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AN ASSESSMENT OF INDIA'S ABORTION LAWS: CRITICAL INSIGHT

Sunishtha Moghe[1], Meghna Sharma[2]

[1]Symbiosis Law School, Pune
[2]Symbiosis International (Deemed University), Pune, India
E-mail: [1]sunishtha.moghe@symlaw.ac.in

Abstract

The primary and only 'abortion' law in India i.e., "Medical Termination of Pregnancy Act, 1971", governs the rights of women with respect to the termination of their pregnancy. Although, considered progressive for the time it was legislated, the law hasn't been amended since then and poses many questions with regard to not only its implementation but provisions that are seen as irrelevant and outmoded. According to a 2015 Guttmacher Institute Report an estimated 78% of medical terminations in India were procured outside of state authorized health centres. Keeping in view the inaccessibility of abortion related services in India, providing a legal support structure that eases the process remains imperative for improving the health structure of the country. While the newly tabled "Medical Termination of Pregnancy (Amendment) Bill, 2020" is most certainly a reformed version of the incumbent act, a lot is still needed to be improved – and it is most certainly warranted by the people of India. The Bill is undeniably reformative and comparatively inclusive, yet by refraining from decriminalising abortion and recognising it as a right, it fails to realise the constitutional vision

Key words: Abortion, Reproductive rights, Women, health, Pregnancy

Introduction

A premature delivery which is made in a voluntary manner but with an intention of terminating the foetus is considered as an Induced Abortion (Williams, 1952). Nonetheless, medical realm considers abortion as untimely delivery of a child before it is viable or able of being reared, when birthing takes place at the time of abortion procedure. When mother is in the twenty eighth week of pregnancy, the child can be considered as being viable (Paul and Schopp, 1980).

Unsafe abortion practices continue to remain one of the most neglected problems facing any developing country in the world today. Nearly one-third of the world's women live in countries that enforce strict abortion legislations, which range from absolute criminalization of abortion to limited state sanctioned abortions. Often, this propels women to adopt unsafe abortion practices. Complications arising due to unsafe abortion results in major health complications, sometimes even resulting in deaths. In India, unsafe abortions continue to be the third largest cause of maternal mortality deaths (Dubey, 2020). In India, fifty six per cent of the estimated 6.4 million abortions every year are unsafe (Hindustan Time, 2019). While Section 312 of the Indian Penal Code, abortion laws of India criminalized all sorts of abortions until the 'Medical Termination of Pregnancy Act' (MTPA) was passed in 1971; the present discourse still revolves around a state-sanctioned authority over a woman's right to abort. Recognizing the need for a designated legislation to give women access to safe pregnancy termination practices; the parliament enforced the MTP Act, 1971. Till date it remains the only legislation in India that deals with termination of pregnancy under 'certain' circumstances. Although, 'miscarriage' that doesn't form an exception to the aforesaid act can lead to criminal liability; it hasn't hindered women and their families from attaining illegal termination of pregnancies.

Indian Penal Code, 1860

In the West of 1960s and 1970s, the legislative and policy reforms on induced termination which were led by varied feminist movements weren't able to play a primary role in India. Rather, it was primarily population control that was the aim of legislators behind framing of abortion laws.

A vestige of the colonial past of India, the Indian Penal Code of I860 (hereinafter referred as the Code) has been considerably influenced by the British Offences against the Person Act of 1861. The antiquated British legislation criminalised causing a miscarriage (Dalvie, 2008). The Code made induced abortion a criminal offence under section 312 to 316. The Section 312 states:

"Causing miscarriage - Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine."

The explanation clause of the aforesaid section implies that the ambit of the 'offender', under the Act, includes the woman herself, or any other person who abets the 'crime'. Furthermore, it refers to two situations: a woman 'with a chid' and 'quick with a child'. While the former refers to the stage wherein gestation begins, the latter refers to an advanced stage in pregnancy.

