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Access to abortion in India: Need to move from decriminalization to an enabling legislation

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Introduction

Until 1972, induced abortion (referred to as 'abortion' henceforth in this paper) was criminal in India under sections 312 to 316 of the Indian Penal Code (IPC), 1860 unless performed to save the life of the pregnant woman. This of course did not mean that no abortions were taking place in the country at that time. The Mudaliar Committee (1959-61)[1] in its report observed that evidence was available that "an appreciable number of abortions" took place in India every year, most of them performed by people with no medical competence to do so safely. While acknowledging that a "good deal" of abortions took place in the country in "wholly undesirable" conditions and being aware of the "strong religious and social reactions" that may emerge if abortion was to be legalised, the committee suggested "serious study and an unbiased approach towards its solution by governments and the people" (Ministry of Health, Government of India, 1961). In early 1960s there were proposals from different quarters within the government to liberalise abortion laws in the country, to save the lives of women who died due to unsafe abortions, and ostensibly as a measure of population control (Chattopadhyay, 1974; Jesani & Iyer, 1995; Hirve, 2004). The Ford Foundation and the recommendations made by the 1965 UN Mission to evaluate India's population policy are also believed to have promoted the idea (Chattopadhyay, 1974; Krishnan, 2015).

The term 'abortion' refers to the termination of pregnancy before the foetus is capable of survival outside the uterus. *(*Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 2003*)*. Abortion may be spontaneous which is also called miscarriage, or it may be induced. Induced abortion may be safe or unsafe depending on who performs it, how, and under what conditions. The World Health Organisation (WHO) defines unsafe abortion as the termination of pregnancy carried out by a person who does not possess the necessary skills or training, or that takes place in an environment that does not meet minimal medical standards, or both (WHO 2012).

In 1964, the Ministry of Health, Government of India established a committee under the chairpersonship of Mr. Shanti Lal Shah, the then Minister for Public Health, Law and Judiciary, Government of Maharashtra to examine the issue of abortion in the country (Chattopadhyay, 1974). The committee, popularly known as the Shah Committee submitted its report in December 1966. The committee estimated that in India's then population of 500 million, there were nearly 6.5 million abortions per year, of which 2.6 million were perhaps spontaneous/natural and 3.9 million were induced. The major concern of the committee was the dangers of unsafe induced abortion, i.e. morbidity and mortality among women. From the experience of different countries that it analysed, the committee concluded that legalisation of abortion helped countries in reducing mortality among women due to unsafe abortion. It therefore recommended that women's access to abortion be

[1] Ministry of Health, Government of India constituted the Health Survey and Planning Committee under the chairpersonship of Dr. A.L. Mudaliar, Vice Chancellor, University of Madras, in 1959 to review the developments in the health sector in the country since the publication of the report of the Health Survey and Development Committee (Bhore Committee) in 1946 to guide future health programmes in the country.

expanded by liberalising the existing provisions under the IPC, on medical and humanitarian grounds. The Shah Committee was of the view that abortion could not be used as a measure of population control because it was practically impossible to provide safe abortion services on such a large scale. Therefore, it called for simultaneously strengthening the efforts to promote the use of contraception and control population growth in the country (Ministry of Health and Family Planning, Government of India, 1966).

The Shah Committee report became the basis for government of India to liberalise abortion laws in the country. First introduced in the Rajya Sabha in 1969, the Medical Termination of Pregnancy (MTP) Act, 1971 (Act No. 34 of 1971) was passed by the Parliament in August 1971. Alluding to the Shah Committee's estimate of nearly four million abortions occurring in the country annually, the Bill was introduced in the Parliament as a measure of emancipating women, and defended on eugenic, humanitarian and health grounds. The Medical Termination of Pregnancy (MTP) Act, 1971 came into effect in April 1972, legalising abortion in certain conditions so that women's health and life could be protected from the dangers of unsafe abortion. The MTP Rules, 1975 and MTP Regulations, 1975 were subsequently framed to specify how the provisions of the Act may be implemented. The MTP Act, 1971 was applicable to all of India except the then state of Jammu and Kashmir. The Parliament was able to legislate on a subject (public health) that is otherwise listed under the state list in the Constitution of India, through entry I of the concurrent list which includes within its purview criminal law including matters pertaining to the IPC.[2] Since abortion was criminal under the IPC and the Parliament sought to modify the provisions of the IPC by making exception to criminalisation of abortion in certain specified circumstances, entry I of the concurrent list authorised it to legislate on the matter (Jacob, 1974).

