CHAPTER-VI

REPRODUCTIVE FREEDOM: CONSTITUTIONAL, LEGAL AND POLICY FRAMEWORK IN INDIA

6.1 Introduction

“WE THE PEOPLE” has given us a Constitution, which guarantees Justice- Social, Economic and Political. In the matters of equality Article 14 confers on men and women equal rights and opportunities in the political, economic and social spheres. Article 15 prohibits discrimination against any citizen on the grounds of religion, race, caste, sex etc. Article 15(3) makes a special provision enabling the state to make affirmative discriminations in favour of women. Similarly, Article 16 provides for equality of opportunities in matter of public appointments for all citizens. Article 39(a) lays down that the state shall direct its policy towards securing all citizens, men and women, equally, the right to means of livelihood, while Article 39(c) ensures equal pay for equal work. Article 42 directs the state to make provision for ensuring just and humane conditions of work and maternity relief. Above all, the Constitution imposes a fundamental duty on every citizen through Article 51A (e) to renounce the practices derogatory to the dignity of women. The question, however, is: Have the women been able to reap the benefits provided for them under the Constitution of India? In tune with various provisions of the Constitution, the state has enacted much women– specific and women-related legislation to protect women against social discrimination, violence and atrocities and also to prevent social evils like child marriage, dowry, rape etc. Notwithstanding the enactment of the laws relating to dowry, rape, violence against women, the factual position is rather distressing. What is true at the national level is also a cause of concern at the global level.¹

Ms. Nirmala Buch (IAS), Former Secretary, Ministry of Rural Development, Government of India, observed that our nation decided long ago that its policy on population would be based on choice. The policy should

¹ A.S. Anand, Justice for Women: Concerns and Expressions 1b-1c (Universal Law Publishing Co., Delhi, 2004).
aim at respecting choice and avoid coercion in the form of targets. Any coerced policy measures do not help in population stabilization. Instead, these make women more vulnerable to abuse. Such measures are fraught with danger. Such law and its implementation affect people’s human rights and reproductive rights, women empowerment and democratic rights. Marginalized sections of the society are worst affected.  

The population policy of a developing country like India has to aim at (i) decreasing birth rate, (ii) limiting the number of children in family to two, (iii) decreasing the mortality, (iv) creating awareness among the masses regarding the consequences of galloping population, (v) procuring contraceptives, (vi) enacting laws like legalizing abortion, and (vii) giving incentives. On the other hand, it also has to aim at: (a) checking the concentration of people in congested areas, (b) providing necessary public services for effective settlement in new areas, and (c) relocation of offices to less populated areas. Once the need for the population policy is realized, it has to be framed by appointing various committees and commissions for studying and advising and consulting experts. It has then to be implemented through various programmes and also evaluated from time to time. India’s population policy is the direct result of (a) the total size of the population, (b) a high growth rate, and (c) the problem of uneven distribution of population in rural and urban areas. Since our policy needs to aim at “enhancing the quality of life”, and “increasing individual happiness”, it has to act as a means to attaining a broader objective of achieving individual fulfilment and social progress.  

As far as reproductive rights in India are concerned there is no specific law to deal directly with reproductive rights. The term ‘reproductive rights’ has not been explicitly used/defined in Indian statutes. However, the law recognizing certain reproductive interests is prevailing in a scattered form. In this Chapter an attempt is made to discuss various provisions relating to the

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reproductive rights incorporated in Indian laws like the provisions of the Constitution of India, Indian Penal Code 1860, Medical Termination of Pregnancy Act 1971 and PNDT Act 1994, Prohibition of Child Marriage Act, 2006. Further the role of judiciary in granting and respecting reproductive rights and analysing the circumstances and the period up to which a pregnancy can be terminated has been an attempt.

6.2 Reproductive Freedom under Indian Constitution

The Constitution of India inscribes justice as the first promise of the Republic, which means that state power will execute the pledge of justice in favour of millions who are the Republic.\(^5\) It is assumed that the philosophy of social justice is a myth without reproductive justice as it covers some basic aspects of life. Nothing would advance women's welfare more than respecting their reproductive autonomy. Such autonomy must encompass and protect the personal intimacies of marriage, motherhood, procreation and child rearing.\(^6\) This autonomy is an essential element for development of one's personality and in such areas, an individual requires to be at liberty to do as he likes.\(^7\) This autonomy is also broad enough to encompass a woman's decision whether or not to terminate her pregnancy.\(^8\)

The expression ‘Reproductive Justice’ - prima facie appears as an alien concept for Indian soil. However, the fertility of the preambular goals and philosophy cultivated with the efforts of judiciary as a guardian, has ingrained it over Indian land explicitly.\(^9\) By virtue of Article 253 of the Constitution of India, International human rights norms as contained in the Conventions are binding on India. Therefore, the Protection of Human Rights Act, 1993 recognizes that the above Conventions are now part of the Indian human rights law. According to Article 253 of Constitution of India, our legislators can give effect to any Convention in the form of law for the betterment of society. On the basis of International Conventions, Hon'ble Supreme Court

\(^8\) Roe et al. v. Wade, District Attorney of Dallas County (1973) 410 U.S.113.
\(^9\) See Supra note 4 at 39-40.
recognized this right to privacy in various pronouncements. Being a signatory to various international instruments of Human Rights, India has assumed the responsibility to provide and protect rights of the women and therefore, it confers a catena of rights upon women. It guarantees not only the equality before law and equal protection of law to women but also confers certain affirmative rights. Article 14 of the Constitution of India certainly ensures equality before law and equal protection of laws. Article 15 prohibits discrimination by state of any citizens on the basis of sex etc. only. Article 15(3) empowers the state to make special provisions for the women and children.

The right to life guaranteed under Article 21 of the Constitution is the heart of fundamental rights. Justice Bhagwati in Francis Coralie Mullin case observed “The fundamental right to life is the most precious human right and forms acme of all other rights.” Privacy, though not expressly provided under our Constitution, it impliedly takes into it the right to privacy as personal liberty in Article 21. A citizen has, therefore, a right to safeguard the privacy of his own, his family, marriage, procreation, motherhood, child bearing and education among other matters.

The Constitution of India under Article 21 guaranteed personal liberty which may include the liberty of conceiving a child and giving birth to it. At the same time under various provisions of other laws woman is given ample

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13. Article 14 of the Constitution of India provides “The State shall not deny to any person equality before the law or equal protection of laws within the territory of India.”
15. Article 15(3) of the Constitution of India provides “Nothing in this article shall prevent the State from making any special provision for women and children.”
16. Article 21 of the Constitution of India provides that “No person shall be deprived of his Life or Personal Liberty except according to Procedure established by Law.”
17. AIR 1981 SC 746.
liberty and discretion in matters like procreation, abortion and sterilization. Therefore right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution. With the vast expansion of the concept of Personal Liberty, the Right to Privacy has also been accepted to be compromised therein and that such Right of Privacy would include the Right to or not to beget and bear a child, the Right to be or not to be a parent, the Right to use or not to use contraceptives, the Right to get sterilized or not to sterilize oneself, the Right to have sex without having a child, or to have child without having sex by artificial insemination. The Right has accordingly been held to include the right to stop the parenthood or motherhood in transit, that is, the Right to terminate pregnancy prematurely by aborting the foetus.

6.2.1 Right to Terminate Pregnancy

As discussed above, reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. Reproductive rights include a woman's entitlement to carry pregnancy to its full term, to give birth and to subsequently raise children. But granting that the Right to Personal Liberty of a woman includes her right to terminate pregnancy depends on whether or not the exercise of such right would affect the Right of Life of unborn child. The answer of this question would obviously depend on the answer to the two questions, viz., (i) whether or not an unborn child is a person within the meaning of the Life as provided under Article 21, and (ii) if somehow we say that the unborn has life then when does the life comes into existence, because some believe that life begins immediately after conceiving and some believe life begins only after

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21 See Supra note 18 at 70.
23 Supra note 12 at 25.
25 See Supra note 12 at 25.
26 As per Section 20 of Hindu Succession Act, Section 99(i) of Indian Succession Act, Indian Penal Code (312-316) child in womb is considered as a legal person capable of enjoying legal rights.
completion of first trimester.\textsuperscript{27} Hence, a woman's right to terminate her pregnancy is absolute and may to some extent be limited by the state's legitimate interests in safeguarding the woman's protecting potential human life.\textsuperscript{28} However, regulations limiting woman's right may be justified only by a compelling state interest, and that legislative enactment must be narrowly drawn to express only the legitimate state interest at stake.\textsuperscript{29}

Besides Fundamental Rights, Part IV of the Constitution enumerates certain Directive Principles to be followed by the state at the time of framing and implementing its policies. These Directive Principles reflect the ideals of a welfare state which are meant for a system where none is dependent on the charity of others;\textsuperscript{30} where it is not the duty of the private individuals but the duty of the state to provide the people whatever is necessary for their welfare; and where it is the duty of the state to secure for every citizen, so far as possible, full opportunity for the development of his talents, unhampered by poverty and ill health.\textsuperscript{31}

The Constitution of India incorporates the concept of social justice in its comprehensive scope- for the legislature, executive and the judiciary. Article 38 clearly spells out the guideline to the state to promote welfare of the people and secure a social order through the institution of the state, and it must be based on the philosophy of justice in its social, economic and political aspects. But the socio-economic backwardness of various communities and increase in maternal mortality rate in India stretched the radius of social justice by including the issue of reproductive justice within its scope. Therefore the Directive Principles of State Policy read with Fundamental Rights as provided under the Constitution of India clearly reflect the constitutional mandate to ensure meaningful freedom for women in the reproductive matters.\textsuperscript{32}

\textsuperscript{27} Sunil Deshta and Kiran Deshta, \textit{Fundamental Human Rights} 95 (Deep and Deep Publication (P) Ltd., Delhi, 2004).
\textsuperscript{28} See \textit{Supra} note 18 at 70.
\textsuperscript{29} See \textit{Supra} note 8.
\textsuperscript{30} Directive Principles of State Policy, (Article 36-51), \textit{The Constitution of India}.
\textsuperscript{32} See \textit{Supra} note 4 at 42, 44.
6.3 Reproductive Freedom under Indian Penal Code, 1860

The Indian Penal Code, 1860 keeping in view the religious, moral, social and ethical background of the Indian community has defined various offences relating to miscarriage, injury to unborn and punishment thereof. These provisions are essentially based on the notion that human life is sacred and the legal protection also extends to the unborn child in the mother's womb. It has made both “causing miscarriage with the consent” or “without the consent” of the woman punishable under Sections 312 and 313 respectively.33

6.3.1 Section 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.34

The Section speaks of miscarriage only, which has nowhere been defined in the Indian Penal Code. The framers of the Code have not used the word 'abortion', in Section 312, which relates to an unlawful termination of pregnancy. This was perhaps done to avoid hurting the sentiments of traditional bound and conservative Indian society. However, miscarriage, in its popular sense, is synonymous with abortion, and means expulsion of the immature foetus at any time before it reaches full growth. Miscarriage technically refers to spontaneous abortion, whereas voluntarily causing miscarriage, which is an offence under the Code, stands for criminal abortion.35

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34 Section 312, Indian Penal Code, 312.
6.3.1.1 Distinction between the concept of ‘Woman with Child’ and ‘Woman Quick with Child’

According to Section 312, IPC voluntarily causing miscarriage is an offence in two situations, namely when a woman is ‘with child’ and the other being a woman ‘quick with child’. As per judicial interpretation, a woman is considered to be in the former situation as soon as gestation begins and in the latter situation when the motion is felt by the mother. In other words, quickening is a perception by the mother that movement of the foetus has started. It obviously refers to an advanced stage of pregnancy. Taking into account the nature and gravity of the offence in the latter case, the Section has prescribed punishment in the form of imprisonment of either description which may extend to seven years and fine, whereas in the former case punishment may go up to three years of imprisonment, or fine, or both depending upon the nature of the offence in question.\(^{(36)}\)

The Explanation as appended to Section 312 of the Code makes it clear that the offender could be a woman herself or any other person. The desire of a woman to be relieved of her pregnancy is no justification for termination of pregnancy. As early as 1886 in Ademma\(^{(37)}\), a woman was charged under Section 312 of the Code for causing herself to miscarry, though she had been pregnant for only one month, and there was nothing which could be called even a rudimentary ‘foetus’ or ‘child’. The lower Court acquitted the woman taking a lenient view of the matter and held that as the prisoner has been pregnant for one month only, she could not be said to have been 'with child' within the meaning of Section 312 of the Code. But the High Court held the acquittal bad in law emphasizing that it was the absolute duty of a prospective mother to protect her foetus from the very moment of conception.

6.3.1.2 Voluntarily Causing Miscarriage

This Section seeks to penalize a woman of causing miscarriage i.e. who herself consents for the miscarriage. When such miscarriage is secured in good faith to save the life of the pregnant woman, Section 312, I.P.C.

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\(^{(37)}\) *Queen Empress v. Ademma* (1886) I.L.R. 9 Mad. 369.
absolves the author of the miscarriage from any crime. The words 'voluntarily causes a woman to miscarry' which constitutes the core of the offence contemplated in Section 312 would include any act such as delivery of medicine which caused the abortion. A person who aids and facilitates a miscarriage is liable for the abetment of the offence of miscarriage under Section 312, read with Section 109 of the Indian Penal Code, even though the abortion did not take place. Where the person has merely pledged the ornaments of the pregnant woman and thereby raised money intentionally to aid and facilitate the miscarriage of the woman, he would properly be charged of abetment of an offence under Section 312. A person is also liable for attempt to commit a criminal abortion under Section 312 read with Section 511, IPC, even if he fails in his endeavour. For instance, in *Queen Empress v. Aruna Begam*, where the term of pregnancy was almost complete and an attempted abortion resulted in the birth of the child, a conviction under Section 312 was set aside and one under Section 511, I.P.C. for attempt to bring about miscarriage was maintained.

6.3.1.3 Abortion permitted on Therapeutic Grounds

Section 312, I.P.C. permits abortion only on therapeutic (medical) grounds i.e., primarily to save the life of the mother. That is to say, the unborn child must not be destroyed except for the purpose of preserving the yet more precious life of the mother. The provision by implication recognizes the foetus right to life.

To claim exemption from criminal liability on therapeutic grounds, the threat of life, however, need not be imminent or certain. If the act is done in good faith, the person is entitled to the protection of law.

