born,[31] and the society puts a phenomenal amount of pressure on women to bear their first child soon after marriage, any form of spousal consent is likely to be detrimental to the interests of women.

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26 Guideline 3.3, FOGSI Good Clinical Practice Recommendation on Medical Termination of Pregnancy, 2004.

27 Women physically bear the burden of bearing a pregnancy. Moreover, women who carry an unplanned pregnancy to term may be unable to finish their school education, or seek higher education. Women are also usually the primary caregivers in a family, and their careers are often adversely affected as they spend a disproportionate amount of time on care-giving.

28 ARNA SEAL, NEGOTIATING INTIMACIES: SEXUALITIES, BIRTH CONTROL AND POOR HOUSEHOLDS 13 (2000).

29 The spousal consent requirement, which has been incorporated into several state statutes in the USA in various forms such as the spousal notification requirement, has been consistently struck down as being unconstitutional, and has been considered as being akin to a total ban on abortions. *Planned Parenthood of Central Missouri* v. *Danforth* 428 U.S. 52 (1976) (Supreme Court of United States of America).

30 WORLD HEALTH ORGANISATION, PREVENTING GENDER BIASED SEX-SELECTION (2011).

31 *Id.*

Despite the recognition of the right of a woman to unilaterally determine whether her pregnancy should be terminated, in practice, married women have little or no control over this decision. The prime facilitator of this loss of control over bodily autonomy, it can be argued, is the medical fraternity itself. Literature suggests that medical practitioners are often unwilling to terminate pregnancies of married women without the consent of their husbands.[32] While some doctors refuse to terminate pregnancies without spousal consent altogether, some others consider it a condition precedent for second-trimester abortions. While on the one hand medical practitioners are fearful of terminating pregnancies without the spouse's consent because of the social backlash that may follow, others state that the same is necessary for abortions that require hospitalization.[33]

The right guaranteed by the MTP Act is further limited by judicial precedents that recognise the termination of a pregnancy without spousal consent as mental cruelty, and hence, a ground for divorce,[34] thus effectively

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32 Manish Gupte *et al*, "*Women's perspectives on the quality of general and reproductive health care: evidence from rural Maharashtra*" in IMPROVING QUALITY OF CARE IN INDIA'S FAMILY WELFARE PROGRAMME (Koenig MA, Khan ME eds.,1999) p. 117-39.

33 *Id.*

34 Suman Kapur v. Sudhir Kapur. AIR 2009 SC 589 (Supreme Court of India).
In this case the husband sought divorce on the grounds of mental cruelty as she had undergone two abortions without his consent. She was unwilling to bear a child, for fear that it would hinder the growth of her career. It was held that termination of pregnancy by the wife without the consent of the husband is mental cruelty, and a ground for divorce. If a husband submits himself for an operation of sterilization without medical reasons and without the consent or knowledge of his wife and similarly if the wife undergoes vasectomy or abortion without medical reason or without the consent or knowledge of her husband, such an act of the spouse may lead to mental cruelty. The Court failed to take into account the fact that she had no objection to adopting a child.
Note that while impotency is a ground for divorce, infertility is not a ground for divorce under any personal laws in India. As such, it is sexual intercourse that statutes consider central to a conjugal relationship, and not reproduction.

curtailing the reproductive rights of married women by making reproduction an essential and non-negotiable component of married life. While there have been dissenting voices, such as in *Mangla Dogra* v. *Anil Malhotra*,[35] wherein it was stated that,

> "*if the wife has consented to matrimonial sex and created sexual relations with her own husband, it does not mean that she has consented to conceive a child. It is the free will of the wife to give birth to a child or not. The husband cannot compel her to conceive and give birth to his child. Mere consent to conjugal rights does not mean consent to give birth to a child for her husband.*"

However, the current judicial attitude towards spousal consent, and the prevalent medical practice of mandating the same forms a grave threat to the reproductive rights of married women.

2. Infantilization of Adult Unmarried Women

Even though pre-marital sex is stigmatised and discouraged, studies suggests that a significant number of young persons engage in sex before marriage in India.[36] It is therefore necessary that reproductive healthcare

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[35] Mangla Dogra v. Anil Malhotra (2012) ILR 2 Punjab and Haryana 446 (High Court of Punjab and Haryana). After the marriage broke down and the spouses separated, the husband discovered that his estranged wife was pregnant. He filed for an injunction to prevent her from terminating the pregnancy. While the trial court granted his request, the High Court reversed the decision of the lower court on the grounds that the Appellant alone had the right to decide whether the pregnancy should be terminated or not.

