**Abortion and Law in India: How Conflicting** **Legislations Create Unintended Barriers to Safe Abortion for Minor Girls**

**Dipika Jain and Brian Tronic**

**Running Title:** Barriers to Safe Abortion in India

**Word Count:** 5737

**Abstract**

This article examines the legality of abortion in India, demonstrating how conflicting laws create unintended barriers to safe abortion. It focuses specifically on the situation of minor girls seeking abortion, showcasing the unintended consequences that arise from the existing lack of clarity in the legal regime.

Contents

[1. Introduction 2](#_Toc536125006)

[2. The Legal Framework on Abortion in India 2](#_Toc536125007)

[3. Inconsistencies in the Legal Framework 4](#_Toc536125008)

[**a.** **Respecting a Woman’s Confidentiality** 4](#_Toc536125009)

[**b.** **Criminal Sanction for Healthcare Providers** 4](#_Toc536125011)

[4. Unintended consequences of the inconsistencies 6](#_Toc536125012)

[**I.** **For Women** 6](#_Toc536125013)

[**II.** **For Healthcare Providers** 8](#_Toc536125014)

[5. Addressing Concerns 9](#_Toc536125015)

[**a.** **Unclear if preservation of products of conception (PoC) is mandatory** 9](#_Toc536125016)

[**b.** **Medico-Legal Certificate preparation before provision of abortion service not mandatory** 10](#_Toc536125017)

[**c.** **Procedure for reporting case to the appropriate authority** 10](#_Toc536125018)

[**d.** **Guardian competent to consent on minor’s behalf** 11](#_Toc536125019)

[6. Conclusion 12](#_Toc536125020)

[7. References 14](#_Toc536125021)

## Introduction

In the past ten years, India has made remarkable progress in reducing its maternal mortality ratio—in 2005, the ratio was 280 per 100,000 live births, but by 2015, it was reduced to 174 (and the government’s data suggests even lower figures) (1). However, India still has the second-highest number of maternal deaths in the world, accounting for about 15% of all maternal deaths in 2015 (2). Unsafe abortions are a significant contributor to this—it is estimated that complications due to unsafe abortions are responsible for 9% of India’s maternal mortality (3). By some estimates, a woman in India dies every two hours from an unsafe abortion (4).

Unfortunately, recently enacted laws and amendments that were intended to protect women and children have unforeseen consequences when applied to minor girls seeking abortion. As it exists today, India’s legal framework provides conflicting guidance to medical providers, does not adequately protect confidentiality, requires parental consent (with no exceptions), treats all pregnant minors as rape victims, and mandates involvement of the criminal justice system. These problematic consequences, together with abortion-related stigma and conservative views regarding pre-marital sex, force many minor girls to seek abortion from unlicensed or unqualified providers outside the mainstream health system, or in the absence of healthcare services, continue unwanted pregnancies to term. This leads directly to unnecessary complications and death, apart from aggravated financial burdens, and psychological and mental health consequences. This report will review the legal framework relating to abortion in India, explain how conflicting laws negatively impact the health of minor girls, provide guidance regarding the law’s requirements, and highlight important issues that deserve further consideration and discussion.

## The Legal Framework on Abortion in India

In India, several laws relate, directly or indirectly, to abortion. Before the enactment of a special law on abortion, sections 312 to 316 of the Indian Penal Code, 1860 criminalized all forms of abortion except to save the life of the pregnant woman, as well as inducement of abortion.

The Medical Termination of Pregnancy (MTP) Act was enacted in 1971 to provide for specific exceptions to the prohibition of abortion as set out in the IPC, primarily in response to concerns about India’s high population growth rate, and lack of safe abortion services that resulted in high rates of maternal mortality. The Statement of Objects and Reasons specifically bases termination of pregnancy in mental and physical health, humanitarian and eugenic grounds. The MTP Act allows women to obtain abortions up to twenty weeks where continuing the pregnancy would involve a risk of grave injury to the women’s physical or mental health or there is a substantial risk that the child would be born with a serious handicap. Section 5 of the Act allows for abortion after twenty weeks of gestation, but only to save the life of the pregnant woman. This ground has come to be widely interpreted by courts and may be said to include the pregnant woman’s mental health (5). The MTP Regulations, 2003 set forth the conditions and procedures for implementing the Act.

The Protection of Children from Sexual Offences (POCSO) Act, 2012, while specifically aimed at protecting children from offences of sexual assault, sexual harassment and pornography, is built around an overarching framework that regards the best interests and wellbeing of the child to be of paramount importance. The Act defines certain sexual offenses against minors, i.e. those below the age of 18 years, and imposes reporting requirements for anyone who knows that an offense has been or is likely to be committed. The Code of Criminal Procedure (CrPC) has a similar reporting requirement for hospitals regarding sexual offenses under the Indian Penal Code (IPC).

The Juvenile Justice (Care and Protection of Children) Act, 2015 (JJ Act) was enacted subsequently with the intent to provide basic needs to children in conflict with law and children in need of care and protection by adopting a child-friendly approach that secures the best interests of the child.