The term ‘good faith’ has nowhere defined in MTP Act. The General

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39 IPC, Section 8, Explanation 2.
40 *Emperor v. Marian Sidi*, 10 Cr LJ 10; 2 IC 453.
41 Section 511, I.P.C. provides punishment for attempting to commit offences punishable with imprisonment for life or other imprisonment.
42 (1873) 19 WR (Cr) 230.
Clause Act, 1897\textsuperscript{45} defines good faith as a thing deemed to be done in good faith where it is, in fact done honestly. Section 52 of Act 45 of Indian Penal Code, 1860 defines good faith, as nothing is said to be done or believed in good faith if it is done or believed without due care and attention. But good faith is deceptive and ambiguous enough to protect most therapeutic abortions so long as they are conducted ostensibly to preserve the mother’s life. In fact, what constitutes good faith is not a question of law, but of fact to be decided in each and every case according to its facts and circumstances.\textsuperscript{46}

6.3.2 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.\textsuperscript{47}

Section 313, I.P.C. penalizes voluntarily causing miscarriage of a woman with child without her consent, while miscarriage with consent is dealt with under section 312, I.P.C. Under Section 313, only the person procuring the abortion alone is liable to punishment, whereas under Section 312, I.P.C. the woman is also liable for punishment.\textsuperscript{48}

In Moideenkutty Haji v. Kunhikaya,\textsuperscript{49} the Kerala High Court held that an offence under Section 313, I.P.C. could not be made out, where the only allegation in the complaint was that on hearing that the woman was pregnant, the accused took her to a doctor, who terminated her pregnancy and there was no case that it was without her consent. On the contrary, the averment showed that the woman willingly submitted herself to abortion and even thereafter had sexual intercourse with the accused and there was nothing to show that abortion was at the instance of the accused. Further, it was not clear from the allegation whether he was only accompanying the lady at her request and whether he even made a request to the doctor to have the abortion done.

\textsuperscript{45} Act 10 of 1897, Section 3 (22).
\textsuperscript{47} Section 313, Indian Penal Code, 1860.
\textsuperscript{48} Queen Empress v. Aruna Begam, (1873) 19 WR (Cr) 230.
\textsuperscript{49} AIR 1987 Ker 184: 1987 Cr. LJ 1106 (1109).
Finally, the doctor who conducted the abortion was not made an accused, which showed that she had no complaint against him.

6.3.2.1 Criminal Abortion without Consent

The last Section i.e. Section 312 applies equally both to the woman miscarrying and to the abortionist who causes her miscarriage. The offence is committed by the latter with the consent of the former. They are, therefore, both particeps criminis. This section deals with the same case presented under different circumstances. It relates to the commission of the same offence when the woman, who is primarily interested in the result, is not a consenting party to the act. This naturally aggravates the crime, and justifies the heavier sentence here provided. It is, indeed, lighter than under English law, where the offence in a similar case would be murder.\(^{50}\)

Miscarriage when has been caused through full and free consent of the woman Section 313 I.P.C. is not attracted at all. In this case a girl over 18 years of age makes an extremely belated complaint of rape on her, and the accused who is not at all connected with the offence just carried the girl to a hospital and where she aborted the child. The Court held that the accused cannot be roped by Section 313, I.P.C.\(^{51}\)

In *Tulsi Devi v. State of U.P.*\(^ {52}\), the accused woman kicked a pregnant woman in her abdomen resulting in miscarriage. Her conviction under Section 313, IPC was sustained by the court.

6.3.3 Section 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 which 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.


\(^{52}\) 1996 Cri LJ 940 (All).
Explanation - It is not essential to this offence that the offender should know that the act is likely to cause death.\textsuperscript{53}

This Section provides for the case where death occurs in causing miscarriage. The act of the accused must have been done with intent to cause the miscarriage of a woman with child. Section 314 is in two parts. If the miscarriage entailing death of the woman concerned is caused with her consent, the offence falls under the first part of Section 314, I.P.C where punishment is less. When the miscarriage entailing death of the woman concerned has been caused without her consent, it attracts second part and the punishment which is severe.\textsuperscript{54}

6.3.3.1 Intending Abortion causing Death

This Section holds the accused responsible for the natural consequence of his illegal act. In so enacting, the law makes no departure from the general law. A person cannot violate the law, and then seek its protection against its natural consequences. The offence consists in doing an act with intent to cause miscarriage. The intention to cause miscarriage would have to be gathered from the surrounding circumstances, such as undue intimacy with the deceased, the procuring of abortive, consulting persons on the subject, and the like. The fact that the woman was not pregnant is, of course, immaterial, for it is not a mistake of fact which justifies his killing her.\textsuperscript{55}

In Jacob George v. State of Kerala\textsuperscript{56}, a homoeopath operated upon a pregnant woman to cause abortion but she died within a few hours of the operation because her uterus bag was perforated. His conviction under Section 314, IPC was upheld. The Apex Court in this case reduced the sentence to one already undergone but enhanced the fine from Rs. 5000 to one lakh rupees to be deposited in the name of the minor son of the deceased and passed a detailed order as to how the money was to be utilized. The court discussed the purpose of punishment at length and emphasized the need for awarding compensation liberally but reasonably to meet the ends of justice.

\textsuperscript{53} Section 314, Indian Penal Code, 1860.
\textsuperscript{54} \textit{Supra} note 38 at 1661.
\textsuperscript{56} (1994) 3 SCC 430.
6.3.4 Section 315- Act done with intent to prevent child being born alive or 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.\(^{57}\)

This offence is separated by a narrow margin from infanticide, which would in the same circumstances be murder, pure and simple. The only difference between such foeticide and infanticide which is murder is that the former offence is committed before its delivery, while the latter can only be committed after its delivery.\(^{58}\)

6.3.4.1 Foeticide in Womb

This Section is aimed at foeticide while in the womb, after the foetus develops sufficiently to assume the human form, which it does in normal cases in the sixth month. When it attains that degree of development, the act which, would if done earlier, by abortion, ceases to be so, as the delivery of an undeveloped child would be premature labour, for which the accused is held more responsible owing to the more advanced stage of foetal life.\(^{59}\)

6.3.4.2 Good faith as Defence

If the act is done with intent to prevent the child from being born alive, with good faith to save the life of the mother the accused is to be absolved from the guilt. The expression good faith has been defined in Section 52, I.P.C.\(^{60}\)

6.3.5 Section 316-Causing Death of Quick Unborn Child by act amounting to Culpable Homicide - Whoever does any act under such circumstances that if he thereby causes death he would be guilty of culpable homicide, and does by such act cause the death of a quick unborn child, shall

\(^{57}\) Section 315, Indian Penal Code, 1860.  
\(^{58}\) See Supra note 50 at 1280.  
\(^{59}\) Ibid.  
\(^{60}\) Supra note 38 at 1664.
be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

**Illustration** - A, knowing that he is likely to cause the death of a pregnant woman, does an act which, if it caused the death of the woman, would amount to culpable homicide. The woman is injured but does not die; but the death of an unborn quick child with which she is pregnant is thereby caused. A is guilty of the offence defined in this Section.\(^{61}\)

This Section punishes offences against children in the womb where the pregnancy has advanced beyond the stage of quickening and where the death is caused after the quickening and before the birth of the child. Any act or omission of such a nature done under certain circumstances as would amount to the offence of culpable homicide, if the sufferer were a living person will, if done to a quick unborn child whose death is caused by it, constitutes here a punishable offence.\(^{62}\)

### 6.3.5.1 Culpable Foeticide

This offence is in reality a modified form of homicide as applied to an unborn child. All it says is that an act which would be culpable homicide of a person born would be an offence here described if the person thereby killed was still unborn. In other respects the act must possess all the elements necessary to constitute culpable homicide. But *Explanation* 3 to Section 299 of the Indian Penal Code, 1860, makes it clear that the causing of death of a child in the mother’s womb is not homicide. But it may amount to culpable homicide to cause the death of a living child, if any part of the child has been brought forth, though the child may not have breathed or been completely born. An attempt at abortion of a non-pregnant woman believed to be pregnant is legally liable to the same consequences as an attempt with the intention of causing a real abortion. However, it is not unlawful to operate on a dead pregnancy, provided the operator believes it to be dead.\(^{63}\)

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\(^{61}\) Section 316, Indian Penal Code, 1860.

\(^{62}\) See *Supra* note 38 at 1665.

\(^{63}\) See *Supra* note 50 at 1281.
6.3.6 Need to Legalize the Abortion Law

Thus, criminal law was quite strict on abortion and the only potent defence appears to be good faith. The strictness in regard to the law of abortion resulted in the mental stress among women and thereby increase in the number of suicides as the last resort to get rid of the resultant child. Hence it is a matter of common knowledge that a large number of maternal death is due to illegal abortions. Despite this, till 1970 criminal law was not liberalized and criminal abortions remained uncombated. Such abortions were being carried throughout the country by quacks, untrained midwives, unskilled persons and persons having no medical experience in abortion and that too under most unhygienic conditions which led to high maternal mortality rates. On the other hand the strict abortion laws were indirectly contributing to high rate of population growth. Such a rapid increase has very serious repercussions on socio-economic development of the nation. As early as 1957, the Mudaliar Committee reported on the problem of illegal abortion in India, also, the third five-year plan observed about the subject in its report on family planning. In 1962, the Family Planning Training and Research Centre in Bombay recommended liberalization of abortion law. The Government of India in 1964 constituted a Committee to study the question of liberalization of the law of miscarriage (abortion) embodied in Section 312 of the IPC which makes induced abortions illegal except to save the life of a woman. In 1964, the Indian Parliamentary and Scientific Committee under the Chairmanship of Lal Bahadur Shastri proposed to recognize abortion as a remedy for failure of contraceptives. In the same year, the Central Family Planning Board (CFPB) recommended the setting up of a Committee to study the problem. A resolution passed by the Health Ministry in September 1964 provided for the establishment of such a committee under the Chairmanship of Shantilal Shah, who was then a member of CFPB. The exhaustive report of this Committee formed the formal base of the MTP Act.

65 Supra note 35 at 215.
6.4 Medical Termination of Pregnancy Act, 1971

The Medical Termination of Pregnancy Act, 1971 was passed by Indian Parliament in August 1971 and it came into force on 1 April, 1972. The MTP Act is modelled in line with the Abortion Act of 1967, of UK. Initially the name proposed for the enactment was ‘Abortion Act’ but this nomenclature did not find favour from the social organizations and the Government. Therefore, the name was changed to ‘Medical Termination of Pregnancy Act’. According to the MTP Act, abortion is legal, if it is performed for one of the several specified reasons within a limited period after conception by a specially designated specialist and under prescribed conditions. The grounds on which the pregnancy can be terminated under the MTP Act are in addition to the Section 312 of the Indian Penal Code, 1860.67

The legalization of abortion faced a lot of hurdles from anti-abortionists and pro-life advocates coupled with the presence of the vital role played by the women's groups.68 When the MTP Act was passed in India, only few countries in the world had legalized abortion including Soviet Union, Sweden, Poland, Ireland and UK. It recognized that unwanted pregnancy could cause serious mental anguish to the women and hence, she should have the right to abort it.69 The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy which has never been recognized as a normal recourse for expecting mothers.70

Women got an absolute freedom and discretion under law whether to conceive or not. But when once this option to conceive was exercised, termination of foetus was an offence under IPC. The Medical Termination of Pregnancy Act, 1971 interferes exactly at this stage and gives a wide degree of autonomy to the woman, subject however, to certain conditions like the circumstances under which the pregnancy may be terminated, the length and duration of the pregnancy, the proper authorities who can perform the

67 Supra note 7 at 130.
The Preamble to MTPA states “an Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidents thereto.” It declares clearly the cases where the termination of pregnancy would be permitted. Moreover, only a registered medical practitioner, who is defined in Section 2(d) of the Act as “a medical practitioner who possess any recognized medical qualification as defined in Clause (h) of Section 2 of the Indian Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act”, is permitted to conduct the termination of pregnancy.\(^\text{72}\)

Its object, besides elimination of the high incidence of illegal abortions, is perhaps to confer on women the right of privacy\(^\text{73}\), which includes the right to, (i) space and limit pregnancies; and (ii) decide about her own body.\(^\text{74}\) The outstanding feature of the Act is its ability to cater to the changing needs of the times as Section 6 empowers the Central Government to make rules for proper implementation of the Act. As such the Act has potential to cater to the developments such as in vitro fertilization. Another important feature of the Act is to encourage a reduction in the rate of population growth by permitting termination of an unwanted pregnancy on the ground of failure of contraceptive device.\(^\text{75}\)

6.4.1 Legal Provisions under MTP Act\(^\text{76}\)

- **Therapeutic Indications:** In order to prevent injury to the physical or mental health of the pregnant woman.

- **Eugenic Indications:** In view of the substantial risk that if the child

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\(^{74}\) *ILL v. Matheson*, 450 U.S. 398 (1980).


were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

- **Humanitarian Indications:** As the pregnancy is alleged by a pregnant woman to have been caused by rape.

- **Social Indications:** As the pregnancy has occurred as a result of failure of any contraceptive device or method used by a married woman or her husband for the purpose of limiting the number of children.

- **Environmental Indications:** In order to prevent a risk of injury to the physical or mental health of the pregnant woman that may arise by reason of her actual reasonably foreseeable environment.

**Important Features and Safeguards**

- The consent of the woman alone is required if she is above 18 years of age, but if she is a minor or a mentally ill person, consent of the guardian is necessary.

- The termination of pregnancy is to be carried out in a government hospital or at a place approved by the government and two medical practitioners are necessary if the pregnancy is of more than 12 weeks but less than 20 weeks duration; for less than 12 weeks one medical practitioner can terminate it.

- In an emergency, a general practitioner can terminate pregnancy at any place, irrespective of its duration.

### 6.4.2 Grounds for Termination of Pregnancy

Section 3 of MTP Act, which is the operative section, has modified the strict provision of the law of abortion as contained under Section 312 of IPC by permitting termination of pregnancy in a number of situations. The Section, *inter alia*, envisages in Sub-Section (2) that the termination of pregnancy by a registered medical practitioner is not an offence, if the pregnancy involves:

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77 Supra note 35 at 217-218.
78 See, M.T.P.A. 1971, Section 2(d).
i) a risk to life of the pregnant woman; or

ii) a risk of grave injury to her physical or mental health; or

iii) if the pregnancy is caused by rape; or

iv) there exists a substantial risk that, if the child were born, it would suffer from some physical or mental abnormalities so as to be seriously handicapped; or

v) failure of any device or method used by the married couple for the purpose of limiting the number of children; or

vi) risk to the health of the pregnant woman by reason of her actual or reasonably foreseeable environment.

