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ABORTION IN INDIA: LEGALITIES AND REALITIES

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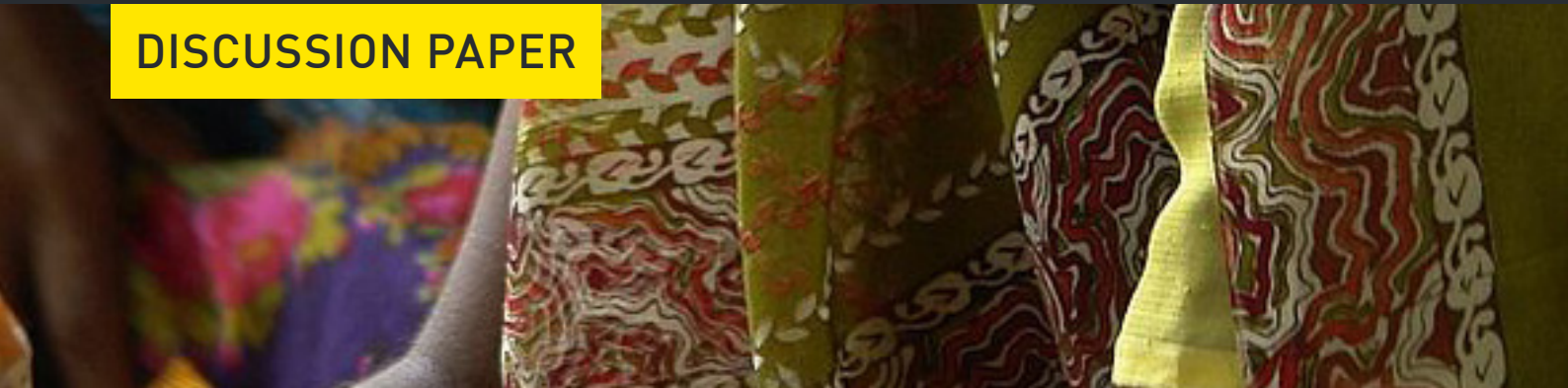
DISCUSSION PAPER



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ABSTRACT

In light of the recent Medical Termination of Pregnancy (Amendment) Bill passed in the Lok Sabha on 17th March 2020, this paper attempts to evaluate the current scenario of abortion-seeking in India. Despite being an essential healthcare need for millions of women and their families, safe and legal abortions continue to be inaccessible almost 50 years after its legalisation. The paper begins by tracing the historical trajectory of abortion-related legislation in the country, and the dominant ideological discourses that set them in motion. The following sections delve into the various problems that hinder abortion-seeking in india, and attempts to assess the ability of the 2020 Bill, if it becomes an Act, to address these issues.

INTRODUCTION AND OVERVIEW

According to the 2011 Census, approximately 31% or 385 million out of India's 1.2 billion population are women who lie in the reproductive age group of 15-49 years. Yet, nearly 50 years after the passage of the Medical Termination of Pregnancy (MTP) Act in 1971, which legalised abortion in the country, safe and legal abortions continue to be inaccessible for a majority of women in India.

MoHFW data suggests that in 2012-13, 636,748 abortions were performed in India, indicating an annual rate of about two abortions per 1,000 women of reproductive age (MoHFW 2013). However, these numbers are greatly underestimated, given that they do not include abortions performed by private-sector medical personnel, both those who do and do not have specific training in abortion service provision. They also do not include medical abortion pills sold without prescriptions or abortions performed in non-medical settings and by untrained providers (Stillman et al. 2014). In fact, one study concluded that the actual number of abortions performed across settings in the country in 2015 was 15.6 million, equalling about 47 abortions per 1,000 women of reproductive age (Singh et al. 2018).