A brief overview of the intent behind enactment of the above laws is necessary to contextualize the operation of these laws in practice and their conflicting aspects, which will be discussed in detail below. But this dialogue will remain incomplete without taking note of the orientation of this report. Not only does this report center the conversation relating to conflicting laws on unintended consequences of such conflicts, but further aims to establish that a majority of these conflicts and ambiguities can be potentially resolved by resorting to the standard that prescribes best interests of the child to be of paramount importance. Article 3.1 of the UN Convention on the Rights of the Child (CRC) requires “the best interests of the child” to be the “primary consideration…in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies.” Child rights jurisprudence has attempted to resolve the problem of indeterminacy of the best interest standard by building a core set of inviolable rights that must be taken into consideration to assess the best interest of a child, and by incorporating a child’s participation in decision making as key to such as assessment (6). The CRC has further urged states to review their legislation in order to guarantee the “best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.” The CRC has also called on states to ensure that “girls can make autonomous and informed decisions on their reproductive health”. Incorporating such principles in an assessment of best interests of a pregnant minor, and in particular a pregnant adolescent, would build strong foundations for a human rights and autonomy-centric child rights jurisprudence in India.

The landmark judgment in the case of *Suchitra Srivastava & Another v. Chandigarh Administration* was the first to determine whether a rape victim could undergo abortion by relying on the “best interests” standard (7). The High Court held that the process of ascertaining which course of action would serve the best interests of the victim was to be decided upon by giving due consideration to “medical opinion on the feasibility of the pregnancy as well as social circumstances faced by the victim”. The Court is to be guided by the interests of the victim alone, and not those of the guardian or other stakeholders. It is this lens that informs the structural and ideological framework of the report, and without which compassionate debate on access to abortion services for pregnant minors may not be possible.

## Inconsistencies in the Legal Framework

The multiple laws that relate to abortion were enacted with different purposes. Some were intended to protect minor girls from sexual abuse, while others were intended to facilitate access to abortion for women that qualify. However, in certain circumstances, minors who undergo abortions can fall under both sets of laws, and this leads to inconsistencies. For instance, given the branding of all minors as children (8), irrespective of age and evolving capacities (9), under the POCSO Act, all sexual contact involving a minor is a sexual offence. This policy position is also reflected in the IPC, where the age of consent was raised to 18 years in 2013 (10). As such, a minor seeking an abortion may be considered a victim of crime, and therefore, a child in need of care and protection under the JJ Act (11). Further notable inconsistencies are also evident in cases of medical confidentiality and when a doctor can perform an abortion without facing criminal sanctions.

### ***Respecting a Woman’s Confidentiality***



### The MTP Regulations contain strict confidentiality protections for women who have an abortion. For example, each abortion provider must maintain a register with the details of all the women who are admitted (12), and the register must be kept “*secret*”—its information “*shall not be disclosed to any person*” and it can only be inspected under the authority of law (13).

However, the POCSO Act appears to conflict with this confidentiality—it requires anyone who knows that a sexual offense has been committed to report this to the police, who in turn must report it to the Child Welfare Committee and the Special Court (or Court of Session) within 24 hours (14). Under the POCSO Act, having sex with a minor girl (under 18) is a crime, even if it is consensual, as the law doesn’t recognise a minor’s capacity to consent to sexual acts and so, precludes the possibility of consensual sex between persons below the age of 18 (15). Therefore, if a pregnant minor girl approaches a doctor seeking an abortion, the doctor must report the girl to the police as a victim of sexual assault, even if this goes against the girl’s wishes. Anyone who knowingly fails to make this report can be punished with up to 6 months in prison (16).

The same issues arise under the CrPC, which requires all hospitals to immediately report incidents of rape to the police (17). Under the IPC and the POCSO Act, even consensual sex with a girl under 18 constitutes rape (18). Therefore, if a pregnant minor girl seeks an abortion from a hospital, the hospital must report her to the police as a rape victim, and failure to do so is punishable with up to one year imprisonment (for the person who runs the hospital) (19).

### **Criminal Sanction for Healthcare Providers**

The wide definition of sexual intercourse under the amended Section 375 of the IPC and the POCSO Act has induced fear amongst healthcare professionals that abortion procedures may amount to rape and attract criminal liability. However, a fundamental element of a criminal offence is the presence of mens rea, or simply a guilty mind or intention to commit a particular offence. To clarify, a service provider who terminates a pregnancy without this requisite intention will not be criminally liable.

The MTP Act shields medical providers from criminal liability as long as the pregnancy is terminated in accordance with the Act (20). Given the intrusive nature of abortion procedures, informed consent of the woman undergoing an abortion is critical (21). In the case of *Samira Kohli* v. *Prabha Manchanda*, the Supreme Court of India held that for consent to qualify as informed consent,

“The consent … should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what [he] is consenting to.”

