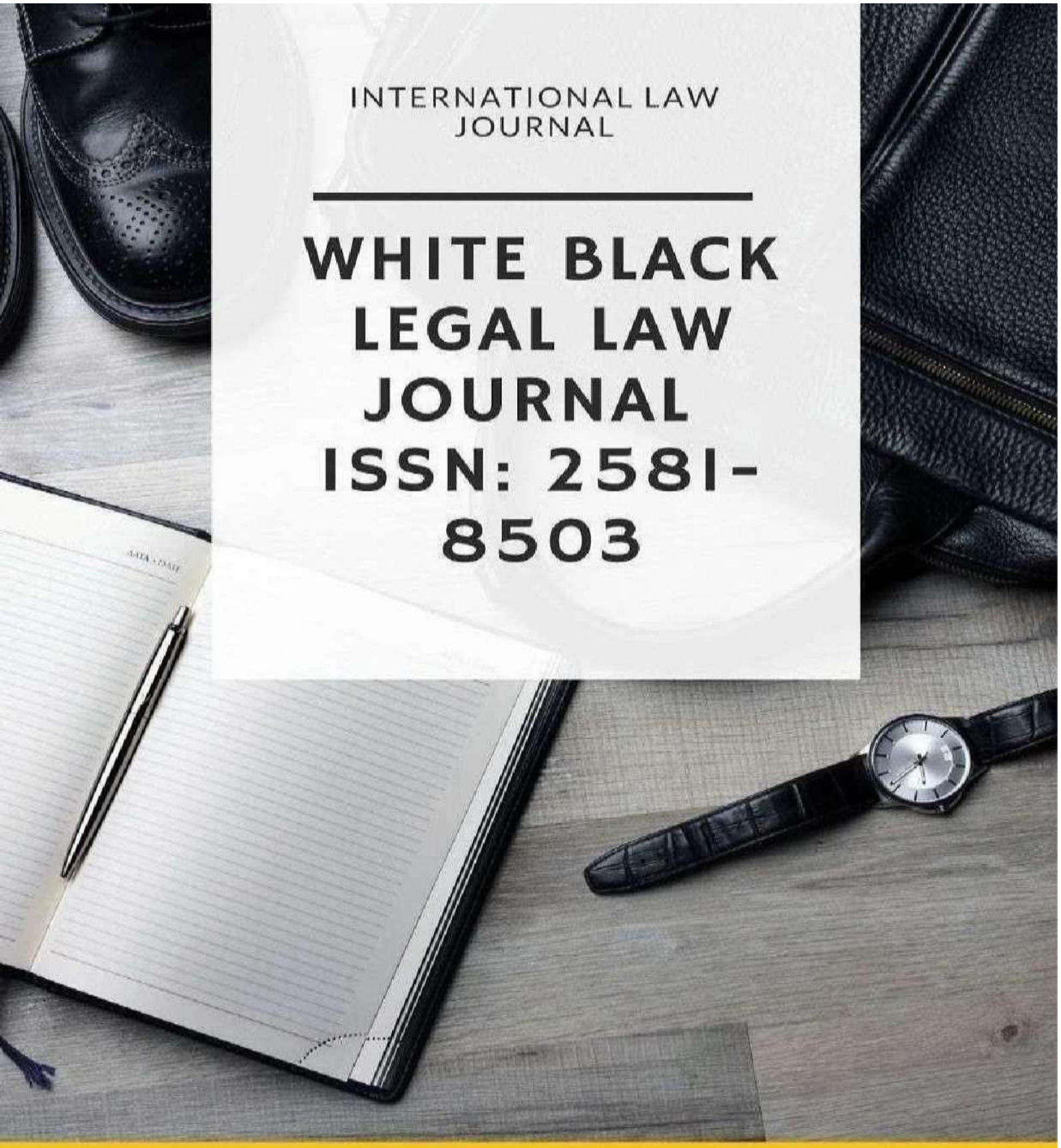

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WHITE BLACK LEGAL is an open access, peer-reviewed and refereed journal providededicated to express views on topical legal issues, thereby generating a cross current of ideas on emerging matters. This platform shall also ignite the initiative and desire of young law students to contribute in the field of law. The erudite response of legal luminaries shall be solicited to enable readers to explore challenges that lie before law makers, lawyers and the society at large, in the event of the ever changing social, economic and technological scenario.