The MTP Act, 1971 was amended in 2002, the Medical Termination of Pregnancy (Amendment) Act, 2002 (64 of 2002). The MTP Rules, 1975 and the MTP Regulations, 1975 were amended in the year 2003. A further amendment to the MTP Act, 1971, the MTP (amendment) Bill, 2020 was passed in the Lok Sabha in March 2020, though not tabled in the Rajya Sabha till the time of writing this paper. Opinions as diverse as "abortion should be considered a fundamental right of a woman" to not encouraging unrestricted abortion as "abortions are a crime against humanity" were put forth on the floor of the House during the debate before the passing of the amendment (thehindu.com, 17 March 2020). **The paper discusses some of the concerns that have been raised about the proposed amendments. It examines whether the legal framework in India facilitates women's access to safe abortion and concludes by underscoring the need to locate abortion within the paradigm of women's rights and autonomy over their bodies rather than conditional decriminalisation.**

[2] Article 246 of the Constitution of India divides the power of the Central and State governments to make laws as per subject matters categorised into three lists. Matters contained in list I or the union list are in the jurisdiction of the central government, those in list II or the state list are in the jurisdiction of the state government and matters contained in list III or the concurrent list are such in which either the central or the state government can make laws. In case of a conflict between the centre and the state on a matter listed in the concurrent list, the union law prevails over the state law according to article 254 of the Constitution (Jacob, 1974).

Salient features of the Medical Termination of Pregnancy (MTP) Act, 1971

Under what conditions does the MTP Act, 1971 allow abortion?

Section 3(2) of the MTP Act, 1971 specifies the conditions under which a pregnancy may be terminated, i.e. if the life of the pregnant woman is in danger or if there is risk of grave injury to her physical or mental health. The act considers the anguish arising due to pregnancy caused by rape, or failure of contraception used by a married woman or her husband as grave injury to the pregnant woman's mental health. The other condition under which the act permits abortion is, if there is substantial risk of the child being born with physical or mental abnormalities leading to serious handicap. The gestation period up to which a pregnancy may be terminated legally is 12 weeks on the opinion of one registered medical practitioner and if it is between 12 and 20 weeks, then on the opinion of two medical practitioners. Section 3(3) of the Act permits a broad interpretation of risk of injury to the pregnant woman's health by allowing the medical practitioner to take into consideration her "actual or reasonable foreseeable environment" while forming an opinion in good faith.

Who can perform abortion legally?

Section 2(d) of the Act defines a registered medical practitioner (RMP) who can provide MTP services. A medical practitioner who possesses a recognised medical qualification as mentioned in clause *(h)* of section 2 of the Indian Medical Council Act, 1956, is registered with a State Medical Council, and possesses the necessary experience or training in gynaecology and obstetrics as prescribed in the rules made under the MTP Act, 1971 is allowed to perform abortion. According to clause 3 of the MTP Rules, 1975, the necessary experience/training comprise six months' house job in gynaecology and obstetrics or one year of practice in obstetrics and gynaecology at any hospital or assisting a registered medical practitioner in performing twenty-five MTPs or possessing a post-graduate degree or diploma in gynaecology and obstetrics.

Whose consent is required to perform abortion?

Section 3(4) of the Act calls for taking only the woman's consent, unless she is below 18 years of age or "lunatic" as defined in the Indian Lunacy Act, 1912, in which case the consent may be given by her adult guardian. In the MTP (Amendment) Act, 2002 the term "lunatic" is replaced with the term "mentally ill" as defined in the Mental Health Act, 1987 that replaced the Indian Lunacy Act, 1912.

Though the husband's consent is not required by law, the supreme court, in the case of Suman Kapur vs Sudhir Kapur, ruled that a wife undergoing MTP without informing her husband amounts to mental cruelty and that the husband is entitled to seek divorce on such ground (Thakker, 2008). In another case, Suchita Srivastava vs Chandigarh Administration, the supreme court ruled in the favour a 'mentally retarded' adult woman by permitting her to continue her pregnancy as per her desire. In doing so, the court differentiated between being 'mentally ill' and 'mentally retarded'. It observed that a guardian could decide on behalf of a 'mentally ill' person under section 3(4)a of the MTP Act, 1971 but not in the case of a person with 'mild mental retardation', whose personal autonomy must be respected (Balakrishnan, 2009).

Where can abortion be performed legally?