One of the requirements of the MTP Act is to get written consent from a minor girl’s guardian before terminating a pregnancy (22). Section 41 of the POCSO Act on the other hand indicates that, for a medical procedure to be exempt from its criminal provisions, the girl’s “parents or guardian” must consent. This suggests that the guardian may not necessarily be the parent of the minor. There is a potential ambiguity as to whether consent can be provided by only a legally recognised guardian or a de facto guardian as well; however, this issue is discussed and resolved later in the report.

Secondly, a provider who fails to get the guardian’s consent would *not* be liable under the IPC despite the fact that Section 375 (the rape statute) also prohibits inserting any object or any body part into a child’s vagina (23). The reason for this is that Section 375 provides that “A medical procedure or intervention shall not constitute rape” without requiring consent of the parents or guardian for the medical procedure (24). Abortion is likely a “medical procedure” under Section 375—the Ministry of Health and Family Welfare has stated that the right to treatment of sexual assault victim includes emergency contraception and the POCSO Rules require medical practitioners to discuss emergency contraception with child victims (25).

At this point, it may be useful to address a common misperception about the role of Child Welfare Committees (CWC) established under the JJ Act. To counter the widespread belief amongst service providers that it is imperative for them to take permission from the CWC before terminating a pregnancy, reliance must be placed on the specific roles designated to the CWC for dealing with minor rape victims, who are termed as children in need of care and protection. Section 30 of the JJ Act that otherwise outlines the powers and functions of the CWC makes no mention of the power to give consent and/or permission for a minor rape victim to undergo an abortion. In the case of *Halo Bi v. State of Madhya Pradesh*, the High Court has further held that there is no need for the doctors to seek permission of jail authorities or the Magistrate to perform an abortion either (26).

Another fear amongst service providers relates to the offence of statutory rape under section 375 of the IPC, that does not view intention as relevant to determining criminal liability. The particular fear here is that penetration of the vagina, regardless of the absence of a guilty mind on the part of the provider, may leave the latter liable for criminal prosecution and punishment. However, the MTP Act provides sufficient guidance in such situations too. Section 8 of the MTP Act reads as under:

“No suit or other legal proceedings shall lie against any registered medical practitioner for any damage caused likely to be caused by anything which is in good faith done or intended to be done under this act.”

The good faith exception contained in the MTP Act saves medical practitioners from being sued or prosecuted under the IPC. The MTP Act, as a specific legislation, must be read harmoniously with the general IPC to conclude that bonafide acts done or intended to be done by medical professionals in the process of terminating a pregnancy will not attract criminal liability. To shed further light on the principle of ‘good faith’, reliance must be placed on the definition of ‘good faith’ under section 52 of the IPC and section 3(22) of the General Clauses Act 1897. The IPC suggests that an act is done without good faith if it is done “without due care and attention”. The General Clauses Act defines an act done in good faith to be one that is “in fact done honestly, whether it is done negligently or not”. In the case of *Smt. Vinitha Ashok v. Lakshmi Hospital & Others*, the Supreme Court of India absolved the doctor of any liability by holding that,

“A doctor is not guilty of negligence where she acts in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art.” (27)

Taken cumulatively then, as long as service providers act honestly and take due care and attention by following standard medical practice, they would not be held liable for any ensuing damage caused during termination.

## Unintended consequences of the inconsistencies

The legal inconsistencies identified above have serious consequences on girls’ access to legal and safe abortion. Girls in India may refrain from seeking a legal abortion because they want to avoid the laws’ mandatory reporting requirement, cannot obtain their guardian’s permission, or fear being prosecuted for criminal activity themselves. In addition, the serious criminal penalties associated with illegal abortion, and the ambiguous legal framework, may deter medical providers from providing abortion even in cases where it is legal.

### **For Women**

According to some estimates, half of all girls in India are sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15 (28). Thus, it is essential for minor girls to have access to safe abortion services. The current legal framework may impact such access in the following ways:

#### Unwillingness to approach healthcare providers because of the mandatory reporting requirement

Requiring medical providers to report minor girls seeking an abortion to the police, apart from violating their fundamental right to privacy (29), may drive some of the girls to seek treatment from unqualified practitioners. If the pregnancy was the result of consensual sex, then the girl will not want to report the matter to the police or see her partner arrested, charged, and possibly sentenced to a lengthy prison term.

Even if the pregnancy was the result of rape, the victim may not want to immediately report the case to the police—she might not feel safe, she may first need counseling, she might prefer to approach a more victim-friendly service (perhaps an NGO with expertise in this area).

Thus, minor girls may choose to go to unqualified practitioners who will not report. In fact, civil society has documented specific instances of such incidents (30). Doctors have also expressed concern that mandatory reporting will result in girls approaching quacks or resorting to other dangerous methods of abortion (31). Similarly, the World Health Organization has noted that “[t]he fear that confidentiality will not be maintained deters many women – particularly adolescents and unmarried women – from seeking safe, legal abortion services, and may drive them to clandestine, unsafe abortion providers,” and that rape victims should not be required “to press charges or to identify the rapist” in order to obtain an abortion (32). Reporting can also be done to the Child Welfare Committee instead of the police directly, which will be a far more sensitive body to deal with the case at hand.