An important feature of the Act is that it does not permit termination of pregnancy after twenty weeks. Sub-Section (2) of Section 3 of the Act which is the pertinent clause on the subject states:

[A] pregnancy may be terminated by a registered medical practitioner:

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

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

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

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

6.4.3 Gaps and Loopholes

It is important to note that certain loopholes exist in the Act. Firstly, nowhere has the Act defined what would involve a risk or grave injury to

79 Supra note 72.
mental health of a woman. The term ‘grave injury’ or ‘substantial risk’ remains undefined. The decision regarding the gravity of the injury or the extent of the risk has been left to the medical practitioner. However, the MTP Act provides some guidance for the doctors in the form of two explanations.

**Section 3(2) 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. Therefore, rape *per se* is not an indication. It is the mental anguish following pregnancy due to rape, which is the main indication. In other words, mental anguish is to be taken into consideration; proving rape and affecting her character is not necessary. Her allegation that she has been raped is sufficient. Further proof of rape like medical examination, trial, and judgment is not necessary.

**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 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.

The Act says that mental anguish caused to a married woman due to contraceptive failure is an indication of a grave injury to the mental health of the pregnant woman. But can an unmarried woman avail of this Clause for termination of pregnancy? She cannot use this, but can get abortion under the general clause of mental indication.

Sub Section (3) clarifies that:

Sub-Section 3(3) in determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in Sub-Section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment. The terms reasonably or foreseeable being left to the interpretation of the medical practitioners. Environmental clauses could include, by interpretation, drunkard husband, low-income group, large family etc.
6.4.4 Consent for Abortion

Section 3(4) of MTP Act clarifies as to whose consent would be necessary for termination of pregnancy

(a) No pregnancy of a woman, who has not attained the age of 18 years, or who having attained the age of 18 years, is a lunatic, shall be terminated except with the consent in writing of the guardian.

(b) Save as otherwise provided in Clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.\textsuperscript{80}

It may be noted that wherever the word ‘lunatic’ appears in the original Act, it has been omitted by the Medical Termination of Pregnancy (Amendment) Act, 2002 and in its place the words ‘mentally ill person’ have been substituted. A ‘mentally ill person’ has been defined in Section 2(b) as a person who is in need of treatment by reasons of any mental disorder other than mental retardation.\textsuperscript{81}

It is important to note that the woman does not require anybody’s consent to terminate her pregnancy, if she is a major. The husband’s consent is irrelevant. Therefore, if the woman wants an abortion but her husband objects to it, the abortion can still be done. However, if the woman does not want an abortion but her husband wants, it cannot be done. But the main issue here is that it is not wise not to involve the husband in the decision making regarding the use of contraception or abortion (if required) as in most of the cases it is the man who has to bear the financial burden of the child and ultimately the family. The issue needs to be viewed from the perspective of both the parties i.e. women’s right over her body and the right to make the choice, and the man’s desire to have progeny. Therefore, if we talk about reproductive freedom it should not be confined only to women’s right over her body but it should include both men and women as for any human freedom of choice is the utmost priority.\textsuperscript{82}

If the pregnant woman is unmarried but above the age of 18 years, her

\textsuperscript{80} Section 3(4), Medical Termination of Pregnancy Act, 1971.
\textsuperscript{81} Section 2(b), Medical Termination of Pregnancy Act, 1971.
\textsuperscript{82} Subhash Chandra, “Right to Abortion: A New Agenda” AIR Jour 130 (1997).
own consent is necessary. The consent of guardian in such case is not necessary. But the problem arises when she is a minor or lunatic. Under MTP Act a minor girl cannot approach a doctor for abortion on her own. The written consent of parent or guardian is required.\(^{83}\) For instance in Shruti Sachdeva’s case, where a minor 15 year-old girl was kidnapped from her house and was found in Goa. She was pregnant from Nishan Singh. The father of the girl demanded the medical termination of the pregnancy of his minor daughter terming it as unwanted conception. The father had pleaded that as his minor daughter was a rape victim, the pregnancy would be a grave injury to her mental health.\(^{84}\) Since she is a rape victim, and minor so the pregnancy can be terminated with the written consent of her guardians.\(^{85}\)

In another case a 16-year-old girl eloped and got married, her father registered a complaint with the police. The police traced the couple and the boy was let on bail by a Judicial Magistrate while the girl was taken to the boy’s house. On a *habeas corpus* petition filed by the father, the Madras High Court in *V. Krishnan v. G. Rajan alias Madiput Rajan and The Inspector of Police (Law and Order)*\(^{86}\), directed the girl be sent to a Home. After a month, the girl was found to be pregnant and the father filed another *habeas corpus* petition, in the Madras High Court seeking a direction for medical termination of his daughter’s pregnancy. The Division Bench of Madras High Court after listening to the girl who was firm on continuing with the pregnancy refused to order the termination of the pregnancy.

Under Indian Penal Code sexual intercourse with a minor wife of 15 years or above is not an offence. The Hindu Marriage Act, 1955 and the Child Marriage Restraint Act, 1929 also does not invalidate the marriage of a minor girl. Therefore, these legislations recognized indirectly the right of a minor girl to marriage and thereby to conceive. The parents of the minor girl cannot force her to terminate the pregnancy against her will and to deprive a minor girl of her natural right to conceive and no legislation confer power on any

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\(^{83}\) *Supra* note 76 at 724.

\(^{84}\) “CJM Defers Decision on Shruti’s Custody” *The Tribune*, November 17, 2012 at 5.

\(^{85}\) “Shruti Case: Court allows DNA test on accused Nishan Singh” *The Tribune*, November 9, 2012 at 4.

person to subject a minor girl to any unwilling treatment.\textsuperscript{87}

\subsection*{6.4.5 The Place where the Pregnancy can be Terminated\textsuperscript{88}}

Initially Section 4 of the Act had provided that the termination of pregnancy under the provisions of Medical Termination of Pregnancy Act shall be made either (i) in a hospital established or maintained by the Government, or (ii) at a place for the time being approved for the purpose of this Act by the Government. By the Amending Act of 2002, this provision has been deleted and substituted by a new Section 4 that runs as under:

\begin{quote} 
“4. No termination of pregnancy shall be made in accordance with this Act at any place other than-
\begin{enumerate}
\item a hospital established or maintained by Government, or
\item 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:
\end{enumerate}
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.”
\end{quote}

Since the abortion has been considered as a statutory personal matter, the name of the person subjected to abortion is kept confidential.

Non-governmental institutions may also take up abortions provided they obtain a license from the Chief Medical Officer of the District. The requirement as regards the availability of an anaesthetist on call has also been done away with under the amended rules.

\subsection*{6.4.6 Exceptions to Section 3 and 4 of the Act\textsuperscript{89}}

As mentioned above, Section 3 provides that the termination of pregnancy could be made up to 20 weeks of pregnancy and if the termination is necessary in the option of the registered medical practitioner(s). It also

\textsuperscript{87} Supra note 20 at 138.
\textsuperscript{88} K. Mathihran and Amrit K. Patnaik (eds.), Modi’s Medical Jurisprudence & Toxicology 1019 (Lexis Nexis Butterworths, New Delhi, 2002).
\textsuperscript{89} Supra note 72.
provides that the pregnancy of a minor or a mentally ill person could be terminated only when the consent of the guardian is obtained. Section 4 provides the place where the termination of pregnancy could take place. Section 5 gives the instances where the aforesaid provisions of Section 3 and 4 would not be applicable. This Section after the amendment\(^{90}\) runs as under:

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

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 the 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 1:** 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.

\(^{90}\) MTP Amendment Act, 2002.
**Explanation 2:** For the purpose 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."

However exceptions are made for emergencies. Under Section 5(1), a doctor may terminate pregnancy if it is “immediately necessary to save the life of the pregnant woman.” In such situations, the requisites relating to the opinions and the venue for operation do not apply. However, it needs to be pointed out that one aspect of this emergency clause tends to restricts rather than liberalize the old law. Section 312 of the IPC permitted abortions by anyone with the object of saving the life of the mother, but under MTPA only a doctor can terminate the pregnancy. Hence, the MTP Act has been given overriding effect by Section 5(2). The Act creates a specific offence where pregnancy is terminated by an unregistered medical practitioner. This is an independent offence and shall not affect the provisions of the Indian Penal Code dealing with the offence of miscarriage.

**6.4.7 Approval of a Place**¹

No place shall be approved under Clause (b) of Section 4.

(1) Unless the government is satisfied that termination of pregnancy may be done therein under safe and hygienic conditions

(2) Unless the following facilities are provided therein namely:

(i) An operation table and instruments for performing abdominal gynaecological surgery.

(ii) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

(iii) Drugs and parental fluids for emergency use.

¹ Clause (b) of Section 4 M.T.P.A. 1971.
6.4.8 **Power to make Rules**\(^\text{92}\)

The Central Government and the State Governments have been given powers to make rules and regulations under Sections 6 and 7 of the Act respectively.

These rules are concerning:

(i) experience or training of a registered medical practitioner if he intends to terminate pregnancy;

(ii) regarding certification by a registered medical practitioner of any opinion;

(iii) intimation of such termination;

(iv) prohibition of disclosure of intimation or information furnished.

The State Government may also make regulations with respect to the intimation given and information furnished to the Chief Medical Officer.

6.4.9 **Legal Protection to the Doctors**

Section 8 of the Act gives legal protection to the doctors for any damage caused or likely to be caused by anything done or intended to be done in good faith for the purpose of termination of pregnancy.\(^\text{93}\) Though MTP has legal protection, since it is woman’s personal matter, secrecy must be observed by the doctor. The name of the woman subjected to MTP should not be divulged. It should not be discussed with fellow doctors or friends as it would amount to violation of rule of confidentiality. In other words, a doctor is exempted from criminal liability for causing miscarriage if it is proved that he acted in good faith to procure the termination of pregnancy. However, if found to be negligent he will be held guilty of criminal negligence.\(^\text{94}\)

6.4.10 **Confidentiality in MTP**\(^\text{95}\)

No information can be given to anyone under any circumstances except for the following exceptions:

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\(^{93}\) See Section 8, M.T.P.A. 1971.


\(^{95}\) *Supra* note 76 at 725.
1. Secretary of Health in Departmental Enquiries
2. First Class Magistrate in Criminal Court Proceedings
3. District Judge in Civil Court Proceedings; and
4. Secretary to the Government of India in the case of bonafide scientific research.

When done in good faith, they are not liable to any legal proceedings or suit for any damage caused or likely to be caused. However, violations not falling exactly under the IPC, 1860, Sections 312-315, being minor in nature, may fall under Section 166 of under the Office Secrets Act, 1923.

6.4.11 Amendments to the Medical Termination of Pregnancy Act 1971

Complications of illegal and unsafe abortion in India remain a major factor in high rates of maternal mortality. In 1997, an expert group was constituted to review the aforesaid Act with a view to making it more relevant to the present environment. The National Commission for Women also suggested certain amendments in the act to remove provisions which were discriminatory to women. Taking into consideration the suggestions of the National Commission for Women and experience gained in the implementation of this Act, the expert group recommended certain amendments to the Act. The Medical Termination of Pregnancy (Amendment) Bill 2002 was approved by the Parliament of India on 5 December 2002, to amend the MTP Act 1971. The amended Act is aimed at eliminating abortion by untrained persons and in unhygienic conditions, thus reducing maternal morbidity and mortality. The main objective of the recent amendments to the MTP Act is to reduce the rate of unsafe abortions by making legal abortion more widely accessible.96

Some of the important amendments are:97

• In Section 2 clause (a) of the Act, for the word “lunatic”, the words ‘mentally ill person” is substituted.

• In Section 2 clause (b) of the Act, “mentally ill person” means a person

96 Asha Bajpai, Child Rights in India 396 (Oxford University Press, New Delhi, 2006).
97 Supra note 76 at 719.
who is in need of treatment by reason of any mental disorder other than mental retardation.

- In Section 3 of the Act, in sub-section (4), in clause (a), for the word “lunatic”, the words “mentally ill person” is substituted.

- In the amended Act, recognition of a place for the purpose of carrying out MTP is now at district level rather than the state capital. Section 4 has been amended with a view to delegating powers to the Government to approve places for medical termination of pregnancy and constituting District Level Committees to be headed by the Chief Medical Officer/District Health Officer.

- In the Principal Act, there was dependence on IPC to enforce discipline. In the amended Act, the punishment is incorporated in the Act itself.

Section 5 of the amended Act prescribes punishment by rigorous imprisonment of non-less than two years, extending up to seven years:

- to clinics which are not authorized to conduct abortions; and

- to persons who are not registered medical practitioners with requisite experience or training for terminating pregnancy.

6.4.12 Grey Areas under the MTP Act

The validity of MTP Act was challenged in the case of Nand Kishore Sharma v. Union of India. It was argued that the Act, particularly Section 3(2)(a) and (b) and Explanation I and II to Section 3 of the Act were unethical and violative of Article 21 of the Constitution of India. The court in the case had to determine when the foetus actually comes to life and hence if his or her right to life is violated by the said provisions. But the court refused to enter

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98 For Section 4 of the principal Act, the following Section shall be substituted namely: no termination of pregnancy shall be made in accordance with the 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.

99 AIR 2006 Raj. 166.
upon a debate as to when foetus comes to life or the larger question touching upon the ethics of abortion, stating that they were “merely concerned with the validity of the relevant provisions of the Act.” The court refused to comment on the attribution of the status of a “person” to the foetus and declared the MTP Act to be valid as it was in consonance with the aims and objectives of Article 21 of the Constitution rather than against it. However, the court took an ambivalent stance when it came to the question of whether the MTP Act would be violative of Article 21 with regard to a foetus, saying it was difficult to determine exactly when a foetus comes to life and hence avoided a closure on the matter. In the context of all the controversies and questions levelled at the MTP Act it would be pertinent at this juncture to analyse the provisions of the said Act and suggest some much required changes.

- Though the MTP Act has legalized termination of an unwanted pregnancy in a number of situations but a woman's right in this respect is doubtful. The reason behind this is that her right is dependent on certain conditions: proof of risk to her life or grave injury to her physical or mental health, substantial risk of physical or mental abnormalities to the child if born and a situation where abortion could only save her life, all to be arrived at by the medical practitioner. Can a woman request a medical practitioner to perform an abortion on the ground that she does not want a child at that time? Here the liberty of the woman is fully dependent on certain other factors, such are quest cannot be said to be just and reasonable.

