



**THE MORE  
THINGS CHANGE,  
THE MORE THEY  
STAY THE SAME.**

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**Analysis of the Medical  
Termination of Pregnancy Act  
(Amendment) 2020 (India)**

**By Dr Suchitra Dalvie**

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Many articles have been shared these past few weeks applauding the passing of the Medical Termination of Pregnancy (Amendment) Bill 2020 by the Upper House of the Indian Parliament in March 2021. It was already passed by the Lower House a year ago before the first Covid 19 lockdown in March 2020. The MTP Amendment Act has been notified in the Gazette of Govt. of India after Presidential assent. However, it will come into force once the Rules have been framed and tabled in Parliament. The journey of this current amendment to the MTP Act 1971 has been a couple of decades long and could merit a separate article in itself, juxtaposed against the socio-cultural, political and legal landscape and the various struggles along the way.

At present, with these amendments on their way to becoming the law, the main critique would involve asking the following questions:

- Do the proposed amendments bring about a shift in power from the doctor/healthcare provider to persons who do not want to continue the pregnancy?
  - Do they increase the pregnant person's autonomy and agency
  - Do they de-criminalize abortions?
  - Do they ensure that no one is turned away or forced into an unsafe abortion or into continuing a pregnancy that is unwanted?
  - Do they increase public sector access and government accountability?
  - Do they ensure that all government hospitals are providing the full range of abortion services including second trimester abortions and without any coercion for contraception?
  - Do they provide for better access to Medical Abortion pills?
  - Do they improve private sector regulation?
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Unfortunately, the answer to all these is a firm no. It is indeed as this [blog](#) states, a story of missed opportunities.

## **The Amendments:**

Here we unpack some of the changes and what they mean in terms of access and autonomy for the person seeking an abortion:

### **1**

There has been some minor and much awaited progress such as opening up the contraception failure clause to 'woman and her partner' rather than only 'married woman and husband' but the policymakers could have taken the opportunity to be trans\* inclusive by saying 'pregnant person' instead of woman.

The 'failure of contraception' clause has often been seen as a more or less free pass since the decision is based on good faith and no proof of any information given by the client is required. However, it has always depended on the attitude of the doctor sitting across the table.

There are clinics which ask for Aadhar card as identity proof and which check back that the address and phone number provided is genuine. They used to ask for marriage certificates and wedding photos also which they probably will not any more but the sex worker who was forced to have sex with the doctor as part of the 'payment' for the abortion or the unmarried girl who is asked to pay 40,000 INR for a first trimester abortion is still not safe from exploitation since neither of them will go to a public sector hospital for fear of being treated badly (and imagine the irony of that).

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## 2

Another improvement has been that now only one provider is needed to approve of the termination upto 20 weeks gestation, as opposed to earlier where one provider could approve upto 12 weeks but two were needed for 12-20 weeks approval.

However, the provider is still defined as an ObGyn or an MBBS doctor with requisite training and certification. There were various attempts over the last decade to include task sharing at least for the 1st trimester abortions with doctors of other systems of medicine such as Ayurveda and Homeopathy as well as trained nurses. However these efforts failed due to serious opposition from the Indian Medical Association (IMA) and members of the Federation of ObGyn Societies of India (FOGSI).

In a country of 1.36 billion there are around 50,000-70,000 ObGyns only. Most of these are based in cities or towns and not all of them are either pro-choice or undertaking abortion provision. Among those who provide abortions not all provide 2nd trimester abortions. A review shows that there was a 121- fold differential between the district with the highest and the lowest density of allopathic doctors.

There are many districts where a person would need to travel upto 40 kms to reach a gynaecologist or a facility that could provide safe abortion services.

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# 3

The upper limit of termination of a pregnancy which was 20 weeks has been extended to 24 weeks. However, this extension of the upper limit to 24 weeks is only in cases of 'special categories' of women. This has not been specified at present but it is suggested that these may include survivors of rape, victims of incest and other vulnerable women (such as differently-abled women and minors).

But if the process of termination of a pregnancy is safe and acceptable at 24 weeks for certain persons then why not extend it for all persons? Why continue to view abortion as a prize that can be awarded only to someone who has been victimized in some way and thus 'deserves' it?

To quote Manisha Gupte who is a well-known figure in the sex determination and safe abortion rights work in India for the past few decades:

*"Some women are not allowed to choose to continue while other cannot choose to terminate. It is easier to offer sympathy to a woman who was forced to have sex. Society is unable to forgive a woman who chose to have sex. Especially the 'wrong' kind of sex. This is the woman who is to receive social punishment by being forced to continue or to die trying to terminate."*

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# 4

If the fetus has a disability then the gestation limit for the termination is even beyond 24 weeks (no upper gestational limit) but as long as a Medical Board approves.