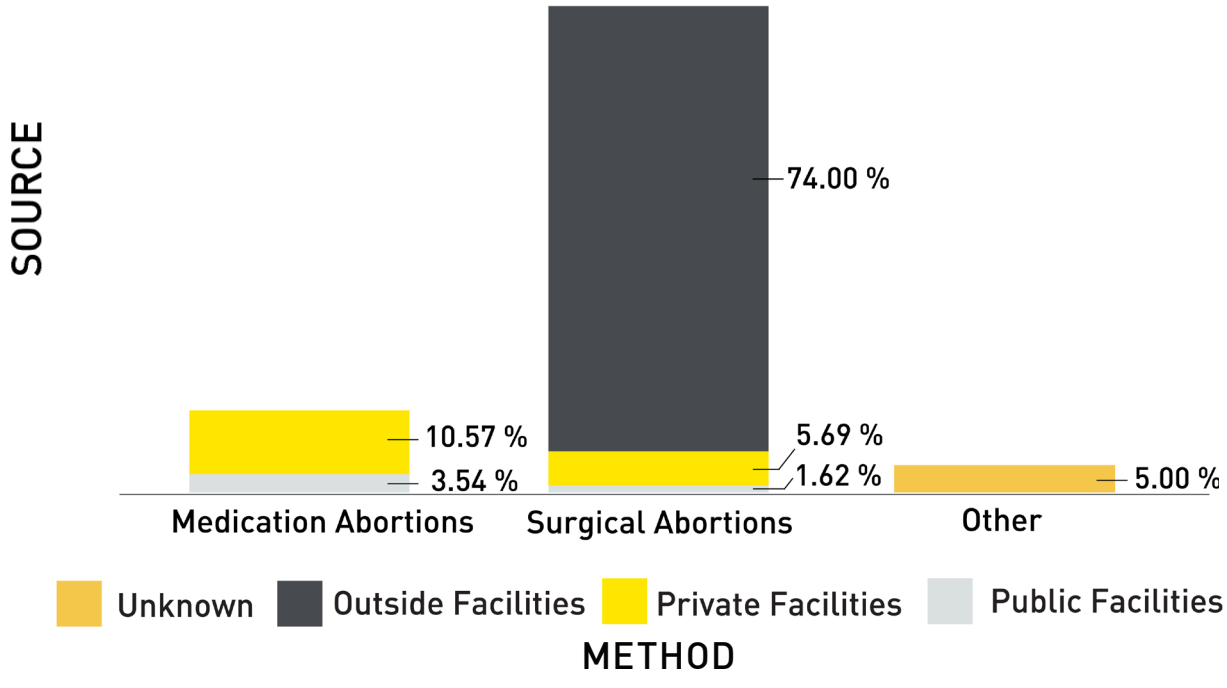
TABLE 1: SOCIO-DEMOGRAPHIC AND HEALTH INDICATORS OF INDIA RELATED TO FERTILITY AND MATERNITY

Population in millions (2011)	1210.19
Median age at first marriage (age 20-49 years)	17.2
Median age at first intercourse (age 20-49 years)	17.8
Total fertility rate (average number of children born to a woman during her lifetime) (2011)	2.4
Women giving birth by age 20 years (%)	45.2
Current use of modern FP among married women (age 20-49 years) (%)	55.8
Unmet need for contraception among currently married women (2007-08)	21.3
Maternal mortality rate (maternal deaths per 100,000 live births) (2007-09)	212
Level (%) of unintended pregnancy (including mistimed and unwanted) (2005-06)	24.3
Births attended by skilled personnel (%) (2005-06)	46.6
Infant mortality rate (infant deaths per 1,000 live births) (2011)	44

SOURCE: CENSUS, 2011

Of the 15.6 million abortions, about 22% were obtained within health facilities, 7.3% were medication abortions[1] done outside of health facilities, and 5% abortions were done outside of health facilities using methods other than medication abortion. Overall, 81% abortions were medication abortions, 14% surgical, and 5% abortions were performed through other, possibly unsafe methods (Ibid.) (Figure 1).

FIGURE 1: DISTRIBUTION OF ABORTIONS BY METHOD AND SOURCE IN 2015 (IN %)