- The MTP Act allows the termination of pregnancy in second trimester if two registered medical practitioners opine in good faith that the continuance of pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health. The need for two doctors to certify opinion for a second trimester MTP is an unnecessary restriction imposed by law. Though the law allows abortion for wide range of reasons construed to affect the health of woman, it only remains with the

102 See Section 3(2) (b) (i), MTP Act 1971.
doctor (and not with the woman) to opine in good faith the need of such
termination. Such a provider dependent policy results in denial of abortion
care to woman in need. The MTP Act has established the medical practitioner
as ultimate gatekeepers.\textsuperscript{103}

- Further the issue in this regard is “how grave must the risk be” to
justify the termination of pregnancy? The statutory language is vague. It
leaves individual doctor with wide discretion in determining what really a
matter of life and death is? Every pregnancy could be then considered a threat
to the mother’s health or life, if one wanted to stretch that point.\textsuperscript{104}

- Other criticism is that the provision of MTP Act makes discrimination
between a married pregnant woman and an unmarried or widowed pregnant
woman thereby denying the access to safe abortion to an unwed mother. As
the provision provides that access to safe and legal abortion is there where
pregnancy occurs as a result of failure of contraceptive device used by a
married woman or her husband. This classification of pregnant woman as
married and unmarried violates the equality clause enshrined under Article 14
of the Constitution of India. The Supreme Court held in \textit{Savita Samvedi v.}
\textit{Union of India}\textsuperscript{105} that differentiation based on marital status is “wholly unfair,
unreasonable and gender-biased” and is violative of the equality clause of the
Constitution. Laws related to abortion must also benefit persons whose sexual
relationships are beyond the legitimacy conferred by law, especially when
some courts have taken the view that live-in relationships are not illegal.\textsuperscript{106}

- The MTP Act 1971 recognizes the free choice of woman to decide
whether and when she can terminate her pregnancy and makes guardian’s
consent irrelevant in case the woman is of the age of eighteen years or
above.\textsuperscript{107} The question arises whether women can terminate her pregnancy
without the consent and against the wishes of her husband and if so, whether
such action on her part would amount to cruelty under Section 13(1)(ia) of

\textsuperscript{103} Supra note 7 at 131.
\textsuperscript{104} Ibid.
\textsuperscript{105} (1996) 2 SCC (380).
\textsuperscript{106} Vikash Ranjan, “Supreme Court gives Legal tag to Live-in-Relationship” \textit{available at}:
\textsuperscript{107} Section 3(4) (a) of Medical Termination of Pregnancy Act, 1971.
Hindu Marriage Act, 1955 and would entitle the aggrieved husband to obtain a decree of divorce against her. The question came for the decision in *Satya v. Shri Ram*\(^{108}\) in which the High Court observed:

In this sort of a case the court has to attach due weight to the general principle underlying the Hindu Law of Marriage and Sonship and the importance attached by Hindu to the principles of spiritual benefit of having son who can offer a funeral cake and libation of water to the manes of his ancestors and held that termination of pregnancy at the instance of wife but without the consent of her husband amounts to cruelty.

Further in *Deepak Kumar Arora v. Sampuran Arora*,\(^{109}\) a Division Bench of Delhi High Court observed that a wife underwent abortion with a view to spite the husband it might, in certain circumstances, be contended that the act of getting herself aborted has resulted in an act of cruelty. Yet in another case, *Sushil Kumar v. Usha*,\(^{110}\) it was held that aborting the foetus in the very first pregnancy by a deliberate act without the consent of the husband would amount to cruelty.

Hence this provision of MTP Act can be a source of matrimonial disharmony at times if, husband sought court to intervene, not to terminate the pregnancy. So, the termination of pregnancy at the instance of wife without consent of the husband has caused matrimonial rifts. As we have discussed earlier that there are number of cases where the husband can seek divorce when his wife terminated her pregnancy without the consent of her husband. Thus, it can be said that even though the MTP Act does not provide for husband's consent in this matter, but in practical life the wife is not as free as it appears to be; if she goes ahead with abortion, she does it at her own peril, inviting displeasure and wrath of her husband and family.\(^{111}\) Hence it can be argued that the provisions of MTP which give absolute power on the wife to terminate the pregnancy without the consent of her husband is purely

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\(^{108}\) AIR 1983, P&H 252.
\(^{109}\) (1983) 1 DMC 182.
\(^{110}\) AIR 1987 Delhi 86.
\(^{111}\) *Supra* note 71 at 125-126.
a myth.

• Other hurdle in the implementation of MTP Act is that according to the Explanation Clause I to Sub-Section (2) to Section 3 to the Act\textsuperscript{112}, abortion is not permitted if the pregnancy is caused as a result of an illegal sexual connection other than rape. Hence, termination of pregnancy in such a case would be criminal and punishable under Section 312 of IPC.

• According to the principles of criminal jurisprudence, a man is presumed to be innocent, until his guilt is established in a court of law beyond reasonable doubt. Hence, the question arises, as to whether the woman subjected to rape should postpone the termination of her pregnancy till the charge of rape is established in a court of law and the accused is found guilty, or get the pregnancy terminated during the pendency of the trial. In the latter case, if the man charged of rape is acquitted of the offence, the woman would be liable to punishment under Section 312, IPC for causing illegal abortion.\textsuperscript{113} And if the former course is adopted no abortion could be possible, because a case would take a minimum of three to four years before it is finally disposed of by a court of law.\textsuperscript{114} But after the report of the Justice Verma Committee there is a recommendation for speedy trial in rape matters.

• The MTP Act, 1971 provides that pregnancy cannot be terminated after the 20\textsuperscript{th} week unless there is a health risk to the mother. There may be cases where reason for termination of pregnancy is not sex of the foetus but some fatal or catastrophic abnormalities in the foetus detected in later weeks of pregnancy.\textsuperscript{115} Despite major advancements in medical technology, certain foetal impairments cannot be detected and fully evaluated until after the 20\textsuperscript{th} week of pregnancy. These are complicated and expensive tests and take time. Many times, pregnancy crosses 20 weeks by the time a diagnosis is confirmed. If the law imposes an arbitrary limit of time-period of 20 weeks, it can lead to haste on the part of the doctors making a diagnosis as well as on the part of parents. The haste can be disastrous as couples may abort on a

\textsuperscript{112} See, M.T.P.A., 1971, Section 3(2), Explanation I.
\textsuperscript{113} In such a situation the doctor procuring the abortion would also be guilty of causing miscarriage under Section 312 IPC.
\textsuperscript{114} Supra note 35 at 219.
\textsuperscript{115} Sarbjit Kaur, “Need to Amend Abortion Law in India” 1 JOLT1 35 (2010).
mere doubt rather than confirming the tests which may take longer time than 20 weeks. The limited access to health care further leads to delay in diagnosis in India. The law, however, has not been changed to cope up with these late abortions of the abnormal foetus if required. A review is, therefore, needed of the Act.\textsuperscript{116}

- The MTP Act has become old and a lot of new scientific and technological developments have taken place since 1971. All techniques of prenatal diagnosis including ‘Triple Test’, Ultrasounds Chromosomal, and DNA Analysis\textsuperscript{117} and test for foetal infection came much later. Non-Invasive test, the 3D or 4D anomaly scan and Foetal Echocardiography, that is carried between 20-24\textsuperscript{th} week of pregnancy gives a complete picture of the heart and any malformation.\textsuperscript{118} Couples carrying abnormal foetus (which is diagnosed after 20 weeks gestation) do not then have the luxury of the 'best possible choice' as all choices available to them then are terrible. Late abortion is terrible if done by quacks and in unhygienic condition and so is allowing the birth with a known abnormality.\textsuperscript{119}

- By forcing the pregnant woman to undergo mental and physical trauma of delivery and raising a deformed child, the MTP Act leads to an avoidable damage to her health and emotional well-being. An unloving mother/family will not be able to provide amenable environment to the unwanted child and that will be against the interest of the foetus/child.\textsuperscript{120}

- Another very disturbing aspect is that of quality control under the MTP Rules. While it allows for monitoring of quality of abortion care in the private sector, its recognition of all public health institutions as abortion facilities by default exempts the public sector from certification. The assumption that a health institution by virtue of being in the public sector is accountable to the public at large, has regulatory processes and do not need extra checks on their functioning, is not valid as such accountability is often only in theory and not

\begin{flushleft}
\textsuperscript{118} Ibid.
\textsuperscript{119} Supra note 7 at 132-133.
\textsuperscript{120} Supra note 115 at 43-44.
\end{flushleft}
in practice. This leads to a substantial discrepancy between the abortion facilities offered by the public sector and the private sector.\textsuperscript{121}

Hence, The MTP Act does not in fact confer upon or recognize the right of any person to carry out an abortion except under the circumstances mentioned in the Act. Even during the first trimester, a pregnant woman cannot abort at her will and pleasure. Hence there is no question of “abortion on demand”. Section 3 of the MTP Act is only an enabling provision to save the resident Medical Practitioner from the purview of the IPC. It has also been stated by the Indian Courts that “termination of pregnancy under the provision of the Act, is not the rule and it is only an exception.”\textsuperscript{122}

6.5 The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994

India is one of the countries where the female foeticide and infanticide are on the rise. Female infanticide is the barbaric practice whereby newly born female infants were killed with prenatal connivance. With the advancement in medical technology, female infanticide has evolved into female foeticide which is the pre-birth elimination of female embryos/foetuses. Sex-selection has resulted in a continuous and alarming decline in Sex Ratio\textsuperscript{123} and Child Sex Ratio in India. The national Sex Ratio of 933 women to 1000 men in 2001 drops to as low as 874: 1000 and 861: 1000 in the Punjab and Haryana respectively while the national Child Sex Ratio in 2011 was 914. An estimated 15 million girls were not born in India over the last decades. A declining Sex Ratio results in increasing incidences of sexual and gender violence against women, upsets the delicate equanimity of nature and threatens our every existence.\textsuperscript{124}

The 11\textsuperscript{th} Five year Plan has emphasized on gender equality, arresting

\textsuperscript{121} Mukesh Yadav & Alok Kumar, “Medical Termination of Pregnancy (Amendment) Act, 2002: An Answer to Mother’s Health and Female Foeticide” 27(1) JIAFM 46 (2005) available at: http://medind.nic.in/jal/t05/i1/jalt05i1p46.pdf (visited on February 9, 2013).

\textsuperscript{122} M. Berer, “Making Abortion Safe: A Matter of Good Public Health Policy and Practice” 78(5) Bull 580 (2000). In India, there continues to be a ratio of approximately 6:1 clandestine to legal abortions, contributing to over 15 per cent of the maternal death rate.

\textsuperscript{123} Sex ratio is a key demographic indicator depicting the number of females per 1000 males in a given population.

the decline in the child sex ratio and ‘Balika Samriddhi Yojana’ schemes for girl child. States have already introduced several girl-saving programmes like Apna Beti Apna Dhan (Haryana), Kanyadhan (Uttar Pradesh), Mahila Samakya Yojana (Andhra Pradesh) and others. But all those have failed to fulfil the object. National Action plan for the girl child was formulated in 1992 for ‘Survival, Protection and Development of the Girl children.’ In 1997, the ‘Balika Samriddhi Yojana’ was a major initiative for protection of girl children where financial supports are given as post-delivery grant to a mother of girl child and other monetary benefits for education and development. Government’s ‘Save the Girl Child’ programme with brand ambassadors like tennis star Sania Mirza and Squash Champion, Joshna Chinnappa, has again failed to generate awareness among public. SAARC declared 1991-2000 as ‘Decade of the Girl Child’ to save female infanticide and foeticide among the member countries. In spite of all these efforts, States have failed to generate awareness among the masses to prevent female foeticide.125

In the good old days when the scientific techniques were not advanced, it was impossible to determine the sex of the child being carried in the womb of mother until it was delivered. However, midwives and traditional medicine persons have tried to determine sex of the unborn child by a variety of unscientific curious methods that were based on interpretations of appetite, tastes, dreams and walk of the expectant mother. But the guess work had failed to unravel the mystery of the gender of the foetus.126 With a series of related scientific and medical developments it has become possible to determine accurately, the sex of the unborn in a way that is easy, safe and completely painless.127

Commonly used medical techniques for sex-selection are128

i. Pre-conception techniques such as Pre-implantation Genetic Diagnosis (PGD) and

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127 Id.
128 See Supra note 124.
ii. Pre-natal diagnostic techniques such as ultrasound scanning, amniocentesis, chorionic villus biopsy, etc.

PGD is an expensive technology used mainly for infertile couples undergoing In-Vitro Fertilization. Amniocentesis and ultrasound scanning are the most common methods of sex-selection practiced in India for the last five decades. Amniocentesis was first introduced in India in the AIIMS in 1975 for detecting genetic abnormalities in foetus and by mid-nineteen eighties; it began to be misused for sex-determination. The most popular technique for sex-determination is ultrasonography. Used normally to determine foetal position or abnormalities, it can determine foetal sex after the fourth month of gestation and has opened the floodgates of female foeticide.129

6.5.1 Factors Responsible for Female Foeticide130

India being the male dominated nation more importance is given to the birth of a son. Economic stability is also attached to the birth of a son. Moreover, with the increase in crime against women parents do not want to have a daughter.

6.5.1.1 Patriarchal Society

Indian society is patriarchal where it is believed that it is a son who carries on the family name. Indian sayings such as “bringing up a girl is like watering a neighbour’s plant” which exemplify the feeling of wasted expenditure on raising a daughter. As daughter has to stay in her husband’s family after marriage, it’s the son only who stays on and looks after the parents. Thus, it is believed that only the son provides old age support. It is also believed that only through son one can attain moksha as the funeral rites of the parents are performed by the son only.

6.5.1.2 Cultural Causes

India has an age old fascination with the boy child. The culture in India is to pressurize the women to have a male child and as a result women are often considered failures and often tend to feel guilty after giving birth to

129 ibid.
a daughter. Giving birth to a daughter can lead to rejection by the in-laws and the community as a whole and sometimes they are being beaten by their husband’s or by the in-laws. So it puts immense pressure on the mother to abort the female foetus in order to secure her position in the in-laws house.

### 6.5.1.3 Economic Causes

Economic cause is also one of the reasons behind this practice. There is no equality in India, some people are too wealthy and some people are living below the poverty line and cannot afford to have two square meals for them as well as their families. Ultimately this puts pressure on them to limit their families and more so for son only. Moreover, son is considered as a earning hand while daughter is a burden on the parents as it is not considered wise to send the daughters in the fields for earning. Further the dowry system which is prevalent in India also contributes to this problem. As the parents of the bride have to give money and gifts to the groom’s family as part of the marriage agreement. In order to shun from these expenses parents avoid having daughters.

