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EFFICACY OF MEDICAL TERMINATION OF PREGNANCY (MTP) ACT, 1971 AND PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUE (PROHIBITION OF SEX SELECTION) ACT, 1994 IN INDIA: A CRITIQUE

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Abstract

Despite strong recent economic growth, gender inequality remains a major concern for India. It is the duty of the government to ensure that women do not suffer complication related to pregnancy or die due to pregnancy problems. There is constant increase in number of maternal deaths and morbidity reveals the failure of government to protect women's rights and comply with International Law. Though government of India has passed two Acts viz. Medical Termination of Pregnancy Act 1971 and Pre-Conception and Pre-Natal Diagnostic Technique (Prohibition of Sex Selection) Act 1994 but still there are not efficient to stop maternal deaths and morbidity in India. Amendments in 2002 and 2003 to the 1971 Medical Termination of Pregnancy Act, including devolution of regulation of abortion services to the district level, punitive measures to deter provision of unsafe abortions, rationalization of physical requirements for facilities to provide early abortion, and approval of medical abortion, have all aimed to expand safe services. Proposed amendments to the MTP Act to prevent sex-selective abortions would have been unethical and violated confidentiality, and were not taken forward. The government should take preventive measures and implement the Acts in totality and held those responsible for the failure of these Acts. This paper discuss the need for the implementation of maternity laws and making constitutional legal norms through international norms to establish accountability for maternal deaths and pregnancy-related.

Keywords: Abortion law and policy, Pre-conception and pre-natal diagnostics techniques, Medical Termination of Pregnancy, International Law.

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Introduction

The right to survive pregnancy and childbirth is a basic human right. Under international law, the government of India bears a legal obligation to ensure that women do not die or suffer complications as a result of preventable pregnancy-related causes. The staggering scale and continuing occurrence of maternal deaths and morbidity in India reveals the government's failure to protect women's reproductive rights, and comply with international law.

The most common causes of maternal mortality and morbidity are widely known and include a range of medical, social and health system-related factors. The vulnerability of certain subgroups of women to pregnancy-related mortality and morbidity based on other health conditions, income, caste and age has been documented, making it possible to assess the risk of mortality in specific populations. Policies aimed at reducing maternal mortality have been in place for decades, but as the current situation shows, they have not had substantial impact.

Application of International Human Rights Law to Maternal Mortality

International law can be used as a tool to reduce maternal mortality, as many of the countries with the highest maternal mortality rates have ratified international treaties that provide a legal basis for the argument that there is a human right to survive pregnancy. United Nations Treaty Monitoring Bodies employ a formal process to investigate and measure party state compliance with treaty provisions, and then issue reports with corrective comments and instructions. Additionally, committees are enabled by the UN to issue general comments or recommendations to provide interpretation of treaty provisions. This form of public international accountability and pressure has the capacity to influence party states' actions to reduce maternal mortality. A brief description of how treaty provisions have been used to combat maternal mortality follows.

The Right to Life

Several international treaties protect the right to life, and UN Treaty Monitoring Bodies and Committees have indicated that parties have an affirmative duty to work to protect women's lives in pregnancy and childbirth. The Committee on the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) has recognized maternal mortality as a violation of a women's right to life. The Committee has repeatedly documented the efforts- or

lack thereof- of specific countries to combat maternal mortality. The International Covenant on Civil and Political Rights, Art. 6(1), states, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." The Human Rights Committee states that parties should take all possible measures to increase life expectancy, including increasing access to reproductive health services. The Committee has, in respect to specific nations, linked maternal mortality to early childbirth, child and forced marriage, and female genital mutilation. The Committee has also stated that the health risks due to illegal abortion implicate a woman's right to life. Additionally, the Convention on the Rights of the Child requires that parties ensure the survival and development of the child. The Committee on the Rights of the Child has noted that parties should "take measures to reduce maternal morbidity and mortality in adolescent girls" due to early pregnancy and unsafe abortion, and work to prevent child marriage.

