

Conflicting abortion laws in India: Unintended barriers to safe abortion for adolescent girls

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Abstract

This article examines the laws related to abortion in India, demonstrating how conflicting laws create unintended barriers to safe abortion for adolescent girls. It focuses specifically on the situation of adolescent girls seeking abortion, showcasing the unintended consequences that arise from the existing lack of clarity in the legal regime. The article also discusses the recommendations of the Committee on the Rights of the Child and the United Nations Convention on the Rights of the Child.

Introduction

Adolescence is generally understood as the transitional phase of development between childhood and adulthood, often considered to begin at puberty. This article uses the term “adolescent” to refer to persons between the ages of 14 to 18¹. Sexuality is an important and normative development during adolescence, as recognised by the Committee on the Rights of the Child (CRC Committee) which calls on States to “balance protection and evolving capacities” when determining the minimum legal age for sexual consent (1). The CRC Committee states that “States should avoid criminalizing adolescents of similar ages for factually consensual and nonexploitative sexual activity.” (1: para 40). It is important to respect and positively affirm the sexual awareness of adolescents and their capacity to engage in sexual activity (2). The need to protect adolescents from predatory adults must be balanced with the need to recognise and validate their sexual desires (2: p 8). It is also now widely accepted that assessing healthcare needs for adolescents requires an understanding of the constantly developing levels of autonomy and capacities to consent (3, 4). This concept of “evolving capacities” is also recognised under Article 5 of the UN Convention on the Rights of the Child.

Criminalising the right of adolescents to engage in consensual sexual activity has negative repercussions on their sexual and reproductive health, and undermines their right to bodily autonomy, privacy and choice. This prevents resources and information on sexual health from reaching adolescents engaging in sexual conduct. Instead, policies are needed to inform and educate adolescents on how to make safe and healthy sexual decisions. Adult framing of adolescents and children disavows their right to sexual agency, sexual actions, or even to express sexual desire (5). Such failure to respect the adolescent sexual self can contribute to disempowerment of such persons (6). Due to their limited social capital, adolescents have been a historically and legally muted group. Convictions of adolescents for consensual sex can have wide spread consequences for the adolescent’s life, even, at times, labelling them as sex offenders. States should follow the “best interests” approach which holds that it is a substantive right for adolescents to have their best interests as the primary consideration in decision-making, with appropriate weight given to their views on all matters that concern them, including sexuality (1, 7).

As it exists today, India’s legal framework provides conflicting guidance to medical providers, fails to adequately protect confidentiality, requires parental/guardian consent (with no exceptions), treats all pregnant adolescents as rape victims or victims of aggravated penetrative sexual assault², and mandates involvement of the criminal justice system. These problematic laws, together with abortion-related stigma and conservative views on pre-marital sex, force many adolescent 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 results in unnecessary complications including death, in addition to aggravated financial burdens and mental health consequences.

This article will review the legal framework relating to abortion in India, explain how conflicting laws negatively impact the health of adolescent girls, show how such laws criminalise adolescent sexuality, and highlight two major issues that deserve further consideration and discussion: mandatory reporting under POCSO and the requirement of a guardian’s consent for abortion. While there are several other legislations that are in conflict, the scope of this paper is limited to a few important legislations.

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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, (8) criminalised all forms of abortion except to save the life of the pregnant woman. These laws are discussed briefly in turn, below.

The Medical Termination of Pregnancy Act, 1971

The Medical Termination of Pregnancy (MTP) Act (9) 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 Regulations, 2003 (10) – framed under the MTP Act, a subordinate legislation and hence binding – contain strict confidentiality provisions such as the maintenance of a secret register with details of the patients; these details are not to be given out to any person, according to Sections 5 and 6 of the Regulations.

The MTP Act allows women to obtain abortions up to twenty weeks if continuing the pregnancy would involve a risk of grave injury to the women's physical or mental health or there is a substantial risk of foetal "abnormalities". However, there are a few qualifications to this provision.