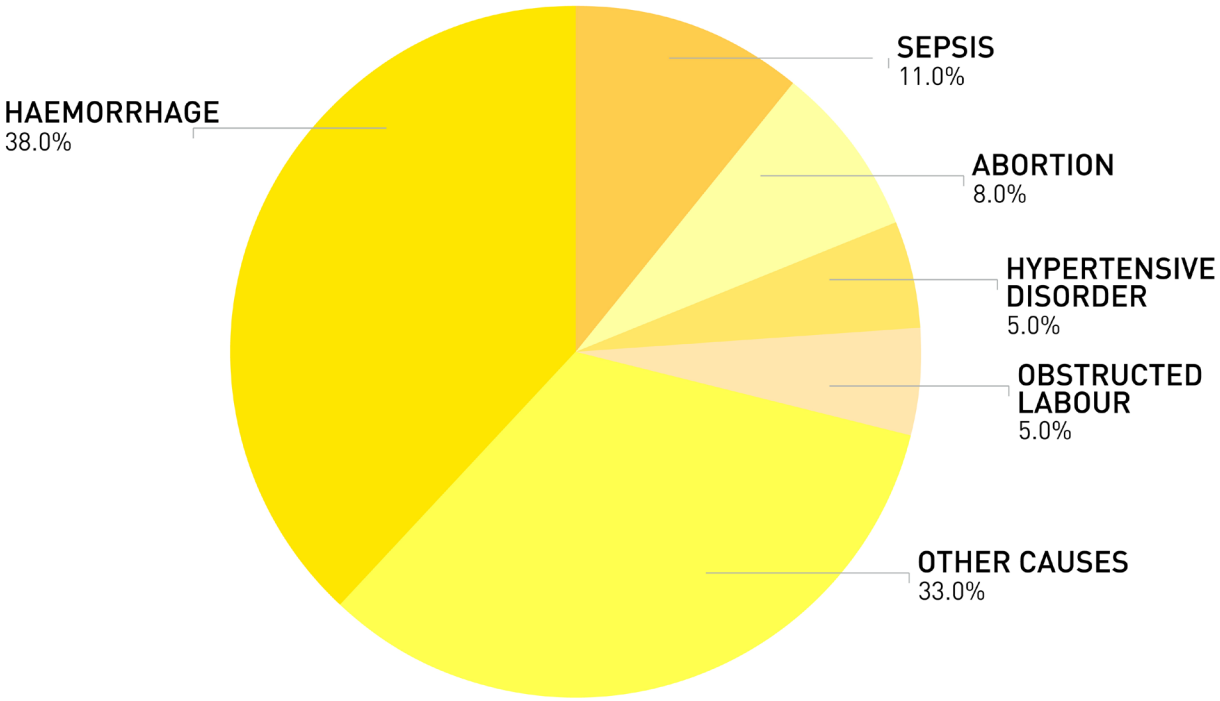


SOURCE: SINGH ET AL. 2018

[1] In India, the two prescription drugs approved for medication abortions are Mifepristone and Misoprostol.

Despite an increase in the overall number of approved abortion facilities over the years, from 1,877 in 1976 to 12,510 in 2010, access to safe abortion remains inadequate for a variety of reasons (Stillman et al. 2014). Unsafe abortions[2] continue to cost thousands of Indian women their lives, with some claiming that 13 women die every day in India due to this reason (Snigdha 2018). This problem is further exacerbated in the case of women who are socio-economically disadvantaged. For instance, the odds of unsafe abortions are about 26% higher among rural as opposed to urban women. Age and education levels also seem to be directly related to unsafe abortions, with the odds of being 13% higher for women aged 20-24 years than higher age groups, and those with no education being 48% more likely to have unsafe abortions compared to university-educated women (Yokoe et al. 2019). According to data from 2010, abortion-related complications is the third leading cause of maternal deaths in India (Registrar General of India and Centre for Global Health Research 2006) (Figure 2).

FIGURE 2: MEDICAL CAUSES OF MATERNAL DEATHS IN INDIA



SOURCE: REGISTRAR GENERAL OF INDIA AND CENTRE FOR GLOBAL HEALTH RESEARCH 2006

In response to the high rates of unsafe abortions in India and the grave consequences on maternal mortality, in March 2020 the Medical Termination of Pregnancy (Amendment) Bill was passed in the Lok Sabha, suggesting changes to the 1971 Act. To understand the impact of the Bill, however, it is imperative to first examine the historical trajectory of abortion-related legislation in India.

[2] WHO defines unsafe abortion as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

TRENDS IN ABORTION-RELATED LEGISLATION IN INDIA

• ABORTION AS A DEMOGRAPHIC ISSUE

The debates surrounding abortion legislation has followed a significantly different trajectory in India than it did in more developed Western countries. In the West, abortion debates are primarily based on two ideological stances, either advocating for women's bodily autonomy (termed 'pro-choice'), or the usually theologically-backed belief in the foetus' right to live ('pro-life') (Patel 2018). In India, however, rather than being a question of women's right to choose and self determination, the legalisation of abortion was linked intrinsically to family planning and population control (Gangoli 1998). In the years following independence, concerns about the economic costs of rising populations caused India to become the first country in the world to launch a state-sponsored family planning initiative, the National Programme for Family Planning of 1952. Soon after, the vocal middle class in India started advocating to legalise abortion, stating that it would not only arrest fertility and hence population growth but also reduce maternal mortality in India, another prominent issue plaguing the country at the time. Abortion was also conceptualised as a private, context-specific family matter. For instance, the case for making legal abortions facilities available to unmarried or widowed women was largely built around discourses of stigma and family honour (Patel 2018).