#### Blanket guardian’s consent requirement unrealistic

Requiring all minor girls to obtain a guardian’s consent may be problematic—in some situations, it may not be practical or safe for a minor girl to obtain a guardian’s consent. For example, where the guardian or one of the guardian’s relatives has raped the girl, getting the guardian’s permission for an abortion may be impossible—allowing the girl to go for an abortion will trigger a police investigation, and the guardian will do everything possible to avoid that. In conservative areas, where premarital sex is highly taboo, a girl who admits to her parents or guardian that she is pregnant may be ostracized, subjected to violence, or even killed. Thus, some girls may seek MTP services from unqualified practitioners that will not require a guardian’s consent. In fact, the World Health Organization has noted that, “Adolescents may be deterred from going to needed health services if they think they will be required to get permission from their parents or guardians, which increases the likelihood of them going to clandestine abortion providers (33).”

#### Criminal Liability

Under the current law, a girl seeking an abortion could be criminally charged if she admits engaging in certain sexual activity. For example, if a minor girl seeking an abortion admits during the medical history that she performed oral sex on a minor boy, the doctor would be obligated to report this to the police because her actions constitute penetrative sexual assault under the POCSO Act (34). In such a case (and all cases where the offender is a minor), the POCSO Act states that the girl would be dealt with under the JJ Act (35).

Therefore, the current legal framework deters minor girls from seeking safe, legal abortion, and instead forces many to get unsafe, illegal abortions that lead to complications and even death.

### **For Healthcare Providers**

The lack of clarity in the current legal framework may deter doctors from providing abortions, even when it would be legal to do so. The European Court of Human Rights has noted this effect—"the risk of a doctor incurring criminal liability produce[s] a ‘chilling effect’ on doctors when they are deciding whether the requirements of legal abortion are met in a particular case.” (36) More specifically:

#### Fear of prosecution for non-reporting

The law is not clear about whether abortion providers should respect a minor girl’s confidentiality, as required by the MTP Act, or report the case to the police, as required under the POCSO Act and the CrPC. This leaves doctors to speculate at what the law requires. In fact, the confusion on this issue was featured in a recent issue of the Journal of Indian Medico Legal and Ethics Association (37).

The journal’s answer was that, under the current law, abortion providers must report cases involving minor girls to the police. The Madras High Court, in the case of *M. Kala v. Inspector of Police*, has confirmed that doctors are obligated under the POCSO Act to mandatorily inform the police when a minor requests an abortion (38). The confusion created by the current legal regime has led to some doctors being harassed by the police for not reporting abortions involving minor girls (39). It is clear that many doctors oppose mandatory reporting, at least for consensual sex—a 2014 news article noted that as many as 29,310 doctors belonging to the Federation of Obstetric and Gynecological Societies of India would be writing to MPs against mandatory reporting of consensual sex to the police (40).

#### Fear of prosecution for failure to obtain guardian’s consent

Performing an abortion on a minor without the consent of a guardian violates the MTP Act (41) as well as the POCSO Act. Medical providers, therefore, may decline to perform abortions on minors because they are afraid that, if they make a mistake, or the guardian later denies providing consent, they could be criminally prosecuted.

#### Other concerns arising from legal ambiguities

There are additional ambiguities in the legal framework for abortion that may further deter medical providers from performing abortion on minors. Medical providers may be afraid that they could mistakenly violate the law, and thereby subject themselves to serious criminal penalties. It is for this reason that many service providers unnecessarily send pregnant minors (and their parents), especially in cases of rape, to the court before performing an abortion. However, various High Courts have clarified that as long as consent requirements under the MTP Act are fulfilled, medical termination of pregnancy does not require judicial approval (42). These additional ambiguities will be discussed in the next section.

## Addressing Concerns

Anecdotal evidence suggests that many abortion providers are unclear about what the law requires of them, and hence may be unwilling to engage in legally ambiguous actions such as providing abortion services to minors. This section will attempt to answer common concerns regarding abortion for minor girls.

### ***Unclear if preservation of products of conception (PoC) is mandatory***

Under Section 201 of the IPC, it is a crime to cause “any evidence of the commission” of an offense to disappear with the intention of screening the offender from legal punishment. Since sex with a minor girl is a crime, this might be read to include the products of conception when a minor girl obtains an abortion. For example, a Professor of Forensic Medicine at a medical college noted in a recent textbook that, where a pregnancy is the result of rape and the woman has not lodged complaint with police, the doctor “*must* report the matter to police, *preserve the products of conception* and hand it over to police for DNA profiling.” (43) Broad language interpreting a doctor’s duty under IPC 201 would support this view. For example, the Indian Army’s guidelines on medicolegal issues, for example, states that “*Medico legal evidence should be preserved and subsequently sent or handed over to the investigating authorities for forensic examination . . . . All evidences will be identified, sealed and labeled properly . . . . Failure to collect, destruction or loss of such an exhibit is punishable under Sec 201 of I.P.C*.” (44) Similarly, Kerala’s Medico-Legal Code indicates that a “doctor is also bound to preserve *all the available material objects which may be of help* in the further investigation of the case.” (45)

However, guidance from the Ministry of Health indicates that doctors are not required to preserve the products of conception in all cases. The Ministry of Health guidelines previously mentioned state that if a sexual assault victim chooses to have an abortion, “[t]he products of conception (PoC) *may be* sent as evidence to the forensic lab (FSL) for establishing paternity / identifying the accused.” (46) The use of the words “may be” instead of “shall be” suggests that it is not mandatory in all cases.

