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Review Article

SAFE AND LEGAL MEDICAL TERMINATION OF PREGNANCY IN INDIA – FAR FROM REALITY.

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ABSTRACT:

Medical Termination of Pregnancy Act 1971 aimed at legalizing abortion by recognizing when to allow termination, by whom and at what places. But the Act failed to address many questions on safe and legal abortion by denying the human rights on the principles of availability, accessibility and justice to the needy women. The consistent judicial trend in past many cases has reiterated the need to change the archaic law by allowing termination of pregnancy post twenty weeks. Lack of political will and biased views of the medical professionals towards the Bill 2014 have raised the obstacles on the road to justice.

The paperaims to address the nuances of safe and legal abortion by tracing the magnitude of the problem, development of law in India, its international relevance, analysis of the proposed Bill and evolving judicial trend in India. The researchers have adopted doctrinal method of research by refereeing to primary data from Bare Act , Rules, Regulations, Supreme Court judgments and secondary data from various books, research articles etc. It is observed that the law and the proposed Bill are far away from reality and needs to undergo many changes

KEY WORDS: Medical termination of pregnancy, abortion, judicial trend.

INTRODUCTION:

Abortion law in India is ahead of several countries, like Nicaragua and El Salvador, where abortion is banned completely; and Nigeria, Ireland where it's heavily restricted, only permitted when the woman's pregnancy endangers her life. The Medical Termination of Pregnancy (MTP) Act 1971 permits a woman to have an abortion up to 20 weeks of pregnancy in a government-approved facility if the pregnancy carries the risk of grave physical injuries, endangers her mental health, results from contraceptive failure in a married woman or from rape, or is likely to result in the birth of a child with life-threatening disabilities.

An estimated 200,000 or more women in the third world countries die every year due to unsafe methods of terminating pregnancy and other additional uncounted thousands suffer severe morbidity. In India it is estimated that unsafe clandestine abortions account for 20% of maternal deaths. Approximately annual number of abortions in the country is over 11.2 million of which 6.7 million are expected to be induced. The estimated ratio of illegal to legal abortions in India is 11 to 1.[i] This dismal scenario indicates that something has obviously gone wrong somewhere. Legalizing abortion in 1971 did not have the expected impact due to various socio economic reasons.

On an average, 10 women die every day in India due to unsafe abortion procedures. An estimated two-thirds of all abortions in India are

unsafe, conducted outside the regulated and authorized hospital and clinic system. The reasons range from lack of access to and denial of services from registered healthcare providers, to countless social factors, like pressure or lack of support from family, social stigma, financial constraints, and lack of awareness and access to information. These factors drive women to seek illegal or unsafe abortion care, leading to misuse of emergency contraceptives, procuring and using of medical abortifacients like mifepristone and misoprostol without prescription or a visit to the doctor, and opting for unsafe back-alley abortion services.

Medical sciences and law have come together to give relief to the women in need of abortion by recognizing their right to autonomy and reproductive health. In India, abortion is seldom discussed as a woman's right; in fact, only one in 10 women in India realize that abortion is legal. The widespread social stigma often leaves women with no traditional support systems. Unplanned and unwanted pregnancies and unsafe abortions are serious public health problems in the developing world. Based on World Health Organisation (WHO) estimates of annual deaths due to unsafe abortion, more than three-quarters of a million women have died since 1994, when this issue was first placed on the world's agenda at the International Conference on Population and development (ICPD).[ii] These problems require increased attention and new actions by policymakers responsible for progress toward the Millennium Development Goals (MDGs) of reducing maternal mortality, promoting gender equality and empowering women, and eradicating poverty. Women's ability to regulate their own fertility is critical to the achievement of these internationally agreed goals. Conversely, the persistence of unsafe abortion in many countries is a key obstacle to meeting the MDGs.

Significance of the study-

The laws restricting inequitable access to safe abortion has resulted to large numbers of maternal deaths and injuries and violations of women's sexual and reproductive rights. These women belong to the vulnerable population that are poor, adolescents, survivors of sexual violence, victims of racial or ethnic discrimination etc. The laws developed as the outcome religious institutions have denied access to abortion in some countries. In developing countries where abortion is allowed by law only to save the woman's life or in the case of rape, safe public sector services are commonly not available even for eligible women. The persistence and prevalence of unsafe abortion has the dimensions of public health, human rights, social justice, and legal issues. Failure of contraception, lack of awareness and use of it, is seen to have resulted into unwanted pregnancy and then termination is seen to be an alternative to contraception. It is widely acknowledged that in countries in which abortion is restricted by law, women seek abortions secretly, often under conditions that are medically unsafe and therefore life- threatening.

