# MTP ACT @50- A Move on the 'Right' Track?

## Spotlight Webinars: A Summary of Deliberations

### Background

The Medical Termination of Pregnancy (MTP) Act (1971) is an Act of Parliament that permits appropriately qualified and trained persons to terminate a pregnancy in an approved facility. An unprecedented and progressive law, the Act has had constitutional provisions for women to have access to safe and legal abortions since 1971 under a wide range of conditions. In 2021 it was amended to enhance its reach to larger number of service seekers. This five-decade journey of the Act has had many partners who played an important role including the government of India, civil society, academicians, researchers, service providers, professional bodies, activists, and community voices.

In September 2021, Family Planning Association of India (FPA India) collaborated with twelve partners[1] to launch an innovative platform, for policy makers, programme planners, subject matter experts, feminists and representatives of the civil society, to come together and deliberate on a series of spotlight themes around the changing abortion landscape in India, over the last 50 years. The series, titled **"MTP Act @ 50 - A move on the 'Right' track?"** was conducted through six webinars at fortnightly intervals.

The inaugural webinar **"The MTP Act (Amendment) 2021: Fulfilling a promise"** launched on the occasion of International Safe Abortion Day on September 28, 2021 looked at the journey till date, promises the current amendments hold and the challenges in the process of fulfilling intent of the Act. The second Spotlight webinar **"Providing MTP services after 20 weeks: The way forward"** on 21st October 2021 led by the Federation of Obstetricians and Gynaecologists Society of India (FOGSI) focused on anticipated challenges in implementing amendments in practice. The third webinar "**Availability and use of data and evidence for decision-making"** on 28th October 2021 was focussed on data needs and guide evidence-based discourse for realization of intent of the current amendments. The fourth webinar entitled **"MTP Act- The more things change, the more they stay the same"** led by CommonHealth and MASUM on 9th November 2021 addressed issues around safe abortion as a service seeker's right. The fifth webinar held on 29 November entitled **"Historical perspectives of MTP Act: The journey so far"** led by Ipas Development Foundation captured the journey and the historical perspectives of the MTP Act with focus on technology, access, and women's agency and conflation of the Act with other laws. The sixth and final webinar of the series led by Pratigya Campaign for Gender Equality and Safe Abortion and FRHS India on 14th December 2021, **"MTP Amendment Act and rules: The way forward"** addressed missed opportunities and way forward.

[1] CommonHealth, Federation of Obstetrics and Gynaecologists Society of India (FOGSI), Foundation for Reproductive Health Services India (FRSH India), Global Health Strategies, International Institute of Population Studies (IIPS), Ipas Development Foundation (IDF), Love Matters, MASUM, Parivar Seva Sanstha, Population Health Services India (PHSI), Population Council and Pratigya Campaign.

## MTP Act: A journey rooted in good intentions

Panellists in the webinars highlighted that despite the MTP Act's reformist provisions and liberal interpretation by service providers, service seekers continue to find access to safe and legal abortion services a challenge, especially vulnerable and marginalized service seekers and those in remote areas. The deep rooted stigma, taboo and culture of silence around abortion prevents women from articulating a desire to terminate a pregnancy, lack of awareness and autonomy as well as systemic response prevents them from accessing safe and legal services. Amendments to the Act were therefore necessary.

The Amended MTP Act notified for commencement on 24th September 2021 relaxed the gestational limit from 20 weeks to 24 weeks for special categories of women, requirement for opinion from two Registered Medical Practitioners (RMPs) to one upto 20 weeks and for legal services for failure of contraception only for married couples. While approval criteria for facilities and eligibility of service provider remain same, it introduced State level medical boards for approving services beyond 24 weeks in case of foetal anomalies and strict punitive measures for breach of service seekers confidentiality. Translation of these amendments in terms of availability of services is likely to be difficult as it rests on standard setting, specialized training and nuanced language to ensure that it does not compromise women's right to health services or further disability stigma.

## Ambiguities and potential challenges: Pandora's box

While the amendments to raise gestational limit were seen as transformative and women centric, multiple challenges in realising intent of the MTP Act at the field level are anticipated. The current definition does not clarify intent of termination of pregnant status or life of the foetus and has the potential of Caesarean section and induction of labour being considered as termination of pregnancy. It also puts single foetal reduction in a multiple pregnancy in the grey zone in the legal context. Ambiguities or exclusions also exist in the definition of "special categories of women" ('single' women, women undergoing divorce are not explicitly stated). Further, what exactly constitute a substantial foetal anomaly and 'Humanitarian' settings has not been clarified and Act says that women with major disabilities would be those specified in Rights of Persons with Disabilities Act of 2016, requiring familiarity of service providers with the Act.

The current process of service provision has multiple opportunities for breach of confidentiality of the service seeker right from case movement in the facility to mandatory prescription for medical abortion, accompanying person's consent in case of surgical abortion, recording of personal identifying information in Form C for reporting to person 'authorised' by law seeking access to records. Since confidentiality breach would now invite imprisonment, this may have chilling effect on service provision. Reporting requirements include date of discharge and report within 3 hours of termination. Both are not possible as service seeker may abort at home and there is no requirement for admission in case of

medical abortion. While legal sanction for abortion after 24 weeks rests on exceptions based on women's vulnerability and on foetal anomalies as understood by the medical board, constitution of medical board and timeline for decision making are not adequately aligned to the decisions needed for safe and timely service delivery. Medical board members other than gynaecologist would be deciding about safety of the procedure in second trimester. There is no clarity about steps to be taken in case of late second trimester abortions when two members of the medical board are in conflict and consequently there is delay.