It is to be noted, that neither the code nor the legislation makes use of the word 'abortion'. While some attribute the reason for the same to avoiding hurting sentiments of traditional Indian community, others believe 'causing miscarriage' and 'medical termination of pregnancy' is aimed at "ensuring that abortion laws in the country aren't framed as granting women a choice or a right to undergo safe abortions, but as procedures to protect doctors against prosecution for conducting abortions." Section 312 provides for only one instance of conducting abortion i.e., medical grounds to protect the life of the mother. However, the imminent or definite threats to her life aren't a ground. A person who performs the act in good faith can be protected by the law. Nevertheless, then 'good faith' becomes a subjective fact that is left to be decided in each and every case according to the facts and conditions, and it doesn't end up being a question of law alone (Gaur, 1986).

It is evident that the law under the code in India was strict in its enforcement. Different surveys conducted at the time suggested that before the enactment of MTP, 1971 five million induced abortions were carried out customarily in India every year, more than three million of them being illegal (Menon, 1974). This was followed by tardy prosecution rates, and other emerging problems like unsafe abortion practices, crimes, suicides, infanticides, exploitation of the women at the hands of unethical doctors, abandonment of children at birth and so on.

The Pregnancy Law of 1971

In 1964, the Government of India successfully constituted Shanti Lal Shah Committee to study liberalization of abortion law and subsequently recommend reforms. "It observed that whatever may be the moral and ethical feelings that are proposed by society as a whole on the question of induced abortion, it is an incontrovertible fact that a number of mothers are prepared to risk their lives by undergoing an illegal abortion rather than carrying that particular child to term (Gaur, 1986)." Hence, on acceptance of its report by the government the "Medical Termination of Pregnancy Act" came into operation on April 1, 1972.

At the time, India became a trailblazer in decriminalizing induced abortion by way of "Medical Termination of Pregnancy (MTP) Act of 1971". Under this act, "the woman can legally avail abortion if the pregnancy carries a risk of grave physical injury, endangers her mental health, when pregnancy results from a contraceptive failure in a married woman or from rape or is likely to result in the birth of a child with physical or mental abnormalities" (Vesaria *et al*, 2004). While Indian Penal Code criminalized abortion, the MTPA makes for exception under the code.

Provisions under the MTPA: An Analysis

Grounds for termination of pregnancy

The Statement and Objects of the MTPA identifies three main objectives behind MTPA are: (i) Healthcare measure i.e., in case of danger to life or mental and physical health risks to women; (ii) Humanitarian grounds i.e., if pregnancy arises from rape or sex with a lunatic person, etc.; (iii) Eugenic grounds i.e., "where there is substantial risk that the child, if born, would suffer from deformities and diseases." Furthermore, Section 4 provides for terminating pregnancy at any hospital or medical institution maintained or owned by state, or a place that the approves for performing such act. However, in case of medical emergency wherein medical opinion deems it necessary to prevent injury to the mother, the compliance to the Act is exempted from section 3 (under sub-section 2) and section 4. Similarly, Section 8 gives doctors immunity from legal action in cases wherein termination is performed in good faith.

Gestation limits under the Act

The time prescribed in abortion legislations forms an aspect of many human rights controversies that revolve around accessibility (Erdman, 2019). The MTPA allows abortion up to 20 weeks. The 20 weeks-limit is based on outdated concepts from 1970s when terminating pregnancy was viewed as a surgery performed by allopathic surgeons (Bedi and Mandhani, 2019). Initially. The MTP Act relied on invasive procedures of abortion and mother's safety in this regard had to be factored in. However, now with evolution in scientific methods and research abortion can be safely carried out even beyond the 20-week limit.