Section 4 of the act specifies the health facilities where an abortion may be performed. These include government health facilities, and private facilities approved by the government for the purpose. MTP Rules, 1975 lay down the requirements to be fulfilled by a private health facility to gain government's approval for being used to provide MTP services, the procedure for applying and acquiring the certificate of approval as well as the process of regular inspection of the health facilities and the cancellation of their approval if need be. The MTP (Amendment) Act, 2002 decentralises the authority to approve private facilities from the state level to a district level committee headed by the chief medical officer of the district, in order to reduce delays in the approval of facilities. The amended MTP Rules, 2003 prescribe a time limit of maximum two months from the date of receiving the application for the committee to inspect the facility and another two months to issue the certificate of approval if the facility fulfils all the required conditions or within two months of the facility correcting the shortcomings observed during inspection. However, there is no mention of further course of action in the event the approval process is not completed within the stipulated time period. In order to make it easier for women to access legal and safe abortion during early gestation, the amended rules relax certain requirements for the provision of medical abortion. They permit trained/experienced RMPs to terminate pregnancies up to seven weeks' gestation using medical method of abortion at facilities which may not be approved under the act, provided they have referral linkage with approved facilities and display certificate to that effect from the referral facility.

Cognizant of the fact that there may be emergency situations in which all the above requirements may not necessarily be fulfilled, section 5 of the act allows the RMP to terminate a woman's pregnancy to save her life irrespective of the gestation period, opinion of a second practitioner, place where termination is performed as well as whether s/he has training/experience in gynaecology and obstetrics. The amendment of section 5 in the MTP (Amendment) Act, 2002 introduces imprisonment of 2 to 7 years for non-registered medical practitioners who perform abortions, for owners of unapproved facilities providing abortion services and for the practitioners providing services at such facilities.

Implementation of the MTP Act, 1971 in the early years

According to an analysis of the first 20 months of the implementation of the act, 48242 legal abortions were recorded across the country between April 1972 and November 1973 against an expected 1 to 1.5 million abortions in the initial few years of the act. Among the states, Maharashtra and Tamil Nadu reported the maximum abortions at 15325 and 8131 respectively, followed by Delhi (4961), West Bengal (3977), Kerala (3062) and Gujarat (2238). Initially 92.5% abortions were performed in the government institutions and by the end of the reporting period, the proportion changed to 43.7% cases in government institutions compared to 56.3% in the private facilities (Jalnawalla, 1974)[3].

[3] Author was the then Deputy Director, Department of Family Planning, Ministry of Health and Family Planning, Government of India, New Delhi.

The following reasons were reported for low number of legal MTPs in the early years of the act from different parts of the country such as Delhi, Sangli (Maharashtra) and Calcutta (West Bengal) (Chattopadhyay, 1974; Jacob, 1974; Kelkar, 1974; Jalnawalla, 1974):

Lack of services due to ill-preparedness of facilities: There was lack of financial resources, adequate infrastructure and trained personnel in government hospitals. Around 20,000 additional beds were estimated to be needed to meet the upcoming demand for abortions. However, the central government did not provide additional resources to the states for delivering MTP services. The need to strengthen the district hospitals in terms of both equipment and trained/experienced doctors was expressed by Chattopadhyay (1974), Jacob (1974) and Kelkar (1974) considering the lack of services at PHCs because of which women from rural areas would approach district hospitals to avail government services.

Reluctance of private providers to apply for approval under the act: The private providers were reluctant to carry out the administrative formalities and additional paper work mandated by the MTP Rules and Regulations, if they wanted to perform MTPs legally. Kelkar (1974) further observed that many of the private qualified practitioners in Sangli, Maharashtra had flourishing practice and perhaps already performed abortions without any legal consequences even before the MTP Act was brought in. Despite the large number of abortions reported to be performed illegally in Sangli prior to the enactment of the MTP Act 1971, only three cases were filed in the court under IPC over a period of 7 years, (1965 – 1972). Such practitioners were therefore likely to continue performing abortions without seeking approval under the act.

Women's hesitation to use government hospitals for MTP: Though not a representative sample, some respondents in Kelkar's study (1974) felt that women may be hesitant to use government hospitals for MTP because of concerns related to confidentiality, as government hospitals are part of public services and because of their "past reputation". Other reasons such as indifference shown towards patients in government hospitals and their general poor administration were said to turn patients who could afford to pay, towards the private hospitals. At the same time, the respondents in Kelkar's study also felt that a vast majority of the poor women would depend on government hospitals, which should hence be equipped to provide MTP services.

Lack of information about enactment of the MTP Act, 1971: Another reason that Chattopadhyay (1974) and Jacob (1974) attributed the rather lukewarm response to the act in its initial years was the fact that the need for the act was not raised by any mass movement or women's movement or people's interest group. It was largely a central government initiative and therefore required much more awareness generation about the act and its provisions, both among the practitioners and the general public, for it to be accepted and utilised. This, they observed was also because some sections of the population in the government and outside were not enthusiastic about the act as they believed it went against their social, religious and cultural beliefs.

Underreporting of MTPs by providers was also cited as a possible reason for low MTP numbers in official records (Jalnawalla, 1974).