With this thought, we hereby present to you

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CHANGING CONTOURS OF ABORTION JURISPRUDENCE, WOMEN CONSENT IN THE WAKE OF THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) ACT, 2021

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Abstract

*India, sees death of approximately 10 pregnant women per day because of an unsafe abortion practice. This number, however, is usually higher decades ago than what it is today. The Shantilal Shah Committee, created in 1964 entrusted with task of working out a liberal and safest approach for adoption practices to fight with rising unsafe deadly abortions in the country and on report of committee "*The *Medical Termination of Pregnancy Act, 1971" was passed subsequently to tackle the menace rising death. Recently parliament passed Amendment to the 1971, Act in 2021, seeking to further ease up and enlarge the horizon of lawful abortion. This Act itself and subsequent amendment over the years brings approaches in tune with making abortion accessible, lawful and secure. Nevertheless, the fineness of law does not inevitably correlate with the quality of deliverance. India's healthcare sphere has a plethora of drawbacks which more frequently challenge the progressive policies adopted by the state. There are also the controversial issues of abortion for adolescents, as well as the notion that abortion should be a woman's choice. This piecemeal of writing endeavors to investigate the Indian abortion regime in the* wake of aforementioned issues, b*y looking into forces of infrastructure, social disgrace and convergence of medical and patriarchal prejudice underestimate the good that regulation can do.*

Keywords: abortion, consent, autonomy.

1. Introduction

Parliament of India enacted in 2021 "The Medical Termination of Pregnancy (Amendment) Act, 2021" which claimed to be significantly improved the erstwhile practice. The act envisaged two important changes first is to expand the horizon of medical termination of pregnancy facility to include women who are unmarried, and second, revision of span of pregnancy up to which termination of pregnancy is permissible. The pregnancies that were earlier terminable on the medical opinion of one doctor can now be terminated till 20 weeks, and in case where opinion of two doctors was required earlier can now be terminated up to 24 weeks, the earlier these periods range from 12 to 20 week respectively. This amendment makes the provisions of act more inclusive and progressive measures[1], these will have far reaching impact to ensure easily access to reproductive rights of women.

1.1 Where does India stand?

When we see at world statistics countries[2] are divided into five classes in relation to abortion framework, oscillating between complete restraint to abortion on application, India finds place in class 4 which includes nations where abortion is permitted on broader societal or economic reasons. Although in India there are least restraining laws in the class of countries decriminalizing abortion on socio- medical grounds, with a manifestly strong prominence on the medical part. The other class of nation which are placed on higher pedestal than India comprises nations where abortion is allowed on application on request, mostly in Europe and North America. For better insight on the subject, a comparative study of India with USA, Canada and U.K is made in present article.

The abortion regulations in the USA, are primarily controlled by the revolutionary ruling of Roe v. Wade[3], where the SCOTUS, interpreted this as right to privacy as enshrined under due process clause of the 14th Amendment of the Constitution and in turn successfully legitimate abortion in all the states. But The verdict came in the case *Thomas E Dobbs v. Jackson Women's Health Organization*[4], in which the top court ruled that The Constitution does not