The MTPA allows the termination of pregnancy by a woman, within 12 weeks from the date of conception, if a registered doctor is of the "good faith opinion" that its continuation would involve grave risk to her mental or physical health, or risk to the unborn child's life or health. At least two medical providers' opinions are required to form a decision with regard to a pregnancy that ranges between 12 and 20 weeks. Thus, although the act legalizes abortion in a limited sense, as the precedent condition determining the final decision subsequently rests with a doctor. That said, this opinion of the doctors "goes beyond the medical diagnosis of whether the woman can have the abortion to doctors exercising their opinions on whether she should have the abortion (Kumar, 2020)."

Role of Medical Practitioners & Constitution of Family Planning Board

Under the Act, a board for family planning and welfare is to be instituted in each constituent state of India. Its chairmanship shall include a director of health services and five qualified medical doctors, a gynaecologist, an anaesthetist and a surgeon as members (Gaur, 1986). This board is responsible for authorizing doctors to perform terminations of pregnancies across the state. Rule 4 prescribes qualifications of a medical professional to be able to perform such terminations. However, it is incumbent upon his/her attaining certification from the aforesaid board. Despite of cumbersome certification processes, the Act awards medical practitioners full immunity against any legal or criminal proceedings in case of injuries caused to women during the termination procedure, given that the act was being done in "good faith".

"In India, though abortion is legally permissible under a wide range of situations, the doctor has the final say. A woman has to justify that her pregnancy occurred despite her having tried to prevent it or that it had been intended but circumstances changed or made it unwanted later. The reality may be that the pregnancy was unwanted from the start, but to justify abortion within the legal framework, the woman may feel she has to say it was contraceptive failure, creating an environment of falsehood (Hirve, 2004)."

Lack of Implementation

Although, the MTPA necessitates that the Government provide for termination facilities at all government health institutes, "the lack of required approval for public health facilities exempts the public sector from the same regulatory processes that apply to the private sector (Hirve, 2004)." To add to this, difference in each state's interpretation in implementation of the same creates unnecessary procedural delays. This reflects upon

the states' attitudes toward abortion. "Certification process, mismanagement, bureaucratic hurdles, lack of response and corruption are commonly encountered (Bandewar, 2002)."

In many cases, it is the healthcare providers who create unnecessary hurdles in accessibility of these services. By insisting on third party consent (which otherwise isn't a requirement under law), they seek immunity for themselves in case any abortion complications arise. "Reasons often cited for provider insistence on spousal consent include the need to safeguard themselves against social and legal problems arising from abortion complications or death, and the low social status of women and their dependence on their husband (Hirve,

Public & Private Sector Divide

Another major challenge is encountered through differing standards followed by public and private health institutions. "In the context of poor quality abortion care in the public sector, same exacting standards should be applied as in the private sector and subject to the same audit procedures that are expected of the private sector." Nonetheless, the private healthcare system remains unorganized and doesn't particularly adhere to quality standards given under MTPA. Moreover, the state lacks quality clinical research allocation to the cause of reproductive health, which leads to it lagging in development of safer abortion practices as compared to international standards.

In the absence of a government approved national enforcement procedure, most principal health centres, as well as many health institutions, lack practitioners who are qualified under the MTP or continue under-prepared. "A facility survey sponsored by the Ministry of Health and Family Welfare in 221 districts throughout the country revealed that only 34% and 28% of community health centres had Boyle's apparatus and standard surgical kits respectively, and only 10% had an anaesthetist. Only 13% of primary health centres had a doctor trained to perform abortions, while only 16% were equipped with vacuum aspirators. (International Institute for Population Sciences, 2001)."

Therefore, it is essential to ensure that the same qualitative standards are maintained by the government healthcare facilities, as are mandated to be upheld by private health centres. This shall help counter the rural-urban divide and ensure equitable accessibility of abortion practices that are provided across India.

Indifferent Attitudes

Most legislative processes in India follow considerations of the interest groups. In case of MTPA, few interest groups played an active role in shaping the legislation. Most political parties also refrained from taking any active stance with regards to the Act. The reason behind this can be attributed to primary initiative which was taken by the government, or religious and social factors that led to stigmatization of accessing reproductive healthcare.