Implementation of the MTP Act, 1971 in the subsequent years

Studies conducted by Duggal & Ramachandran, 2004, Hirve, 2004 and Barge et al, 2002 documented women's restricted access to legal abortion over the years despite the MTP Act, 1971 being in place for almost three decades. It is estimated that only about 10 percent of the abortions that took place in India were reported in the mid-1990s, at around 0.6 million per year (Duggal & Ramachandran, 2004; Hirve, 2004; Barge et al 2002). The number of MTPs reported officially remained in the range of 0.6 million to 0.7 million between 2006-07 and 2014-15 (Statistics Division, MoHFW 2017). While the number of legal abortions reported has been low, Singh et. al. (2018) estimated a national level incidence of 15.6 million abortions in the year 2015, at the rate of 47.0 abortions per 1000 women aged 15-49 years.

The number of health facilities approved to perform MTP under the act increased by only 8–10% in 1970s and 1980s and so did the number of abortions reported by them (Hirve 2004). The rate of increase of approved facilities declined in the decade of the 90s to an average of 4% (Statistics Division, MoHFW, GoI, 2017). A study of 118 abortion facilities carried out across the country in 1999 showed that their approval was delayed by 1 to 7 years (Hirve 2004). The availability of MTP services continued to be skewed between rural and urban areas since the early years of the act (Kelkar, 1974). Around two-thirds of the approved facilities were located in urban areas of the country in 1997, although more than 70% of the population resided in rural areas (Hirve 2004).

An all-India multicentre research project called the Abortion Assessment Project-India (AAP-I) launched in 2000 studied 380 formal abortion facilities (of which 285 were private facilities) across six states of India. The study found that only about a quarter of the private abortion facilities surveyed were approved to perform MTPs under the MTP Act, 1971. In contrast to the findings reported above by Hirve (2004), on an average these facilities had obtained approval within a month of applying implying that the certification process was not necessarily prolonged or cumbersome. Of the remaining facilities that did not have the certification, 68% facilities had never tried to obtain approval because they were either not keen to register or did not want to become accountable to the authorities (Duggal & Ramachandran, 2004). Considering that these facilities nevertheless provided MTP services reaffirms the observation made by Kelkar in 1974 that private medical practitioners are likely to continue providing MTP services without coming into the ambit of the MTP Act. At the same time, findings of the abortion assessment project revealed that two-thirds of the providers in non-approved facilities had the necessary experience/training as mandated by the MTP Act to perform abortions. The infrastructure such as availability of equipment and instruments, and physical conditions of these facilities was also comparable to the approved facilities. Thus, it may be inferred that a large number of private facilities may not be providing legal abortions but do provide safe abortions (Duggal & Ramachandran, 2004).

Other challenges documented by studies in the provision of legal MTP services include the lack of adequate approved facilities within the reach of poor women, high cost of abortion, use of the invasive dilatation and curettage technique, insistence by providers on certain specific methods of post abortion contraception, and inadequate information about the legality of abortion, and associated misconceptions among women, their families as well as providers. These constraints mean that only a small proportion of total abortions are performed legally and reported officially. A large number of

abortions that occur outside the formal system remain unreported and so do mortality and morbidity due to such abortions (Duggal & Ramachandran, 2004; Hirve, 2004; Ramachandar & Pelto, 2004; Barge et al, 2002; Stillman et al, 2014).

Discussion: Legal framework and access to abortion

Does the MTP Act enable a woman to take decisions related to her body?

The act provides conditional access to abortion with the final decision resting with the provider. Though the act allows providers to interpret the conditions permitted in the act liberally yet women have to give an explanation that fits within one of those conditions. Hence, single women cannot seek abortion legally and married women too have to concede failure of contraception in order to be eligible for legal abortion. Such a conditionality completely ignores the reality of a large number of married Indian women who may have no control over their own bodies and sexuality, including the use of contraception. The time limit of 12- and 20-weeks' gestation period that is prescribed in the act is another limiting factor. Women may not necessarily be in situations where they come to know about the pregnancy soon enough, are able to take the decision to terminate the pregnancy or have the financial and other resources to access legal abortion services within the stipulated time period. Thus, despite the act, several women are compelled to either continue unwanted pregnancy or seek illegal abortion services (Zavier et al., 2012; Dalvie, 2008).

