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Women and Abortion Laws in India: A Comparison of the Medical Termination of Pregnancy Act, 1971 and The Amendment Act, 2021

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The Medical Termination of Pregnancy (Amendment) Bill, 2020 was approved and passed by Lok Sabha in the year 2020 and by Rajya Sabha in 2021. The Bill was then sent for Presidential assent, which it finally received on 25.03.2021, and the Bill became The Medical Termination of Pregnancy (Amendment) Act, 2021 (hereinafter referred to as "Amendment Act"). The Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as "MTPAct") was the first and foremost law enacted by parliament in India with the objective to provide for termination of pregnancies under certain circumstances only by an approved medical practitioner and the law came into force on 01.04.1972. The MTP Act does not give any reproductive right to any woman to terminate pregnancy and pregnancy cannot be terminated except under the circumstances listed in the Act. A woman cannot abort the pregnancy of her own will and pleasure even in the beginning or in the first stage of pregnancy. Under the MTP Act, there was no provision for abortion on demand and the Act only provided an enabling provision to protect a Registered Medical Practitioner from any penalty under the Indian Penal Code,1860 (hereinafter referred to as "IPC, 1860"). The IPC,1860 under its Chapter XVI through Sections 312-316 criminalized abortion unless it was performed with the aim of protecting a pregnant woman's life. Section 312 of the IPC, 1860, criminalizes the act of wilful miscarriage of a pregnant woman, however, the MTP Act allows the same to happen if it is done with the intention to protect the life of a pregnant woman. Section 316 of IPC, 1860 prescribes punishment for causing the death of a quick unborn child by an act amounting to culpable homicide. After 1971, the MTP Act was amended first time vide Act 64 of 2002, which came into

force on 18.06.2003. The Medical Termination of Pregnancy (Amendment) Act, 2002 made amendments to Section 2, Section 3, and Section 5 of the Act. Also, Section 4 of the Act which dealt with the place where pregnancy may be terminated was substituted by a new Section. Under the amended Act the word lunatic was substituted with the word mentally ill person and further, the amendment also increased the punishment for termination of pregnancy by a person who is not a registered medical practitioner. With the advancement of medical science and technology, more amendments were proposed to the MTP Act in the years 2014 and 2017, to bring the old law in consonance with the present-day medical technology and techniques which can detect fetal abnormalities even at a very advanced stage of pregnancy. However, these bills lapsed for want of approval by either one or the other house of the parliament. The MTP Act was the only law that laid down a procedure that should be followed while dealing with medical termination of pregnancy. This paper shall highlight the changes which will be brought forth by the recent amendment to the MTP Act, 1971, and will throw light on the rights of women under the amended Act and the Indian constitution.

Keywords: *pregnancy, termination, abortion, laws, constitution.*

INTRODUCTION

Women have used many "methods" of controlling birth for centuries. In all this, since abortion is "the fulcrum of a much bigger ideological conflict in which the fundamental definitions of the family, the state, motherhood, and young women's sexuality are questioned," these practises have resulted in strong "moral, ethical, political, and legal arguments". Females used abortion openly or surreptitiously, but their access to services has been limited by societal as well as lawful limitations, some of them are based on morals and religious practices. The ethical standards "*governing abortion have been constantly reshaped to fit the times and social settings in which they are applied*". In spite of their differences in structure, meaning, and, application, the said standards have always been directed at meeting social requirements that overlook women's right to choose their "sexuality, fertility, and reproduction".[1] The first abortionist in Europe were "Lay women healers who practised "medicine" among the peasantry". When medicine, was a profession controlled solely by males, who got up as a strong power in the mid-nineteenth century, its practitioners were facing declining

[1] Annas, 'The Supreme Court, Privacy and Abortion' (1989) 321 (17) The New England Journal of Medicine

competition from all 'non-professional' practitioners, the majority of whom were women and abortion providers. As a result, doctors became the torch bearers in launching and organising the first anti-abortion campaign. Physicians are prohibited from performing abortions under the Hippocratic Oath, which forms the basis of medical ethics. The medical profession turned to this Oath for its justification on the issue of abortion. The American Medical Association (AMA) declared that "*abortion should be illegal at its meeting in 1859*". Abortion was declared a contravention of the belief and grounds for excommunication by the Church a decade later, in 1869, with the "Apostolic sides Pius IX".