During this time, the Indian Penal Code still followed the colonial Offences Against the Person Act of 1861 which criminalised abortion except in instances where it could save the life of the woman. Eventually, to circumvent the criminality clause in the law, and following the recommendations of the Shah Committee, the MTP Act was passed in 1971. The State maintained that the Act was passed purely on medical and compassionate grounds to prevent the deaths of women, rather than as a population control strategy (Hirve 2004). The MTP Act 1971 legalised abortion for women above 18 years of age, as well as women below 18 years and mentally ill women with a legal guardian's permission, within 20 weeks of gestation. Within 12 weeks' gestation, the act permitted abortion with the opinion of one registered medical practitioner. Within 12 to 20 weeks' gestation, the act allowed abortion with the opinions of at least two registered medical practitioners, provided that the pregnancy: (i) Risks death or grave injury to the woman's mental or physical health, that the pregnancy is caused by rape, or contraceptive failure in a married woman; or (ii) Will lead to a child being born with severe mental or physical abnormalities.

Regardless of the motivation behind the Act, legalising abortions was considered to be a welcome step towards women attaining the right to bodily autonomy. However, the deeply patriarchal nature of Indian society presented another disturbing trend: the preference for sons over daughters. Despite the fact that family planning services resulted in smaller families and lower rates of childbirth over time, the pressure on women to give birth to at least one son remained. Medical breakthroughs in the 1980s saw the rise of ultrasonography technologies that allowed parents to determine the sex of fetuses prior to birth. This technology began to be used extensively to abort female fetuses, resulting in a sharp decline in sex ratios (Stillman et al. 2014). To address the complex dynamic between abortion and sex selection, the government passed the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act in 1994 and its amendment, the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PC-PNDT) in 2003, with the goal of eliminating prenatal sex determination and consequent sex-selective abortions.

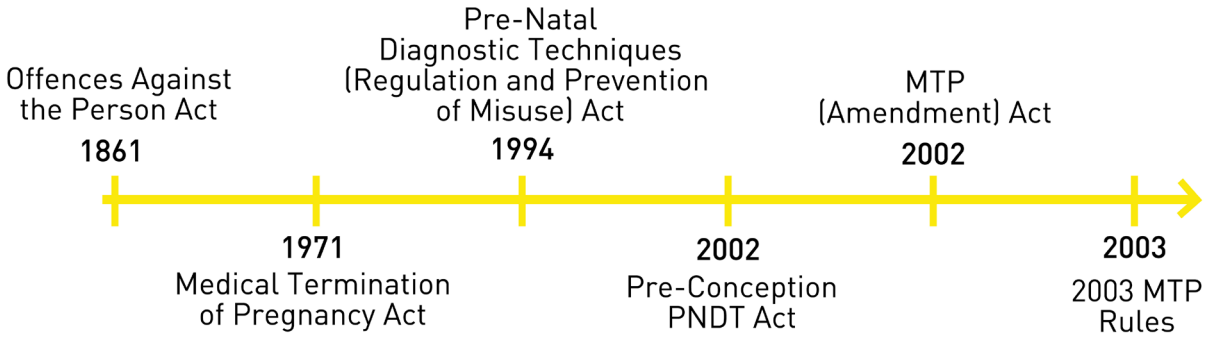
However, the PC-PNDT and the MTP Acts gave rise to illegal back door service providers that offer ultrasounds to detect foetal sex, as well as abortions for fetuses over 20 weeks of gestation (often referred to as a "cottage industry"). Many of these service providers are often not fully qualified or equipped to conduct such medical procedures, resulting in risks of botched abortions and even deaths of women (Patel 2007).

• ABORTION AS A HUMAN RIGHT

Due to the scarcity of lower-level public facilities to provide legal abortion services, the National Population Policy in 2000 recommended that all public health facilities should be able to provide abortion services up to eight weeks' gestation, including primary health centers. This move was intended for the benefit of rural women, for whom primary and community health centers continue to be the most accessible avenue to receive healthcare. Despite this, acquiring abortion services in the more rural and remote areas remains a challenge because most primary health centers are not equipped with certified abortion providers (Stillman et al. 2014). Furthermore, the highly medicalised and bureaucratised rules and regulations defined by the Act requires that providers of abortion receive a level of training that is difficult to achieve in India, given the shortage of training facilities in the country and the absence of incentives to receive formal training (Johnston 2002).