### 6.5.1.4 Political Reasons

The lack of interest of the political parties in implementing policies to prevent female foeticide is another cause of this menace. Policies are not enforced properly and laws are not implemented effectively. Another reason for the prevalence of sex- selection abortion is India’s attempt to control its population. Although the government has not adopted coercive methods since the Emergency in the 1970s under Indira Gandhi’s rule, yet it has become unfashionable to have a large family in India. As two child norms is prevalent and one son is necessary, therefore parents are anxious to know the sex of the expected child and thus results in the practice of female foeticide. According to general psychology, the balanced family consists of one male and a female child. If one has a female child then sex selection is considered, so that the expected second child should be a male, although the such minded never call a family of two male children as ‘an imbalanced family’.

### 6.5.1.5 Crime against Women

Society is filled with crime against women like rape, dowry, abduction,
kidnapping, prostitution, domestic violence, sexual harassment etc. and parents are afraid of their daughter’s future. To get rid of all their tension, they avoid the birth of a girl child. After the recent incident of Damini rape/murder case\textsuperscript{131}, no parent wants to have a daughter and no girl would like to be born as a girl in her next birth.

6.5.1.6 Daughter’s claim in Parent’s Immovable Property

In many regions of rural India, there is a strict social taboo on a daughter inheriting land, since if she does so the land is lost by her father’s lineage. The recent Hindu Succession (Amendment) Act, 2005 deletes the gender discriminatory clause in agricultural land, but its benefits extend only to the Hindu women, leaving intact the obstacle faced by non-Hindu women.

Responding to this alarming situation where the dignity and rights were being violated even before birth, of the girl child, women activists took up cudgels against it. Parliament, too, realizing the grave implications of the misuse of prenatal diagnostic techniques, attempted to limit the use of same only for medical purposes. The government realized that the abuse of techniques, which were originally used to detect genetic disorders or chromosomal abnormalities or congenital abnormalities or sex-linked diseases, was leading to female foeticide which was discriminatory against the female sex and also affected the dignity and status of women. For the above reasons, Parliament passed the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PNDT Act) which came into force on 1.1.1996.\textsuperscript{132}

6.5.2 Objective

The Act provides for the regulation of the use of pre-natal diagnostic techniques in order to check the illegal and anti-social practices of pre-natal sex- determination. PNDT Act has been amended as “Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex-Selection) Act, 2003” (PC & PNDT Act) for curbing the pre-conception sex-selection through the misuse of technology. It provides for the prohibition of sex selection, before or after

\textsuperscript{131} Where six persons allegedly gang raped 23 year-old Para-Medical student in the moving bus and brutally raped and killed her.

\textsuperscript{132} Supra note 92 at 141-142.
conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto.  

6.5.3 Important Provisions of the Act

This Act prohibits any advertisements relating to pre-conception and pre-natal determination of sex and prescribes punishment for its contravention. The person who contravenes the provisions of this Act is punishable with imprisonment and fine. Central Supervisory Board was constituted, to supervise the activities under this Act, and function provided by this Act. By the Amendment Act, 2002, State Supervisory Board and Union Territory Supervisory Boards also were constituted for assisting the Central Supervisory Board. All genetic counselling centres, genetic laboratories and genetic clinics should be registered according to the manner prescribed by Act.  

6.5.4 Amendment of 2002

The amendment has brought ultra-sonography machines and the newly emerging techniques of pre-conception sex-selection used by infertility clinics, within the regulatory purview to pre-empt the misuse of such technologies, which contribute considerably to the declining sex ratio. PC and PNDT Act defines sex-selection as including any procedure, technique, test or administration or prescription or provision of anything for the purpose of enduring or increasing the probability that an embryo will be of a particular sex. The basic spirit of the PC and PNDT Act is to legislate against any discrimination based on sex using any diagnostic technique whether pre, intra or post conception. This amendment Act has come into operation w.e.f. 14th February, 2003. And some amended important provisions are as follows:

- Changed the titled and object of the Act.

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133 Substituted by Amendment Act, 2002.
134 Ibid.
135 Section 2(o), PC and PNDT Act, 2003.
• The original law targeted only post-conception medical techniques like sonography and amniocentesis, useful for the detection of genetic or chromosomal disorders or congenital malformations. Since pre-conception was not covered by any law, several clinics were openly offering sex selection services. The amendment expands the ban on sex determination tests to include pre-conception sex selection techniques. It makes the use of techniques like pre-implantation genetic diagnosis, which allows doctors to detect an embryo's genetic disorders and also identify its sex, illegal if used for sex selection.

• Maintenance by doctors of written records of procedures carried out.

• The amended Act asks the state authorities to create public awareness about the issue.

• It also provides for the possibility of further amendments, which may be needed to deal with changes in technology and social condition.

• The State’s monitoring authorities will have to include non-government entities like women activists and doctors.

• Vesting in authorities, at the State, district, and sub-district level, powers equivalent to those of Civil Courts to ensure compliance with the law.

• Pre Birth determination of sex with purpose of female foeticide (abortion of foetus) is an offence.

• Nobody can compel a pregnant woman to undergo such tests.

• Nobody is allowed to advertise to do pre-birth sex determination or abortion for purpose of female foeticide.

• It is mandatory for all places, persons and bodies by whatsoever name called, doing genetic counselling prenatal diagnostic procedures tests having ultrasound machine, echo or scanner capable of detecting sex of foetus, to get registered with the appropriate authority.
• Increased the punishment of fine from 50,000 to Rs. 1,00,000.137

6.5.5 Regulation of Genetic Laboratories and Genetic Clinics

No PNDT activities shall be conducted in genetic counselling centre, genetic laboratory or genetic clinic unless registered under the Act. They cannot employ or take services of any person whether on honorary basis or on payment who does not possess the prescribed qualifications. No medical geneticist, gynaecologists’ paediatrician, registered medical practitioner or any other person shall conduct such tests at a place other than registered one.138

Section 3A prohibits sex selection and provides that no person shall conduct sex selection on a woman or on man or on both or on any tissue, embryo, conceptus, fluid or gametes derived from either or both of them.139 Section 3B, which prohibits sale of ultrasound machines to unregistered persons, clinics, laboratories etc. provides that no person shall sell any ultrasound machine or imaging machine or scanner or any other machine capable of sex detection of foetus to any genetic clinic or any other person not registered under the Act.140

6.5.6 Regulation of PNDT

Section 4 which lays down an important provision, that no PNDT shall be conducted except for abnormalities; namely, chromosomal abnormalities, genetic metabolic diseases; haemoglobinopathics, sex linked genetic diseases; congenital anomalies; any other abnormalities or diseases specified by the control supervisory board.141 The pre-natal diagnostic techniques may be conducted if any of the following conditions are fulfilled, namely:142

(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.

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137 Ibid.
138 Section 3, PNDT Act.
141 Section 4, PNDT Act, 1971.
(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 or mental retardation or physical deformities such as, spasticity or any other genetic disease.

(v) Any other condition as may be specified.

Section 5 requires that side and after effects of such diagnostic procedure must be explained to the pregnant women and her written consent to undergo such procedure be obtained in the prescribed form in the language which she understands. No person shall communicate to the pregnant woman or her relative or any other person the sex of foetus by words, signs or in any other manner. Similarly, conducting of prenatal diagnostic techniques including ultrasonography for determining the sex of foetus is prohibited by Section 6 of the Act.143

6.5.7 Administrative Machinery

The provisions of the Act will be mere otiose if not backed by supervisory and administrative machinery. The Act provides for setting up of the Central Supervisory Board, Appropriate Authority and Advisory Committee. The Central Supervisory Board shall be monitored by the Central Government and the Board shall consist of:144

(a) Minister in charge of the Ministry of Department of Family Welfare who shall be the Chairman ex-officio.

(b) The Secretary to the Government of India in charge of the Department of Family Welfare, who shall be the vice chairman, ex officio.

(c) Three members to be appointed by the Central Government to represent the ministries of Central Government in charge of Women and Child Development, Department of Legal Affairs or Legislative Department in the Ministry of Law and Justice and Indian System of Medicine and Homeopathy, ex-officio.

143 Ibid.
144 Section 7, PNDT Act, 1994.
(d) The Director General of Health Services of the Central Government, ex-officio.

(e) Ten members to be appointed by the Central Government, two each from amongst -

(i) Eminent medical geneticists.
(ii) Eminent gynaecologist and obstetrician or expert of stri-roga or prasutitantra
(iii) Eminent paediatricians
(iv) Eminent social scientists
(v) Representatives of Women Welfare Organisations

(f) Three women members of Parliament of whom two shall be elected by the house of the people and one by the council of states.

(g) Four members to be appointed by the Central Government by rotation to represent the states and the Union Territories, two in the alphabetical order and two in the reverse alphabetical order but no application shall be made except on the recommendation of the State Government or the Union Territory, as the case may be.

(h) An officer, not below the rank of a joint secretary or equivalent to the Central Government Member - Secretary, ex-officio.\textsuperscript{145}

Section 16 of the Act, empowers the Board to perform following functions:\textsuperscript{146}

(i) To advise the Central Government on policy matters relating to the use of and against the abuse of PNDT.

(ii) To review and monitor the implementation of the Act and rules made thereunder and recommend to the Central Government for the changes in the said Act and rules.

(iii) To create public awareness against pre-natal determination of sex of foetus leading to female foeticide.

\textsuperscript{145} \textit{Id.}
\textsuperscript{146} \textit{Id.}, Section 16.
(vi) To lay down the code of conduct to be observed by persons working at genetic counselling centres, genetic laboratories and genetic clinics.

(v) Any other functions as may be prescribed under the Act.\textsuperscript{147}

6.5.8 Offences and Penalties\textsuperscript{148}

Section 22, which relates to the prohibition of advertisement relating to pre-conception and pre-natal determination of sex, provides that no person or organization, genetic counselling centre or a centre having ultrasound machine or any other technology capable of undertaking determination of sex of foetus or sex issues shall issue, publish or cause to be issued or published any advertisement in any form regarding facilities of pre-natal determination of sex or sex selection before conception available at such centre, laboratory, clinic or at any other place. Further, no person or organization including genetic counselling centre or genetic clinic shall issues, publish, distribute etc. and advertisement in any manner regarding pre-natal determination of sex by any means whatsoever, scientific or otherwise. Any person who contravenes the prohibition shall be punished with imprisonment for a term, which may extend to three years and fine not exceeding Rs. 10,000/-. 

Section 23 provides that any medical geneticist, gynaecologist, registered medical practitioner, who owns a genetic counselling centre or clinic or is employed at any such place and renders professional or technical service to or at such a centre and who contravenes any of the provisions of the Act or rules made thereunder, shall be punished with imprisonment for a period not exceeding three years and fine not exceeding Rs. 10,000/-. Secondly the name of medical practitioner shall be reported by the appropriate authority to State Medical Council for necessary action including suspension of registration if the charges are framed by the Court till the disposal of the case by the Court, if he is convicted, name shall be removed from register for five years and permanently for the subsequent offence.

Section 23(3) provides that any person who seeks the aid of genetic counselling centre or registered medical practitioner for sex selection or

\textsuperscript{147} Ibid.  
\textsuperscript{148} Supra note 142 at 254-255.
conducting pre-natal diagnostic centre, he shall be punished with imprisonment for a period not exceeding three years and fine not exceeding fifty thousand rupees for the first offence and for any subsequent offence with imprisonment which may extend to 5 years and with fine which may extend to 1 lac rupees. However, the provision shall not apply to woman, who was compelled to undergo such diagnostic techniques or such selection.

According to Section 24 unless the contrary is proved the Court shall presume that the pregnant women was compelled to undergo such test by husband or any other relative and such person shall be liable for the abetment of the offence. According to Section 25, whoever contravenes any of the provisions of the Act or rules made thereunder for which no penalty has been prescribed under the Act shall be punished with imprisonment for a period not exceeding three months or fine not exceeding Rs. 1,000 or both and for continuing contravention an additional fine not exceeding Rs. 500. Where an offence under the Act is committed by a company every person who at the time of committing the offence was in charge of and responsible to company shall be deemed to be guilty of the offence and liable to punishment. Section 27 provides that every offence under the Act is cognizable, non-bailable and non-compoundable. Section 28 provides that no Court other than that of a Metropolitan Magistrate or Judicial Magistrate Class I shall try any offence punishable under the Act.

Thus, the Act has made many provisions to prevent the abuse of these techniques.\footnote{149}{Ibid at 256.}

In landmark case, \textit{Centre for Enquiry into health & Allied Themes (CEHAT) v. Union of India}\footnote{150}{(2001) 5 SCC 577.}, the Supreme Court of India issued a direction to Central Govt. to create public awareness in sex detection and female foeticide, to implement provisions and rules of PNDT Act, 1994 with all vigour and zeal. The court also directed Central Supervisory Board (CSB) to meet once in six months. Central Supervisory Board shall issue directions to States and Union territories to furnish quarterly returns and shall also review, monitor and examine the implementation of the law. The court observed in
Chetna, Legal Advisory WCD Society v. Union of India\textsuperscript{151}, case that if need be, the National Human Rights Commission can also be approached in this matter to solicit the assistance of the Commission in proper implementation of National Programme for Eradication of Female Foeticide and Infanticide and its improvement wherever necessary. In another Centre for Enquiry into Health & Allied Themes (CEHAT) v. Union of India\textsuperscript{152} case, again direction was issued by the Supreme Court of India to State Governments to further survey so that unregistered clinics do not operate in any part of the country. The Act largely non-implemented as petition filed by CEHAT\textsuperscript{153} and other organizations and no appropriate steps were taken by the Central Government for proper implementation of this law after enactment.

6.5.9 Grey Areas under PC and PNDT Act

After analysing all the provisions of PC & PNDT Act, the researcher observes that though India has a strong law in order to control female foeticide but there are still gaps and weaknesses and the Act is not giving the desired result because it lacks effective implementation.