The first explanation to section 3(2) (b) states that where the pregnancy is alleged to have been caused by rape, then "the anguish caused by such pregnancy" is presumed to constitute a grave injury to mental health. The second explanation states that if the pregnancy is a result of the failure of any contraceptive method or device used by a *married* woman, the anguish caused by this pregnancy is presumed to constitute grave injury. In addition, section 3(4)(a) of the Act states that if a woman has not attained the age of eighteen years, her pregnancy cannot be terminated without the consent, in writing, of her guardian.

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 been read liberally by courts and may be said to include the pregnant woman's mental health (11, 12). The MTP Regulations, 2003 set forth the conditions and procedures for implementing the Act.

The Protection of Children from Sexual Offences Act, 2012

The Protection of Children from Sexual Offences (POCSO) Act, 2012 (13) is specifically aimed at protecting children³ ie persons below the age of 18 years, from offences of sexual assault, sexual harassment and pornography. It assumes and treats all pregnant adolescent girls as rape survivors and mandates that anyone having knowledge of the commission of a sexual offence against a child, which includes healthcare providers, report the abuse. This obligation to report contradicts the confidentiality and privacy protections under

Section 4 of the MTP Regulations. The mandatory reporting requirement can act as a deterrent for adolescent girls from accessing safe abortion services (14) in situations where the pregnancy resulted from consensual marital or non-marital sex, as well as non-consensual situations where the perpetrator is a family member. The Code of Criminal Procedure (CrPC) (15) has a similar reporting requirement for hospitals regarding sexual offenses under the Indian Penal Code (IPC). These legislations are framed such that any consensual adolescent sex is criminalised. When their sexuality itself is criminalised, adolescents are less likely to seek out qualified healthcare providers for their reproductive health needs and the law becomes a barrier to abortion access.

The Juvenile Justice Act, 2015

The Juvenile Justice Act (JJ Act) (16) was enacted to provide basic needs through proper care, protection, development, treatment, and social re-integration to children in conflict with the law and children in need of care and protection, by adopting a child-friendly approach that secures the best interests of the child. Although it does not contain any provisions on termination of pregnancy, the Act is meant for the care of all "children" and, as such, must be taken into account when discussing barriers to safe abortion access for adolescent girls.

Article 3.1 of the UN Convention on the Rights of the Child (CRC) (3) 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 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 an assessment (17). The UNCRC has further urged states to review their legislation in order to protect the "best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions." It has also called on states to ensure that "girls can make autonomous and informed decisions on their reproductive health". In addition, the CRC Committee has urged States to take measures that ensure adolescents have access to confidential sexual and reproductive health information and services, including legal abortions for adolescent girls (7).

Incorporating such principles in an assessment of the best interests of pregnant adolescents 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 v. Chandigarh Administration* was the first to uphold the reproductive autonomy of women by relying on the "best interests" standard (18). The Supreme Court held that the process of ascertaining which course of action would serve the best interests of the survivor must be decided by giving due consideration to "medical opinion on the feasibility of the pregnancy as well as social circumstances

faced by the victim". The Court further stated that it is to be guided by the interests of the survivor alone, and not those of other stakeholders, such as the guardian or societal norms (18: para 19). It is this lens that informs the structural and ideological framework of the article, and without which compassionate debate on access to abortion services for pregnant adolescents 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 adolescent girls from sexual abuse, while others were intended to facilitate access to abortion for women that qualify. However, in certain circumstances, adolescents who undergo abortions can fall under both sets of laws, and this leads to inconsistencies and conflicts. For instance, the POCSO Act brands all persons under eighteen as children in need of protection (13), irrespective of age and evolving capacities (7), and states that any sexual contact involving a child 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 (8). As such, an adolescent girl seeking an abortion would be presumed to be a survivor of rape or penetrative sexual assault, and the healthcare provider would be obligated to report this to the police (16). Further, notable inconsistencies are also evident in cases of confidentiality and lack of clarity on when a doctor can perform abortions on adolescents without facing criminal sanctions. These will be discussed in the sections below.