To address this shortage of service providers, 2002 and 2003 saw additional amendments to the MTP Act and its rules and regulations. The 2002 amendment decentralised the regulation of abortion facilities from the state level to District Level Committees, and the subsequent amended Rules in 2003 streamlined the facility registration process to speed up the process of certification of private facilities. The Rules also led to abortion facilities no longer being required to have onsite capability for managing emergency complications, instead mandating the presence of personnel trained to recognise complications and refer patients to another facility for emergency care (MoHFW 2002; MoHFW 2003). Local governments, thus, became empowered to regulate abortion services. Operationally, however, implementation continues to be uneven due to many District Level Committees being nonfunctional (Stillman et al. 2014).

FIGURE 3: TIMELINE OF ABORTION-RELATED LEGISLATION IN INDIA BEFORE 2020



Nearly 50 years after the passage of the MTP Act, therefore, safe and legal abortions continue to be inaccessible to a majority of women in India. As stated by Ramachandran and Duggal, "Abortion seeking remains a private, sensitive act with negative moral and emotional connotations…" (2007: xiv). It is in this context that women's rights advocates have called for the recognition of access to safe abortions as a human right rather than only a demographic or medical issue, further stating that abortion, alongside other

family planning services, is an imperative need for individual and societal well-being. Hence, beyond just providing technical solutions, addressing other critical indicators like child marriage, early pregnancy, lack of contraceptive awareness and stigma associated with abortion needs to be addressed (Muttreja and Singh 2019).

THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL 2020

These and several other issues with the existing legislation, discussed later in the paper, finally led to the Ministries of Health and Law to propose a new set of amendments to the MTP Act in 2014. Some of the changes proposed included expansion of abortion provision to nurses, ANMs and practitioners trained in the Indian System of Medicine with recognised qualifications in Ayurveda, Unani, Siddha or homeopathy; increasing the age limit for abortion to 24 weeks of gestation; replacing the term “married women” with “all women” and the word “husband” with “partner” in the contraceptive failure clause in order to clarify that abortion is legal for all women, not only those who are married; and mandating that the name and other details of the woman seeking an abortion remain confidential (MoFHW 2014). The 2020 Medical Termination of Pregnancy (Amendment) Bill, while not following all, took into account some of the changes proposed in the 2014 draft.

The 2020 Bill proposes that medical termination of pregnancy be legalised upto 24 weeks of gestation, with only one registered medical practitioner’s opinion being required upto 20 weeks, as opposed to the previously mandated two. The opinions of two registered medical practitioners would be required between 20-24 weeks. In case of foetal abnormalities, there is no upper time limit to seek termination. The Bill also aims at enhancing the gestational limit for “special categories” of women, which include survivors of rape, incest, and other vulnerable women like minors and those with disabilities. It also stipulates, like its 2014 draft, that the name and other details of the woman seeking an abortion should remain confidential, except to a person authorised in any law that is currently in force (The Medical Termination of Pregnancy (Amendment) Bill, 2020).

The MTP (Amendment) Bill 2020 is a significant step in the right direction for a variety of reasons. For starters, foetal anomaly scans can usually be accurately conducted only after the 20th-21st week, making the revelation of an anomaly in the foetus and subsequently seeking termination of the pregnancy within 20 weeks almost impossible (Gupta 2019). The Bill also seeks to relax one of the regressive clauses of the 1971 Act, i.e., single women could not cite contraceptive failure as a potential reason for termination of a pregnancy. However, whether the several positive aspects of the Bill will be able to address most of the outstanding barriers to attaining safe abortion facilities in India, remains to be seen.