According to a study that Lancet Global Health undertook, in 2015 alone 15.6 million abortions were procured in India. Out of these, 78% occurred outside health facilities i.e., illegally (Sharma, 2019). One of the intricacies of abortion law can be attributed to its regard for prenatal life, in addition to it being influenced by protection of women's health and rights (Cook & Dickens, 2003). The latter objective may be informed by religious or secular ideas, and prenatal life may be protected as an independent right or a state interest against different ends. "Even when lawful and accessible, the stigma of abortion as an immoral or socially undesirable act may lead to the adoption of non-evidence-based practices around informed consent in the clinical setting (Erdman, 2017)."

Sex Selection Law & MTP: Contradictory Legislations?

The "Medical Termination of Pregnancy Act" ensures that the law doesn't curb women's choice for terminating their pregnancy. Its core objective being reduction in health risks and dangers facing women's health due to life-threatening pregnancies. However, it is important to note that the Act doesn't have any nexus to The Prohibition of Sex Selection Act as might have been misconceived by many. The MTPA does not impinge on the requirements of the aforementioned act.

The state governments in the past have overlooked the significance of MTPA under the garb of preventing female infanticide, and have legislated separate policy directives that hinder the objectives of MTPA. For instance, a spate of policies launched by the Maharashtra government have been criticized for being misguided. These included recommendations "to reduce the abortion limit to 10 weeks; introduction of a silent observer technology that relays ultrasound images from pregnant women to authorities to track potential sex selective abortions; and requirement that doctors take digital images of the fetus after abortion (Jain, 2013)." The policies are not just an invasion on one's fundamental right to life and personal liberty as pronounced under Article 21 of the Indian Constitution, but also drive women towards procuring unsafe abortion practices that blatantly go against the objectives of MTPA.

It must be noted that female infanticide is altogether a different issue and is included under "Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 (hereinafter referred as PCPNDT)". The PCPNDT Act administers "pre-natal diagnostic techniques" and "genetic counselling" in a way that disfavours eugenic practices (Sibal, 2020).

Medical Termination of Pregnancy (Amendment) Bill, 2020

On March 02, 2020 "Medical Termination of Pregnancy (Amendment) Bill, 2020" was tabled in the Indian Parliament by the Health and Family Welfare Minister. The bill seeks to amend the 1971 legislation. While the present amendments to the bill seem progressive in comparison to the present MTPA, the legislation is still away from a rights-based approach to abortion.

The recently tabled bill takes a step further by increasing the gestational limit to 24 weeks. Although it is to be noted that 24 weeks' limit shall be applicable to a special category of women, which shall include 'rape survivors, incest victims and other susceptible categories of women (differently-abled, minors, etc.) Furthermore, it proposes a requirement of medical opinion from one medical professional as against two in the current framework. The two providers' opinion is required for termination between 20-24 weeks of gestation now.

Another significant development to the proposed legislation involves constitution of a 'Medical Board' that every state shall be required to form. It shall constitute a gynaecologist, a paediatrician, a radiologist or sinologist, and any other member as the government may deem fit.

Another significant correction that the new bill makes is in regards with the 'Explanation 2' provided under Section 3(2) of the MTP Act 1971, which includes the termination of pregnancy that is a result of failure of contraception device or any medically authorized method used by any "married women or her husband". The new bill shall include unmarried women in its ambit for the implementation of the aforesaid section. Nonetheless, the onus of examining the impact of pregnancy on the mental health of a pregnant woman shall rest upon the doctor. In addition to this, the bill seeks to address the privacy issue that was overlooked by the 1971 Act. It stipulates that the privacy of the woman whose pregnancy is terminated or under consideration would be maintained. The name and particulars of the woman shall not be revealed, except to the person authorized by the law. Any contravention to the same, shall be dealt with strict punishment, leading up to imprisonment, or fine, or both.