Aims and objectives-

- to study the existing law and unaddressed legal and social issues in Indian society
- to study the judicial trend on the issue
- to observe the gap between law and reality by critically analyzing the law
- to study the basis of Indian law on the background of developments at international level

Methodology adopted

The researchers have adopted doctrinal method of research by refereeing to primary data from Bare Act , Rules, Regulations, Supreme Court judgments and secondary data from various books, research articles and internet based sources. The researchers have visited the libraries of SavitribaiPhule Pune University and some law colleges in Pune.

Definition-

Unsafe abortion is defined by the World Health Organization as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both[iii].

In accordance with principles of women's human rights, governments have a duty to put such laws in place and take steps to ensure that the laws are fully implemented. At the international level, governments agreed at the International Conference on population and Development (ICPD) in 1994 that "any measures or changes

related to abortion within the health system can only be determined at the national or local level according to the national legislative process." They settled on an uneasy compromise that "in circumstances where abortion is not against the law, health systems should ensure that such abortion is safe and accessible" (United Nations, 1999). This project has the focus on abortion that is safe and legal at the same time.[iv] This has a bearing on access, cost, social and cultural dimensions, and women's control over decision and choice and other related issues. Abortion services in India have assumed serious concern in the context of women's reproductive health needs.[v]

The Present Scenario: 46 years after legislation

India has the highest number of second trimester abortions in the world, which indicates that not only is this a serious public health issue, but an indicator of the problem and failure of widespread use of contraception[vi] The situation is worsened even with heinous practice of sex selective abortion of female fetuses. Accessibility, availability, affordability and denial of justice are the major problems associated with healthcare of women in India. It becomes an economic and social issue when MTP is treated as a "woman's issue" and not as a health problem, which is entitled to a significant budgetary allotment.Abortion has thus emerged as a criminally neglected public health issue.[vii]

The barriers that women face in accessing abortion services are many. The studies by CEHAT explored the issues and observed that the abortion facilities available in the country are unable to meet the demand for abortion. Women especially in rural areas have to go to non-registered abortion care facilities and unqualified practitioners as abortion care facilities are scarce in rural areas. The study in tehsils of Pune and Ratnagiri districts reveals that 63% abortion care services are located in urban area. The public sector has a meager 11 percent share in the total abortion care services.[viii] Moreover, government facilities that is supposed to provide free abortion services often charge women for abortion services, placing another barrier to safe abortion services from the formal health care system.

The restrictive nature of the law providing abortion only on certain grounds, makes it difficult for a woman to approach a registered MTP centre if her case does not 'fit into' those stated conditions. The Act differentiates the women on the ground of their marital status giving more privileges to married women. Also there is lack of anonymity and confidentiality particularly in primary health care centers. In many places the providers ask for husband's signature, especially in public health facilities, thus further pushing the woman to private and often untrained providers where her identity is secure but not her life.[ix]

(a) International status

The international discourse on women's rights is primarily centered around The Convention on the Elimination of all Forms of Discrimination against Women **(CEDAW)**. Within the 1979 statute, Section B on Sexual and reproductive health acknowledges that discriminatory laws criminalizing abortions and a lack of access to safe health facilities cause thousands of deaths every year. The convention calls all countries to action by enforcing the decriminalisation of abortion as the first step.[x]Article 1 of the American Declaration of Rights and Duties of Man, and the Inter American Commission of Human Rights allow abortion to the females falling under its purview up till the end of the first trimester[xi]. Further, *A*rticle 6(1) of the International Covenant on Civil and Political Rights, Article 2 of the European Convention of Human Rights and Article 4 of the African charter of Human and Peoples' Rights, call to protect the Right to Life.[xii] The right to choose abortion has support in guarantees of life, health, freedom from discrimination, autonomy in reproductive decision-making, freedom from cruel, inhuman, or degrading treatment and the right to enjoy the benefits of scientific progress.