[1] IPAS, *India progresses in amending its abortion law*, March 27, 2009, available at https://www.ipas.org/news/india-progresses-in-amending-its-abortion-law/ (last visited on 25th September 2022)
[2] The Hindu, *How many countries allow abortion on request, where is abortion completelyprohibited, and more*, March 04, 2020, available at https://www.thehindu.com/data/data-how-many-countries-allow-abortion-on-request-where-is-abortion-completely-prohibited- and-more/article30981255.ece (last visited on 25th September 2022).
[3] *Roe v. Wade* 410 U.S. 113. (1973).
[4] *Thomas E Dobbs v. Jackson Women's Health Organization* U.S 19-1392 2022.

confer a right to abortion; Roe and Casey[5] are overruled; and the authority to regulate abortion is returned to the people and their elected representatives. Three judges of the liberal block, in a vociferous dissent from the majority, emphasis that suppression of abortion rights curbs "women's status as equal and free citizens" and "diminishes women's opportunities to participate fully and equally in the Nation's political, social and economic life".

Analogous to the USA, the dawn of the usual abortion regime in Canada can Be traced back to one important ruling, that is of *R. v. Morgentaler*[6], where section 251 of the Criminal code (which permitted only abortions executed at qualified hospitals, by prior approval from the hospital's Therapeutic Abortion Committee) was found to be in contravention of section 7 of the Canadian Charter of Rights and Freedoms. This section caused a situation where even in lawful abortions a woman had little say in relation to her body. By this verdict abortion is deregulated, by making that no other regulation will control abortion, either criminal or otherwise is in operation. So, abortion in Canada is legal at all stages.

When compared with US and Canada, UK has a very well defined and broadly recognized regulation, laying down exact and explicit guiding principle, on all facets of abortion with littleor no room for further construal. The Abortions Act, 1967,[7] is the legislation which permits abortion in the country UK which else would have been a crime under the "Offences Against the Person Act, 1861"[8]. This Act commands that an abortion is permissible if it is accomplished by a medical expert with the sanction of two doctors. The gestational ceiling as per section 1(1)(a) of the Abortion Act, 1971 is 24 weeks. The prerequisites of the Act explicitly stipulate that if in the estimation of the medical practitioner, it would be advantageous to the mental health of the woman, for not continuing with the pregnancy, the abortion is to be called as legal- even if it is harmless choice to stay with the pregnancy. Section 1(2) of the Act also enumerates reasonably foreseeable for the woman. Hence, a joint reading of sections 1(1) and 1(2) articulate that it is totally legal in UK if an abortion is a outcome of the failure of the woman to support the pregnancy any more, virtuously in relation of finance. It is also to be stated that the doctor must have adequate reason to be certain of that the declarations made by the woman are undeniably factual.

[5] *Doe v. Bolton* 410 U.S. 179 (1973).
[6] *R v. Morgentaler* (1988) SCR 1.
[7] The Abortion Act, 1967 c. 87.
[8] Offences Against the Person Act, 1861, 24 & 25 Vict. c 100.

New Zealand, another notably democratic and progressive nation has recently passed the "Abortion Legislation Act 2020[9]"under which a gestational limit of 20 weeks provided without constraint.

From a succinct assessment, it is obvious that the prevailing abortion regime of India is allegedly modern in its approach in the framework of other operative laws, in terms of gestational bounds, and process of termination, the newest amendment has made termination of pregnancy more comprehensible by increasing the time ceilings and by covering such a right to unmarried women. What makes it admirable is that India is a visible outlier in the class of nations that have analogous regulations, keeping in mind the fact that India is largely a traditional nation as compared to the others.

However, at the same time, it is also appropriate to not get immersed in the shadow of rhetoric, and scrutinize not just the legislation but also the device through which such legislation is implemented. This writing aims to achieve a multifarious censorious study of the operation of the Act so far in terms of policy application, voids, flaws and previously suggested changes and to study the scope and likelihood of the changes that the amendment will bring in the near-future.