- As evident in the matter of sex-selection, both the service-seeker and service-provider are perpetrators while the female foetus is the only victim. Conviction is rare as there is non-reporting of crime and absence of evidence or witness.\textsuperscript{154}

- PC and PNDT Act do not intend to restrict the medical professionals but only to regulate them. Ultrasound machines are needed to watch natural growth and development of foetus and also health of mother. But if those machines are used for detecting sex of foetus followed by abortion then it is not the defect of machines but those men who are operating the machines.\textsuperscript{155} So it is the medical fraternity who are more to be blamed than common man as these diagnostic techniques can be operated by them alone. But unfortunately, government is putting the onus of pregnant women rather than focusing on medical practitioner,

\textsuperscript{151}(1998) 2 SCC 158.
\textsuperscript{152}AIR 2002 SC 3689.
\textsuperscript{153}Centre for Enquiry into Health & Allied Themes (CEHAT) v. Union of India, AIR 2003 SC 3309.
\textsuperscript{154}Meeta Mohini, “Law against Sex Selection in India” 118 Cri LJ 303 (2012).
\textsuperscript{155}Supra note 125 at 251.
the major culprits. For instance, on April news report titled "Pregnant women beware, Big Brother's watching", quotes Director (Health) Dr. D.P.S. Sandhu saying that all pregnant women in Punjab who already have two daughters will be placed under observation. If such a woman undergoes an abortion, she will have to satisfy the health authorities about the reasons for this. Women's health activists are up in arms about this, terming it a violation of fundamental reproductive rights and access to abortion.156

- The requisite bodies under the PC and PNDT Act do not exist in all the states and wherever they exist, they are stymied because of inadequate legal orientation, expertise and initiative. Sex selective abortion enjoys a social sanction and is not perceived as a crime but as a method of ensuring the birth of sons. Further, it becomes difficult to distinguish cases of female foeticide and MTP.157

- There are shortcomings also in the receipt of quarterly reports from States and Union Territories. Duly completed forms containing details of pregnancy-related tests conducted by sonography clinics are either not sent by the stipulated time or never submitted at all. The panel, which is supposed to scrutinize the forms, fails to meet regularly. Much time is wasted upon regulation of clinics and routine administrative works while clinic records are not strictly and regularly monitored. Further it is impossible to regulate all private clinics that offer facilities for pre-conception and pre-natal diagnostic techniques/test/procedures or to monitor the whereabouts of mobile ultrasound machines. Fake addresses of patients and/or wrong reasons for doing sonography are recorded.158

- Further the involvement of the police only contributes to corruption, since the persons running the ultrasound centres get prior information and either wind up operations or run away from the scene. In fact, the police need not enter the picture at all, since the PNDT Act provides

156 Supra note 72.
157 Supra note 154 at 303.
158 Ibid.
for an "Appropriate Authority' to implement the law. Faulty interpretations of the law add to biased implementation.  

- Issuance of summons and search warrants, and punishment for violating the provisions of the PC and PNDT Act are rare. For instance, under the Act, the 13 Court cases were launched in 2006. However, the number came down to six in 2007 and again in 2008, it was six, whereas in the first eight months of the current year it came down to two.  

Regarding convictions just 13 cases of conviction under the PNDT Act were reported in 2010 exposing the complete failure of all state governments in effective implementation of the law to prevent the killing of unborn daughters while also bringing related schemes under the scanner. According to the provisional figures of census 2011 a total of 805 cases have been filed in court against doctors till March 31, 2011 ever since the revised PC and PNDT Act came into force. Only 55 convictions have been recorded since then. The rest of the cases are either in progress or dropped for "poor investigation and insufficient evidence against the accused."

- Further the drugs Mifepristone and Misoprostol are widely used as medical termination of pregnancy pills. But these drugs are available with chemists over the counter. Drugs, which are so potent and which can be so easily utilized for killing the female foetus, must only be available through a written prescription of a registered medical termination of pregnancy, under the MTP Act, 1971.

- Then there is technological aspect. The record of ultrasounds conducted can be easily deleted from the ultrasound machine or they may not be saved at all by the person conducting the ultrasound.

- Moreover, the issue of sale of ultrasound machines will also come up for debate considering the fact that despite regulated sale based on the

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159 See Supra note 72.  
162 “Poor Rate of Convictions” The Tribune, April 21, 2011 at 13.  
163 Saket Kumar, “Plugging Sex-Test policy loopholes” The Tribune April 21, 2011 at 13.  
164 Ibid.
conditions, such machines are being installed with impunity.\textsuperscript{165}

- The PNDT Act is more likely to be misused for knowing the sex of the foetus with the advent of 3-D and 4-D ultrasound techniques these days. These 3-D and 4-D ultrasound scans, which are readily available at diagnostic centres across the country, enable a pregnant woman and her relative/attendant to see the sex of a foetus on the screen. Thus, the PNDT Act, which prohibits sex-determination tests, has been rendered practically useless, with 3-D and 4-D ultrasound scans.\textsuperscript{166}

- By protecting the pregnant women under Section 23(4) of the PC and PNDT Act, the law takes a lenient view of her fault in her failure to fight against sex selection. Therefore, Section 23(4) of the PC & PNDT Act is gender discriminatory on the ground that it punishes men for the crime of sex selection while leaving the pregnant women unpunished, although she may have willingly participated in the crime of sex selection.\textsuperscript{167}

6.6 The Prohibition of Child Marriage Act, 2006

The Child Marriage Restraint Act, 1929 was enacted with a view to restraining the solemnization of child marriages. The Act was subsequently amended in 1949 and 1978 in order, \textit{inter alia}, to raise the age limit of the male and female persons for the purpose of marriage. The Act though restrains solemnization of child marriages yet it does not declare them to be void or voidable. There has been growing demand for making the provisions of Act more effective and the punishment thereunder more stringent so as to eradicate or effectively prevent the evil practice of solemnization of child marriages in the country. This will enhance the health of children and the status of women. The National Commission in its Annual Report for the year 1995-96 recommended that the Government should appoint Child Marriage Prevention Officers immediately. It further recommended that.\textsuperscript{168}

\textsuperscript{165} “Jolted by Grim Sex Ratio, Centre to review PNDT Act” \textit{The Tribune}, April 11, 2011 at 2.
\textsuperscript{166} “3-D and 4-D Ultrasound Scans make PNDT Act Redundant” \textit{The Tribune}, July 23, 2011 at 7.
\textsuperscript{167} \textit{Supra} note 154.
(i) The punishment provided under the Act should be made more stringent;

(ii) Marriages performed in contravention of the Act should be made void; and

(iii) The offences under the Act should be made cognizable.

The National Human Rights commission undertook a comprehensive review of the existing Act and made recommendations for comprehensive amendments therein vide its Annual Report 2001-02. The Central Government after consulting the State Governments and Union Territories Administration on the recommendations of the National Commission for Women and the National Human Rights Commission has decided to accept all the recommendations and give effect to them by repealing and re-enacting the Child Marriage Restraint Act, 1929. Hence the Prohibition of Child Marriage Act, 2006 came into being. At a glance the highlights of the Act are as under:-

(i) It declares the child marriage as voidable at the option of the contracting party to the marriage, who was a child at the time of marriage.

(ii) The husband or, if he is a minor at the material time, his guardian to pay maintenance to the minor girl until her re-marriage.

(iii) It makes provision for the custody and maintenance of children born of child marriages.

(iv) If a child marriage has been annulled by a decree of nullity under Section 3 of the Act, 2006 every child born of such marriage, shall be legitimate for all purposes.

(v) The District Court is empowered to add to, modify or revoke any order relating to the maintenance of the female petitioner and her residence and custody or maintenance of children etc.;

(vi) If a male adult above 18 years marries a child, he shall be punished with rigorous imprisonment which may extend to 2 years or with fine upto Rs. one lakh or with both.

(vii) The courts can issue injunctions prohibiting solemnization of
marriages in contravention of the provisions of the Prohibition of Child Marriage Act, 2006;

(viii) In certain circumstances the Court can declare the child marriage as void;

(ix) Offences under the prohibition of Child Marriage Act, 2006 are cognizable and non-bailable;

(x) Child marriage Prevention officers to be appointed by the State Governments;

(xi) The State Governments to make rules for effective administration of the legislation.\textsuperscript{169}

The Prohibition of Child Marriage Act, 2006 is apparently aimed at prohibiting marriage of girls below 18 years and any boy below 21 years of age. However, according to the National Family Health Survey (2005-06), as much as 46\% of women in the 18-29 year age group were married before they turned 18.\textsuperscript{170} Further District Level Household and Facility Survey- 3 data brought out in 2010, 43\% of women in India aged 20-24 were married before 18 years. It is estimated that there are more than 23 million child brides in India, which is 40\% of the child brides globally. In the last 15 years the decline in child marriage is 11\%, which is less than 1\% per year.\textsuperscript{171} The Ministry of Health’s Family Welfare Statistics 2011 showed that almost all states had registered a decline in under aged brides between 2005 and 2009. But too little is happening and what is happening is taking place too slowly, for it is estimated that India still has the largest number of child brides in the world.\textsuperscript{172}

6.7 Administrative Measures

Like many other developing countries the three prominent associated problems confronting India are population, poverty and pollution. The root cause of these problems appears to be unprecedented size of the Indian

\textsuperscript{169} Ibid.


\textsuperscript{171} Letters “Child Marriages” XLVIII No. 52 Economic and Political Weekly, Dec. 28, 2013 at 5.

\textsuperscript{172} Supra note 170.
population. The consecutive five-year plans emphasized the need to check population growth. In 1950 health care services were predominantly urban, hospital based and curative but it is out of reach of services of poor. In 1960, an encouragement scheme for acceptors and service providers was introduced and safe, effective vaccines for the prevention of six childhood diseases and effective contraceptives for birth became available. During 1960s, sterilization remained the focus of the National Family Planning Programme. Efforts were made to popularize vasectomy and to provide services in rural areas through camps. In 1968, the Government hazed the concept of social marketing in its family planning programme. In the mid-1970s, the family planning programme received a setback in the wake of charges of compulsion and focus on women sterilization only. Increasing concern about the rapidly growing population led to the National Family Planning Programme being included as a priority sector programme during the fifth plan of 1976. The massive sterilization drive of 1976 did result in eight million persons undergoing sterilization. In 1979, the Programme was renamed as the National Family Welfare Programme and increasing integration of family planning services with those of maternal and child health and nutrition was attempted. So the late 1970s was heavily influenced by the international discussions leading up to and flowing from the International Conference on Primary Health Care, held in 1978 at Alma-Ata. This meeting, which resulted in the so-called Alma-Ata declaration “of” Health for all by 2000, had an important influence on the Indian national health policy.

The Alma Ata Conference in 1982 mobilized a “Primary Health Care Movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries. Being signatory to Alma Ata Declaration, India too had formulated National Health Policy on 1982 and reorganized its health service delivery as

a three-tier structure with Sub Centres, Primary Health Centres and Community Health Centres. The Universal Immunization Programme (UIP), started in 30 districts in 1986, was extended to cover 448 districts by the end of the Seventh Plan. The result of this was witnessed in terms of eradication of various deadly diseases, increase in immunization levels, care of expectant mothers and safe deliveries, acceptance of family welfare programmes and health awareness.\textsuperscript{176}

In 1986 Central Government introduced a wider concept of family welfare. Its aim was to check the population growth rate through family planning on voluntary basis round, free choice of the methods best suited to the acceptors and the two child norm regardless of the gender. It also intended to address the needs of the families particularly women and children. To improve the quality and outreach of family welfare services, in 1992 Government of India introduced Child Survival and Safe Motherhood Programme to reduce maternal and child mortality. Nevertheless, the programme failed to come up to its title of “family welfare” as the thrust of the programme has been disproportionately focused on demographic targets by increasing contraceptive prevalence and notably female sterilization mainly. In this process, these are the women whose need for the empowerment and betterment has been generally overlooked. The improper focusing and implementation of the programme lead to disturbing consequences in terms of poor reproductive health. It has made apparent the need for a holistic approach on reproductive health of the women fully sensitive to socio-cultural restraints faced by women and adolescent girls in accessing to reproductive services.\textsuperscript{177}

Hence, a flagship programme of the Central Government, the Family Planning program suffered from excesses and high-handedness of implementation authorities during the Emergency period which made the communities first resent, then defy and ultimately reject the Family Planning Programme. This only leads to the understanding that if welfare programmes cater less to the needs of the communities on the ground and more to achieve

\textsuperscript{176} Rajeshwari, “The Perils of Ignoring Primary Health Care” \textit{The Tribune}, May 5, 2011 at 11.
\textsuperscript{177} \textit{Supra} note 173.
demographic targets, they usually collapse.  

The sexual and reproductive health situation in India has undergone major changes over the last decade or so. For one, the policy and programme environment has undergone a significant shift from a narrow target-oriented family planning approach to a broader orientation that stresses sexual and reproductive health and the exercise of reproductive rights more generally. Second, there have been considerable changes in the sexual and reproductive health scenario. Some changes have been positive, such as declining infant mortality, increased access to skilled attendance at delivery and declining unmet need for contraceptives. Others are extremely disturbing, such as stagnating levels of maternal mortality, the spread of sexually transmitted infections notably human immune deficiency virus (HIV), misuse of parental diagnostic techniques for sex selection, the persistence of wide gender imbalances and the compromised exercises of reproductive right by large segments of the population, notably women. Third the past decade has also seen a growing concern about the unique sexual and reproductive health needs of the young, a group whose needs remain, however, poorly understood and served. In short, despite the strides made on several fronts, the sexual and reproductive health situation in India continues to be characterized as considerable ill-health and lack of informed choice.

But there has been growing recognition of the importance of rights of men and women in health care over the past few decades. The Programme of Action (POA) of the 1994 International Conference on Population and Development (ICPD) in Cairo highlighted the right of men and women to be informed and to have access to safe, effective, affordable and acceptable health services. A key component is clearly the quality of health care. The Programme of Action (POA) formulated at the end of the Conference and for which India is a signatory postulated that population policies should be viewed as an integral part of programmes for women’s development, women's

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rights, women's reproductive health, poverty alleviation and sustainable
development. It was felt that population policies, which are based on macro
demographic considerations and accepted-target-driven programmes, are
unnecessarily and unevenly burdening women with the task of regulating
reproduction to suit macro level policies. In India, improving the quality of
health care is a challenge as efforts are mapped against a background of
limited resources, often pitted against the demands of vast health needs. This
challenge is even more critical while addressing such sensitive health issues
as abortion, where an individual's privacy, dignity and rights are crucial and
legal stipulations are the guiding factors. India too realized that neglect of
reproductive health services has been greatly responsible for denial of gender
equality in its jurisdiction. Thus it decided to re-orient its family welfare
programme with comprehensive focus on reproductive health needs and
services, much beyond demographic targets and female sterilization. The first
major step in this direction was taken on October 15, 1994 by launching of
Reproductive Care and Child Health Programme (RCH). It owes its origin to
two reports, one submitted by the Swaminathan Committee in 1994 and the
ICPD POA. This programme is more gender sensitive and responsive to the
needs of the women, in comparison to any earlier programme, as it converges
on decentralized participatory planning, the target free approach and grant of
quality services. Alongside the document recognizes that the knowledge and
use of reproductive health services is inextricably tied to level of social
development within a community and, therefore, gives importance to the
issues of women empowerment, especially through education.