[36] Shveta Kalyanwala *et al*, *Abortion Experiences of Unmarried Young Women in India: Evidence from a*

services are made easily available to this demographic as well. However, in several parts of the country, unmarried women, irrespective of age, are expected to obtain the consent of at least one parent for the termination of pregnancy.[37] Where this practice is not strictly followed, women are required to produce an attendant, a relative or friend, who is informed about the abortion. Reasons cited for this practice are similar to those cited for the spousal consent, most notably that consent is necessary to avoid any liability in the event of medical complications.

The parental consent requirement, apart from wholly infantilising adult women, also acts as an obstacle to the right to safe and legal abortions. Given the stigma attached to pre-marital sex and pregnancy in most parts of India, and the grave implications that pre-marital pregnancy can have on social standing of a woman and her family,[38] the parental consent requirement also acts as an obstacle to obtaining abortion services.

The reasons cited for this practice are untenable, as a person is not refused treatment for any other medical treatment for lack of parental consent. The general practice is to ask for the name of an emergency contact person in case complications. Not only do the above-stated practices infringe upon statutorily guaranteed rights, they are also reflective of a culture that

Facility-Based Study In Bihar and Jharkhand, Vol. 36, No. 2 INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, (2010), pp. 62-71, *available at* http://www.jstor.org/stable/27821031 (Last visited on November 8, 2015).

37 *Id.*

38 Purandare VN *et al*, *A study of psycho-social factors of out-of wedlock pregnancies*, JOURNAL OF OBSTETRICS AND GYNAECOLOGY OF INDIA 303–307 (1979).

refuses to recognise women as individuals in their own right. They also show the different ways in which statutorily guaranteed rights are nullified in practice.

IV. MINOR GIRLS – DO CHILDREN LACK BODILY AUTONOMY?

While the poor implementation of the MTP Act deprives a large number of women from exercising their reproductive rights, the MTP Act fails to recognise the rights of certain categories of women, including minor girls and mentally-ill women. The MTP Act states that a minor girl cannot get her pregnancy terminated without the written consent of her guardian. This requirement stems from the incapacity of minors to consent to a legally binding contract.[39] Since every intrusive medical procedure requires consent, it cannot be performed on a minor without the consent of her guardian, as stated in Clause 7.16 of the Code of Medical Ethics, 2002.[40] One exception to this rule is that in case of an emergency, a minor may be subjected to invasive treatment without the consent of her parents. The emergency exception recognises that the authority of the guardian is not absolute, and must yield to more immediate interests.[41]

This requirement of parental consent gives rise to several absurdities, some of which are listed below:

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39 Section 10, Indian Contract Act, 1872.

40 7.16. Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of a minor, or the patient himself as the case may be, Code of Medical Ethics, 2002.

41 T.T. Thomas v. Elisa AIR 1987 Ker 52 (High Court of Kerala). *See* J. Shoshanna Ehrlich, WHO DECIDES? THE ABORTION RIGHTS OF TEENS (2006).

- A minor girl, who is willing to terminate her pregnancy, may not be permitted to do so, and may be forced to carry the pregnancy to term by a guardian who withholds consent to termination of pregnancy. Such denial of consent has indelible consequences for the minor. The consequences suffered by women due to denial of pregnancy termination services are not mitigated by minority, but are rather made more severe by it. Apart from the mental cruelty suffered by her for being made to carry an unwanted pregnancy to term, she suffers grave socio-economic consequences, considering the loss of probable education and employment opportunities.[42]

- A minor girl, whose consent to termination of pregnancy is irrelevant, may be forced to undergo an abortion by her guardian. Generally, if a medical person administers treatment to or performs an operation upon a patient without the latter's consent, her actions amount to an actionable assault.[43] However, the language of Section 3(4)(b) seems to suggest that this rule does not apply to minor girls, or to mentally-ill women.

The overwhelming power given by the statute to the guardian in such cases is problematic not only because it is based on the premise that minors are incapable of making responsible decisions when it comes to their own bodies, but also because it assumes that the guardian's decision will always be

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42 *Id.*

43 Samira Kohli v. Prabha Manchanda (2008) CPJ 56 (Supreme Court of India).

unbiased, and in the best interests of the minor girl. These assumptions are challenged below.

