

Abortion laws in India

(By Shallu Jaglan)

The foetus has its own unique DNA, it has a life of its own, and aborting it, is a murder'- this was how a viewer commented on an abortion debate video, featured on YouTube. More striking is the fact that not many people disagreed, rather they spoke in the same tone. What these views reflect is the ethical dilemma that lies ahead of any legislative action about the question of abortion. It was, somewhere on similar ethical grounds that abortion was prohibited before 1971 in India. Section 312 of the Indian Penal Code, 1860 described it as intentionally 'causing miscarriage' and made it a punishable offence. In the 1960s, amid rising maternal mortality rates owing to unsafe abortions, the Government of India decided to set up a committee under Shantilal Shah for reviewing the abortion aspects in the country. The committee recommended the Government legalise abortion and also provide safe abortion facilities. These were accepted in 1970 and were introduced and passed from the parliament in the following year i.e., 1971. The Act was called the 'Medical Termination of Pregnancy Act 1971' or more popularly- MTP.

MTP 1971- the act allows women to terminate pregnancy till 20 weeks of the gestation period, but not without any of the following conditions-

1. When the continuation of the pregnancy is a risk to the life of the woman
2. When the foetus is at the risk of substantial physical and mental illness once born
3. When the pregnancy is caused by rape
4. When pregnancy is caused by the failure of contraception used by the 'married' woman or her 'husband'.

The act mandates that for the termination of up to 12 weeks, the opinion of a single registered medical practitioner (RMP) is required, if termination extends beyond 12 to 20 weeks, then the opinion required is of two RMPs. Regarding the issue of consent, as per the provisions – only the consent of the pregnant women is sought whereas, in the case of a minor or a mentally ill person, the guardians get the say. A cursory glance at the act may not hint at any major issue with it, but a critical review will bring its several provisions into question. It is crucial at this point to look at the recent amendments and proposed amendments. The very first came in 2002, this amendment primarily sought to expand the provider base, i.e. the facilities providing safe abortion services. As per it, the private hospitals are authorised to offer MTP services, once approved by their respective District Committees. Another crucial breakthrough was the language change, the original act uses the word 'lunatic' which this amendment replaces with 'mentally ill person'- hinting at someone who requires treatment due to some mental illness. This change in terminology marked the beginning for some of the other changes to come later.

Despite the act and the amendment, the provisions did not go very far in reducing the unsafe abortions taking place due to the lack of safe abortion facilities or legal hindrance. According to the Lancet's (Global Health Journal) report on abortions in India, out of an estimated 15.6 million abortions in 2015, around 11.5 million were done via medical methods outside facilities. It was in the backdrop of such findings that the Union Cabinet passed another 'Medical Termination of Pregnancy Bill' in 2020. It was subsequently passed from Lok Sabha, but the approval of the other house is still awaited. In all likelihood, nonetheless, the bill has fair chances of enjoying the life of an act. Thus, a look at its provisions ought to complete the picture.

MTP BILL, 2020 –

1. First and foremost, it extends the time limit of terminating the pregnancy to 24 weeks for special categories of women. Special categories include rape victims, incest victims,
2. Secondly, the bill includes within its ambit the unmarried women as well, and replaces the word 'husband' with 'partner'.
3. It provides for anytime termination of pregnancy in case of foetal abnormalities as approved by the state medical board. The bill mandates all the states and union territories to set up such medical boards.
4. Regarding the opinion of the registered medical practitioner (RMP), the bill changes it to one RMP's opinion till 20 weeks, and that of two for beyond 20, till 24.
5. Lastly, the bill prohibits disclosure of the identity of the women whose pregnancy has been terminated by the RMP.

Even after these proposed changes, some of the demands and grievances remained unanswered. The very first is related to the status of abortion right in India. According to several women's rights activists, abortion is a 'conditional' right in India and not a legal right. The final say on terminating pregnancy rests with the doctors and not the women themselves. Thus, it is also believed that a doctor's approval can often come down to -whether a woman should have an abortion, denying her the agency over her body.

Secondly, the critics also believe that the 24 weeks extension should cover all women and not just the categories that it proposes.

The third objection comes from the lack of focus on expanding the provider base. This is primarily due to the strict definition of who can perform the termination of pregnancy. The act specifies that abortions can only be performed by experienced Obstetrics-Gynaecology specialists. It is owing to the technology of dilation and curettage (D &C) that was the only

available one when the Act was passed in 1971. As per D&C, ‘anaesthesia is used for removing products of conception by using a metal curette’. In medicine jargon, this technology requires special skills and is equally risky, which is why WHO recommended doing away with it. To take its place are other advanced technologies like manual vacuum aspirations and electrical vacuum aspirations.

Manual Vacuum Aspiration (MVA)- removal of uterine contents by a hand-held plastic aspirator and Electric Vacuum Aspiration (EVA)- usage of an electric pump for the same.

Both of these methods do not require the specialisations as needed with the D&C, thus these can be performed by any RMP- any medicine graduate.

Apart from these, the most widely used method today is MMA- Medical Methods of Abortion.

This involves the prescription of a combination of two drugs, as per the Indian Act, which can be given by the RMPs. But, a wide range of medical personnel can be easily trained to carry out the MMA, including the AYUSH practitioners or the nurses.

The next concern is with the provision of medical boards that needs to be set up for approving abortion in foetal abnormality cases. Here, the bill fails to give a time frame within which the board should give its decision, which might lead to delay. Secondly, a large population of the country living in the rural areas, for which access to medical facilities, in general, is limited, would find it extremely difficult to obtain approval from the state’s medical boards.

Yet another set of concerns is linked to the ‘minor’ question. Most crucial is the privacy question, the POCSO act considers any sexual intercourse with a minor as rape, notwithstanding consent. Therefore, if a minor approaches the doctor for abortion then the doctor is bound to report it as sexual assault. This, however, contradicts the provision of the act which stresses maintaining the confidentiality of the woman going for an abortion.

It can be agreed upon that the abortion laws in India are moving towards a more progressive trajectory but it can also not be denied that there still is scope to better these, which can be done by initiating a dialogue with the stakeholders- the people.

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