Once again, if the process of termination itself is safe and acceptable beyond 24 weeks, then why not extend it to all who need it? Why focus only the *abla nari* (helpless woman) identity and prioritize the one who has been raped or is a 'victim' or the 'anomalous' fetus that is less than perfect to be a part of our society?

Every woman should have the right to decide if she does not want to have a child with a disability since she is most likely to be the primary caregiver and we have no social protection or financial support schemes in our country for such families. But to assume in such an ableist way that everything possible must be done to ensure that this pregnancy can be terminated for the reason of the fetus having a disability and not because the pregnant woman may not want to continue, takes away the opportunity to shift the power dynamic inherent within this law.

It also takes away the spaces for conversations around disability being a social construct and the need to create an inclusive society where we eliminate the discrimination and not the people with disabilities.

We are reading many quotes from experts claiming that this extension in gestational age is a boon. But for whom? For the rural poor and tribal communities where women are still not getting even the basic 3 antenatal visits and iron tablets or for those with wanted pregnancies who can get an anomaly scan at 22 weeks?

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*"...Many a times you get pregnancies with severe congenital abnormalities but the gestation period is over 20 weeks, so we cannot abort even if know the baby will not be healthy. Also, because sometimes the level to scan is done only at 20 weeks and by the time abnormality is known, the permitted limit to abort is already crossed. It is also safe to abort till 24 weeks..."*

said Dr Anuradha Kapur, senior director and head of unit, Institute of obstetrics and gynaecology, Max Healthcare.

The Medical Board is also a violation of the person's human rights by requiring a third- party authorization of a decision that affects their body and their life. It also makes one wonder whose interest the Board is expected to serve. Is it there to prevent the 'mistaken' termination of a 'good' fetus or is it there to ensure the interests of the pregnant person with an unwanted pregnancy?

This entire exercise leads to a gestational age circus wherein the doctor (obstetrician gynaecologist) is otherwise qualified and recognized to provide care for a pregnancy all the way to term and conduct complicated and risky procedures like emergency caesarean sections, post- partum hysterectomy, manage post- partum haemorrhage, eclampsia, obstructed labour, difficult deliveries at full term, even terminating a pregnancy at any time to save the life of the person, but is suddenly not capable enough to decide on a termination of pregnancy at 20 weeks ( needing a second opinion) or 24 weeks ( needing an entire Board).

One has to question what makes an abortion such a different concern compared to say neurosurgery or cardiac surgery?

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There are laws which already provide for criminal punishments for grievous injury which would encompass any such surgery without consent or done with negligence or criminal intent, whether open heart or termination of a pregnancy. Why can those similar laws not apply to abortions also and the decision of providing the service be left to the person who is pregnant and their doctor?

If we can trust doctors with the training to do brain surgery, which can have the potential for irreversible damage while an abortion is the removal of a fetus that one could potentially make again or adopt a child or become a parent through surrogacy then why is an abortion law needed when a neurosurgery law isn't?

How come the woman's fetus and the choices she makes about continuing to host it inside her body or not warrant an Act of Parliament?

## 5

The amended law states "Name and other particulars of a woman whose pregnancy has been terminated shall not be revealed except to a person authorized in any law for the time being in force."

While some people have praised this, the reality is that this actually dilutes the strict confidentiality the original Act provided.

As per the MTP Act 1971 regulations there is a very strict protocol wherein the name of the person is not to appear on any register and only a code that is assigned is to be used. It also states that the Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

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There is a clause which clarifies: Admission Register not to be open to inspection- The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorised by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open for inspection by any person except under the authority of law.

The new amendment states “shall not be revealed except to a person authorized in any law for the time being in force.” which could cover the whole gamut from AFSPA (Armed Forces Special Powers Act) to POCSO or Indian Divorce Act or any other unrelated law.

## Conclusion

There are some who say this is still progress and we should be happy but honestly, it is too little, too late. Here is a recent case study published in the [BMJ](#) in October 2017 and aptly titled ‘So near, yet so far: access to safe abortion services remains elusive for poor women in India.’