The medical community and the Church had teamed up in the 1870s to make abortion illegal, and they had succeeded. Abortion was recognised as an exemption only as a curative motive for protecting the life of a woman. This order was in effect for a century until 1973, when the Supreme Court, in the *Roe vs Wade*[2] case, started the process of liberalisation. The Abortion Act of 1967 in the United Kingdom liberalised "abortion services up to 28 weeks of pregnancy". Until the "Medical Termination of Pregnancy (MTP) Act" was implemented in our country, abortions were illegal (if not medically necessary). The women's movement, which lacked a strict feminist movement until the early 1970s, was not the source of the demand for a liberalised statute. As a result, the movement of the time was centred on criminal law subversion rather than an autonomous charter of political demands. Instead, demographers and medics took on the task of persuading policymakers, who were guided by their "professional interests and beliefs". Medical professionals were aware of the detrimental consequences that abortions (performed unhygienically by non-registered, undertrained, and not well-equipped providers) could have on women's health, while people in favour of "family planning and population control" advocated for economic liberalisation to reduce the birth rate.[3]

The study agenda in the 1950s and 1960s was directed at studying and assessing occurrence patterns in the setting of "age, economic status, marriage length, pregnancy, and contraceptive

[2] *Roe v Wade* [1973] 410 U.S 113

[3] R.V. Bhatt & J.M. Soni, 'Criminal Abortion in Western India' (1973) 22 (3) Journal of Obstetrics and Gynaecology of India

histories". Academicians concerned with birth control were compelled to establish a relationship between liberalisation and population control as the emphasis on "family planning in the health agenda grew in the 1960s". Themes such as liberalisation and its potential for population control, as well as the prospective consequences of liberalisation on the social fabric, began to emerge in this setting. Many academics also computed the number of abortions required to save a pregnancy.

METHODS FOR PRACTICING ABORTION BEFORE 1860

Religious tribunals prescribed numerous austerities for the females or ex-communication for a cleric who conducted an abortion, according to India's Vedic and Smriti rules, which expressed worry over the male seed of the three upper classes. Abortion was mentioned as being performed by surgeons or barbers in the days of the epic Ramayana. The only proof of the capital punishment for abortion in old law may be discovered in the "Code of Assura, c. 1075 BCE", and it is only applied to women who aborted their child without the consent of the husband. The Ebers Papyrus, written around 1550 BCE in Egypt, is the first recorded proof of induced abortion.[4]Various non-surgical procedures were used in early cultures hard labour, climbing, paddling, lifting, and diving were all popular physical activities. Others included using "*irritating plants, fast, bloodshed, pouring hot water on the abdomen, and lying down on a heated coconut shell. In almost all communities, abortion techniques evolved through observation, an adaptation of obstetrical processes, and transculturation*". In the Early Modern Period, "battery, exercise, and tightening the belt were all common means of inducing abortion in English women".Early surgical efforts at foetal removal have been uncovered; however, given how rarely they are mentioned in ancient writings, such treatments are unlikely to have been common.

According to an eighth Sanskrit book, females who desire to cause end their pregnancy should sit over "a pot of steam or stewed onions". Massage abortion, which entails "putting pressure on the expectant abdomen, has been used in Southeast Asia for decades". One of the bas reliefs

[4] Aditi Iyer & Amar Jesani, 'Abortion: Who is Responsible for our Rights?' (*Cehat*) <https://www.cehat.org/publications/1490871985> accessed 25 April 2022

on the temple of "Angkor Wat in Cambodia", which originates from around 1150, shows a demon performing an abortion on a woman being sent to the underworld.[5] In Japan, induced abortion has been documented in documents reaching back "to the 12th century". It was widespread during the Edo period, particularly among the peasantry, who were disproportionately afflicted by the era's repeated famines and very high taxes. In memory of an abortion, miscarriage, stillbirth, or early childhood death, a temple in Yokohama began constructing sculptures of the "Boddhisattva Jizo" as early as 1710.