A case in the Mumbai High Court in 2008 brought much public attention to the MTP Act and initiated a debate about raising the permissible gestation limit for MTP. In what is known as the Niketa Mehta case, the petitioner Niketa and her husband filed a petition in the Mumbai High Court seeking permission to terminate Niketa's 23-week pregnancy on account of a congenital heart anomaly in the foetus. The petitioner's plea in the case was that since the anomaly itself was detected at 23 weeks, she should be allowed to undergo MTP even though it is beyond the legal time limit of 20 weeks. The court, however did not grant the permission to the petitioner to terminate the pregnancy. This case nevertheless opened up a public debate on the issue leading the government of India to examine the possibility of reviewing the provisions of the MTP Act (Madhiwalla, 2008). Consequently, in an attempt to liberalise the abortion law and increase the availability of legal MTP services, the Ministry of Law and Justice drafted the MTP (Amendment) Bill 2014. The bill took into consideration suggestions made by experts from a variety of stakeholder groups including the National Commission for Women (MoHFW, 2016). The bill proposed to extend the gestation period for legal MTP to 24 weeks from the earlier 20 weeks in case of certain categories of women as may be prescribed and no time limit for termination of pregnancy necessitated by the diagnosis of substantial foetal abnormality. The bill proposed that pregnancy up to 12 weeks be terminated on the request of the woman without enquiring the reason for it and also made it legal for single women to seek abortion. Another new clause that would encourage women to seek legal abortion was that on ensuring privacy of the woman. The draft bill was put out for suggestions in the public domain in October 2014 (MoHFW, 2014) and based on the feedback received, it was revised (MoHFW, 2016). However, in May 2017 the Prime Minister's Office sent the draft Bill back to the Ministry of Health and Family Welfare with the recommendation that the draft be further strengthened (Pachauri, 2017).

While the government was in the process of revising the draft 2014 Bill (Gupta, 2019), several petitions were filed in different courts across the country by women seeking permission to terminate pregnancies beyond 20 weeks' gestation. In most of these cases either the pregnancy was a result of sexual abuse and came to be known later into the pregnancy or foetal anomalies were detected late (Rastogi & Chandrashekar, 2019; Sharma, 2019). Taking the above developments into consideration, a revised Medical Termination of Pregnancy (amendment) Bill, 2020 was tabled and passed in the Lok Sabha in March 2020. The MTP (amendment) Bill, 2020 defines termination of pregnancy as a procedure to terminate a pregnancy using medical or surgical methods. It raises the upper limit of MTP from the current 20 weeks to 24 weeks in case of certain categories of women as may be prescribed in the rules. Opinion of two doctors is required for termination of pregnancies between 20 and 24 weeks while a single doctor has the discretion to perform MTP up to 20 weeks, unlike 12 weeks in the principal act. The amendment removes the time limit for an MTP that is considered essential because of 'substantial foetal abnormality diagnosed by a medical board' (MoHFW, GoI, 2020).

Though the MTP (amendment) Bill, 2020 broadens the criteria for women to seek legal abortion yet it does not alter the fundamental nature of abortion laws in India. Abortion continues to be permitted only in certain conditions and one or two providers or a medical board have the decision-making authority, rather than the women themselves. To that extent, the amendment goes back on what was proposed in the draft MTP (Amendment) Bill of 2014, which permitted a pregnancy up to 12 weeks to be terminated on the request of a woman. Discussed below are some specific concerns raised by different stakeholder groups with regard to the proposed amendments and women's ability to take decisions related to their bodies.

Increasing the gestation limit: One viewpoint that opposes increasing the gestation limit for MTP is that it could open the door for sex-selective abortions. Counter-view to this is that implementation of one law should not hamper the services to be provided under another law. Implementation of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) (PCPNDT) Act, 1994 should be dealt with separately without conflating it with the MTP Act (Krishnan, 2015). A community-based study in Maharashtra and Rajasthan highlighted the role of factors such as women's lack of decision-making power, prior unsuccessful attempt to terminate the pregnancy and distance from the facility in leading to the situation that required seeking second trimester abortion rather than sex-selective abortion being the primary reason for it (Zavier et al., 2012). The advancement in technology both to detect congenital anomalies and to provide safe abortions in late pregnancy should be used for women to take decisions according to their situation (Gupta, 2019). Another objection to raising the gestational limit for MTP is on the grounds of potential disabilities in the foetus. The disability rights groups argue that foetal abnormality should not be specified as a separate reason for permitting MTP as it reinforces the eugenic notion that persons with disabilities are not wanted in the society. Such a clause may be discriminatory and the decision should be left to the pregnant woman, depending on the medical advice she receives and her life circumstances (Jain, 2020). It is argued that if abortions can be safely performed at any gestational age in case of 'foetal abnormalities', the same can then be done for other reasons as well. Hence, women should be allowed to terminate their pregnancies without the restriction of an upper gestational age in case they are survivors of sexual abuse or experience such changes in their lives that make the pregnancy unwanted at any stage (Jain, 2020; Coalition of civil society organisations, n.d.).

