

Recent Amendment in the Medical Termination of Pregnancy Act in India: Empowering Women's Health

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Summary

In 1971, the Medical Termination of Pregnancy (MTP) Act was implemented to deal with unsafe abortions, fetal complications, and maternal mortality. In India, it is estimated that more than half of all abortions are unsafe leading to infection, hemorrhages, injury to internal organs, and sometimes maternal death. To address these issues, the MTP Act was amended in 2021 to promote uniformity, accessibility, availability, affordability, and quality of MTP services with appropriate management in case of any adverse event.

Key words: Comprehensive abortion care, maternal mortality, Medical Termination of Pregnancy Act, unsafe abortion

INTRODUCTION

Unsafe abortion accounts for 8% of maternal deaths in India; this is because of complexities arising from risky fetus removal. Inaccessibility to information and adequate health services to termination of pregnancy superimposed with gender bias and low-socioeconomic status are major factors that lead these women to adopt unsafe methods for abortion/pregnancy termination.^[1]

THE PREMEDICAL TERMINATION OF PREGNANCY ACT PERIOD

In 1860, the British government passed a law that prohibited any form of pregnancy termination. The law proclaimed that “prompting an early termination added up to the punishable crime, and that any individual performing it would be exposed to detainment for at least 3 years or potentially installment of a fine.” The penalty was to be waived only if the termination had been done to save the life of the woman. In 1967, this law was changed in England, but not in India. An incalculable number of women died because of dangerous unlawful early terminations because of the presence of this reformatory code. The burden of high maternal deaths along with the strain of a rising populace compelled the public authority to reform this regulation in 1971.^[2]

MEDICAL TERMINATION OF PREGNANCY ACT 1971

Access to safe and legal abortion services to all was provided by the introduction of the Medical Termination of Pregnancy (MTP) Act in 1971. The MTP Act, in 1971, expressed that “a pregnancy might be terminated on the counsel of one registered medical practitioner (RMP) on the condition that the duration of the pregnancy is in no <12 weeks or on the exhortation of two clinical experts on the off chance that the duration of the pregnancy is in the middle of between 12 and 20 weeks.” This Act laid out the conditions in which the termination of pregnancy is to be allowed, the criteria of the medical center, where the said procedure is to be done, has to meet and the license of the individual performing the procedure.^[3]

Amendments of the Act in 2002 gave clear instructions that any center where medical termination is to be done has to get an approval of the district authority. Stringent actions would

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be taken if MTP was done in an unauthorized place or by unauthorized persons.^[4] In addition, this amendment allowed the use of oral drugs for the termination of pregnancies within 7 weeks of gestation.

In 2003, the law permitted licensed medical practitioners to prescribe oral drugs for termination of pregnancy outside the approved facility on the condition that facilities of emergency services were available in the approved facility.^[5]

In 2015, around 56% of total number of abortions were unsafe, 22% of total number of abortions were done in health facilities, and 73% were medical abortions done outside the health facilities. Around 5% of early terminations were finished with presumably dangerous techniques.^[6]

Due to the advancement of prenatal tests for fetal disorders, there is a large number of cases being diagnosed with fetal anomalies. This stresses the need for raising the upper limit of gestational age for terminating pregnancies.^[7]

MEDICAL TERMINATION OF PREGNANCY AMENDMENT ACT, 2021

The mandate to safe and lawful early termination on remedial, compassionate, and social grounds is given by the MTP Amendment Act 2021 contributing toward finishing avertable maternal mortality to help meet the Manageable Improvement Objectives (SDGs) 3.1, 3.7, and 5.6.^[8]

The key modifications include:^[8,9]

- Permissible gestational age for termination pregnancy was extended from 20 weeks to 24 weeks for females under circumstances such as sexual assault, incest, or if the female is differently abled or a minor
- Consultation of one RMP is necessary to evaluate till the gestational age of 20 weeks. Consultation of two RMP is required if a pregnancy of 20–24 weeks has to be terminated
- In the event of significant fetal irregularities found past 24 weeks, early termination can be completed by consent of a state-level clinical board comprising an obstetrician, pediatrician, and radiologist. There could be no constraint of gestational age for congenital anomalies. The decision of the board has to be prompt and based on careful analysis of the available medical reports
- Confidentiality statement: name and personal details of a female whose pregnancy has been terminated will not be uncovered but only to an individual approved by law giving enough security and secrecy to the beneficiaries to access this service
- Access to the MTP facility has been stretched out to unmarried females under the clause of failure of contraception
- RMP with 3 months of experience in obstetrics and gynecology or trained with the execution of 10 MTP cases under the guidance of an RMP in an MTP-approved center will be considered eligible to perform MTP of

pregnancies under 9 weeks of gestation. Such RMPs are recognized as medical methods of abortion (MMA) only providers.

The requirement of consultation of only one RMP for 20 weeks of pregnancy and the availability of MMA-only providers have made the MTP services available in the remotest primary health centers and referral centers. Now, females from distant regions can approach safe abortion services.

Females under vulnerable circumstances can avail of MTP services between 20 and 24 weeks. These circumstances include if a female is minor, widowed or divorced, physically disabled, mentally deranged, survivors of sexual assault, rape, or incest. Pregnant females with fetus having malformations or pregnancy in disaster or emergency settings are included in this clause.

The setting of the clinical board for the decision of pregnancy termination beyond 24 weeks has increased access to safe abortion services. Previously, fear of legal disputes had led females to undergo unsafe methods for pregnancy termination.

Despite the new amendment, many issues still remain unresolved. First, the termination of pregnancy has not been made a legal right for women. Women rely on the decision and will of the medical professionals even for early termination. Second, this adds to the mental and monetary pressure on women. Third, the extension of termination of pregnancy beyond 24 weeks is guaranteed only in special circumstances. Anyone not falling under these circumstances will not be able to terminate their pregnancy adding to their physical and mental well-being. Fourth, fixing the furthest reaches of gestational age for assault, rape, or inbreeding survivors might be dissolving the entire thought of broadened period for fetus removal in such cases, as there are procedural deferrals at police headquarters and trials.

COMPREHENSION ABORTION CARE

The principles of CAC are rooted in the conviction that women should have access to high quality, reasonable early termination care where they live and work. It was first presented in India in 2000 by IPAS (an international and nongovernmental organization) recommending that early termination administrations ought to have a graceful approach with its three critical components of decision, access, and quality.

Proper preprocedure counseling should be done to inform about the various available modalities with their benefits and risks for the termination of pregnancy and postabortal contraception. She should not be forced to choose against her consent.

Great consideration ought to be given as per guidelines including satisfactory precounseling and testing, security to maintain confidentiality, use of appropriate technology, postprocedural care, and availability of contraception.

Early termination of pregnancy ought to be made accessible close to her home so that time and expenditure are reduced. Women have to be made aware that early termination is lawful and helpful. They ought to be given information that it is socially suitable and different social boundaries ought to be eliminated.^[10]

The greatest obstacle to giving safe early pregnancy termination in Indian settings is over-the-counter accessibility of drugs and self-admission of MTP pills. In such a situation, the precounseling and testing are missed leading to hazardous complications. The significant reasons contributing to this might be lack of education, obliviousness about the available contraceptives, inaccessibility to centers with MTP services, and fear of lack of privacy, as abortion is considered a social taboo.^[9]

Complications such as hemorrhagic shock (7.7%), sepsis (2%), the need for blood transfusion (13%), intensive care unit admission (0.7%), and maternal deaths (0.3%) were seen and about.^[7]

The Act in its present form does not put a check on how many times a woman should be allowed for induced pregnancy termination.

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Conflicts of interest

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