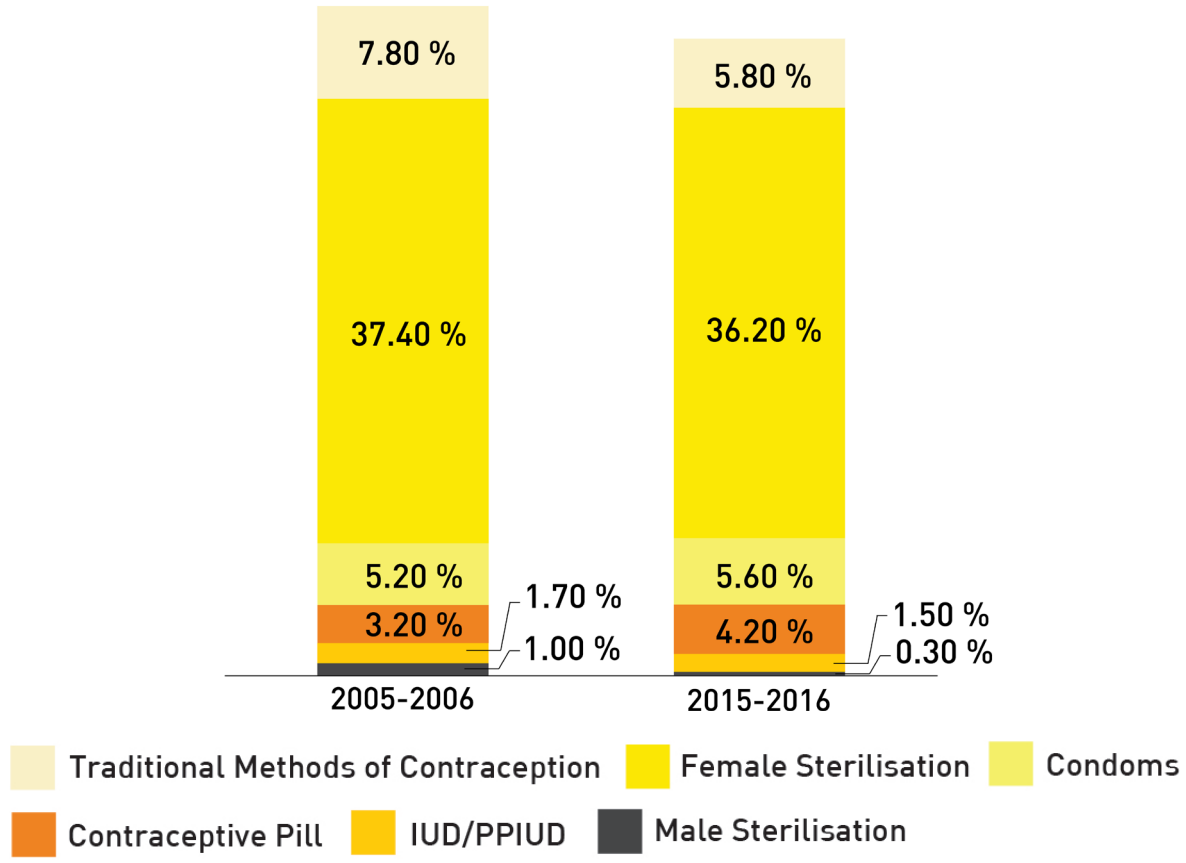
ISSUES SURROUNDING ABORTION IN INDIA

- **LOW USAGE OF AND ACCESS TO CONTRACEPTION**

Unintended pregnancies are the most common reason for abortions in India, with other reasons being underlying health conditions of the mother or unborn child, and the desire for a boy over a girl child. A high number of unintended pregnancies suggests inadequate access to and ineffective use of contraceptives as well as pervasive gender inequalities that often hinder women's ability to negotiate contraceptive use during sexual intercourse (Stillman et al. 2014).

In 2007-08, around 21% of married women reported an unmet need for contraception, i.e., they were not using a contraceptive but did not desire a child. Unmet need was higher among rural, low-income and younger women (IIPS and Population Council 2010). The National Family Health Survey 2015-16 shows that the overall contraceptive use among married women of reproductive age fell from 56% to 53% in a decade, with 86% of women using sterilisation to prevent pregnancy (Figure 4). In some states, the usage of certain methods like the contraceptive pill had dropped by over a half (Cousins 2017). A cross-sectional study conducted in public and private health facilities in rural Bihar and Uttar Pradesh, the two most populous states in India, suggested that very few women had knowledge of more than one method of contraception, and of these only about 62% received the method of their choice from a health facility (Mozumdar 2019).

FIGURE 4: CONTRACEPTIVE USE IN INDIA



SOURCE: NFHS 3 AND NFHS 4

Availability of contraception remains intrinsic to maternal health by reducing the need for abortions, with one study spanning 172 countries concluding that 104,000 maternal deaths per year can be prevented (a reduction of 29%) if the unmet need for contraception is addressed (Ahmed et al. 2012). Hand-in-hand with abortion-related legislation, therefore, India should also focus on policies aimed at increasing accessibility, awareness, affordability and availability of a wide variety of contraceptive methods. Capacitating existing frontline workers like ASHAs, ANMs, reproductive, maternal, new born, child and adolescent health (RMNCH) counsellors and adolescent health counsellors can potentially be crucial in this aspect (Muttreja and Singh 2018).

- **EARLY MARRIAGE AND CHILD MARRIAGE**

According to NFHS-4, around one out of four (27%) women in India were married before the age of 18, with 8% of women between 15-19 years of age either already mothers or pregnant. India is among the countries with the highest prevalence of child marriage among girls (United Nations Children's Fund 2014). Lower age of marriage is typically characterised by lower rates of family planning and henceforth increased need for abortion services. Child marriage, early conception, motherhood, and abortion all pose significant physical and emotional risks to young mothers. The issue of unwanted pregnancies (including mistimed ones) and abortion, therefore, cannot be solved while ignoring the prevalence of early marriage in India.