2. The relationship of policy accomplishment vis-à-vis infrastructure

Prima facie it appears that Indian legal framework for abortion is at par with European and other countries as our legislative provision are progressive and in prolongation of abortion rights. Nevertheless, there is an innate need to scrutinize the implications of a legislation & to spot out what the limitations are, as the resolve of introducing a law is vanquished if it unable to achieves its objective and to reach the proposed beneficiaries. "The Medical Termination of Pregnancy Act-1971"[10] by its preamble states that it is an Act "*to provide for the termination of certain pregnancies by registered medical practitioners and matters connected therewith or incidental thereto*." The Act has been in action for 50 years as of the present day, which is sufficient to scale the hitches and complications that appear in its implementation of it and to assess how successful this Act has been. To commence with, a pioneer hindrance that encompasses the whole of India's healthcare sector is the deficiency of competent doctors in

[9] The New Zealand Abortion Legislation Act, 2020 No. 6, Public Act.
[10] The Medical Termination of Pregnancy Act no. 34 of 1971.

the country, even more, germane for MTP as it sternly recommends only medical practitioners. The World Health Organisation ("WHO") has postulated[11] the proportion of 1:1000 (doctor: populace) as a prescription. At this juncture, it is appropriate to spotlight the deficiency of doctors that India experiences, which therefore makes it difficult to accomplish any policy, no matter how well-defined or adroitly conscripted, as India has only one doctor for every 10,189 persons. moreover, it must be noted that 64% of the populace resides in countryside areas[12], we are only having a total of 1,351 gynecologists and obstetricians in community health centersin rural areas, as per All India Rural Health Statistics[13]. The doctor-population proportion has seen an upsurge each year, nevertheless, it is not significant, and insufficient to balance the health-related requirements of our republic. For abortion, it is an important concern, which as per law lawful only if it is performed by a registered medical practitioner. Otherwise, abortion will be a voluntary miscarriage which is an offense under the Indian Penal Code, 1860 which postulates a maximum sentenceof 7 years with a fine[14].

Even after decades of enactment of the law, it is to be noted that there are nearly 22 thousand public health care facilities in countryside areas, mostly missing indoor medical treatment and others having indoor medical treatment facilities for sterilization procedures lacks wards for post-operative sterilization treatment. Besides lacking infrastructure, the inadequacy of doctors[15] in these facilities makes the situation grimmer, in terms of supportive drugs, supporting staff, oxygen, specific labor rooms, and operation theatres. These facilities failed to achieve the objective of their establishment purposes initially set out for them. Furthermore, it is time and again felt that under MTP patriarchal biased arises in form of medical biasedness[16].

The unavailability of an adequate number of medical practitioners, and the requirement for the opinion of two doctors as per the MTP act for abortion make it difficult to opt for abortion in

[11] WHO, *Global Health Workforce statistics database*, (till 2019), available at https://www.who.int/data/gho/data/themes/topics/health-workforce (last accessed on 25th September, 2022)
[12] The World Bank, *Rural population (% of total population) – India*, (2018), available at https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=IN (last accessed on 25th September, 2022)
[13] Government of India, *Rural Health Statistics 2018-2019* (December 24, 2019) at https://main.mohfw.gov.in/sites/default/files/Final%20RHS%202018-19_0.pdf (last accessed on 25rd September, 2022)
[14] The Indian Penal Code, 1860 section 312.
[15] Amar Jesani, Aditi Iyer, *Abortion – who is responsible for our rights?*, CEHAT – Our Lives, Our Health, August 1995, 114.
[16] Siddhivinayak S Hirve, *Abortion Law, Policy and Services in India: A Critical Review,* 12 RHM Journal, (2004)

rural areas for more than 20 weeks of pregnancy[17]. The legislature did not take into account this even while amending the act.