Besides funding the states for augmenting human resources, including
specialists and staff nurses, it also provides funds to local governing bodies to
provide emergency transport. Ensuring availability of drugs, consumables,
safe blood, equipment’s and trained service providers is a key focus for which
states are given financial support. Financial incentives are provided to the

181 K Srinivasan, Chander Shekhar, et. al., “Reviewing Reproductive and Child Health Programmes in
India” Economic & Political Weekly, July 14, 2007 at 2931.
182 Supra note 180.
183 Supra note 181.
184 Rachel Kumar, “Gender in Reproductive and Child Health Policy” Economic and Political Weekly,
Aug10, 2003 at 3370.
staff for attending deliveries after working hours.\textsuperscript{185}

The second major step, in this regard, is the adoption of National Population Policy, 2000 which recognizes the link between high infant mortality and excessive population growth. The challenging policy aims to advance “The commitment of Government towards voluntary and informed choice and consent of the citizens while availing of reproductive health care services -continuation of the target free approach in administering family planning services- to achieve net replacement levels by 2010.”\textsuperscript{186} The Policy also aims to achieve 80 per cent deliveries in institutions and 100 per cent deliveries by trained personnel by the year 2010. In pursuance of the National Population Policy 2000, the government has constituted the National Technical Committee on Child Health with a view to harness professional inputs regarding implementation of programmes for child survival with special focus on newborn’s health. So all efforts are made in National Population Policy to provide essential supplies, improve efficiency and ensure accountability-especially in the states where performance is currently suboptimal-so that there is incremental improvement in performance. An Empowerment Action Group attached to the Ministry of Health and Family Welfare has been constituted in 2001 to facilitate capacity building in poorly performing states/ district so that they attain the goals set in the Policy.\textsuperscript{187}

This policy has a long-term objective of stabilizing the population of the country by 2045, along with immediate policy object of providing integrated services for basic reproductive and child health care. The other specific programme targeting at women’s health was National Health Policy - 2002. The policy notes that women, along with other under - privileged groups, are significantly handicapped due to a disproportionately low access to health care. NHP 2002 has been formulated taking into consideration the ground realities in regard to the availability of resources. In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives. Social, cultural and economic factors continue to

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\textsuperscript{185} Anuradha Gupta, “Putting the Mother and Child First” \textit{The Tribune}, June 16, 2011 at 11.
\textsuperscript{187} Supra note 174 at 132.
\end{flushright}
inhibit women from gaining adequate access even to the existing public health facilities. This handicap has an adverse impact on the health, general well-being and development of the entire family, particularly children. The various policy recommendation of NHP - 2002, in regard to the expansion of primary health infrastructure, will facilitate the increased access of women to basic health care and it also recognizes the catalytic role of empowered women in improving the overall health standards of the community including children.\textsuperscript{188}

The second phase of Reproductive and Child Health Program i.e. RCH-II has been commenced from 1\textsuperscript{st} April 2005. RCH-II which was launched under the umbrella of NRHM has been committed to substantially augment funding to the States with a greater willingness to look into the state-specific needs and contexts through a flexible funding pool. The main objective of the programme is to bring about a change in mainly three health indicators i.e. reducing total fertility ratio, infant mortality rate and maternal mortality with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India.\textsuperscript{189}

The Government of India pledged to bring down maternal mortality ratio by three quarters by 2015, specifically to less than 100 per 1, 00,000 live births by 2010. The key strategy to achieve the goal would be to ensure that “all women have access to high-quality delivery care ... namely, a skilled attendant at delivery, access to emergency obstetric care in case of a complication and a referral system to ensure that women who experience complications can reach life-saving emergency obstetric care in time.” The goals of India’s National Population Policy 2000 had been set to achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained birth attendants by 2010.\textsuperscript{190}

\textsuperscript{188} www.mohfw.nic.in Draft National Health Policy, 2001 (visited on August 16, 2013).
\textsuperscript{189} Supra note 185.
\textsuperscript{190} Lindsay Barnes, “Women's Experience of Childbirth in Rural Jharkhand” \textit{Economic and Political, Weekly} December 1-7, 2007 at 62.
In order to implement the assurance made at MDG, various schemes have been introduced by the Central as well as the State Governments. The prominent among these schemes are Janani Suraksha Yojna (JSY)\(^{191}\), National Maternity Benefits Scheme.\(^{192}\) Integrated Child Development Services.\(^{193}\)

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\(^{191}\) The Janani SurakshaYojana, a path-breaking conditional cash transfer initiative launched in 2005 to encourage deliveries at government health care facilities, has achieved some of its goals. It was launched at a time when India accounted for 20 per cent of maternal and 31 per cent of neonatal deaths in the world. Benefits started accruing a year after the scheme came into operation: the number of deliveries in government health facilities shot up by 36 per cent in Rajasthan and 53 per cent in Madhya Pradesh. A study based on survey data put out by the government for the period between late 2007 and early 2009 has been published recently in The Lancet (India's Janani SurakshaYojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation, by Stephen S. Lim et al.). With a budget of Rs.1.540 crore and 9.5 million beneficiaries, JSY is the world's largest conditional cash transfer scheme. It has demonstrated that providing an incentive of Rs.600 and Rs.700 to women in urban and rural areas in non-high-focus states, and Rs.1000 and Rs.1400 in the case of high-focus States can bring about an overall reduction in the pre-natal and neo-natal deaths.

The JSY is a safe motherhood intervention scheme under the National Rural Health Mission (NRHM) implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This was launched on 12th April 2005. It is a 100% centrally sponsored scheme and integrates cash schemes with delivery and post-delivery care. The JSY identifies the Accredited Social Health Activist (ASHA) as an effective link between the Government and the poor pregnant women. She usually works under an Auxiliary Nurse Midwife (ANM) and their work is expected to be supervised by a Medical Officer (MO). This Scheme requires ASHA and other agencies to take up the following tasks:

1. Identify pregnant woman as a beneficiary of the scheme and report or facilitate registration for ANC. This should be done at least 20-24 weeks before the expected date of delivery.
2. Assist the pregnant woman to obtain necessary certifications wherever necessary, within 2-4 weeks of registration.
3. Provide and/or help the women in receiving at least three ANC check-ups including TT injections, IFA tablets,
4. Identify a functional Government health centre or an accredited private health institution for referral and delivery, immediately on registration.
5. Counsel for institutional delivery.
6. Escort the beneficiary women to the pre-determined health centre and stay with her till the woman is discharged.
7. Arrange to immunize the new born till the age of 14 weeks.
8. Inform about the birth or death of the child or mother to the ANM/MO.
9. Postnatal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary.
10. Counsel for initiation of breastfeeding to the new born within one-hour of delivery and its continuance till 3-6 months and promote family planning.
11. A micro birth plan must necessarily be prepared by the ASHA or equivalent health activist.

\(^{192}\) The National Maternity Benefit Scheme (NMBS) basically talks of providing cash assistance of Rs.500 to pregnant women.

\(^{193}\) This Scheme was put in the course of implementation in 1975. The Scheme provides for improving the nutritional and health status of children in the age-group 0-6 years; laying down the foundation for proper psychological, physical and social development of the child; reducing the incidence of mortality, morbidity, malnutrition and school dropout; achieving effective co-ordination of policy and implementation amongst the various departments to promote child development; and enhancing the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The Schemes provides following facilities 1. supplementary nutrition, 2. immunization, 3. health check-up, 4. referral services, 5. pre-school non-formal education and 6. nutrition and health education.
Antyodaya Anna Yojna,194 ASHA (which is trained local community based workers who act as an effective link between the government and the poor pregnant women and National Rural Health Mission, etc.195 But the reality is that government schemes such as Janani Suraksha Yojana (JSY), and Rashtriya Swasthya Bima Yojana196 (RSBY), meant to provide financial support to families belonging to the lower economic strata, are being misused in some pockets. In Rajasthan, there have been reports of female infanticide being committed to benefit from JSY funds while in states like Andhra Pradesh, Gujarat, Rajasthan, Chhattisgarh and Bihar, increasingly young women, a majority of them below 35 years, are being made to undergo unindicated hysterectomies by health-care providers also to avail RSBY benefits. Clearly, instead of limiting the entitlement only for treatment, health insurance schemes should provide overall health cover for families.197

The National Rural Health Mission has been launched on April 12, 2005 with an objective to reduce maternal mortality, infant mortality and total mortality. In order to fulfil the pledge and international obligations, it guaranteed certain services to be made available by 2010 (according to the timeline prescribed by the Government).198 The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectorial convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water,

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194 This Scheme provide for rations up to 35 Kgs which would include grains and nutritional supplements.
195 Supra note 4 at 56-58.
196 Government of India launched RSBY for Below Poverty Line (BPL) families in the unorganized sector on October 1, 2007. Up to January 15, 2009, 22 States and Union Territories had initiated the process to implement the process to implement the scheme.
198 These services include that task for early registration of pregnancy before 12th week of pregnancy, minimum of 4 antenatal checkups first-when pregnancy is suspected, second - around 26 weeks of pregnancy, third - around 32 weeks, fourth - around 36 weeks, associated services like general examination such as weight, BP, anaemia, abdominal examination, height and breast examination. Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHV), minimum laboratory investigations like haemoglobin, urine albumen and sugar, identification of high-risk pregnancies and appropriate and prompt referral, counseling. Folic acid supplementation in the first trimester. Iron and Folic Acid supplementation from twelve weeks, skilled attendance at home deliveries as and when called for, a minimum of 2 postpartum home visits. First within 48 hours of delivery, second within 7-10 days, initiative of early breastfeeding within half hour of birth, counseling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding. (As per Guidelines of GOI on Essential Newborn Care) and STI/RTI and HIV/AIDS.
sanitation, education, nutrition, social and gender equality. Under the NRHM, the focus was on a functional health system at all levels, from the village to the district. In 2011-12 alone more than Rs. 1135 crore has been provided till date, to the states for drugs, supplies and ambulance/transport systems through programme implementation plans (PIPs) under the NRHM. The Mission is expected to achieve the goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals, NRHM facilitates increased access and utilization of quality health services by all, forge a partnership between the Central, State and the local governments, set up a platform for involving the PRIs and the community in the management of primary health programmes and infrastructure and provide an opportunity for promoting equality and social justice. The NRHM establishes a mechanism to provide flexibility to the States and the community to promote local initiatives and develop a framework for promoting inter-sectoral convergence for promotive and preventive health care. The Mission has also defined core and supplementary strategies.199

India’s sustained efforts over the years to achieve population stabilization are finally beginning to yield the desired results. Preliminary results from the Census of India 2011 reveal several positive trends in India’s population growth:

• 2001-2011 is the first decade (with the exception of 1911-21) when the absolute increase in population over the ten-year period has been less than in the previous decade.

• The percentage decadal growth during 2001-2011 has recorded the sharpest decline since Independence.

• The average exponential growth rate for 2001-2011 has declined to 1.64 per cent- down from 1.97 per cent for 1991-2011.

• Fifteen states and Union Territories have grown by less than 1.5 per cent per annum between 2001-2011 as against only four states during the previous decade.

• The growth rate of population has fallen significantly, perhaps for the first time, in the eight Empowered Action Group (EAG) states (Bihar, Chhattisgarh, Jharkhand, Rajasthan, Madhya Pradesh, Orissa, Uttar Pradesh and Uttarakhand) that have traditionally reported higher than average rates of fertility and population growth.

• The percentage growth rates of the six most populous states- Uttar Pradesh, Maharashtra, Bihar, West Bengal, Andhra Pradesh and Madhya Pradesh- have all fallen during 2001-2011 compared to 1991-2011.200

After analysing all the above figures it can be concluded that no doubt there is a decrease in the population growth rate but in the health-care sector it continues to lag way behind many developing countries even though government is spending close to 2 per cent of the Gross Domestic Product (GDP) on health services. Much of the modest increase in public spending on health was channelled into the National Rural Health Mission (NRHM). In the past decade, there have been marked improvements in the reproductive and child health care. While infant mortality rate (IMR) has declined to 42 per 1000 live births, it is higher than Bangladesh, where IMR is 33. Maternal mortality rate (MMR) has only dropped from 212 to 178 in 2013. In comparison, the MMR rate in other South Asian countries like Thailand is 48 and in Sri Lanka it is 35. Therefore, despite the fact that NRHM did scale up infrastructure across the country and hired more frontline personnel in low performing states, the goal of achieving universal health care is still a distant dream as three quarters of maternal deaths are reported in rural areas in states where Empowered Action Groups (EAGs) have been set up as many as two-thirds of women die seeking some kind of health care.201

In this era of globalization, when health needs are changing fast, there is a need to achieve Health for All through various programmes and policies of the government. Most importantly, a focused state health policy as well as implementation of the state women's policy is required if the state is to achieve the goals of women's empowerment and gender equity. As the

200 Supra note 174 at 133.
201 Supra note 197.
exercise of reproductive freedom have two facets viz. the liberty to decide and the means to implement it. Whereas, the first part belongs to the field of civil liberty, the second refers to the economic and social aspect of the freedom. While the National Population Policy and Reproductive Care and Child Health Programme sharply focusses on the later segment of the reproductive freedom, they fail miserably in ensuring the first segment of this liberty. This is one of the main reasons for marginal success of the reproductive initiatives of state so far.  

6.8 Judicial Approach towards Reproductive Freedom

The present legal framework seems to be insufficient because of the backwardness of education in abortion matters, caused by long taboo, and totalitarian pronationalism. It appears that the future battle for gaining this right would be waged through the courts rather than Parliament or State Legislatures. The judiciary too, unfortunately appears to be clinging to the divide between public and private domains. Whereas in matters of employment, by and large, courts have been vigilantly protecting the women's equality in private domain they have been less forthcoming.