### ***Medico-Legal Certificate preparation before provision of abortion service not mandatory***

Rule 5(3) of the POCSO Rules states that “*No medical practitioner, hospital or other medical facility centre rendering emergency medical care to a child shall demand any legal or magisterial requisition or other documentation as a pre-requisite to rendering such care*.” Emergency contraceptives are specifically listed as part of this emergency medical care (47). Furthermore, the Ministry of Health’s guidelines on medico-legal care for survivors of sexual violence state that they are intended to “ensure that all survivors of all forms of sexual violence . . . have *immediate access* to health care services that includes . . . emergency contraception . . . *and* *access to safe abortion services* . . . .” (48) Similarly, a recent textbook on forensic medicine states that, where a pregnancy is caused by rape and the woman has not lodged complaint with police, the “MTP can be done.” (49)

Similarly, in the context of mandatory reporting under the POCSO Act, the National Commission for the Protection of Child Rights (NCPCR) has written that that health professionals must “*unconditionally provide appropriate treatment with informed consent before doing anything else*” and must “perform their duty of providing medical care first, while reporting is a secondary duty.” (50) The previously mentioned Ministry of Health guidelines also make clear that “[p]roviding treatment and necessary medical investigations is the prime responsibility of the examining doctor” and that “[a]dmission, evidence collection or filing a police complaint is not mandatory for providing treatment.” (51) Nor is a police requisition required (52). The Ministry also declared that “police cannot interfere with the duties of a health professional.” (53)

T

he CrPC doesn’t discuss this directly, but it does state that hospitals must treat victims of sexual assault “immediately.” (54) Regardless, to the extent that the CrPC is inconsistent with the POCSO Act, the provisions of the POCSO Act control (55). In the case of *Bashir Khan v. State of Punjab and Another*, the High Court ordered “instructions [to be] given by the Director General of Police to all the police stations who register cases of rape and who come by information that the victim has become pregnant to render all assistance to secure appropriate medical opinions and also provide assistance for admission in government hospitals and render medical assistance as a measure of support to the traumatized victim.” (56) Here, the High Court clearly held that the State is not required to apply to a court before a minor rape victim can undergo an abortion.

### ***Procedure for reporting case to the appropriate authority***

The NCPCR has stated that a medico legal certificate made to the police is sufficient to comply with the reporting requirements under the POCSO Act (57). The doctor is not required to file an FIR—the POCSO Rules explicitly place the responsibility for filing an FIR on the officer who receives the information reported under the mandatory reporting requirement (58). As the Supreme Court stated in *Parmanand Katara* v*. Union of India*:

Whenever any medico-legal case attends the hospital, the medical officer on duty should inform the Duty Constable, name, age, sex of the patient and place and time of occurrence of the incident, and should start the required treatment of the patient. *It will be the duty of the Constable on duty to inform the concerned Police Station or higher police functionaries for further action*. (59)

After reporting the case to police, medical providers should take some form of written acknowledgement from the officer receiving the information (60).

Given that the minor will be considered a “child in need of care and protection” under the JJ Act, it would also suffice for the doctor to approach a Child Welfare Committee with the case, and then carry out the abortion following the directions of the District Child Protection Unit, in compliance with Rule 34(5) of the Juvenile Justice Rules. However, this does not mean that the doctor requires the consent of the Child Welfare Committee to carry out an abortion. The Committee is not a guardian of the minor, and prior permission of the Committee for termination of pregnancy is not contemplated as a requirement under the JJ Act.

### ***Guardian competent to consent on minor’s behalf***

“Guardian” is defined in the MTP Act as “a person having the care of the person of a minor.” (61) This raises the question of whether someone must be legally appointed to be a guardian for the purposes of the Act, or whether someone who does not have legal guardianship but is exercising practical control over the minor can also be a guardian. In this conflict, the MTP Act makes clear that it preempts other laws that would hold doctors liable in situations that it would not (62). Therefore, the definition of “guardian” in the MTP Act controls the definition in the JJ Act (as read into the POCSO Act), and a *de facto* guardian can consent to a termination of pregnancy for a minor girl.