Setting up of medical boards: The requirement of medical boards to diagnose 'substantial foetal abnormalities' in case of pregnancies more than 24 weeks, takes the decision-making further away from women. A study conducted by the Pratigya Campaign to analyse the usefulness of medical boards in the judgements given by the supreme court and high courts in the country from June 2016-April 2019 revealed that it leads to substantial delay in accessing abortion services. It also puts additional physical, emotional and financial burden on women who may already be in a very vulnerable situation (Coalition of civil society organisations, n.d.; Rastogi & Chandrashekar, 2019).

Privacy and confidentiality: The MTP (amendment) Bill, 2020 is weak on protecting the privacy and confidentiality of the woman seeking MTP by making it incumbent on the provider to reveal her identity to a person authorised by any law in force at that time, which can be used to harass the woman as well as the provider. (Coalition of civil society organisations, n.d.; Jain 2020). The 2014 amendment, on the other hand provided absolute protection of the woman's privacy by directing that the provider shall not reveal her identity.

An enabling amendment in the 2020 bill, which was also proposed in 2014, is that it makes it legal for single women to seek MTP. In section 3(2), explanation II is amended to read 'any woman or her partner' rather than 'any married woman or her husband' and the phrase 'or preventing pregnancy' is added after 'limiting the number of children'.

Does the MTP Act help the medical practitioner to provide a woman the services that she needs?

By decriminalising abortion under particular conditions, the MTP act allows the medical practitioners to terminate pregnancies that meet those conditions. Further, under section 5 of the act, the RMP is permitted to terminate a pregnancy to save the woman's life irrespective of the fulfilment of the conditions laid down in the act such as the gestation period, opinion of a second practitioner, place where termination is performed as well as whether the RMP has training/experience in gynaecology and obstetrics. Section 8 of the act also provides protection to the RMP from any suit or legal proceedings in case of any damage or likely damage caused due to actions performed in good faith. Hence the MTP Act provides protection to the medical practitioners and also vests in them significant decision-making power. The practitioners may choose to exercise such protection and power to interpret the act liberally and provide women the services that they need while staying within the boundaries of the law. At the same time, the fact that any action of theirs that falls outside the purview of the act may be considered criminal under the IPC, thereby inviting stringent punishment, makes them extremely cautious and conservative in their approach towards providing abortion legally (Jain, 2019). In the case of Dr. Nisha Malviya and Anr. v/s State of MP, the high court of Madhya Pradesh held two doctors, who had carried out MTP of a 12-year-old rape survivor, guilty under section 313 of the IPC for terminating the pregnancy without the girl's/ her guardian's consent and section 201 of the criminal procedure code (CPC) for destroying the material evidence of rape i.e. pregnancy. The doctors argued that the girl's mother had consented to the abortion and that the 12-year old unmarried girl would have suffered mental anguish if she had to deliver a child, therefore section 3 of the MTP Act, 1971 provided them protection. The court, however, did not accept their argument as the mother said that she did not give consent and the doctors could not produce her written consent before the court (Gupta, 1999).

The medical practitioners' ability to provide abortion services according to the MTP Act, 1971 is also constrained by the flawed implementation of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) (PCPNDT) Act, 1994 and contradictory provisions in acts like the Protection of Children from Sexual Offences (POCSO) Act, 2012. These aspects are discussed in detail in a section below.

Further, under section 5A of the MTP 2020 amendment bill, the medical practitioners are obliged to share identifying information of women whom they may have provided MTP services with a person authorised by any law in force at that time. Not doing so is punishable with imprisonment up to one year, or fine, or both. This provision can be misused, for instance to elicit information during inspections carried out for monitoring the enforcement of the PCPNDT Act, 1994 leading to the harassment of the providers if they refuse to reveal their clients' details. Such a clause may further deter the medical practitioners from providing legal abortion services. (Coalition of civil society organisations, n.d.; Jain 2020).

A common practice followed by several medical practitioners from the early years of the MTP Act is refusing to provide abortion services to women who visit alone or if the husband or a close relative does not give written consent, though the act only seeks the women's consent (Kelkar, 1974; Duggal & Ramachandran, 2004). Adopting such a practice is going beyond the provisions of the law and could restrict women's access to legal abortion services.

Do the MTP Act and its amendments take into account the developments in the public health and medical fields?

The Programme of Action (PoA) adopted by 179 countries, including India, during the International Conference on Population Development (ICPD) held in 1994 in Cairo, recognised women's reproductive health and rights to be fundamental to a country's and the world's development (UNFPA, 2019). It anchored the efforts to bring about a paradigm shift to the family planning programme from fertility control to reproductive rights of women. It strengthened the argument to consider abortion as a matter of the woman's right over her body rather than one of medical opinion (Sebastian et al., 2013).