A. The Unbiased Guardian

In a society where the sexuality of women is closely monitored, and where pre-marital pregnancy of a daughter in the family leads to social exclusion, it is unlikely that any decision taken by parents for a minor girl will ever be unbiased, with only her best interests influencing it. Moreover, studies suggest that an overwhelming number of Indian women face sexual abuse at the hands of family members, including fathers and brothers.[44] In case of a pregnancy resulting from such sexual assault within the family,[45] it is unlikely that the decision to terminate it will be influenced by concern for the minor, who in such cases loses complete control over her body.

The Child Bride

"*I did not want a child so soon after marriage. My mother-in-law told me to have the child. For six months she did not take me to a doctor. Actually my mother-in-law was scared that I might go to the doctor for termination of pregnancy. That is why she does not even allow me to go to a doctor...*"[46]

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44 Harsh Mander, *The Dangers that Lurk Close to Home,* THE HINDU (September 5, 2015), *available at* http://www.thehindu.com/opinion/columns/Harsh_Mander/harsh-mander-on-sexual-abuse-at-home/article7615539.ece.

45 In a study conducted delay in getting a pregnancy aborted, it was found that those who had a second-trimester abortion were more likely than those who had a first-trimester abortion to report that the pregnancy had resulted from forced sex (35% vs. 12%). Pallikadavath and Stones, *supra* note 7.

46 Alka Barua and Kathleen Kurz, R*eproductive Health-Seeking by Married Adolescent Girls in Maharashtra*, Vol. 9 (17) REPRODUCTIVE HEALTH MATTERS (2001), p. 53-62, *available at* http://www.jstor.org/stable/3776398 .Accessed: 08/02/2015 (Last visited on November 15, 2015).

Another situation in which the guardian has vested interest in the pregnancy is in the case of child marriage. The husband of a minor girl is considered her guardian.[47] Where a minor married girl seeks abortion, the requirement for guardians consent amounts to spousal consent, and is as such, a major obstacle in the way of obtaining an abortion, especially as child brides face social and familial pressure to begin childbearing soon after marriage.[48] The husband and the mother-in-law, in the case of young brides, are the decision makers when it comes to seeking healthcare in India.[49] Treatment for adolescent girls is often delayed as they negotiate this familial decision-making process, making the incidence of second trimester abortions more common among married adolescents.[50]

B. Abortion – A Decision like none Other

While the general defence for the practice of obtaining the guardian's consent for a medical procedure, as stated above, is that a minor does not have the capacity to consent to a contract, it is argued here that the decision to abort a pregnancy is fundamentally different from other medical decisions, and therefore, should be accorded special treatment. The abortion decision is fundamentally different from other kinds of medical decisions because the minor's parents have a vested interest in the pregnancy in allowing or disallowing an abortion.

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47 Section 21, Guardians and Wards Act, 1890; Section 6(c) Hindu Guardians and Wards Act, 1956.

48 Sandhya Rani *et al* , *Maternal Healthcare Seeking among Tribal Adolescent Girls in Jharkhand*, Vol. 42 (48) ECONOMIC & POLITICAL WEEKLY p. 56 (2007).

49 *Id.*

50 *Id.*

Apart from that, the abortion decision is of a special nature because of its temporal nature and enduring impact. It is not a decision that can simply be postponed to a later time. Unlike the decision to marry, or to enter into an employment contract, the decision to terminate one's pregnancy is extremely time-sensitive, and becomes more and more so with the lapse of every week. The decision to terminate one's pregnancy thus requires to be treated differently from other medical decisions. This has been recognised by the Supreme Court of USA in *Planned Parenthood of Central Missouri* v. *Danforth*,[51] where J. Blackburn stated that,

> "*It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the non-consenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure.*"

It was with this decision that the judicial bypass rule was formulated, that allowed minors to seek *parens patriae* jurisdiction of the courts to obtain consent for the termination of pregnancy. While the implementation of such a judicial bypass rule is likely to be lax in India, given the slow pace of the justice system, it could be a step towards fulfilling India's obligations under

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[51] *Planned Parenthood of Central Missouri* v. *Danforth* 428 U.S. 52 (1976) (Supreme Court of United States of America).

the UNCRC, which urges signatory nations to ensure universal access to sexual and reproductive healthcare facilities.[52]

V. RECOMMENDATIONS

The state is under an obligation to not only implement the MTP Act, but also to build a legal framework that safeguards the fundamental rights of women. The failure of the state to do the same is in violation of such basic rights. For the state to fulfil its obligation, it must ensure that *all* women have access to safe and legal abortion. This chapter seeks to make certain recommendations for achieving this objective.