LAW LAID DOWN IN INDIAN PENAL CODE, 1860 UNDER SECTIONS 312 TO 316

Sections 312 to 316[6] of the Code are titled as follows "*Of the causing of miscarriage, of injuries to unborn children, of the exposure of infants, and of the concealment of births*"

When the miscarriage isn't "caused in good faith for the purpose of saving the woman's life", Section 312 provides that: "Whoever voluntarily causes a woman with child to miscarry shall be punishable with imprisonment of either description for a term which may extend to three years, or with fine, or both, if the miscarriage is not caused in good faith for the goal of safeguarding the woman's life"; and, if she is "quick with child," punishment shall be imposed. Section 313[7] refers to purposely inducing a miscarriage without the woman's permission. It states that anyone who "commits the offence" stated in the previous section without the "woman's permission, whether or not the woman is pregnant with a child, will be punished with life in prison", or imprisonment of any kind for ten years, as well as a fine. Section 314[8] refers to death as a result of an act committed with the intent of inducing a miscarriage. It states that anybody who undertakes any act that results in the demise of a pregnant woman with the intention to cause her miscarriage will be penalised by "imprisonment of any kind for a period up to ten years, as well as a fine".

[5] *Philosophy and Practice of Medical Ethics* (British Medical Association, London 1988)
[6] Indian Penal Code, 1860, ss 312 and 316
[7] Indian Penal Code, 1860, s 313
[8] Indian Penal Code, 1860, s 314

Acts that are done by anyone with the intention to prevent a child to take birth alive or to cause the child's death after birth are covered by Section 315[9]. It states that any person who does any act with the intent of preventing the child to be born alive or starting to cause it to die after its birth and succeeds in preventing "*that child from being born alive or causing it to die after its birth, shall if such act is not done in good faith for the purpose of saving the mother's life, be punished with imprisonment for a period for a term that may extend to ten years, or with fine, or with the both, be punished*". Section 316[10] refers to a culpable murder act that results in the killing of an unborn child. It states that anyone who engages in activities that would make him guilty of culpable homicide if he caused death, and who does so by killing an unborn child after quickening, will be punished by imprisonment of any kind for 10 years, as well as a fine.

SHANTILAL SHAH COMMITTEE REPORT

The Government of India created a committee in the mid-1960s, chaired by Shantilal Shah, a medical practitioner. A report was submitted on 30.12.1966, and parliament passed the MTP Act in 1971. The Shantilal Shah Committee recommended that abortion laws be liberalised in 1964 in order to improve their effectiveness and reduce the "number of unsafe abortions and maternal death rates" associated with illegal abortions. Based on the Shantilal committee report, the medical termination of pregnancy law was introduced in both the houses of parliament in December 1966 and passed by the parliament in 1971. This Act applies to the entire Indian subcontinent. This Act was enacted on April 1, 1972, and has been in effect since. The Act was revised once more in 1975, this time to make it less difficult and more efficient.

CHANGES MADE BY MTP ACT, 1971

In India, the MTP Act is based on the "concepts of a British act established by the British Parliament in 1967". The MTP Act is intended "to provide for the termination of certain pregnancies by registered Medical Practitioners and for matters associated therewith or incidental thereto". Essentially, it deregulates as well as (tries to) regularise medical practices and institutions regarding abortion, allowing "medical liberalisation" to take precedence over

[9] Indian Penal Code, 1860, s 315
[10] Indian Penal Code, 1860, s 316

medical criminalization. Therefore, the MTP Act failed to include a basic right to induced abortion, but rather liberalises the circumstances under which women can obtain abortion services from certified medical practitioners. As a result, medical liberalisation implies the medicalization of the Act's liberalised conditions. This is accomplished by "*broadening the earlier medical indication for rescuing a pregnant woman to encompass medical and psychological morbidity, as well as the risk of such morbidity if the woman is compelled to carry an undesired pregnancy to term*". As a result, from a medical standpoint, terminating a foetus becomes a "therapeutic" rather than a "right" intervention. Medical professionals arbitrating female access to abortions now have a stronger position under the new law, which states that pregnancies can only be ended in recognised healthcare centres only when they are approved. The length and kind of pregnancy are the two factors that are considered. According to the Act, a single doctor can authorise the "termination of a pregnancy up to 12 weeks", but those between 12 and 20 weeks require the input of two doctors.