- **STIGMA AROUND ABORTION**

Despite abortion being legal in India for almost five decades, the subject of abortion remains clouded in stigma. This includes shaming of women seeking abortion, and even refusal to provide abortion services by medical personnel who may or may not be aware of the relevant laws (Suresh and Kurian 2018; Makleff et al. 2019). This situation is especially exacerbated for unmarried women (in both urban and rural contexts), with sex before marriage being a taboo and hence resulting pregnancies being almost unthinkable in the Indian imagination. These women often fail to have a support system within close family or friends, choosing to keep their pregnancies secret for fear of penalisation. For a majority of unmarried women and girls, therefore, legal abortion services remain inaccessible and often unaffordable, causing them to seek out unsafe methods (Unnamed Author, Hidden Pockets 2019). A study among women aged 15–24 in Bihar and Jharkhand in 2007–2008 showed that compared to married young women, single women often had to travel long distances for an abortion in a facility that would maintain confidentiality. Unmarried young women also experienced an average delay of one month between recognising the pregnancy and obtaining an abortion at a certified facility, commonly due to first, and unsuccessfully, attempting to abort through the services of a chemist, nurse or some other uncertified provider (Kalyanwala et al. 2010).

The moral stance of the medical practitioner also plays a significant role in the inaccessibility of abortion services for unmarried women. Cases where doctors refused to provide abortions to adult unmarried women without parents' permission, shamed, guilted, or simply denied the procedure to them despite following the legal regulations remain rampant (Unnamed Author, Hidden Pockets 2019). Even the MTP Act, 1971 does not explicitly cover pregnancies among unmarried women in its terminology, providing additional impetus to doctors for turning them away (Krishnan 2015). The Act, therefore, while choosing to protect doctors who perform (legal) abortions, forces women to justify their abortions and further

makes them dependent on the doctor's interpretation of the law.

While the MTP (Amendment) Bill 2020 helps the cause of these women by including unmarried women within the terminology and making confidentiality a necessary clause, without accompanying initiatives to break taboos and destigmatise pre-marriage sexual activities, significant improvements cannot be made in this regard.

- **LACK OF AWARENESS**

Lack of awareness about the legal status of abortion and the more nuanced rules and regulations related to it further serve as barriers to accessing safe abortion services in India. Studies show that on average, 78% of unmarried, abortion-seeking women thought that abortion was only legal for married women. Others who knew that abortion was legal, nevertheless were unaware of the time limit to access abortions legally, thus causing them to potentially be too late in availing the service (Stillman et al. 2014). Awareness is especially low in rural areas, with a study in Rajasthan showing that many women believed that their husbands' consent was required for termination of a pregnancy (Elul 2011). Similarly a survey in Jharkhand showed that almost 95% of women aged 15-24 were unaware that abortion is legal (Banerjee et al. 2012).

Lack of awareness was also recognised on the part of medical personnel and health service providers themselves. According to Stillman et al. (2014), studies have suggested that many trained and qualified providers posted at lower-level public health facilities often do not provide abortion services due to a lack of awareness of the legal status of abortion or a false impression that their facility is not legally approved to provide such services[3]. These lower-level facilities are often the only service points accessible to rural or poor women, and gaps at this level severely impact many women's ability to seek abortion services.

- **LACK OF ACCESSIBILITY TO SAFE HEALTHCARE SERVICES**

Perhaps more than any other issue, the prevalence of unsafe abortions in India is a testament to the fact that the country's public health system remains severely underdeveloped. Lack of professionals trained to provide abortions, unequal distribution of trained professionals across regions and across urban and rural areas, and misconceptions and lack of awareness among qualified professionals about which facilities are legally approved to offer abortion services, are some of the issues plaguing the public healthcare system that hinder women from all socio-economic backgrounds gaining safe and affordable abortion services (Stillman et al. 2014). As mentioned in the previous section, public facilities at the primary health center level and higher are intended to be the main service points, especially for poor and rural women, but they often lack the resources to provide adequate services. Tables 2 and 3 provide a comprehensive understanding of the state of primary and community health centres in India.