The Right to Health

Article 16 of CEDAW specifically recognizes the right of women to determine the number and spacing of their children and have access to information, education, and means to do so. Additionally, Article 12 of the International Covenant on Economic, Social, and Cultural Rights protects the right to the highest attainable standard of physical and mental health, and includes a provision that parties take necessary steps to reduce the stillbirth rate and infant mortality rate and provide for healthy child development. The Committee on Economic, Social and Cultural rights has interpreted this provision as guaranteeing the right to maternal, child, and reproductive health, and requires states to implement measures and resources accordingly. The Committee has drawn attention to disparities within party states regarding the right to health, and notes that the right to health is comprised of availability, accessibility, acceptability and quality. The CEDAW Committee has noted that a high maternal mortality rate is indicative of a state's failure to ensure access to health care for women. Further, Article 24 of the Convention on the Rights of the Child requires that states take steps to ensure proper health care for mothers and children, and the Committee has expressed concern over the criminalization of abortion, indicating that severe criminal policies lead to higher rates of unsafe abortion and hence maternal mortality.

Right to Equality and Non-discrimination

Article 12(2) of CEDAW explicitly prohibits discrimination against women in health care. CEDAW requires states to provide appropriate pre-natal and obstetric care to women that should include free services where necessary and access to adequate nutrition during pregnancy and lactation. The CEDAW Committee has additionally categorized women's lack of access to reproductive health information as discriminatory. It has noted that certain groups of women (including sex workers, the young, the poor, and women from marginalized communities) are particularly likely to suffer from discrimination. CEDAW instructs states to "eliminate discrimination against women in all matters relating to marriage and family relations" and has identified eighteen as the youngest appropriate age for marriage. The United Nations Rapporteur on Violence Against Women specifically identified the complications from early pregnancy and childbirth in declaring child marriage to be a form of violence against women. The Human Rights Committee has also indicated that a lack of access to health care is a violation of women's rights to equality.

Many constitutions of countries that suffer high maternal morality rates also implicate the state's duty to protect the rights to life, health, and nondiscrimination of its citizens. Some litigators have used the courts to attempt to enforce these rights as applied to maternal mortality, with some degree of success. For example, several recent Indian Supreme Court decisions indicate the willingness of the high court to enforce governmental obligations to ensure maternal health care for women.

Right to Abortion

Abortion is an issue misted up with the question of morality, infanticide, suicide, ethics, religious belief and women's rights. Today some 50 to 60 million abortions occur every year throughout the world, up to half of them illegal and dangerous killing about half a million women annually. Apart from this, at least 500 million women around the world are placed at the risk of repeated pregnancies with serious health problems. However, it is shocking that such a basic right as the right to help with planning or preventing the birth of an unwanted child· has been denied to women. It emerges that the clash for gaining this right would be earned through the courts rather than Parliament or State Legislation. Sooner or later, the right to life and personal liberty as guaranteed by Article 21 of the Constitution would have to interpret in such a way as to include

the right to abortion also. In Satya (smt) v. Shri Ram[1], the High Court of Punjab and Haryana held that termination of pregnancy at the instance of wife but without the consent of her husband amounts to cruelty. In Deepak Kumar Arora v. Sampuran Arora[2] a division bench of Delhi High Court has observed that if a wife undergoes abortion with a view to spite the husband, it may, in certain circumstances be contended that the act of getting herself aborted has resulted into cruelty.

In an English case Forbes v. Forbes[3] it was held that if a wife deliberately and consistently refuses to satisfy her husband's natural and legitimate craving to have children and the deprivation reduces him to despair and affects his mental health, the wife is guilty of cruelty. In Sushil Kumar v. Usha[4] the Delhi High Court held that aborting the foetus without the consent of the husband would amount to cruelty. However, judiciary has denied right to abortion of woman if there is no consent of the husband by declaring it as cruelty which is one of the grounds of divorce under personal law. Such a decision discourages woman to exercise her right to take decision to abort child if she is not physically or mentally ready for it. The MPT Act has allowed woman to take decision without the consent of her husband. But such right cannot be exercised by a woman freely if court marked it as matrimonial cruelty. Here, court is required to have wider viewpoint taking into consideration the reproductive right of woman.