The law also requires medical professionals to consider the "actual or reasonably foreseeable environment" that may endanger the health of the pregnant lady. A pregnancy after rape (not including marital rape) or failure of contraceptive for a married lady is cited as particular signs in two different explanatory notes in this regard. "Physical or mental abnormalities" that could "severely impair" the unborn kid are among the numerous health issues depicted. Obviously, the pregnant woman seeking an abortion will have to explain herself. She is disqualified if she claims that the pregnancy was desired "at the time of conception but is now undesirable". A woman is obligated to "provide explanations that fall within the Act's broad liberal yet stringent criteria". As a result of this scenario, many interpretations of the Act are possible. The contemporary preoccupation with population control, as well as the medical profession's rather dubious objectives, have resulted in a liberal interpretation of the legislation. But, there is still a risk that this liberal interpretation could become restricted without changing the language of the text. This might occur due to a variety of socioeconomic and demographic pressures.[11] The Act further stipulates those abortions can only be performed legally by a

[11] Goyal, 'Legalisation of Abortion: A Social Perception' in Health and Population: Perspectives and issues' (1978) 4

certified Medical Practitioner "with such experience or training in gynaecology and obstetrics" and at a location that has been approved by the competent government. This stipulation is both necessary and admirable. A liberalised statute, on the other hand, provides little benefit to those women who want to end their pregnancies in the absence of a well-equipped category of abortion providers. The MTP Act is ineffectual in lowering the number of illegal abortions because it doesn't recognise the right to enjoy as an enforceable right.

THE AMENDMENT MTP ACT, 2021

The MTP Amendment Act of 2021 contains the following key provisions:

"*Termination due to failure of a contraceptive method or device: The Act allows a married woman to terminate a pregnancy*" following the failure of a contraception technique or device for up to 20 weeks. Unmarried women can also terminate the pregnancy for the same reason. For pregnancy terminations of 20 weeks of gestation, one Registered Medical Practitioner (RMP) opinion is required. Two RMPs' perspectives on aborting a fetus at 20-24 weeks. On the other hand, an opinion of a medical board formed at the state level is needed if pregnancy is aborted after 24 weeks due to substantial foetal abnormalities. The top gestation limit for "particular categories of women, such as survivors of sexual assault, incest victims, and other vulnerable women, is raised from 20 to 24 weeks (differently abled women, minors, among others)". Confidentiality: "A woman whose pregnancy has been terminated name and other particulars shall not be revealed," except to any person authorised under existing law.[12]The newly amended law will help to "achieve the Sustainable Development Goals (SDGs) 3.1, 3.7, and 5.6 by reducing preventable maternal death". SDG 3.1 is about lowering the maternal death rate, whereas SDGs 3.7 and 5.6 are about providing universal access to sexual and reproductive health and rights. The modifications will "broaden the scope of safe abortion services available to women and ensure dignity, autonomy, secrecy, and justice for women who need to end their pregnancy".

[12] Jane Hurst, Abortion in Good Faith : The History of Abortion in the Catholic Church: The Untold Story' (1991) 12 (2) Conscience

LEGAL PRECEDENT

In the last few years, the notion of "abortion entailed weighing the legal individuality of the unborn foetus against the mental and physical health of the expectant mother". This frequently takes the form of oratorical queries such as "where does life begin?" and then contrasting the rights of the child in the womb"against the rights of the expectant mother". The Supreme Court, on the other hand, gave a landmark judgement on the subject on July 26, 2016, noting that the issue was "life versus life." The court said that the "petitioner, 'Ms. X,' an alleged rape survivor, will be allowed to terminate her pregnancy after the legally authorised 20-week mark because the woman's life is in danger". Since it is now accepted that a "20-week-old foetus" has a medically viable existence, this case addressed issues of law and morality surrounding abortion. The petitioner claimed that the law laid down by the parliament is not constitutional and therefore violates a woman's right to life as protected by Article 21 of the Constitution.[13]

The judges, which included Justices JS Khehar and Arun Mishra, granted this privilege under Section 5 of the MTP, 1971, which enables the unborn to be aborted even beyond 24 weeks if the mother's life is threatened medically. Section 5 establishes a legally mandatory exception that overcomes the MTPA, 1971's 20-week limit to enable an abortion if it is "immediately necessary to save the pregnant woman's life." "The medical board has determined that the continuation of the pregnancy would significantly harm the mother's physical and mental health," the Bench stated. We're happy with the diagnosis and, under Section 5 of the MTP Act, 1971, it is legal to terminate the pregnancy. We grant the petitioner's liberty, and she is free to terminate the pregnancy if she so wishes." The apex court's decision opens new paths in the field of women's reproductive health in the country, which has been regulated by a 45-year-old rule that is outdated, arbitrary, and strikes at the heart of women's fundamental rights.[14]

[13] "Abortion law: SC's judgment is perfect time to push for changes in pregnancy termination act", July 27, 2016.
[14] ICMR, "Illegal Abortions in Rural Areas, Indian Council for Medical Research, New Delhi. ICMR (1991)", "Evaluation of Quality of Family Welfare Services at Primary Health Center Level", 1989

"*Following the proposal of the Shantilal Shah Committee Report in 1966, which recommended that abortion and reproductive rights should be governed by legislation*", the MTPAct was enacted in 1971. In 2002, the MTPA was changed to decentralise abortion law by permitting criminal penalties for prohibited means of abortion, as well as the establishment of MTP guidelines in 2003.