The contribution of Indian judiciary in administering reproductive justice can be highlighted with the help of a various cases where the court expanded the scope of right to life and personal liberty guaranteed under Article 21 of the Constitution of India. The court in India moved the wheel of justice to its fullest extent by incorporating various rights under the ambit of Article 21 and ingrained the philosophy of reproductive justice in India. A woman's right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution. In B.K. Parthasarathi v. Government of Andhra Pradesh, the court went a step further and held that one aspect of the right to privacy is right to procreate or right to reproductive autonomy. The Andhra Pradesh High Court upheld “the right to reproductive autonomy” of an individual as a facet of his “right to

\[\text{Supra note 173 at 102.}\]


\[\text{AIR 2000 AP 156.}\]
privacy” and agreed with the decision of the US Supreme Court in *Jack T. Skinner v. State of Oklahoma*\(^{206}\), which characterized the right to reproduce as “one of the basic civil rights of man”

In *Javed v. State of Haryana*\(^{207}\), a full bench of the Apex Court got an opportunity to comment directly on the women reproductive freedom. In this case constitutional validity of Sections 175(1) (q) and 177(1) of *Haryana Panchayati Raj Act* 1994 was challenged inter-alia on the grounds of arbitrariness and discrimination. As these sections disqualify a person having more than two children, after one year of the date of commencement of the Act, from holding or contesting election to specified offices in Panchayats. The Apex Court, referring to the Statement of Objects and Reasons of the Act concluded that the purpose of the enactment is to popularize family welfare in tune with the National Population Policy and declared the enactment to be consistent with the aforesaid policy. The court was so pre-occupied with the need to check the population growth, that in the name of national interest it strongly supported the idea of imposing disincentives through legislation. It ignored the paradigm shift in the New Population Policy from the use of the coercive techniques to utilization of motivational tools. On the same lines the plea that impugned provisions hit the women very hardly, as they do not have independence in reproductive matters and have to bear children helplessly, was dismissed by the court in very cold and summary manner. Rather the honourable court pointed out that if a man compels his wife to bear the third child; he would disqualify not only his wife but himself as well. Then, the court hastily added:

We do not think that with the awareness which is arising in Indian womenfolk, they are so helpless as to be compelled to bear a third child even though they do not wish to do so. At the end, suffice it to say that if the legislature chooses to carve out an exception in favour of the females it is free to do so but merely because women are not expected from the operation of the disqualification it does not render it

\(^{206}\) 316 US 535.
\(^{207}\) AIR 2003 SC 3057.

In yet another landmark decision, namely Air India v. Nargesh Meerza, the Supreme Court struck down the provision which provided that the services of the Air hostess would be terminated if she marries within first four years of her service or on the first pregnancy. The Supreme Court found the condition of the first pregnancy unreasonable and arbitrary as it amounted to compelling the Air-hostesses not to bear any children and this was an open insult to Indian womanhood. The court observed:

A woman does not after bearing children become weak in physique or in her Constitution. There is neither any legal nor medical authority for this bald proposition. Having taken the air hostess in service and after having utilized her services for four years, to terminate her services if she becomes pregnant would amount to compelling the poor air hostess, not to have any children and thus interfere with divert the ordinary course of human nature. It is not only a callous and cruel act but an open insult to Indian womanhood- the most sacrosanct and cherished institution. Such a course of action is extremely detestable and abhorrent to the notions of a civilized society. Apart from being grossly unethical, it smacks of a deep rooted sense of utter selfishness at the cost of all human values. Such a provision, therefore, is not only manifestly unreasonable and arbitrary but contains the quality of unfairness and exhibits naked despotism and is, therefore, clearly violative of Article 14 of the Constitution.

208 Ibid at 3073.
210 Ibid at 12-13.
211 AIR 1981 SC 1829.
In *V. Krishnan v. G. Rajan* the Madras High Court considered the question: whether the guardian of a minor girl is entitled to get an order from the court for issuing directions to terminate the pregnancy of minor girl when minor girl is not agreeable for such termination. The Court did not grant permission to terminate the pregnancy.

In *Suchita Srivastva and Another v. Chandigarh Administration*, the Hon'ble Supreme Court recognized reproductive rights of mentally retarded women. The case came before the Supreme Court in appeal against the judgment of Punjab and Haryana High Court allowing the Chandigarh Administration to terminate the pregnancy of mentally-challenged 19-year old girl who was raped by security guard at a nari niketan in Chandigarh. The victim had crossed the 19th week of pregnancy but the medical examination of the victim had shown no physical abnormality of the foetus and that victim was medically fit to deliver the baby. The Supreme Court held that the language of the MTP Act clearly respected the personal autonomy of mentally retarded persons who were above the age of majority. Since none of the other statutory conditions had been met in this case, it was amply clear that a dilution of the requirement of consent for proceeding with a termination of pregnancy could not be permitted. The court held that it was aware of the fact that she would not be able to bring up the child. “But this could not be the basis for the abortion”. Meanwhile, three organizations have come forward to take care of the rape victim and her child. They include the Union Government-run National Trust for the Welfare of Person with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, the Disabled Rights Group and Parivar and the national federation of parents association for persons with these four disabilities.

Pointing out she wanted to have a child and was physically fit to give birth, the Chief Justice said: “If somebody is ready to take care of the child should the court order the termination of her pregnancy even then.”

Looking at the provision of the Act, the Supreme Court expressed its opinion

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213 1994 (1) LW (Cri.) 16 (Madras).
214 2009(11) SCALE 813.
in favour of continuation of pregnancy as the court observed:

“Her reproductive choice should be respected in spite of other factors such as the lack of understanding of the sexual act as well as apprehensions about her capacity to carry the pregnancy to its full term and the assumption of maternal responsibilities thereafter. We have adopted this position since the applicable statute clearly contemplates that even a woman who is found to be ‘mentally retarded’ should give her consent for the termination of a pregnancy.”217

In the opinion of the researcher, there are numerous cases where the court decided that the woman has an absolute right to abortion and no one can take away this right from her. The judiciary has interpreted the right to life and personal liberty as guaranteed by Article 21 of the Indian Constitution to include the Right to abortion also.

In D. Rajeshwari v. State of Tamil Nadu218, where the court granted the permission to terminate the pregnancy of an unmarried girl of 18 years who was praying for issue that bearing the unwanted pregnancy of the child of three months made her to become mentally ill and the continuance of pregnancy has caused great anguish in her mind, which would result in a grave injury to her mental health, since the pregnancy was caused by rape. The court considered the relevant provisions of Medical Termination of Pregnancy Act, 1971 and having regard to factual position of the case, was constrained to come to the conclusion that unless the pregnancy of petitioner was terminated, mental shock and anguish would be caused.

Similarly in Dr Nisha Malviya and Anr. v. State of MP219 the accused had committed rape on minor girl aged about 12 years and made her pregnant. The allegations are that two other co accused took this girl, and they terminated her pregnancy. So the charge on them is firstly causing miscarriage without consent of the girl. The court held all the three accused guilty of termination of pregnancy which was not consented by the mother or

217 Supra note 214.
218 1996 Cri LJ 3795.
219 2000 Cri LJ 3671.
the girl.

In *Kamalavalli v. C.R. Nair*\(^{220}\), the High Court of Madras granted permission to the twenty eight years old rape victim to cause the abortion, subject to the doctor's permission.

Expressing concern about the misuse of modern science and technology in preventing the birth of a girl child the apex court in 2003 in *Centre for Enquiry into Health and Allied Themes (CEHAT) v. Union of India*\(^{221}\) directed the concerned authorities to strictly monitor the activities of the ultrasound diagnostic clinics to prevent illegal female foeticide. However, with no change in the mind set about females, the sex determination test adds to the adverse situation. This was evident from a recent case\(^{222}\) decided on 7\(^{th}\) August, 2007 in which Bombay High Court turned down the request of a couple Vijya Kirti Sharma who had two daughters and wanted a son to create a 'balance' in their family, to get the pre-natal test conducted, so that they could choose a male child. The court held sex determination is not only against the spirit of the Constitution; it also insults and humiliates womanhood. The court rightly said:

“It is unfortunate that people should be under the influence of out dated notions regarding son versus daughter. As long as such notions exist, the girl child will be unwanted.”

Further in *Vinod Soni v. Union of India*\(^{223}\) the Constitutional validity of the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 was challenged on the ground that it is violative of Article 21 of the Constitution. But the Supreme Court rejected this contention and held the Act to be constitutional.

Therefore it is due to the effort of Supreme Court after considering a PIL which was filed in 2000 by Centre for the Enquiry of Health and Allied Themes (CEHAT), the Mahila Sarvangeen Utkarsh Mandal (MASUM) and D. Sabu George that the Government amended the PNDT Act and make it more

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\(^{220}\) 1984 Cri LJ 446.
\(^{221}\) 2003 (7) SCALE 345; AIR 2003 SC 3309; (2003) 106 DLT 487(SC); JT 2003 (Suppl) SC 76. Judgement was delivered by M.B. Shah and Ashok Bhan, JJ.
\(^{222}\) *Times of India*, September 8, 2007 at 13 (Pune).
\(^{223}\) 2005 Cri LJ 3408.
comprehensive after having directives from the Court and renamed it as PC and PNDT Act.\textsuperscript{224}

But the decision of the Bombay High Court in regard to Medical Termination of Pregnancy Act, 1971 surprised everyone and open a new debate to amend law of abortion. The Bombay High Court, upholding the provisions of the MTP Act, which bans the abortion of foetus more than twenty weeks old, refused permission to the petitioner Nikita and Harsh Mehta to abort their twenty five week old foetus which was diagnosed with congenial cardiac disorder\textsuperscript{225} which means that the heart rate of the child will be less than the normal 72. In this case, the baby's heart rate is 55. The medical experts advised that the baby would require permanent pace-maker implantation at birth and as the pace-maker has limited life of 4-5 years, it would require replacement subsequently. As a result, the child might require several surgeries (pace-maker replacements) throughout its life-span, which would cause financial and emotional hardships for the parents. It would need hi tech operation theatre to perform the procedure. Since it is a surgical procedure, it has its own set of complications such as infections, risk of anaesthesia etc. After putting the pacemaker there will be restrictions on activities of the child (such as swimming, running etc.) It may have detrimental effect on foetal brain. In general, the experts predicted that the quality of life of the child would be poor. The petitioners expressed their inability to bear the psychological and monetary burden of giving birth and raising a child suffering from serious health problems. The petitioners sought a declaration from the court that Section 5 of the MTP Act be pronounced as a bad law as it does not allow termination of pregnancy beyond 20 weeks unless there is immediate risk to expectant mother’s life. They pleaded that Section 5(1) should be read to include the following words “and when 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” and hence direction should be issued to the respondents to allow the petitioner (Niketa Mehta) to

\textsuperscript{224} Su\textit{pra} note 124 at 188.
\textsuperscript{225} “It is a Job of the Legislature to help you Alter the Provision. We Cannot Legisllate the Provision”, the Judges Observed. For details “HC says no to aborting 25-week Foetus” \textit{The Tribune}, August 52, 2008 at 2.
terminate the pregnancy. But the Mumbai High Court disallowed there plea to terminate the pregnancy considering it equivalent to mercy killing.\textsuperscript{226}

The court observed that the medical experts have not expressed any ‘categorical opinion that the child if born would suffer from serious handicaps’. Strictly applying the provisions of the MTP Act, the court held that the patient does not have any choice in the matter and cannot terminate the pregnancy beyond 20 weeks which is the applicable law in this case. The court said that the legislature in its wisdom has imposed certain time period within which pregnancy can be terminated. The court cannot raise that period on its own. In the absence of any specific provision in that regard, nothing prohibits the court from laying down certain guidelines whenever required for effective implementation of any statutory provision. However, that would not include the power to frame law relating to the substantive rights of the parties. Assuming there is a defect or an omission in the words used by the legislature, the court could not go to its aid to correct or make up the deficiency as it would amount to usurpation of legislative power. Under the guise of reading down a provision of law, the court is not empowered to legislate upon a statute. This is essentially the function of the legislature.\textsuperscript{227}

Soon after, Nikita had a miscarriage.

Till recently, the issue of abortion was discussed in India only in the context of declining sex ratio, however, with the Mumbai High Court verdict, an altogether new angle in termination of pregnancy was emerged. Nikita Mehta's case has triggered social and medical debates in the country about the need to raise the legal limit of twenty weeks and to charge/amend certain laws. Such type of decision is going to cost the couple their entire life of trips to the hospitals, medical bills, extra efforts to generate money and the list goes on. Such incidents will make the people lose faith in law and justice and any hopes of receiving the justice to any issue.\textsuperscript{228}

\textsuperscript{226} Supra note 115 at 37-38.
\textsuperscript{227} Dr. Nikhil D. Datar and others v. Union of India and others, Writ petition (L) No. 1816 of 2008 of the Mumbai High Court, popularly known as Niketa Mehta case at para 19, 24.
\textsuperscript{228} “It is Time for Abortion Laws to Change” available at: www.yasni.com/ext-php?url (visited on November 6, 2014).
6.9 Conclusion

To be true, no one can deny or dispute that population control is the dire necessity of our time and the liberal law relating to termination of pregnancy is expected to go a long way to fulfil that necessity. The struggle for free abortion rights for women has also now been inseparably linked with the broader struggle of women to gain equality. But then, to save our laws relating to medical termination of pregnancies from all Constitutional challenges, it may be necessary to declare, may be by Constitutional Amendment, that a foetus is not a person within the meaning of the life/liberty clause in Article 21 of the Constitutional at least up to a certain stage of pregnancy.\textsuperscript{229} Further the line should be drawn at viability, so that before that time the woman has a right to choose to terminate her pregnancy.\textsuperscript{230}

In India, the reproductive choices of women have been misappropriated by techno-medical interventions for the non-medical purposes of satisfying the patriarchal aspirations for sons. Unfortunately, modern diagnostic techniques/tests/procedures have turned a woman's body into a son vending machine. The medical fraternity in India is divided in its opinion on the issue of sex-selection but desists from speaking aloud because of the sensitivity of the issue. Advocates of sex selection question the comprehensive ban on PGD and argue that PC and PNDT Act restricts the MTP Act, infringes woman's inalienable right to have abortion and he freedom to choose the sex of her child. Promoters of sex-selection argue that Government should allow the deserving couples to have access to sex-selection facility, as it is an effective tool for rendering the social service of “family balancing” to couples burdened with daughters. Their case is that sex-selection does not affect the overall child sex ratio as couples undergo sex-selection only after the birth of few daughters. Supporters also feel that sex selection liberates female foetuses from a life of discrimination and is a solution to dowry demand. They believe that pre-conception sex-selection releases mother from repeated sex selective abortions that are mostly conducted in the fourth or fifth month.

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\item \textsuperscript{229} Supra note 27 at 99.
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of pregnancy. They further argue that sex-selection controls population by preventing the birth of unwanted daughters.\textsuperscript{231}

Such arguments are socially off beam because sex-selection defines the quality of life and is not an antidote to dowry. It has been upheld by Mumbai High Court that there is no right natural or constitutional as “right to a balanced family”. Using diagnostic techniques for family balancing is violative of Article 14 of the Constitution. Creating artificial balance within the family is leading to socio-economic unrest in the nation.\textsuperscript{232}

To conclude, we can say the three wings of the state i.e. the Parliament, Executive and Judiciary from time to time have enacted various laws, framed the policies and interpreted the legal provisions to ensure social justice in its all spheres including reproductive justice too and making India a welfare state. However, making of laws or policies alone is not sufficient; what is required is that these laws and policies should be implemented strongly so that they can achieve their desire result.

\textsuperscript{231} Supra note 124 at 277.
\textsuperscript{232} Mr. and Mrs. Soni v. Union of India and CEHAT, 2005.