In its 83rd Report, the Law Commission considered a similar issue under the Guardians and Wards Act, 1890. The Commission noted that “guardian” under the Guardian and Wards Act is defined to include persons “having the care of a minor,” which suggests that the term “guardian” includes *de facto* guardians (persons who, as a matter of fact, have custody and care of a minor) (63). The Commission recommended that the Guardians and Wards Act be amended to clarify that “a *de facto* guardian is included within the deﬁnition of ‘guardian.’” (64) The Commission also noted that the definition of “guardian” in the MTP Act is similar to the definition in the Guardian and Wards Act, 1890 (65). Thus, it is reasonable to conclude that a guardian under the MTP Act includes a *de facto* guardian as well and that legal guardianship is not required to give consent for an abortion.

However, the POCSO Act suggests a different result. Under the POCSO Act, a doctor can insert medical equipment into a minor’s vagina only if it is done with the consent of the child’s “parents or guardian.” (66) The POCSO Act does not define the term “guardian,” but it does state that, for undefined terms, we should look to the IPC, CrPC, JJ Act and Information Technology Act, 2000 (67). The only one of these that defines “guardian” is the JJ Act, which provides as follows:

“guardian” in relation to a child, means his natural guardian or any other person having, in the opinion of the Committee or, as the case may be, the Board, the actual charge of the child, and *recognised by the Committee or, as the case may be, the Board as a guardian in the course of proceedings*. (68)

Thus, under the POCSO Act, as interpreted by JJ Act, a person must be *legally recognized* before they can qualify as a child’s guardian. Under this definition, a person who has *de facto* care of a minor, but who has not been legally recognized as guardian, cannot consent to an abortion on behalf of a minor. A doctor who performed an abortion in such a situation could be criminally prosecuted under the POCSO Act. This conflicts with the MTP Act because, as explained earlier, under the MTP Act, a person does not need to be legally recognized to be a guardian—they can just have custody and care of a minor.

## Conclusion

This article examined the unintended consequences of the legal framework related to abortion in India, specifically in relation to abortion for minor girls. It addressed concerns regarding abortion for minor girls, for healthcare providers and the written permission requirement from the guardian. It also highlighted the implications for women and healthcare providers of the lack of clarity in the legal framework.

The article raises several issues for further discussion, including whether legislation should be amended to decriminalise consensual sex with a minor in certain cases (69), and whether the mandatory reporting of sexual offences to the police be abolished. On the one hand, mandatory reporting fails to recognize victims’ autonomy and drives minor girls to seek MTP services from unqualified practitioners who will not make a report. On the other hand, mandatory reporting may be useful to guard against rape victims being pressured to not file a criminal case against the perpetrator.

The article also highlights the need for clarity on various technicalities that create ambiguities in the law, thereby creating further obstacles to access safe abortion services for minor girls. These include the need to clearly define ‘guardian’ competent to consent on a minor’s behalf under the MTP Act, perhaps in the State JJ Rules, which are yet to be formulated. The relationship between the IPC and the MTP Act also needs to be clarified, with if need be, necessary amendments to the relevant sections of the IPC.

Other issues for debate include the need for guardian’s consent in all cases, and the need to create exceptions to the same, especially in cases where the guardian of the minor may not have the latter’s best interests as the paramount consideration. In the United States, for example, minors are allowed, in certain situations, to terminate a pregnancy without a guardian’s consent through a court procedure known as a “judicial bypass.” (70) Given that this process has also been criticized, the capacity of adolescents to consent to certain medical procedures to avail of sexual and reproductive health services must be considered. The “best interests of the child” standard promises to resolve many ambiguities within and between laws. Though contained in text of the JJ Act and the POCSO Act, the standard has of late come to a new light in judgments that have begun to methodically assess applications for undergoing abortion through the criteria of best interests.

While this article introduces this lens as a powerful and compassionate tool for future child rights advocacy in the case of access to abortion services, it also acknowledges that these continue to be important issues to be discussed and addressed and resolved, and it is hoped that there will be momentum to do so in the near future.

## References

1. World Bank [Internet]. Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births). Geneva; 2015. Available from: <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=IN>
2. Trends in maternal mortality: 1990 to 2015. Geneva: World Health Organization; 2015. 92 p. Available from: <https://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf;jsessionid=1B502CD6A8CBDC3EB978AF29AF52994D?sequence=1>
3. Stillman M, Frost JJ, Singh S, Moore AM, Kalyawala S. Abortion in India: A Literature Review. New York: Guttmacher Institute (US); 2014 Dec. 48 p.
4. Menon M. Unsafe abortions killing a woman every two hours. The Hindu [Internet]. 2013 May 6. Available from: <https://www.thehindu.com/news/national/unsafe-abortions-killing-a-woman-every-two-hours/article4686897.ece>
5. Ms X v. Union of India. WP(C)593 of 2016 (Supreme Court of India); Mamta Verma v. Union of India Writ Petition(C) 2250 of 2017 (Supreme Court of India).
6. Kashyap A, Menon P. Demystifying the Best Interests Principle in India. CRY; 2007. 37 p. Available from: <https://www.cry.org/resources/pdf/NCRRF/Aruna_&_Pratibha_2007_Report.pdf>
7. Suchitra Srivastava & Another v. Chandigarh Administration. SLP(C) 5845/2009 (Supreme Court of India).
8. Protection of Children from Sexual Offences (POCSO) Act of 2012, Sect. 2(1)(d).