In response to the ICPD conference, government of India reoriented its family planning and maternal and child health programme called the Child Survival and Safe Motherhood (CSSM) programme (1991-96) into a new, more comprehensive and integrated programme called the Reproductive and Child Health (RCH) programme in 1997. Medical termination of pregnancy was mentioned as a distinct component among the key programme elements in GoI's scheme for implementation of the RCH programme (Mavalankar, 1999). Though far from addressing women's access to abortion as their right, the 2002 amendment of the MTP Act, 1971 may have been brought about in response to some of these changes, along with the advent of the safer medical methods of abortion (MMA)[4] (Sebastian et al., 2013). The amendments such as the decentralisation of approval of facilities to perform MTP

[4] Medical abortion is a multistep process involving two medications-mifepristone and misoprostol, and/or multiple doses of one medication-misoprostol (World Health Organization,2014).

from the state to the district level and conditional use of medical method of abortion by trained/experienced RMPs to terminate pregnancies up to seven weeks' gestation sought to increase access to legal abortion.

An inconsistency that remains between the legal provisions and the developments in the medical field is that the MTP Rules 2003 permit MMA (using mifepristone and misoprostol combination) to be used up to seven weeks of pregnancy while the Drug Controller General of India approved the use of the combipack to terminate pregnancy up to nine weeks in 2008. In fact, an opinion is that the use of MMA should be considered up to 12 weeks' gestation as recommended by the World Health Organisation. The MTP (Amendment) Bill, 2020 does not address this inconsistency (Coalition of civil society organisations, n.d.; Chandrashekar et al., 2019).

In 2012, the Population Council released a study conducted in India which demonstrated that abortions performed by trained mid-level health-care providers were as safe and acceptable as those conducted by physicians (Jejeebhoy, 2012). The study findings were in consonance with evidence-based recommendations made by the WHO (WHO, 2012). Based on such evidence, the MTP (Amendment) Bill, 2014 provided for the expansion of the ambit of abortion providers. It proposed to include registered health care providers belonging to the disciplines of Ayurveda, Yunani, Siddha and Homeopathy (AYUSH) as well as nurses and auxiliary nurse midwives within its fold. Though such a provision could increase women's access to safe abortion, particularly in places where doctors are unavailable, the Indian Medical Association (IMA) opposed it. It argued that including these groups would encourage quackery and put women's health at risk. IMA also claimed that allowing non MBBS personnel and mid-level providers to perform MTP would be a violation of the Clinical Establishments Act, 2010 which does not permit the paramedical personnel to conduct medical procedures (Gupta, 2019; Economic Times, 6 Nov 2014). As mentioned earlier, the 2014 bill was ultimately withdrawn and the MTP (Amendment) Bill, 2020 does not mention anything about expanding the provider base.

How do other legislations affect the implementation of the MTP Act?

The section below discusses the conflation and contradiction of the MTP Act with the PCPNDT Act and the POCSO Act, two legislations that directly impact the provision of legal abortion services.

- Conflation of the PCPNDT (Prohibition of Sex Selection) Act, 1994 and the MTP Act, 1971

In order to address the problem of declining child sex ratio[5], the Pre-natal Diagnostics Techniques (Regulation and Prevention of Misuse) (PNDT) Act, 1994 was adopted by the Parliament of India and came into effect from January 1996. The act was amended in 2003 by the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) (PCPNDT) Act, 1994. The act prohibits the use of pre-natal diagnostic techniques including ultrasonography, for the purpose of determining the sex of a foetus or the selection of sex before or after conception (Ministry of Law and Justice, 2003).

[5] Child sex ratio is the number of females per 1000 males in the age group of 0 to 6 years. It reduced from 983 in 1951 to 945 in 1991 (Census of India, 1991)

Though the objectives of the PCPNDT Act and the MTP Act are very different from each other yet there has been considerable conflation of the two since the PCPNDT Act was enforced. There has been intense public focus on preventing sex-selective abortion, including orders by the high courts and the supreme court for effective implementation of the PCPNDT Act in response to several petitions filed in the courts by concerned groups (Chandra et al, 2019). In the zeal to monitor and ensure implementation of the PCPNDT Act, the MTP Act often does not get as much attention. A possible reason cited for this is the apprehension that talking openly about legal and safe abortion may encourage sex-selective abortion (Ravindran et al, 2019). Studies have recorded greater awareness about the newer PCPNDT Act both among lay people and service providers than of the MTP Act and some of its specific provisions. Stigma against abortion and women who seek abortion has been reported at the community level, along with confusion about the legal status of abortion (Ravindran et al, 2019; Sebastian, 2013; Duggal & Ramachandran, 2004). However, as Duggal & Ramachandran (2004) found out, sex selective abortion tends to be acceptable to the family and the community at large for women having many daughters. The community members, in their study justified it on the pretext that women's social status and continuity of their marriage often depends on whether they can beget sons. Thus, more social stigma seems to be associated with abortion than with sex-selective abortion. With distinction between the PCPNDT Act and MTP Act getting blurred, the widespread perception is that all abortions are illegal. Government officials too, either due to lack of clarity or under pressure to strictly implement the PCPNDT Act, clamp down heavily even on approved facilities providing legal MTPs and qualified medical practitioners. This has made several providers particularly apprehensive about performing second trimester abortions[6] and in some instances any abortion at all, making women's access to legal abortion even more difficult (Ravindran et al, 2019; Sebastian, 2013; Duggal & Ramachandran, 2004). An action that is illegal under the PCPNDT Act, i.e. sex determination of the foetus is inappropriately combined and confused with a service that is legal under the MTP Act (Prasad, 2015).