The first decade of enforcement of the law on MTP witnessed a marginal addition of recognized abortion centers and reported numbers of abortions are just 1/10th of the actual number of abortions.[18] The number of abortions reported by those facilities and the next decades also portrayed a declining percentage of abortions reported in sanctioned facilities. After 5 decades of coming into action of the Act, the majority of the sanctioned abortion clinics are in urban areas, while most population resides in villages.[19] Having a deficiency in abortion clinics make people apprehensive and lack confidence in resorting to abortion clinics.[20] In the absence of robust health infrastructure, it is illogical to contend that the new amendments will bring a change in abortion practice.

Inadequacy of public health clinics paves way for private healthcare but as we know private clinics are set up for the obvious reason of profit-making due to this private healthcare industry has also made inroads into urban areas as most private healthcare approx. 67% of centers are limited to major cities[21]. Almost 86% of rural residents pay a visit to these hospitals at the cost of time and money to avail of quality healthcare.[22] This indicates that either there is no facility in a rural area or there is a lack of quality among those in the rural area. Approximately 3/4th of the total competent medical staff in a state (reckoning both doctors and nurses/midwives) are employed in the private sector, again showing the failure of the government to attract trained doctors or adequate investment in public healthcare facilities.[23] There is also an issue with the quality of medical staff, research conducted in rural Rajasthan points out that almost 40% doctors in the private sector are without a medical degree, 18% had no medical or paramedical training at all, and 17% were not even high school graduates.[24] By research, it is

[17] The Medical Termination of Pregnancy Act, 1971 Sec. 3(2)(b).
[18] Hirve, *supra* note 13 at 115.
[19] Barge S. *Situation analysis of medical termination of pregnancy in Gujarat,Maharashtra, Tamil Nadu and Uttar Pradesh* in Health Panorama no. 2, CEHAT (2001).
[20] The Government of India "Family Welfare Yearbook, 1991-92", New Delhi (1992)
[21] Indranil, Montu Bose, *Private healthcare industry in India: 4 common myths debunked,*Business Today, July 16, 2020, available athttps://www.businesstoday.in/opinion/columns/private-healthcare-industry-in-india-five-common-myths-debunked-public-and-private-sector/story/409872.html (last accessed 16thApril, 2021)
[22] R. Kumar, *Academic institutionalization of community health services: Way ahead inmedical education reforms*, 1 JFMPC 1 (2012).
[23] Tej Ram Jat et al. *Factors affecting the use of maternal health services in Madhya Pradesh state of India: a multilevel analysis*, 10 Int J Equity Health 59 (2011).
[24] Sanjay Kumar, *Much health care in rural India comes from unqualified practitioners,* 328 British Medical Journal (2004)

also discovered that trainee medicos aided in or executed an average of 12–13 abortions, contrasting to the agreed norm of 25.[25]

Section 4 of the Medical Termination of Pregnancy Act, 1971 has a clear mandate that pregnancy can be aborted only at either of

i) A hospital formed or continued by the Government or

ii) A hospital that has been permitted by the Government.

The delay in registration due to administrative bottlenecks makes already constructed centers awaiting recognition criminally liable for performing an abortion and medical practitioner also comes into the ambit of legal claws. To escape from criminal liability, the practitioner contends that such termination was the need of the hour to save the woman's life[26]. This not only flouts the law but endangers the life of pregnant women. The bureaucratic latches, over-regulation, red tape, and inefficacious administration curtail the inspiration to invest. Resultantly, the operational healthcare facilities have poor asepsis conditions related to water and toilet. The absence of technologies that are essential to perform the abortion safely, like suction technologies, dilaters, and pain killer medicines among other things, coupled with an errant power supply[27]. Performing abortions by ill-equipped, unhygienic hospitals adds to the agony of women. Governments had done nothing in the past to tackle these problems which arose very early and present as such till now. The amendments by the legislature debatably have a negligible outcome in rural areas, as the foundation itself is weak in rural areas. Besides making important amendments to the act it is also necessary to look into auxiliary considerations to bring it in accord with the outlined policy. Although the government has made strides in assessing and subsequently making appropriate improvements in law as per society requirements, the tangible assets and fabric that carry the policy on its shoulders have been ruined a long time before, with no ostensible plan of action in sight.