1. The concept of ‘evolving capacities,’ recognised under Article 5 of the United Nations Convention on the Rights of the Child, suggests that children’s competencies grow with age, which allows them to take greater responsibility for actions affecting their lives.
2. Indian Penal Code (IPC) of 1860, Sect. 375.
3. Juvenile Justice (Care and Protection of Children) Act of 2015, Sect. 2(14)(viii).
4. Medical Termination of Pregnancy (MTP) Regulations of 2003, Sect. 5(1).
5. MTP Regulations of 2003, Sect. 5(3), 6.
6. POCSO Act of 2012, Sect. 19(1), (6) read with Sect. 21.

1. POCSO Act of 2012, Sect, 2(d), 3(a).
2. POCSO Act of 2012, Sect. 19(1), 21(1).
3. Code of Criminal Procedure of 1974, Sect. 357C; IPC of 1860, Sect. 376.
4. IPC of 1860, Sect. 375.
5. IPC of 1860, Sect. 166B (as amended 2013).
6. Medical Termination of Pregnancy (MTP) Act of 1971, Sect. 3(1) (“Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.”).
7. Samira Kohli v. Prabha Manchanda. Appeal (C) 1949 of 2004 (Supreme Court of India).
8. MTP Act of 1971, Sect. 3(4)(a). The term ‘guardian’ is not defined in the POCSO Act. A minor seeking an abortion is considered a child in need of care and protection under the Juvenile Justice Act. As per this Act, a ‘guardian’ includes the natural guardian of the child, as well as any person who has the actual charge of the child. One may look to the personal laws to determine who a child’s natural guardian is – mother, father, or husband, in most cases. In the ordinary course of things, a shelter home may not be said to be the guardian of the child unless it has the physical charge of the child, and the child is unwanted within the definition of the Act.
9. IPC of 1860, Sect. 375(b) (as amended 2013).
10. IPC of 1860, Sect. 375 (as amended 2013).
11. Guidelines & Protocols: Medico-Legal Care for Survivors/Victims of Sexual Violence. New Delhi: Ministry of Health and Family Welfare; 2014 Mar 19. 100 p. Available from: <https://mohfw.gov.in/sites/default/files/953522324.pdf>; POCSO Rules, 5(4)(iv).
12. Halo Bi v. State of Madhya Pradesh & Ors. WP(C) 7032/2012. High Court of Madhya Pradesh (Indore Bench).
13. Smt. Vinitha Ashok v. Lakshmi Hospital & Others. Appeal (C) 2977/1992. (Supreme Court of India).
14. Kumar R, Kumar M. Teenage Girls Health Development: Nutrition, Mental and Physical Growth. Deep and Deep Publications; 2009. 456 p.; Gupta MK, Mishra CP, Prabha C. Perception Regarding Sexuality among Adolescent Girls: A Community Based Study from Rural India. Indian J Prev Soc Med. 2013;44(1-2):64-73.
15. Justice Puttuswamy v. Union of India, Writ Petition (Civil) No. 494 OF 2012. (Supreme Court of India)
16. Network of Lawyers (NOL). 1st Training Programme Report. New Delhi: Lawyers Collective. 2014. 21 p. Available from: [www.lawyerscollective.org/wp-content/uploads/2008/08/NOL\_TRAINING\_REPORT\_1.pdf](http://www.lawyerscollective.org/wp-content/uploads/2008/08/NOL_TRAINING_REPORT_1.pdf).
17. Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act, 2012; 2014 Aug 8-9; Mumbai, India. Available from: <http://esocialsciences.org/Download/Download.aspx?qs=sO61F/RYd+YqfWs04so3Md7C167rWaW5plNQ5lJXErDs1rLlJND5icKvEAnX2oubrR6CQnplQwl1pwLrG1JLIJLJIblg3F9QbbmPnMxNx4hUMd7cDYnjK1Cz+cbjBe0lgL6ZQDhf1UriEKOnedp5hQ>== .
18. World Health Organization. Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd ed. Geneva; 2012. 132 p at 68.
19. World Health Organization at 68.
20. POCSO Act of 2012, Sect. 3(b), (d), 19(1).
21. POCSO Act of 2012, Sect. 34(1).
22. RR v Poland. No. 27617/04. 2011. (European Court of Human Rights)
23. Readers Ask, Experts Answer. J Indian Med Leg Ethics Assoc. 2015;3(2):55.
24. M. Kala v. The Inspector of Police. WP 8750/2015. (Madras High Court).
25. Training Manual on Protection of Children from Sexual Offences (POCSO) Act & Rules 2012 for District Child Protection Officers (DCPOs) of District Child Protection Units (DCPUs). New Delhi: National Institute of Public Cooperation and Child Development; 2015. 212 p. Available from: <http://nipccd.nic.in/reports/posco/dcp.pdf>.
26. Porecha M. Doctor’s Dilemma: Minor's Sexual Ailment. DNA India [Internet]. 2014 Oct 22. Available from: [www.dnaindia.com/mumbai/report-doctor-s-dilemma-minor-s-sexual-ailment-2028280](http://www.dnaindia.com/mumbai/report-doctor-s-dilemma-minor-s-sexual-ailment-2028280).
27. Given that MTP Act provides exceptions to the IPC provisions on abortion, an act falling outside of the purview of the former may be said to punishable under the latter.