According to the World Health Organization (WHO), about 21.6 million women had unsafe abortions in 2008.[xiii] These unsafe abortions were responsible for the deaths of nearly 47,000 women. The incidence of unsafe abortion is closely associated with high maternal mortality rates. Therefore, laws that force women to resort to unsafe procedures infringe upon women's right to life Several United Nations (UN) human rights bodies have framed maternal deaths due to unsafe abortion as a violation of women's right to life. As a result, they have called on states to review

restrictive laws that criminalize abortion and increase access to family planning and sexual and reproductive health information, in order to reduce the number of unsafe abortions.[xiv]

The Programme of Action adopted at the International Conference on Population and Development (ICPD) in 1994 called upon governments to consider the consequences of unsafe abortion on women's health. It states that governments should "deal with the health impact of unsafe abortion as a major public health concern." At the 1995 Fourth World Conference on Women, the international community reiterated this language and urged governments to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions."[xv]

(b) National status:

Developments in India and legal lacunae

Shah Committee, appointed by government of India, carried out comprehensive review on socio-cultural, legal and medical aspects of abortion and in 1966 recommended legalizing abortion to prevent wastage of women's health and live on both compassionate and medical grounds.[xvi] The law of abortion in India is governed by the **Medical Termination of Pregnancy (MTP) Act, 1971**, with certain provisions relating to miscarriage *given under* sections 312-316 in the Indian Penal Code (45 of 1860).

In India, under the MTP Act, **abortion is a qualifiedright**. An abortion can't be performed based solely on a woman's request. It **can only be performed by a registered medical practitioner before 12 weeks of pregnancy.** In case the woman had been pregnant for more than 12 weeks – but for less than 20 weeks – the opinions of two medical practitioners are required. However, the underlying condition remains: an abortion is permitted only if continuing the pregnancy poses a 'substantial risk' to the woman's life or to her 'physical or mental health'. Alternatively, if the child that is yet to be born faces similar substantial risk – in that it would suffer from 'physical or mental abnormalities' or may be 'seriously handicapped' – an abortion may be allowed.[xvii]

In case of pregnancies caused by rape, or a failure of birth control (for married women), the risk to their mental health is an admissible ground for abortion. The premise of keeping the window for abortion open only until 20 weeks is that, generally, abnormalities can be detected by that time. However, some rare congenital diseases can be detected only after 20 weeks putting both the lives of the mother and the child at risk. The law at present does not address the issue.

Considering the lack of governmental support for persons with disabilities, the argument for the foetus's right to life needs to be rethought. Complications can drastically affect the child's lifespan and quality of life. The state's control should be minimal, as it is the woman and her family who will be responsible for taking care of the child. Moreover, the socio-economic conditions prevalent in India do not always promise a 'dignified life' for the child. Therefore, without legal recourse, pregnant women who find themselves in difficult situations may opt for illegal abortions resulting to serious complications and even death.

MTP Bill 2014- However, New MTP Bill has considered some of the issues unresolved by the Act of 1971. The Bill is based on the following grounds:

- The time limit of 20 weeks is regarded as an arbitrary one and The detection of some foetal abnormalities within 20 week is actually not possible, according to many scientists and doctors.
- There has been a demand for incorporating a provision for allowing women to exercise their freedom of choice.
- It discriminates the women on the ground of marital status. The act does not take into account the plight of rape victims in a separate manner.

The Bill proposes to increase the time limit to 24 weeks and to allow medical assessment by any registered health care provided need to be subjected to a critical appraisal no doubt. But to shove aside the possible benefits of amending an archaic law, is something that must not be resorted to, especially when the subject pertains to furthering the cause of maternal health care, and

controlling their mortality and morbidity rates. If substantial foetal abnormalities are detected, the amendment also allows an exception on the time limit for pregnancies to be terminated.

The Bill proposes to replace 'registered medical practitioners' with 'registered healthcare providers' and this is opposed by the doctors practicing modern medicine on the ground of safety and has made the women's right inaccessible and unavailable. However, the wait for justice has forced the pregnant women in distress seeking abortion through the courts. The Bill has differentiated the medical abortion and surgical abortion and has proposed to allow only medical abortion at the hands of the Ayush doctors.

The Judicial trend in India

A series of Supreme Court verdicts has brought into limelight the issue of safe and legal abortion in case of minor rape survivors whose pregnancies exceeded beyond 20 weeks. A recent Supreme Court judgment allowing a rape survivor to terminate her 24 week pregnancy has brought the controversies surrounding the right of a woman to abort her pregnancy to the limelight. Abortion and the right of a woman over her body has been an ongoing tussle for decades, if not longer. With a complicated juxtaposition of morality, ethics, strict legal rights and human rights marring its very foundation, the laws passed pertaining to this subject have been a mixed bag of reactions of various countries to the problem.[xviii]