3. Adolescents and abortion

There is a stark difference between India and the countries we discussed earlier concerning abortion policies that although we are similar on the footing of legislation we are primarily a conservative society whereas others are liberal in approach. simply liberal societies have more

[25] ME Khan, S Barge and N. Kumar, *Abortion in India: Current situation and future challenges* in Implementing a Reproductive Health Agenda in India: A Beginning, New Delhi Population Council (1999).
[26] The Medical Termination of Pregnancy Act, 1971 sec. 5.
[27] Bela Ganatra, Batya Elul, *Legal but not always safe: Three decades of a liberal abortionpolicy in India*, 139 Gac Méd Méx (Suppl. 1) (2003).

acceptance of abortion[28] as compared with conventional societies which dissent on a host of grounds principally linked to morality arising from religious philosophies and dogmas. So right to abortion of an adolescent needs to be considered in light of the Act and judgments.

Section 3(4)(a) of the MTP Act states that if a female has not reached the age of eighteen years, her pregnancy cannot be terminated without the consent, of her guardian in writing. The Supreme Court bench of **Justices DY Chandrachud, A.S. Bopanna, and J.B. Pardiwala** observed that "a woman who seeks legal abortion cannot be required to seek consent from her family. *It is only the woman's consent (or her guardian's consent if she is minor or mentally ill) which is material*[29]*."*

In contrast with the USA, e.g, the right of an adolescent to abortion may or may not depends on the consensus of the guardian or parent. The finality is contingent on the state in which the abortion has to be performed. In some states, adolescents have access to hassle-free abortions. The ones who reside in restrictive states can choose to travel to the state with fewer restrictions for abortion.Among the countries with liberal abortion laws, the United States of America sees the highest i.e 1/4th of pregnancies culminated in abortions[30]. Liberal abortion laws prompt reporting accurately and regularly, Further,it has been noted that abortion rates go down when it is made legal, along with easier access to contraceptives[31].

In India, adolescent pregnancies in rural areas are closely double of urban adolescent pregnancies[32]. Pregnancy at a youthful age affects the mind and body of a female. Nearly 40 % of adolescent females in India are malnourished with a BMI of less than 18.5[33]. BIMARU states have a higher proportion of teenage pregnancies as performing worst in all social indexes. Pregnancies of this nature are due to a lack of sex education and the use of birth

[28] Guillaume Agnes, Rossier Clementine, *Abortion around the world- an overview*, 73Population 2 (2018).
[29] X vs Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi | 2022 LiveLaw (SC) 809 | C.A 5802/2022 | 29 September 2022 | Justices DY Chandrachud, A.S. Bopanna and J.B. Pardiwala
[30] Guttmacher Institute, *Adolescent Pregnancy and Its Outcomes Across Countries*, August2015, available at https://www.guttmacher.org/fact-sheet/adolescent-pregnancy-and-its-outcomes-across countries#:~:text=According%20to%20a%20recent%20review,2011%20and%202010%2C %20respectively).&text=The%20next%20highest%20rates%20are,17)%2C%20all%20in% 202011) (last accessed on 26th September 2022)
[31] Maggie Fox, *Abortion rates go down when countries make it legal: report,* NBC, March 21, 2018, available at https://www.nbcnews.com/health/health-care/abortion-rates-go- down-when-countries-make-it-legal-report-n858476 (last accessed on September 26th 2022)
[32] Shoba Suri, *There's a need to end teenage pregnancies in India, it's harming the nationaleconomy*, ORF, January 14, 2020, available at https://www.orfonline.org/research/theres-a- need-to-end-teenage-pregnancies-in-india-its-harming-the-national-economy-60307/ (last accessed on 26th September 2021)
[33] Id

control devices is an unwarranted and heavy burden on families.