- Contradiction between the POCSO Act, 2012 and the MTP Act, 1971

The Protection of Children from Sexual Offences (POCSO) Act, 2012 is an important legislation to protect children, defined as people below 18 years of age, from sexual offences such as sexual assault, sexual harassment and pornography. Consistent with the best international child protection standards, it provides for mandatory reporting of sexual offences against children (Ministry of Women and Child Development, 2013). However, access of adolescent girls to legal abortion services under the MTP Act, 1971 has come into conflict with the POCSO Act, 2012. The POCSO Act, 2012 directs any person, including a medical practitioner, who has knowledge that a sexual offence has been committed against a 'child', to report it to the special juvenile police unit or the local police. Failure to report may lead to imprisonment for six months or fine or both. Such mandatory reporting is in conflict with the provisions of confidentiality under the MTP Act. Adolescent girls may be reluctant to seek legal abortion services due to fear of their partners/husbands being arrested in case of consensual sex or due to fear and power dynamics in case of abuse where the perpetrator is a family member or someone in position of power. Girls would also be concerned about their own identities being revealed

[6] Sex of the foetus can be determined in the second trimester of pregnancy, therefore second trimester abortions are more closely associated with sex selective abortions

and may therefore be compelled to resort to illegal abortion (POCSO Act, 2012; Jain & Tronic, 2019; Ravindran et al, 2019).

In summary, the MTP Act, 1971 and its amendments provide women conditional access to abortion, with the final decision-making power vested in the hands of the provider(s) or a medical board. Thus, despite the broadened criteria to seek MTP if the MTP (amendment) Bill, 2020 is passed by the Rajya Sabha, the fundamental nature of abortion laws in India remains unchanged. Imposition of such conditionalities fails to recognise the fact that several women in the country may neither have control over their own bodies and sexuality nor be able to access abortion services within these conditions. For the providers too, the possibility of being prosecuted under the IPC, limits the use of their discretionary power to provide greater access to legal abortion services. Additionally, the conflict with other laws such as the (PCPNDT) Act, 1994 and the POCSO Act, 2012 makes the providers even more cautious. Discrepancy between what is legally permissible and medically recommended, i.e. use of MMA up to seven weeks though WHO recommends its use up to 12 weeks' gestation and expansion of the provider base also limits access to legal abortion services.

Conclusion

The MTP Act, 1971 when first enacted was a bold and progressive move as it recognised that there may be occasions when women need to terminate their pregnancies and that they should be able to do so in a legal and safe environment. Amendments to the act and its rules and regulations over the years responded to some of the issues that arose in the effective implementation of the act. For example, decentralisation of the authority to approve health facilities from the state to the district level, prescribing a definite time period to grant approval to the health facilities to provide MTP services, relaxation in the conditions to provide medical abortion up to seven weeks' gestation and introducing penal action for providing MTP services in violation of the MTP Act. However, several concerns resulting from the socio-cultural changes that the Indian society has gone through in the last half century and the progress made by science and technology, are yet to be addressed. These include the necessity to fit into one of the permissible conditions to access abortion legally, restriction on the gestation period up to which abortion may be available including the short period up to which medical method may be used and the limited range of providers who can provide the service.

The shift in approach of the country's health programme from population control to reproductive and sexual rights of women combined with the improvement in women's socio-legal status, resulting from decades of national and international movements and struggles (Saheli Women's Resource Centre, 2000), calls for locating abortion within the paradigm of women's rights over their bodies and their reproductive choices. To this end, it is critical that legalising abortion is approached in a manner that it can be availed like any other medical procedure without any discrimination, rather than as an exception to its criminal status under the IPC. The legal framework of abortion in the country ought to be overhauled to overcome the challenges discussed above and enable women to exercise their choice instead of depending on gate keepers with whom rests decision-making power as second or third party, such as the treating doctor or the medical board.

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