Indian Laws related to Maternal Health

In India only two laws cater to the Maternal Health viz. Medical Termination of Pregnancy Act 1971 and Pre-Conception and Pre-Natal Diagnostic Technique (Prohibition of Sex Selection) Act 1994.

The Medical Termination of Pregnancy Act of 1971

The Act went into effect on 1 April 1972, significantly liberalized abortion laws in India. Prior to enactment of the legislation, the Indian Penal Code (Act No. 45 of 1860) permitted abortion only when it was justified for the good faith purpose of saving the life of the woman. Article 312

[1] AIR 1983 P&H 252.
[2] (1983) I DMC 182.
[3] 9(1955) z AJI ER 311.
[4] AIR 1987 Del 86.

of the Penal Code provided that any person performing an illegal abortion was subject to imprisonment for three years and/or payment of a fine; if the woman was "quick with child", the punishment was imprisonment for up to seven years and payment of a fine. The same penalty applied to a woman who induced her own miscarriage.

The Medical Termination of Pregnancy Act of 1971 had the effect of allowing abortions to be performed under broader grounds than the Penal Code. Under the Act, a pregnancy can be terminated if its continuation would involve risk to the life or grave injury to the physical or mental health of the pregnant woman or if there is substantial risk that, if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. In determining whether continuance of the pregnancy would involve a risk of injury to the health of the pregnant woman, the Act allows account to be taken of the woman's actual or reasonably foreseeable environment. The Act also presumes that the anguish caused by a pregnancy resulting from the rape of any woman or from the failure of any contraceptive method used either by a married woman or her husband for the purpose of limiting the number of children constitutes grave injury to the mental health of the woman.

A pregnancy may be terminated on these grounds within the first 12 weeks of pregnancy on the opinion of one registered medical practitioner. If the pregnancy has lasted more than 12 weeks, but fewer than 20 weeks, two registered medical practitioners must be of the opinion formed in good faith that the required grounds exist. An abortion can be performed only by a registered medical practitioner in a hospital established or maintained by the Government or in a facility approved by the Government. In cases in which a registered medical practitioner is of the opinion formed in good faith that the termination of the pregnancy is immediately available to save the life of the pregnant woman, an abortion can be performed anywhere at any time during pregnancy without the approval of an additional registered medical practitioner. Consent of the woman or written consent of the guardian of a woman under the age of 18 or a mentally retarded woman is required before performance of an abortion.

The Medical Termination of Pregnancy Act of 1971 was enacted by the Government of India with the intention of reducing the incidence of illegal abortion and consequent maternal mortality

and morbidity. However, according to Government data, only about 1 million abortions were performed annually under this Act. Implementation of the Act has been slow and geographically uneven; abortion services are often inaccessible and women are reluctant to utilize those services because of the lack of anonymity and confidentiality. Therefore, the number of illegal or unregistered abortions performed by medical or non-medical practitioners is still very high. According to various estimates, the number of abortions performed outside approved facilities varies between 2 million and 6 million per annum. It has been observed that the women who make use of hospital facilities for the medical termination of pregnancy are mostly educated, from an urban middle-income family, married and between 20 and 30 years of age. In contrast, the women admitted to public hospitals with complications from illegal septic abortions are largely illiterates from poorer segments of the population. These observations are consistent with other findings indicating that the level of awareness of the legality of the procedure is fairly low, and the existing facilities for the legal medical termination of pregnancy are either not available or are not utilized by many high-risk women who seek illegal abortions.

Implementation of the Pre-Conception and Pre-Natal Diagnostic Technique Act (PNDT)

The use of sex-determination technology by parents for the purpose of sex-selective abortion has been the prime concern of the country. Internationally, the UN Special Rapporteur on Violence against Women among others has condemned such practices. Similarly, in India, there is enactment and enforcement of the Pre-natal Diagnostic Techniques Act, 1994 to prohibit sex determination or sex-selection of the foetus. The use of these new technologies has resulted into the killing of female fetuses and sex selective abortions. The reproductive right does not include a freedom of the couples to decide on their child's sex if that is for the devaluation of any of the sexes. There has been great number of sex-selective abortions of females in India and China as a sign of devaluation of women. There has been world wide son preference but it is grave in South Asia and the Middle Ea of the dowry system where considerable costs of marrying off a daughter have to pay. Also, if the daughter does not marry she will remain dependent upon her family. Thus, pre-natal tests meant to detect the abnormalities of the foetus are being widely used to determine the gender of the child. There has been, therefore, prohibition of sex determination or selection through government initiative where the pre-natal diagnostic technique including ultrsonography for the purpose of determining the sex of a foetus is prohibited under the PNDT