Concerning confidentiality, the POCSO[34] Act and the MTP regulations are at odds. The MTP Regulations envisage strict confidentiality for women who opt for abortion. Abortion clinics must keep a register with the names and addresses of women and this data should not be divulged to anybody without appropriate permission. While under the POCSO Act adolescent pregnancy is illegal as the consent of an adolescent girl for intercourse is not recognized under the law and it amounts to rape.[35] So, if the adolescent girl looks for an abortion, the doctor must report the case to the police as a sexual assault victim notwithstanding the consensus of the adolescent. Essentially, the POCSO Act makes inroads into the protection ordained by MTP regulations in the instance of adolescents and intrudes upon privacy. This in turn poses a barrier for teenage girls accessing safe abortion services.[36] This ambiguity devoids girls from seeking abortions and if doctors don't follow this mandatory requirement criminal action can be initiated against the doctor. Which in turn promotes unsafe abortion practices fatal to the body and mind of women. This is primarily due to the social stigma surrounding adolescent consensual sex, so even after having laws in place, the benefits cannot be secured.

In Suchitra Srivastava v. Chandigarh Administration[37], the Apex Court said "*There is no doubt that a woman's right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India."* The Court remarked that it should be motivated solely by the survivor's desires, not those of other stakeholders like the guardian or social norms. The landmark *Puttaswamy*[38] judgment affirmed the reasoning of the Court in Suchitra Srivastava and reiterated that under Article 21 of the Indian Constitution, women have the fundamental right to make reproductive decisions as part of their liberty.

SC in its latest judgment ended away with the mandate of guardian's consent, the consequence of which for an adolescent girl in rural India is the possibility of being made an outcast, or even subject to an "honorkilling" which is a reality even for adult women.[39] Therefore, the

[34] The Protection of Children from Sexual Offences Act, Act no. 32 0f 2012.
[35] A combined reading of section 2(d), which defines a child as any person under the age of18, and 3(a), which describes penetrative sexual assault by any person.
[36] Dipika Jain et. al, *Abortion laws in India: A review of court cases.* CHLET JGLS,November 1 2016, 90
[37] *Suchita Srivastava and Another vs. Chandigarh Administration*, AIR 2010 SC 235
[38] *K. S. Puttaswamy v. Union of India* (2017) 10 SCC 1.
[39] X vs Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi | 2022 LiveLaw (SC) 809 | C.A 5802/2022 | 29 September 2022 | Justices DY Chandrachud, A.S. Bopanna and J.B. Pardiwal.

laws which are meant to serve the needs of pregnant women become misnomers owing to juxtapositions and vagueness. Whereas the amendment effectively broadened the scope of abortion, technical requirements, as well as the convergence of various laws, hinder the delivery of the legal considerations that the MTP Act affords for those residing in less-developed regions of the country.

4. A woman's conformity in abortion

The Preamble to the MTP Act itself portrays that this is an Act that affords for termination of specific pregnancies by medical practitioners. Thus, the object largely is to abort pregnancies those in the opinion of doctors fall within the justification by the Act. So act facilitates the de-criminalization of various abortions so that doctors do not suffer criminal liability, contrasting with the conception that a woman, as a part of her life and personal liberty must have control over her bodily and reproductive independence, which our Apex court has observed is an aspect of individual autonomy essential in the right of privacy in Common Cause v. Union of India.[40]

Section 3(2)(i) of the MTP act articulates that a pregnancy may be aborted by a medical practitioner on the concurrence of the opinion of two doctors that the continuation of the pregnancy would either result in a risk to the life of the woman or grave injury to her physical or mental health. 2nd explanation in the section communicates that in the instance of rape, and the event of a futile contraceptive device, it shall be treated as grave mental injury and physical torment for the woman. Irrefutably, the termination of a pregnancy in a majority of the scenarios hinges on the opinion of a medical practitioner and the woman as per law has no say in it.