Confidentiality and mandatory reporting

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 (10), 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 (10: Sec. 5(3)).

However, the POCSO Act conflicts with this confidentiality—it requires anyone who knows that a sexual offense has been committed to report it to the police or the Special Juvenile Police Unit, who in turn must report it to the Child Welfare Committee and the Special Court (or Court of Session) within 24 hours (13: Sec. 19(1), 19(6), 21). Under the POCSO Act, having sex with an adolescent girl is a crime, even if it is consensual; the law does not recognise an adolescent's capacity to consent to sexual acts and, so, precludes the possibility of consensual sex between persons below the age of 18 (13: Sec. 2d, 3a). Therefore, if a pregnant adolescent girl approaches a doctor seeking an abortion, the doctor must report the girl to the police as a survivor of sexual assault, even if this goes against her wishes. Anyone who knowingly fails to make this report can be punished with up to six months in prison (13: Sec 19(1), 21(1)). The same issues arise under the CrPC, which requires all hospitals to immediately report incidents of rape to the police (15).

This provision of mandatory reporting is tremendously problematic. Although the rationale is to ensure that there is no immunity in child sexual abuse offences, the requirement may actually discourage people from reporting, especially if the abuser is a family member (19). Studies conducted on the working of POCSO Special Courts in several states show that where the perpetrator is a family member or partner, adolescent girls often turned hostile while testifying (20). In its 2011 report on the POCSO Bill, the Parliamentary Standing Committee had also recommended that reporting be optional, as making it mandatory could be counterproductive (21: para 10.2). Adolescent girls who seek out contraceptive or other reproductive health services may be reluctant to do so out of fear that doctors will report them, and that criminal action may be taken against their partners.

Criminal sanction for healthcare providers

Healthcare professionals are fearful that the wide definition of sexual intercourse under the amended Section 375 of the IPC and the POCSO Act may inadvertently label abortion procedures as rape and attract criminal liability, as Section 375 of the IPC, which provides definitions for rape, prohibits inserting any object into a child's vagina with or without her consent (8: Sec. 375b).

However, Exception 1 to Section 375 states that medical procedures are excluded from the definition of rape. Similarly, Section 41 of the POCSO Act provides an exemption for medical interventions, if done with a guardian's consent. Finally, Section 3(1) the MTP Act shields medical providers from criminal liability, as long as the pregnancy is terminated in accordance with the Act (9).

There is some legal ambiguity as to whether consent can be obtained from a *de facto* guardian or only from a legally recognised guardian. The authority on this is the JJ Act, which overrides all other laws where children are concerned. The requirement of guardian's consent is discussed in more detail later. As explained here, medical providers are shielded from criminal liability if they carry out procedures in accordance with the laws. Nevertheless, the requirements of mandatory reporting under POCSO Act and the need to obtain guardian's consent have resulted in a "chilling effect", wherein providers are hesitant to offer abortion services to adolescent girls.

Unintended consequences of the inconsistencies

The legal inconsistencies identified above have serious consequences on the adolescent's access to legal and safe abortion. Girls in India may refrain from seeking a legal abortion, or resort to unsafe abortions, in order to avoid the laws' mandatory reporting requirement, or if they cannot obtain their guardian's permission. 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 adolescents

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 fifteen (22, 23). Thus, it is essential for adolescent girls to have access to safe abortion services, information and counselling. 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 adolescent girls seeking an abortion to the police, apart from violating their fundamental right to privacy (24), may drive some girls to seek treatment from unqualified practitioners. If the pregnancy was the result of consensual sex, the girl will not want to report the matter to the police for fear of seeing her partner arrested, charged, and possibly sentenced to a lengthy prison term. This leads to criminalisation of adolescent sexuality.