The Supreme Court, in its judgement in ***Dr. Jacob George v. State of Kerala***[xix], clarified that "after the enactment of MTP, provisions relating to miscarriage have become subservient to this Act because of the non obstante clause in *section 3* of that Act." Section 5(1) stands as an exception to sections 3 and 4 of MTP, wherein a registered medical practitioner is allowed to terminate a pregnancy regardless of the length aforementioned, if she bona fide is of the opinion that the termination of the said pregnancy is immediately necessary to save the life of the women in question, as stated in ***Bhim Singh Bisht v. The State Govt. of NCT of Delhi and Ors.***[xx]In the case of ***R and Anr v. State of Haryana and Anr***[xxi] the court directed the Centre to make necessary amendments to the MTP Act to clearly stipulate that doctors will not be unnecessarily prosecuted if they act in good faith to save a rape survivor's life, or to prevent grave injury to the woman's mental and physical health. In ***Dr. Nikhil Dattar v. Union of India***,[xxii](May 2016) the Bombay High Court, in a controversial pronouncement, chose to stick to a strict interpretation of the provisions of MTP, thereby refusing to give a 24 weeks pregnant woman the right to abort her malformed foetus.For cases of pregnancy resulting due to rape, pronouncements in cases such as ***Dr. Rajeswari v. State of Tamil Nadu and Ors***[xxiii] *and* ***Bhavikaben v. State of Gujarat*** [xxiv](Feb 2016) allowed the victims to seek relief by way of termination of pregnancy, on the grounds that keeping the unborn child would result in grave mental health injury. In the latter case, the victim was 24 weeks pregnant.In the case of ***Nand Kishore Sharma v. Union of India***,[xxv] the constitutionality of sections 3 and 5 of MTP were challenged as against A*rticle 21*. The court took a vague stance by stating that since it was difficult to determine when exactly the foetus comes to life, the Right to Life of the unborn child was not being violated under the current law.

The MTP Act (Amendment) in 2002 brought in a twofold change to the existing law. First, it replaced the word 'lunatic' with 'mentally ill', thereby expanding its purview. Second, it decentralised the legislative and administrative process from the state to the district level, calling for the creation of district committees with representatives from both the government and non-governmental organisations to provide safer access to health care facilities to women together. This was done to dispel the notion that India is a country that has been unable to grant access to safe abortion despite having legal reforms.

The judiciary has at times been progressive, pronouncing judgments that support reproductive rights. But at times, the courts have succumbed to the old 1971 law as well. The Supreme Court has held that a crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. In a *suomotu* case, the Bombay high court – while dealing with the medical termination of pregnancy of two under-trial prisoners in Thane jail – clearly

stated that it is applicable to all women irrespective of their marital status or whether she was a working woman, a homemaker or a prisoner.[xxvi]

The legislation of the provisions in the MTP Act in 1971 was guided either by concerns about population control, or preventing high mortality in women resorting to non-qualified and non-regulated abortion service providers. The proposed amendments, in addition to this, are finally addressing the previously neglected aspect of women's choice and autonomy. The amendments will allow for abortions on-demand up to 12 weeks, and will extend the previous 20-week limit to 24 weeks in cases where the health of the pregnant woman and abnormalities in the foetus, physical and mental, are to be considered by the healthcare provider in deciding to conduct an abortion. Another welcome amendment is the one that detaches the marital status of women from citing contraceptive failure as the reason for seeking abortion. With social and medical circumstances having undergone drastic changes since 1971, a law such as the MTP Act cannot remain a static law.

As Rosalind Petchesky has contended,[xxvii] "Abortion is the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood and young women's sexuality are contested." While these amendments may be a step in the right direction, there are larger questions that need to be addressed. The healthcare providers play a key role in informing women about their options and providing them the required care in a safe and humane manner. Abortion care and access to contraception is a public health issue and must be treated as such. Women should be treated as autonomous individuals in their own right, and best capable of understanding and taking decisions about their bodies, sexuality, and reproductive choices.

CONCLUSION:

It is high time that restrictive abortion laws are liberalised paralleling societal changes. Irrespective of the marital status of women, access to safe abortion services and quality post-abortion care, including counseling, need to be guaranteed. A strong recognition of women's right to freely exercise their reproductive and sexual rights, including the right to abortion, should be there. The MTP (Amendment) Bill 2014 that, along with other amendments, talks of removing the word 'married' and substituting 'husband' with 'partner', should be pulled up from under the pile and enforced at the earliest. A progressive law cannot be suppressed with the excuse that sex-selection abortions will happen more often. Preventing the misuse of law cannot happen with the suppression of another's right.

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