In *Savita Sachin Patil vs. Union of India*[41], the Court disallowed the abortion of a 27-week pregnancy on the opinion of the medical board that there was no bodily risk to the mother. In the majority of instances, the opinion of the medical board is given importance and the view of the woman is not taken into account at all. Another germane issue is the fact that about the 20th week of pregnancy that women who deliberately did not take a pregnancy assessment

[40] *Common Cause v. Union of India* W.P. (Civil) 215 of 2005
[41] *Savita Sachin Patil vs. Union of India*. W.P. (Civil) No. 121 of 2017.

know about their pregnancy due to the protrusion of the stomach.[42] In this aspect, the Government has positively taken a step in the right direction by increasing the upper ceiling of the period to 24 weeks. However, if pregnancy is outside 24 weeks ceiling, then the woman is entirely at the behest of the doctor for an abortion, going by the prevailing jurisprudence.

South Africa in their new Constitution cherished the right to make choices regarding reproduction in Section 12(2)(a) and (b).[43] In the lawsuit of *R v. Morgentaler*, the Supreme Court of Canada turned down a law that permitted women to secure legal abortions only if a therapeutic abortion committee comprised of three doctors certified that the prolongation of pregnancy will be likely to threaten her life or well-being, affirming it to violate Section 7 of the Canadian Charter of Rights and Freedoms, which asserts that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except following the principles of fundamental justice.'

The contradiction between the abovementioned states and India is that the earlier have an abortion framework with the autonomy, liberty, and privacy of the woman as the centerpieces, and Indian legislation does not place any emphasis on the agency and choice of the pregnant woman. The formerhas a rights-based approach which encourages individual rights whereas the latter has a need-based approach, where a medical expert may abort the pregnancy of a woman based on his view with the help of circumstances like "grave injury to her physical or mental health" and "serious physical or mental abnormality" of the fetus. Abortion in India is in all realism a physician-sanctioned termination contrasting with the exercise of the fundamental right of reproductive discretion of a woman, which over time and again declared by India's courts. Even though our Courts have on numerous occasions acknowledged the right of a woman over her reproductive elections, independence, and pride, the regulation that is in action positioned such rights on the rear end, giving importance to state confirmation.

5. Conclusion

The Medical Termination of Pregnancy (Amendment) Act, of 2021 is certainly a step on the right track when it comes to widening the accessibility of abortion to women. however, it does not contemplate an enlargement of the reproductive choices of a woman, as delineated

[42] Deepika Singhania, Yahoo News, *Abortion Options for Indian Women: Is the New MTP (Amendment) Bill, 2020 Better and Safer?*, November 29, 2020, available at https://in.news.yahoo.com/abortion-options-for-indian-women-is-the-new-mtp-amendment- bill-2020-better-and-safer-030017248.html (last accessed on 19th April 2021)

[43] The Constitution of the Republic of South Africa, 1996, ¶ 12(2)(a) & 12(2)(b).

explicitly in this article. The problem is not only limited to the legislative front but the lack of infrastructure facilities creates a hindrance to the effective implementation of this act even after 50 years of enactment. Further, there is a huge mismatch in service quality and health infrastructure in rural and urban areas. Urban areas are only able to reap its benefits easily and appropriately so the lopsidedness of health infrastructure in rural areas needs to be addressed priority basis. To conclude, the legislation still portrays to be a state-sanctioned device for medical termination of pregnancies as contrasting to a rights-based context in line with the fundamental rights of women as per the Indian Constitution. Due to the abovementioned weaknesses, the Act will supposedly only further trivial advancement to the current status quo, whilst not taking up the glitches that have been troubling the regime since the commencement of the original Act, and therefore fail in carrying a reformist and transformational revolution. But the supreme court the guardian of the rights of vulnerable sections of society constantly evolves law on this and held in a recent case that it is fundamental to respect the consent of matter in termination choice no other person will have any say on that matter, it appears to be a welcoming decision.