Even if the pregnancy was the result of rape, the survivor may not want to immediately report the case to the police—she might not feel safe, she may first need counselling, and she might prefer to approach a more survivor-friendly service (perhaps a non-governmental organisation (NGO) with expertise in this area). Thus, adolescent girls may choose to go to unqualified practitioners who will not report. In fact, civil society has documentation of specific instances of such incidents (25). Doctors have also expressed concern that mandatory reporting will result in girls approaching quacks or resorting to other dangerous methods of abortion (26). 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 survivors should not be required “to press charges or to identify the rapist” in order to obtain an abortion (27).

Due to pervasive stigma around both abortion and sexual intercourse outside marriage, adolescent girls already face significant barriers in their ability to exercise reproductive autonomy. Mandatory reporting by healthcare providers further impairs their access to abortion. Not only do these provisions essentially penalise consensual sex by rendering adolescent girls completely incapable of consent, they also force healthcare providers to choose between their duty to provide quality care to their patients and their obligation to report. Moreover, the provisions are detrimental to survivors of child sexual abuse, who may be hesitant to seek healthcare services if the abuser is a close relation. Without the guarantee of confidentiality, many pregnant adolescent girls choose to forego medical attention from qualified practitioners and instead seek out risky procedures which can pose serious dangers to their health.

Blanket requirement for guardian's consent unrealistic

Requiring all adolescent girls to obtain a guardian's consent may also be problematic—in some situations, it may not be practical or safe for an adolescent 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 ostracised, subjected to violence, or even killed. Thus, some girls may seek MTP services from unqualified practitioners who 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.” (27: p 68)

As recommended by the CRC Committee to India, the State must take measures to ensure that adolescents have access to confidential sexual and reproductive health information and services. This includes emergency contraception as well as abortions (7). Requiring abortion providers to get the consent of a guardian in every instance of an adolescent girl seeking abortion would thus be a breach of confidentiality and deter girls from approaching qualified providers.

At this point, it may also be useful to address a common misperception about the role of the Child Welfare Committees (CWCs) established under the JJ Act. According to section 29 of the Act, CWCs are empowered with the authority to dispose of any cases for the “care, protection, treatment, development and rehabilitation of children in need of care and protection.” Given these wide powers, many people, including service providers and CWC members, believe that it is imperative for medical practitioners to receive permission from the CWC before terminating a pregnancy (28). However, Section 30 of the JJ Act, which defines the responsibilities of the CWC, makes no mention of the power to give consent and/or permission for an adolescent rape survivor to terminate her pregnancy. The role of the CWC is limited to recognising a guardian for a child survivor, and to assign a support person. If adolescents were compelled to seek CWC permission before getting abortions, it would invariably delay their access to reproductive healthcare.

Violation of reproductive autonomy

The criminalisation of consensual sex, even between two adolescents, is a violation of their rights to sexual and reproductive autonomy. The POCSO Act makes it an offence to engage in any sexual activity with a “child” who is under the age of 18; children themselves are not exempt from these regulations. Some data suggests that many rape cases registered against children in conflict with the law are “teenage romances” but the law is unable to make a distinction between consensual adolescent sex and rape (29). Where pregnancy occurs as a result of consensual sex between two adolescents, criminalisation acts as a deterrent against adolescent girls seeking abortion services. Adolescents must have the right to autonomous decision-making, in line with evolving capacities, as recognised under international law (30).

The belief that young people *i.e.* adolescents are incapable of making decisions about their sexual and reproductive health is misguided. The UN Convention on the Rights of the Child (UNCRC) understands that children are “active subjects, rather than simply passive objects of state or parental authority” (3: Art 12). Article 12(1) of the UNCRC explicitly states that due weight should be given to the child’s views in accordance with their age and maturity.