The possibility of legal and ethical dilemmas in case of services for minors and in case the foetus is born alive have not been addressed in the current amendments. The mandatory reporting of a minor seeking abortion services required under POCSO Act may result in services being denied to them forcing them to access medical abortion drugs over the counter or seek termination from uncertified providers. In case of a malformed live baby, the parents may refuse to accept it, while the baby will have fundamental rights as any other living being. On the other hand, a dead foetus of more than 24 weeks gestation or 500 grams in weight will not be accepted as biomedical waste. The service provider may have to report it as stillbirth.

Deliberations were also held on research needs and uptake of research data on vulnerable groups, community practices in the context of the amendments. Two high priority areas for research identified in the context of amendments were preparedness of facilities and the awareness of stakeholders including potential service seekers. Current health data system tends to disregard sensitive issues such as freedom, pleasure and rights and data on abortion needs and experiences of vulnerable populations. Vast majority of medical abortions (>80%) are self-managed and through pharmacists, yet this data is currently fragmented and incomplete.

## Intent to reality: Making most of the opportunity

***Clarity in definitions and protocols:*** Definition of MTP should be revised to include intent i.e. a procedure to "cause or hasten stoppage of foetal heart" as well as to "cause discontinuation of pregnant state" so that foetal reduction in case of multiple pregnancies will automatically get excluded. The definition should also exclude "treatment for medical condition" so that Caesarean section and induction of labour get excluded. Similarly, "Humanitarian" settings and "substantial foetal malformations" should be clearly defined. The list of malformations identified during the Nikita Mehta case should be referred to save time.

Special categories of women should be clearly defined to include single or unmarried, survivors of sexual violence/rape/incest and there should be clarity in protocol about service seeker undergoing divorce. List of disabilities under Rights of Persons with Disabilities Act of 2016 should be made available and steps should be taken to make RMPs aware of these. Protocol should clarify steps to be taken in those advised foetal reduction and should include use of Potassium Chloride for termination of life of the foetus while it is in the womb as it is the most humane way of ensuring that dead foetus is expelled.

Separate category of biomedical waste should be created for disposal of products of conception expelled following MTP beyond 24 weeks.

***Simplified yet comprehensive training***: With the advent of safe medical methods and surgical techniques such as vacuum aspirations, rules formation for the amended Act offer an opportunity for incorporating a simpler and curtailed training programme for service providers of first trimester abortions. This has the potential to ensure that trained MBBS doctors or medical officers are available at Primary Health Centres and Community Health Centres that are closer to service seekers' residence. Training of service providers should include session on their obligations in the context of other laws / Acts that have bearing on abortion services and include sessions on values clarification to address their beliefs and attitudes that come in the way of service delivery.

***Safer services:*** The COVID19 pandemic has brought to the forefront the need to innovate service delivery. To ensure that amendments to enhance safe and legal service reach upto 20 weeks do not remain on paper, leveraging of telemedicine route and use of safer, less invasive and more effective methods such as medical abortion pills needs to be explored and advanced. Only gynaecologists should be permitted to conduct late second trimester procedures and that too after some specialized / refresher training and these should be permitted only at tertiary care hospitals.

***Exceptions to confidentiality breach:*** Protection should be provided to RMPs on procedural breach for mandated processes or processes beyond their control and as long as rest of the stipulations under the Act are met. Identifying information from Form C does not serve any purpose and should be removed. In case personal information is revealed by 'person authorized by law', the person concerned should be held responsible for breach in confidentiality.

***Rational constitution of medical boards:*** Only the gynaecologist member should be permitted to decide about safety of the procedure. Others should help the gynaecologist take decision based on their expertise on the foetal anomaly in question. Constitution of board requiring government service providers should be reconsidered and decision of the board should be available within three days of application as earlier the abortion is done, safer it is likely to be. Further, to facilitate timely decision, a list of anomalies based on those identified after wide-ranging consultations during the Nikita Mehta case should be made available wherein the approval for termination is automatic.

***Precision in reporting requirements:*** There should be separate timeline and reporting structure for medical abortions.

***Reliable data for decision making:*** A hybrid approach that is not necessarily representative but balances non-response, fear of disclosure, privacy and confidentiality needs and yet highlights the level of vulnerability needs to be adopted to design studies based on the principles of non-discrimination and inclusion in collaboration with those working with vulnerable groups.

Instead of modification of government registers and data system that requires intense advocacy and more time, a sentinel surveillance system in select areas with ethical oversight and de-identified data should serve the purpose. Pharmaceutical industry needs data on sales, distribution, marketing and use to reduce risk of investment, to plan expansion of medical abortion drugs' reach and assess net positive effect of policy change or amendments for the industry as well as to those in need.

***Flexible and germane stipulations:*** While these amendments are the first step in the right direction, a more transformative approach that goes beyond 'safety' and centres around women's 'unconditional' access is needed. Safety of self-managed abortion has been documented. To ensure unfettered access to safe abortions services, advocacy for inclusion of self managed abortion within the legal purview should be pursued and ultimately, the conversation around decriminalization of abortion should gain traction.