Act. However, in India, the situation of sex selective abortion resulted into female foeticide continues to worsen even after the introduction of the PNDT Act.

The reason could be non-implementation of the Act as well as the growing misuse of reproductive technologies. In 1998, a Public Interest Litigation was filed in Supreme Court in a case of (Centre for Enquiry into Health and Allied Themes) CEHAT v. Union[5] of India for direction to implement Pre-natal Diagnostic Act. The Hon'ble Court passed a constructive interim order in May 2001 directing the Central Government and States to take all necessary steps to realize this law. Compliance with the Act in serious note, therefore, initiate with the passing of this order. Here, while executing the Act the Court has revealed loopholes and problems inherent in the Act. The main shortcomings highlighted were .that there were no clear provisions regulating pre-conception techniques in the Act. Further, it was asserted that the Act drafted at the time when amniocentesis was considered to be the main threat which was incorrectly drafted as far as the use of ultrasound tests were concerned.

Moreover, that the Appropriate Authorities constituted under the Act were abusing their powers and harassing practicing doctors. Thus, the prenatal test meant to discover abnormalities of the foetus are being used to determine the sex of the child, effecting abortion if it is a female. Although, it is appropriate to spot out at this crossroads that the compliance affidavits filed by the States in the Centre for Enquiry into Health and Allied Themes (CEHAT) case shows that most of the actions taken against doctors is on the ground of non-maintenance of proper records. There are very few cases where doctors have been caught in the· act of disclosing the sex of a foetus. The Supreme Court issued a series of directions during 2001-2003 to the following authorities (i) Central Government, (ii) Central Supervisory Board (iii) State Government/ Union Territories Administration, and (iv) other appropriate authorities. The Apex Court directed all the States to confiscate ultrasound equipment from clinics that are being run without licenses. It was found that many Genetic counseling centers, laboratories or clinics were not registered and no action has been taken as per the provision of the Act, besides issuing warning. The Centre assured the Supreme Court that it will set up a National Inspection and Monitoring Committee for the implementation of the Act. In 2003, the Court was informed that the PNDT Act has been

[5] AIR 200 I SC 2007.

amended in pursuance of the direction of the Supreme Court taking necessary steps to achieve the object of the Act. But the saddest truth is that sex selective abortion is still prevalent in the country.

Conclusion

The strong preference for sons under patriarchal traditions and the availability of inexpensive prenatal diagnostic techniques have resulted in an increased use of prenatal gender tests in India, even among the rural poor. Some private clinics provide such tests and then offer an induced abortion if the parents are dissatisfied with the sex of the foetus. Induced and unsafe abortion is an important public health problem and a significant cause of maternal mortality in India. The most important factors associated with mortality from induced abortion in developing countries include inadequate delivery systems for contraception needed to prevent unwanted pregnancies, restrictive abortion laws that limit women's access to safe abortion care, pervading negative cultural and religious attitudes to abortion, poor health and social infrastructures for the management of complications, and women's low social status. The application of a public health approach based on primary, secondary, and tertiary prevention can reduce morbidity and mortality associated with unsafe abortion in developing countries. Primary prevention includes the promotion of increased use of contraception by women at risk of unwanted pregnancy. Secondary prevention involves the liberalization of abortion laws and programs to increase women's access to safe abortion care in developing countries. Tertiary prevention includes the integration and institutionalization of post-abortion care for incomplete abortion and the early and appropriate treatment of more severe complications of abortion. Efforts to address these problems will contribute to reducing maternal mortality associated with induced abortion and to achieving the MDGs in developing countries.

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