28. For e.g. High Court of Punjab and Haryana, Kamla Devi v. State of Haryana & Others, 9 February 2015 (WP(C) 2007/2015); High Court of Gujarat, Janak Ramsang Hanzariya v. State of Gujarat, 7 May 2010 (Crim. App. 702/2010); High Court of Punjab and Haryana, Vijender v. State of Haryana & Others, 7 October 2014 (WP(C) 20783/2014) (“A rape victim shall not be further traumatized by putting through a needless process of approaching courts for taking permission. The Medical Termination of Pregnancy Act does not contemplate such a procedure at all and the medical personnel before whom the person shows up is bound to respond to an information regarding the complaint of rape...the medical personnel will take the decision regarding the termination and carry out the procedure.”)
29. Aggrawal A. Essentials of Forensic Medicine and Toxicology. Avichal Publishing Company; 2014.
30. Medicolegal Issues: Guidelines to Medical Officers. New Delhi: National Health Systems Resource Centre. Available from: <http://qi.nhsrcindia.org/sites/default/files/medico_legal.pdf>.
31. Kerala Medico-legal Code. Directorate of Health Services, Kerala. Available from: <http://dhs.kerala.gov.in/docs/orders/code.pdf>.
32. Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act (n 31)
33. POCSO Rule 5(4)(iv).
34. Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act (n 31) at 5.
35. Aggrawal (n 43) at 466.
36. Lawyer’s Collective Women’s Rights Initiative, UNICEF. Monitoring Guidelines for NCPCR/SCPCR for Roles and Functions of Various Stakeholders. New Delhi: National Commission for Protection of Child Rights; 2014. 61 p.
37. Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act (n 31), at 20.
38. Ibid at 24 (“If a person has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age). A police requisition is not required for this.”).
39. Ibid at 41.
40. Code of Criminal Procedure of 1974, Sect. 357C.
41. POCSO Act of 2012, Sect. 42A.
42. Bashir Khan v. State of Punjab & Another. WP(C) 14058/2014. High Court of Punjab and Haryana.
43. Monitoring Guidelines for NCPCR/SCPCR for Roles and Functions of Various Stakeholders (n 50).
44. POCSO Rule 4(2)(a).
45. Parmanand Katara v. Union of India & Ors. 1989 AIR 2039. Supreme Court of India.
46. Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act (n 31), at 34 (“After the examination the medical practitioner should document the report, formulate opinion, sign the report and handover the report and sealed samples to police under due acknowledgement.”);   
    Health Department Haryana. Haryana Medico Legal Manual. 2012. http://gurgaon.haryanapolice.gov.in/writereaddata/Images/pdf/Haryana\_Medicol\_egal\_Manual\_2012.pdf. (“Whenever a suspected medico legal case is brought in the emergency, it shall be the duty of the Medical Officer on duty to send information to the police station/post of the area, in Form I in triplicate. Information shall be sent to the police by the quickest possible means. Acknowledgement from the police officer receiving the information will be kept in the file of the patient and in other OPD cases it shall be pasted in the OPD register or with the Medical Officer for further reference.”); Kerala Medico-Legal Code 2011, at 24, http://dhs.kerala.gov.in/docs/orders/code.pdf (“Intimation should be written in duplicate. The original should be issued to the police and the receipt of the same may be acknowledged on the office copy by the Officer receiving the same”).
47. MTP Act of 1971, Sect. 2(a).
48. Ibid at Sect. 3(1).
49. Eighty-Third Report on the Guardians and Wards Act, 1890 and Certain Provisions of the Hindu Minority and Guardianship Act, 1956. Law Commission of India; 1980. Sect. 4.10, 4.13.
50. Ibid at Sect. 4.13.
51. Ibid at Sect. 4.14.
52. POCSO Act of 2012, Sect. 41.
53. Ibid at Sect. 2(2).
54. Juvenile Justice (Care and Protection of Children) Act of 2000, Sect. 2(31)
55. Children/Child Labor - 2011. New Delhi: Indian Social Institute; 2011:14-15. Available from: [www.isidelhi.org.in/hrnews/HR\_THEMATIC\_ISSUES/Children/Children-2011.pdf](http://www.isidelhi.org.in/hrnews/HR_THEMATIC_ISSUES/Children/Children-2011.pdf).
56. Planned Parenthood of the Rocky Mountain [Internet]. 2016. Available from: <https://www.plannedparenthood.org/planned-parenthood-rocky-mountains/planned-parenthood-parental-notification/judicial-bypass>.