The CRC Committee recognises the importance of valuing adolescence and shifting from problem-focused interventions to building an environment that guarantees the rights of adolescents and supports their holistic development (1). A range of factors including the potential for exploitation and respect for evolving capacities need to be considered in order to enable adolescents to exercise their agency. For adolescent girls specifically, the Committee notes that a lack of access to sexual and reproductive health services contributes to this group being most at risk for “dying or suffering serious or lifelong injuries in pregnancy and childbirth”. In particular, there should be no requirement for third-party consent or authorisation in delivering information or services related to reproductive healthcare to adolescent girls.

Thus, adolescent girls need to be seen as capable of informed decision-making, especially in regard to their own health. States should ensure that the best interests of adolescents are of primary concern in any legal process they undertake. The right to reproductive healthcare including the right to abortion is a basic human right, and the inability of adolescent girls to exercise this right freely is indeed, an urgent concern.

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 (31).” More specifically:

Fear of prosecution for non-reporting

The MTP Act requires abortion providers to maintain strict confidentiality. However, where adolescents are concerned, the POCSO Act overrides this and Section 19(1) places an obligation upon the provider to report this to the relevant authorities⁴. The Madras High Court, in the case of *M. Kala v Inspector of Police*, confirmed that doctors are obligated under the POCSO Act to mandatorily inform the police when an adolescent girl requests an abortion (32).

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 Gynaecological Societies of India would be writing to MPs against mandatory reporting of consensual sex to the police (33). As it stands, however, the law is clear that not

reporting would carry a penalty of six months’ imprisonment. This has deterred many abortion providers from offering their services to adolescent girls.

Fear of prosecution for failure to obtain guardian’s consent

Performing an abortion on a child without the consent of a guardian violates the MTP Act as well as the POCSO Act. Furthermore, since the MTP Act provides exceptions to the IPC provisions on abortion, any act falling outside the purview of the former may be said to be punishable under the latter. Medical providers, therefore, may decline to perform abortions on adolescent girls 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 abortions on adolescents. Medical providers may fear 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 adolescents (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 approval⁵. 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 adolescents. This section will attempt to answer common concerns regarding abortion for adolescent girls.

Preparation of medico-legal certificate before abortion 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 prerequisite to rendering such care” (34). Furthermore, the MoHFW 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* . . .” (35: p 5). The 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 (35: p 20).” Nor is a police requisition needed (35: p 24).

Furthermore, the CrPC clearly states that hospitals and doctors must provide survivors of sexual assault with treatment “immediately”; and free of cost (15: Sec. 375C), and *thereafter* immediately inform the police (19).

In the case of *Parmanand Katara v. Union of India* (36) the Supreme Court observed that the Code of Medical Ethics – drafted by the Medical Council of India (MCI) – is the prevailing law for the medical profession. An affidavit filed by the Secretary of the MCI in that case specifically noted that the formalities of the CrPC should not come in the way of providing medical care. Additionally, in the case of *Bashir Khan v. State of Punjab and Another*, the Punjab and Haryana 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 survivor 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 traumatised victim” (37).

Accordingly, it is clear that healthcare professionals are not required to apply to a court or any other legal authority before an adolescent rape survivor 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 (38). The doctor is not required to file an FIR—the POCSO Rules explicitly place the responsibility for filing an FIR on the police officer who receives the information reported under the mandatory reporting requirement (34: Rule 4(2)(a)). As the Supreme Court stated in *Parmanand Katara*:

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 (36).

Given that an adolescent girl *may* be considered a “child in need of care and protection” under the JJ Act, there is an outstanding question of who can act as a guardian and whether the permission of the Child Welfare Committee is required before carrying out an abortion. This is addressed in the section below.

Guardian competent to consent on adolescent's behalf

“Guardian” is defined in the MTP Act as “a person having the care of the person of a minor (9: Sec. 2a)” 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 adolescent can also be legally considered a guardian.