Abortion Without Punishment

Decriminalization of abortion shall mean getting rid of criminal liability against abortion from a state-sanctioned authority, and making certain policy decisions in order to achieve: flexible laws for those providing safe abortions, respecting privacy of the woman, not allowing judicial interventions unless really necessitated by certain circumstances, focusing on de-stigmatization of abortion and treating it like any other health care issue i.e., adding the resource base for development of better services and applying incumbent law in strictly dealing with negligent practices.

Historically, restrictions on abortion were introduced for three main reasons: (Berer, 2017)

1. Abortion was dangerous and abortionists were killing a lot of women. Hence, the laws had a public health intention to protect women—who nevertheless sought abortions and risked their lives in doing so, as they still do today if they have no other choice.

2. Abortion was considered a sin or a form of transgression of morality, and the laws were intended to punish and act as a deterrent.

3. Abortion was restricted to protect fatal life in some or all circumstances

Since, now with scientific research and innovation safer abortion practices have emerged, the first reason stands invalid. Similarly, reason two takes an archaic and narrowly callous perspective of what abortion should entail. Hence, law on abortion invites scrutiny only for protection of fatal life over that of a woman's and reduction in unethical practices that pose danger to the life of the woman.

Many international bodies like the Human Rights conventions have started calling for a comprehensive law on 'legal and safe abortion practises'. Even more so, they have started calling for 'decriminalization of abortion'. To differentiate between the two approaches: "legalizing abortion means keeping abortion in the law in some form by identifying the grounds on which it is allowed, while decriminalizing abortion means removing criminal sanctions against abortion altogether." According to the WHO, the need for abortion cannot be decreased simply by placing constraints on legal access to abortion. What it is likely to proliferate is the number of women seeking illicit as well as unsafe abortions, leading to increased morbidity and maternal deaths (World Health Organization, 2012). These end up creating "chilling effect" by deterring not just women but healthcare providers, from obtaining safer services and instead going for illegal and unsafe recourses like midwives or unauthorized practitioners.

The only nation till date that has been able to successfully decriminalize abortion altogether is Canada. Through a Supreme Court decision in 1988, Canada effectively legislated in this regard (Arthur, 2016). In India, while the gestational limits are far more progressive than other developed countries like the US, the law treats abortion as a state-sanctioned exemption rather than a woman's right to her own body and the criminalization of abortion is only evident of the same. That said, it should be noted that decriminalization of abortion does not mean absolute abolition of any law pertaining to induced termination of pregnancies, rather making abortion services available on women's request and regulating safer practices at community level itself.

Conclusion

While the Medical Termination of Pregnancy (Amendment) Bill, 2020 is deemed to be progressive in its approach, it still lags behind in recognizing women's agency over their own body. The Apex Court in *K.S. Puttaswamy Case* (*AIR 2014 SC 1863)* has held that reproductive rights and bodily autonomy fall within the purview of Article 21 of the Constitution. Despite of this fact, the bill persistently emphasizes the eugenics over the health of the women. Bringing about an imperative change in the abortion laws can be a work of years. Legislators and allies play an especially crucial role in the same. While India has made particularly liberal strides in bringing about MTPA, for that time and then tabling the new bill; what remains to be seen is the stricter enforcement of laws to ensure protection and easy accessibility to women rather than creating cumbersome institutional barriers. Apart from legislative alterations many socio-cultural aspects of India have stigmatized the topic of reproductive health is general. While incremental changes in the law are unlikely to revolutionise the understanding of abortion, they will definitely provide an enabling legal framework within which women can demand the enforcement of their rights. Nevertheless, even as a legitimate and feasible right, the stigma surrounding medical termination as a vile or socially objectionable act may lead to the implementation of "non-evidence-based practices around informed consent in the clinical setting." It is the duty of the state to not only efficaciously implement the MTPA but also ensure that the dignity and fundamental freedoms of women are upheld under the Constitution of India

References

1. Aneesh Bedi & Apoorva Mandhani, Jun 03,2019; India's Abortion Law-Ahead of its Time in 1971 But Now Behind Science, Societal Demands; https://theprint.in/india/indias-abortion-law-ahead-of-its-time-in-1971-but-now-behind-science-societal-demands/244884/.