A. Narrowing the Space for Negotiation

By differentiating between the normal and the abnormal, medical science creates an order in society.[53] In this sense, the network of medical practitioners forms the central part of a system of moral regulation of society.[54] It is therefore important to recognise that medical practitioners are a part of the society that we live in, and are influenced by the same patriarchal values that are entrenched in us. As seen in the last chapter, the morality of the society is enforced through the medical practitioners who, by misinterpreting the law, nullify the rights guaranteed to women under the MTP Act, by either demanding parental or spousal consent from adult

52 Centre for Reproductive Rights, *Reproductive Rights under the Convention on Rights of the Child* (2014).
53 B Subha Sri, *Women's Bodies and the Medical Profession*, Vol. 45 (17) ECONOMIC AND POLITICAL WEEKLY (2010).
54 Agnihotri, *supra* note 3, at 49.

women, or by making compulsory birth control a pre-condition for conducting an abortion.[55]

The poor implementation of the MTP Act, as far as the rights of adult mentally sound women are concerned, is a result of a flaw in the design of the law itself. The Act provides a space for negotiation between the doctor and patient, wherein the doctor has the authority to make judgements on the immediacy or need of an abortion based on extra-medical factors that include making various socio-economic determinations. The abortion decision is one of the few treatments that can be refused by a doctor to a patient solely because of non-medical reasons.

Furthermore, it can also be argued that the MTP Act, by merely setting a minimum threshold of the consent requirement, gives doctors the freedom to demand parental or spousal consent. It does not specifically bar them from refusing abortion services to women who fall within the framework of Sec. 3, nor does it prohibit doctors from actively seeking the consent of persons other than the patient herself, in breach of their duty to maintain confidentiality.[56] It is therefore submitted that the MTP Act should be

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55 In a study conducted on the attitudes of medical practitioners to women seeking maternal health services, it was found that in Bihar, Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh, the interactions of doctors with women were not respectful, and many insisted on sterilisation as a precondition for conducting abortions. Alka Barua and Hemant Apte, *Quality of Abortion Care: Perspectives of Clients and Providers in Jharkhand*, Vol. 42 (48) ECONOMIC AND POLITICAL WEEKLY p. 71 (2007).

56 Preservation of a patient's confidentiality is a central aspect of medical professionalism, with Hippocratic roots. Confidentiality is of greater significance in matters of sexual or reproductive health, as patients are likely to forego help altogether, instead of seeking it from someone who is unlikely to maintain confidentiality. Rebecca Cook *et al*, REPRODUCTIVE HEALTH AND HUMAN RIGHTS (2003).

amended to prohibit registered medical practitioners from seeking parental or spousal consent from adult women of sound mind, to enable them to exercise their right to reproductive autonomy.

Additionally, to address the issue of legislation sponsored requirement for spousal consent in the case of minor married women, and that of parental consent in the case of minor unmarried women, it is submitted that a provision for judicial bypass should be made, to enable minor women to overcome additional obstacles.[57] Given the high rate of pendency of cases, a special court or committee, similar to the Child Welfare Committee under the Juvenile Justice Act, 2000 can be established. In addition to the same, the consent of the minor should be made a pre-condition to abortion, to ensure that no minor is forced to terminate a pregnancy that she wishes to carry to term.