The POCSO Act does not define the term “guardian,” and states that, for undefined terms, we should look to the IPC, CrPC, JJ Act and Information Technology Act (13: Sec. 2(2)). Of these, the JJ Act is the only statute that defines “guardian” and provides as follows (16: Sec. 2):

“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.

The confusion arises primarily when a child does not have a natural guardian who can provide consent. Rule 4(3) of the POCSO Rules lists the circumstances in which a child may be considered in need of care and protection: if the offence has been committed or attempted or is likely to be committed by a person living in the same or shared household with the child; if child is living in a child care institution and is without parental support if the child is found to be without any home and parental support. In these circumstances, the CWC may designate the Superintendent of the institution as the guardian. This guardian would then be competent to consent to an abortion for the adolescent girl.

Nevertheless, fear of prosecution results in doctors turning away adolescent girls seeking abortion services or urging the girls and their families to approach the court and get permission in order to terminate their pregnancies. The legal framework in the MTP Act is clear that abortions are legal up to 20 weeks and no court order is required. Compelling adolescent girls to obtain judicial authorisation inevitably creates significant barriers in access to safe abortion for adolescents.

Conclusion

In sum, the conflicting laws of India's legal framework on abortion creates nearly impossible barriers to adolescent access to abortion services. Doctors are fearful of harsh penalties for violating the law, either by performing an unlawful abortion or failing to report the procedure as evidence of child abuse. Adolescent pregnant girls are afraid to even seek out medically safe abortions for fear that their partners will be reported as rapists, or that confidentiality will not be respected, and they will be in danger from their families. The human rights of adolescent girls are truly in jeopardy, as are their lives. The rate of maternal mortality in India is significant; thanks, in large part, to the use of medically unsafe and unlicensed abortions. These unintended consequences violate the adolescents' right to health (protected by the Indian Constitution as well as international law) and are untenable.

The ambiguities created by the conflict amongst India's laws, including the MTP Act and the POCSO Act, in totality, not only create barriers to a necessary healthcare service (ie, abortion) but also criminalise adolescent consensual sexual activity.

If all adolescent abortions are seen as evidence of child sexual assault, all partners to such pregnancies, as well as the pregnant girls themselves, are denied the right to consent to sexual activity; they are either child-victims (pregnant adolescent girls) or rapists (their partners). This legal regime fails to distinguish between consent and non-consent, thus, disincentivising the need for consent in adolescent sexual relations; a consequence which, assuredly, no legislator should support. The need for streamlined, understandable and holistic laws on adolescent access to abortion is sorely needed in order to protect the right to health of pregnant adolescent girls and to save the lives of girls currently forced to seek unsafe abortions from unlicensed medical professionals. Furthermore, a more approachable and comprehensible system would allow medical professionals to do their jobs safely and assuredly within the confines of the law; thereby, increasing access to safe and licensed abortion services within India.

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Notes

- 1 The Child and Adolescent Labour (Prohibition and Regulation) Act, 1986 (amended in 2016) defines 'adolescent' under Section 2(i) as "a person who has completed his fourteenth year of age but has not completed his eighteenth year"
- 2 The term 'aggravated penetrative sexual assault' is used instead of rape in the Protection of Children from Sexual Offences (POCSO) Act of 2012.
- 3 The term child is used in place of adolescent wherever legislations and case laws are being discussed. Child refers to all persons below the legal age of majority i.e. 18 years.
- 4 Section 19(1) reads as follows: "Notwithstanding anything contained in the Code of Criminal Procedure, 1973, any person (including the child), who has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed, he shall provide such information to:
 - a. the Special Juvenile Police Unit, or
 - b. the local police.
 The Supreme Court in the Dr. Sr. Tessa Jose v. State of Kerala case (38) has clarified the meaning of "knowledge" as used in Section 19. The Court stated that:

"knowledge" which means that some information received by such a person gives him/her knowledge about the commission of the crime. There is no obligation on this person to investigate and gather knowledge.
- 5 See 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.").

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