*“In this case study, we describe our experiences with a woman employed as a housemaid who sought unsafe abortion services from a private doctor. This was her sixth pregnancy, after previously giving birth to one son and two daughters and undergoing two induced abortions. Her husband remained opposed to the use of contraception. Initially, she had sought medical termination of pregnancy through a government hospital but was denied because of procedural delays, specifically the non-availability of an ultrasonography report consequent to a lack of proof of identity (ie, the AADHAAR card, unique identification card for recording biometric and demographic data in India).*”

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*She finally sought the services of an unqualified private physician and received oral abortifacient agents. Consequently, she was required to seek treatment for bleeding per vaginum from the dispensary staff at a government hospital. We note that many such incidents occur in our daily practice but remain unnoticed and undocumented. Although this patient was eligible for sterilisation (ie, tubectomy), her husband was uncooperative.*

This case illustrates the lack of decision-making power experienced by Indian women who have a low societal status."

None of these barriers are likely to be resolved by the recent Amendments since the changes needed are far more substantive and even radical.

This MTP Amendment Bill 2020 which has been passed in the midst of a pandemic and lockdowns that have exposed the cracks in all our systems, could have been a game changer that actually addressed the genuine barriers faced by women and pregnant persons in our patriarchal society. This amendment has taken efforts of a large and varied number of advocacy groups and strategies working on the issue for over two decades and it does not even include some of the suggestions that could have expanded access to services by task shifting.

The resultant gestational age circus makes it clear that the abortion is safe at any gestation if it is done for the 'approved' reasons that do not make the patriarchy uncomfortable. If they are done simply for the woman's choice then suddenly an abortion at 26 weeks is dangerous and to be controlled..

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The drafting of the Act could have taken into consideration the visionary and clear statements made by the highest courts of the land.

The Supreme Court Bench that deliberated on the Right to Privacy have already articulated a far broader interpretation:

*“Recognising a woman’s prerogative to make decisions about her health and body, the bench ruled that “there is no doubt that a woman’s right to make reproductive choices is also a dimension of ‘personal liberty’ as guaranteed under Article 21. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating.” The judgment further states that “a woman’s freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy.”* [Read more here.](#)

In a suo motu PIL concerning the deplorable condition of a female prison inmate, the Bombay High Court categorically stated in 2016 that a “woman alone should have the right to control her body, fertility and motherhood choices.” The high court also addressed the status of the legitimate state interest in protecting “potential life.” It stated that since pregnancy takes place within a woman’s body and profoundly affects her health, mental well-being and life, an unborn foetus cannot be put on a higher pedestal than the rights of a living woman.”

For any law to truly bring about wide- ranging change we must remember one crucial thing about true change—it happens only with a shift in power.

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Union Health Minister Harsh Vardhan said that the Amendments in the Bill had been made after studying global practices and after wide consultation within the country. The amendments, he said, had been made pursuant to the rising number of pleas in the court.

*“Under the leadership of the Prime Minister Narendra Modi, we will not frame any law which harms women. This is to preserve and protect the dignity of women,”* he said.

Contrast this with the news item from 2017:

“Marking India’s 71st Independence Day, Prime Minister Narendra Modi, in his address to the nation on August 15, said promoting the advancement of women was key to his vision of creating a “New India” by 2022. Yet, in the same month, his administration defended in

the Supreme Court a clause in the Indian Penal Code that essentially prevents a man from being prosecuted for raping his wife if she is 15 years of age or older.

The government, in response to a petition filed by a non-governmental organisation challenging the clause, said the clause was meant to “protect the institution of marriage”.

(According to the National Family Health Survey-4 (2015-2016), an authoritative nationwide survey, 29% of women between 15 and 49 years of age said they had faced physical or sexual violence at the hands of their husbands.)

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The most important question that is not being asked is-- why do we need the MTP Act in the first place when all other medical procedures are done based on the clinical judgement of the doctor?

The reason we need the MTP Act is because the Indian Penal Code (absorbed mostly un- changed from the British penal Code of 1860) criminalizes miscarriage in clauses 312-316.

We need to look at first de-criminalizing it from there and then creating a law which protects women's and pregnant persons' right to their body by ensuring that they have access to free and good quality safe abortion services (surgical and medical) at all public health sector facilities, without any coercion for contraception and at private sector facilities without extortion.

What we need from a good law is that it should ensure no pregnant person is turned away or forced into an unsafe abortion or into continuing a pregnancy that is unwanted.

These current amendments do not address that nor do they in any way hold the government and the public health sector facilities accountable for ensuring any of this.

It is 50 years since the MTP Act 1971 and we still do not have abortion as a right in our country.

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