B. Sensitisation

As noted above, it is the primary implementers of MTP Act who control access to abortion. While on one hand it is necessary to create a legal obligation on their part to safeguard and cede to the reproductive rights of women, on the other hand, it is also important to educate them about the position of women in the decision making process, and their role in elevating the same. Sensitisation of healthcare service providers to the gendered power-

[57] In the past, there have been instances where the Court assumed *parens patriae* jurisdiction for determining whether an abortion would be in the best interests of a pregnant woman who is incapable of consenting to medical treatment. *See* Suchita Srivatsava v. Chandigarh Administration 2009 (11) SCALE 813 (Supreme Court of India).

dynamics of the abortion decision is therefore, imperative. To that end, the content and process of medical education, which has an important role to play in shaping the attitudes of doctors, should be revised.[58]

The books generally used by students of obstetrics and gynaecology, refer to the MTP Act and the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994, and educate the students about the legal and regulatory aspects of the same. However, none of these books makes any references to how the provisions of the Acts relating to confidentiality and consent should be interpreted, the struggles women face in the decision making process, and the relationship between gender inequity and lack of access to abortion.[59]

Medical practitioners also need to be made aware of the needs of special groups of patients, such as adolescents, and their lack of information on aspects related to sexuality and contraception, the difficulty they face in talking to adults on such matters and their financial constraints, which results in delay in care seeking.[60] The education that students of medicine receive can prevent the medicalisation of women's bodies, and enable doctors to locate women in the socio-economic background that they come from.

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58 Keerti Iyengar, *How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?*, Vol. 40 (18), ECONOMIC AND POLITICAL WEEKLY, p. 1839. (2005). In her review of *Shaw's Textbook of Gynaecology*, Howkins and Bourne, 12th edn. 2002, D.C. Dutta's *Textbook of Obstetrics including Perinatology and Contraception*, 5th edn., 2001, and *Holland and Brews Manual of Obstetrics*, 16th edn., 1998, Keerti Iyengar concludes that the authors and editors have failed to include directions on counselling women, and tend to take a paternalistic view of solutions to maternal health problems. Moreover, the textbooks do not discuss the problems faced by vulnerable groups of women, adolescents, etc., that can enable doctors to provide services in a non-judgemental manner.

59 Renu Khanna, *Obstetrics and Gynaecology: A Women's Health Approach to Textbook*s, Vol. 40 (18) ECONOMIC AND POLITICAL WEEKLY, p. 1876 (2005).

60 *Id.*

C. Awareness and State Action

Statistics show that women who have finished high school are more likely to be aware of their right to abort in the event of an unwanted pregnancy, and such women are less likely to delay their decision of abortion to the second trimester, thus minimising the chance of complications. This is especially true in the case of unmarried women, a large number of whom are unaware that they can legally abort an unwanted foetus.[61]It is therefore submitted that for the complete realisation of women's right to bodily autonomy and consequent reduction in maternal mortality, it is crucial that the state make sincere efforts to spread awareness about women's right to make autonomous and unhindered reproductive choices.

VI. CONCLUSION

Abortion is, and continues to be, a healthcare service that is layered with meaning. While incremental changes in the law are unlikely to revolutionise the understanding of abortion, they will definitely provide an enabling legal framework within which women can demand the enforcement of their rights.

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[61] In a study conducted on young unmarried women seeking maternal healthcare services, it was found that only 22% of respondents were aware that unmarried women can legally abort their pregnancy. Moreover, women were more likely to be aware of this if they had a high school education rather than less education. Those who had the procedure in the first trimester were more likely than those who had it in the second trimester to report that they had participated in the decision making process. Suchitra S. Dalvie, *Second Trimester Abortions in India*, Vol. 16 (31) REPRODUCTIVE HEALTH MATTERS, (2008), pp. 37-45, *available at* http://www.jstor.org/stable/25475399 (Last visited on November 8, 2015).

It was observed in this paper that women play a rather insignificant part in the process of deciding whether a pregnancy should be terminated or not. Remnants of the feudal society that considers women as chattel, which either belongs to the father or the husband remains, and are reflected in the different ways in which the control that they should exercise over their own bodies is transferred into the hands of parents or spouse, either with or without the sanction of the law. Maternal healthcare providers often act as intermediaries through whom such social norms are enforced.

It is submitted that the government must take responsibility for the various societal practices that deprive women of agency in deciding whether they should terminate their pregnancy or not, in order to fulfil its international and constitutional obligations. A three-pronged approach has been suggested for the same. Firstly, the MTP Act should be amended to disallow doctors from seeking the consent of a second party when they are approached by women for termination of pregnancy. Secondly, it is necessary to sensitise doctors to societal realities and the lack of agency of women, to enable them to understand the challenges faced by their patients. For this purpose, contextualised understanding of the provisions of the MTP Act must be incorporated into textbooks on gynaecology and obstetrics. Finally, women must be made aware of their rights under the MTP Act, to enable them to seek the maternal healthcare services.