2. Arthur J. (2016). Canada: Proof that no country needs an abortion law" http://www.safeabortionwomensright.org/portfolio/canada-proof-that-no-country-needs-an-abortion-law.

3. Bandewar S. (2002). Quality of Abortion Care: A Reality From Medical, Legal and Women's Persective. Pune: CEHAT.

4. Berer M. (2017). Abortion Law and Policy Around the World, Health and Human Rights. 19(1) Special Sections: Abortion and Human Rights Drug Control and Human Rights. pp. 13-27.

5. Cook R.J. & Dicken B.M.(2003).Human rights dynamics of abortion law reform. Human Rights Quarterly 25(1). pp. 1-59.

6. Dalvie, S. S. (2008). Reproductive Health Matters.Women's Health and Public Policy. pp. 37-45.

7. Dubey S. (2020, February 03). Taking A Step Towards Being Pro-Choice, FEMINA https://www.femina.in/trending/in-the-news/abortion-laws-in-india-is-india-taking-a-step-towards-being-pro-choice-147652.html.

8. Erdman J. N. (2017). Health and Human Rights. Special Sections: Abortion and Human Rights Drug Control and Human Rights. 19(1) pp. 29-40.

9. Gaur K.D. (1986). Abortion and the Law in India. Journal of the Indian Law Institute, 28(3). pp. 348-363.

10. Hindustan Times. (2017, March 29) Behavioural Shift and Communication Can Raise Awareness About Safe Abortion In India, HINDUSTAN TIMES https://www.hindustantimes.com/health-and-fitness/behavioural-shift-communication-can-raise-awareness-about-safe-abortions-in-india/story-nZ2t3BFyO8jZluHPj9WCwK.html.

11. Hirve S. (2004). Reproductive Health Matters. 12(24) Supplement: Abortion Law, Policy and Practice in Transition. pp. 114-121.

12. https://www.livemint.com/science/health/why-india-needs-a-new-mtp-act-1567317067262.html.

13. International Institute for Population Sciences. Facility Survey [Under Re- productive and Child Health Project] Phase -I, 1999. Mumbai: 2001.

14. Jain A. (2013). BMJ: British Medical Journal, 346(7902). p. 8.

15. Joanna N. Erdman J. N. (2017). Health and Human Rights. 19(1). Special Sections: Abortion and Human Rights Drug Control and Human Rights. pp. 29-40.

16. Kumar S. (2020, May 17). Why India's law on abortion does not use the word 'abortion'. https://theprint.in/opinion/india-law-abortion-medical-termination-pregnancy-act/423380/.

17. Menon N.R. (1974). Population Policy, Law Enforcement and the Liberalisation of Abortion: A Socio-legal Inquiry into the Implementation of the Abortion Law in India. Journal of the Indian Law Institute 16(4): 626-648.

18. Paul E. W., & Schaap P. (1980). Abortion and the Law in 1980. New York Law School Law Review. 25(3) 500- 502.

19. Sharma N C. (2019, September 01). Why India Needs a New MTP Act. LIVEMINT

20. Sibal S. (2020, July 14). Amendments We Should Be Asking For in the Medical Termination of Pregnancy Bill; https://thewire.in/women/medical-termination-of-pregnancy-bill-amendments.

21. Visaria L, Ramachandran V., Ganatra B., Kalyanwala S. (2004). Abortion in India. Economic and Political Weekly, Nov. 39(46) pp. 5044-5052.