The MTPA was challenged in 2006 in "*Nand Kishore Sharma v Union of India*[15]*, on the grounds that it breaches Article 21 of the Constitution's right to life and dignity*". In this decision, the Court held that the "relevant MTPA provision was not unconstitutional and complied with Article 21". The Court, on the other hand, "did not express an opinion on whether the Act violates the foetus' right to life, arguing that it would be difficult to know when the foetal' existence begins". In *Dr. Nikhil Dhattar v Union of India*[16], the petitioners, Haresh and Nikita Mehta asked the High Court of Bombay to "enable them to terminate their 26-week-old child, which had been diagnosed with a heart abnormality", a situation identical to Ms. X's. The medico-legal narrative was startled into consciousness during this case about how the progress of medical technology necessitated a change in the understanding of foetal viability as well as changes in the law. Their appeal was dismissed due to professional medical advice. The Court stated that only the legislature has the power to modify the law.[17]

The current instance demonstrates that the existing legislation has significant problems. The Ministry of Health proposed an amendment bill to the MTPAct in 2014, which allows termination beyond the 20-week limit under certain circumstances. It also provides that a "healthcare practitioner may "in good faith" allow termination between 20 and 24 weeks of pregnancy" if there is a threat to the mother or child, or if the abortion is "alleged by the pregnant woman to have been caused by rape." The draught law highlights current conditions in which rapes are common and declares that pregnancy caused by rape "may be believed to constitute a grave impairment to the pregnant woman's mental health," and that such an injury

[15] *Nand Kishore Sharma v Union of India* AIR 2006, Raj. 166
[16] *Dr Nikhil Dhattar v Union of India* (2009) Special Leave Petition (Civil) No. 5334/2009
[17] Phillips. and Ghouse, 'Septic Abortion - Three Year Study, 1971-73; Hazards of Septic Abortion as compared to Medical Termination of Pregnancy' (1976) 26 (5) Journal of Obstetrics and Gynaecology of India

to mental health might be a basis for legalising termination. With the decision of the Supreme Court, the moment has come to try to change the MTPAct to permit a revised abortion legal limit. The impact, which was established in 1971, could not anticipate the developments in the medical-technological world that have resulted from the widespread use of ultrasound and magnetic resonance imaging (MRI) to assess foetal health and well-being. The MTPA, which was enacted in 1971, did not contain provisions for sexual and reproductive health rights and women empowerment, thus now appears to be the ideal time to press for these reforms in the law.

THE APPROACH HEREINAFTER: CONCLUDING REMARKS

The sceptic's dilemma emphasises the drawbacks of recognising abortion as a civic right for individual liberty and privacy. Legality simply gives a thin layer of protection and political legalisation that is important but insufficient to transform the material circumstances of women's life. To begin with, it allows anti-abortionists to "juxtapose the civil rights of the unborn child with the civil rights of the pregnant woman in a conservative political climate". This has been the case in opinion polls on the issue of abortion in the United States since 1973, indicating that Americans are extremely hesitant on the subject. Despite their belief that abortion is wrong and unethical, more than two-thirds agree that the final decision "should be made by a woman and her physician rather than by a government mandate". Anti-abortionists have been quite effective in juxtaposing the rights of the expecting woman with those of the unborn child, attempting to transfer the conviction that abortions are "an act of immorality" into state-sanctioned legal limits.[18] A civil right to "*abortion is not the same as a social right to abortion that is accompanied by all of the necessary enabling conditions*" to make it achievable and universally accessible. Furthermore, truly safe abortions can only be achieved by integrating abortion services into a comprehensive set of social services, including health care, prenatal care, safe childbirth, childcare, reliable contraception, sex education, and protection from

[18] Malini Karkal, 'Abortion Laws and the Abortion Situation in India' (1991) 4 (3) Issues in Reproductive and Genetic Engineering, 223-30

sexual and sterilisation abuse, among others. These services must be run under the watchful eye of women's organisations to guarantee that women have meaningful access to them.