[3] A complete guidance for implementing authorities at the state and district levels and also to providers and owners of facilities offering abortion services in the public and private sector, or those who wish to do so, can be found here: http://www.nrhmtn.gov.in/guideline/SafeAbortionHandbook.pdf

TABLE 2: CHARACTERISTICS OF LOWER-LEVEL PUBLIC HEALTH FACILITIES IN INDIA

Primary health centers	
Female medical officer on staff	24 %
Open 24 hours	53 %
Offers referral services for complicated pregnancy/delivery (among 24 hour facilities)	55 %
Meets Indian Public Health Standards[4]	15 %

Community health centers	
Obstetrician-gynecologist on staff	25%
Delivery services offered 24 hours	90%
Has operating theater	65%
Designated as first referral units (FRUs)	52%
FRU with functioning blood storage facility (Among community health centers designated as FRUs)	9%
Meets Indian Public Health Standards[5]	15%

SOURCE: STILLMAN ET AL. 2014

TABLE 3: STAFFING LEVELS AT LOWER-LEVEL PUBLIC FACILITIES IN 2012

	No. of staff required*	**No. of staff actually in position**	**Shortfall in staff**
Community Health Centres			
Obstetrician-gynecologists	4,833	1,615	3,005 (62%)
Physicians	4,833	940	3,667 (76%)
Primary Health Centres			
Allopathic doctors	24,049	29,984	Not applicable

*According to Indian Public Health Standards, one obstetrician-gynecologist and one physician is required at all community health centers, and one doctor is required at all primary health centers.

SOURCE: STILLMAN ET AL. 2014

While public facilities remain underequipped, there are problems in the private sector of healthcare as well. According to the MTP Act 1971, private facilities are required to obtain government certification before they can provide abortion services legally (refer to footnote 3).

[4] The guidelines for public health standards for primary health centres can be found at: http://www.iapsmgc.org/userfiles/4IPHS_for_PHC.pdf

[5] The guidelines for public health standards for community health centres can be found at: http://tripuranrhm.gov.in/Guidlines/IPHS_Guidelines_Health_Centres.pdf

This involves a tedious administrative process that many facilities wish to avoid, thus rendering a majority of private sector providers unable to offer abortion services in a legal way. In some states, a lack of District Level Committees, the entities responsible for evaluating and registering abortion facilities, has also led to lags in private facilities gaining certification. In other states, the devolution of abortion provision regulation to the district level has created more opportunity for state governments to interpret and implement laws according to their own needs and objectives, thus causing a lack of uniformity in the certification process and inequality in access by region. Other than abortion services, health facilities are also required to provide a range of services like counselling, contraceptive advice, and postabortion care, all of which are similarly lacking in a major way (Ibid., Yokoe et al. 2019).

The MTP Act 1971 requires an extremely high level of medical and bureaucratic qualification to be able to meet the requirements for legal abortion provision, a fact that the government attempted to change in the 2002 Amendment and the subsequent Rules. Despite this, the fact that the control over abortion provision remains rooted firmly in the hands of the allopathic doctor, in a country where qualified doctors are rarely available, severely curtails women's accessibility to safe abortions. While the 2014 draft Amendment Bill tried to rectify this by recommending that nurses, ANMs and practitioners trained in forms of medicine other than Allopathy are capacitated to provide abortion services, the 2020 Bill failed to take into account this need to expand the provider base (Sharma 2020).

- **FINANCIAL BARRIERS TO SEEKING ABORTION**

Related to the problems mentioned in the previous section is also the problem of affordability of abortion facilities. Although abortion services are generally provided free of cost in public facilities, women may incur a variety of additional costs while seeking them, such as costs of anesthesia, antibiotics or other medications, as well as transportation costs and costs borne due to loss of earnings (Stillman et al. 2014). Private sector providers, on the other hand, are free to charge at their own discretion, and their prices may range anywhere between INR 1,000 to INR 15,000 or even higher (Gupta and Trivedi 2017). The lack of sufficient public health facilities, as discussed in the previous section, thus forces women to turn to the private sector to terminate their pregnancies. These facilities often remain unaffordable for a majority of women, the financial burden thus becoming a significant barrier to accessing safe and legal abortions.

- **JUDICIAL LAGS IN APPROVING ABORTIONS**

In cases where the gestational period has surpassed the 20 week limit but the pregnant woman wants an abortion, the MTP Act 1971 requires that she get permission from the court to do so. Such cases usually take place due to many foetal anomalies coming to light after the 20th week of pregnancy, as mentioned previously. However, while these cases are common, the Indian judicial system is well known for turning down such requests, or delaying the cases to the extent that abortion becomes potentially dangerous to the mother. Many examples can be cited of such judicial lags. For instance, in 2016, two cases were turned down by the Supreme Court because the foetuses were 26 weeks old, despite the risk of one being born with Down Syndrome and the other with congenital heart defects (Soni 2017).

Cases where the pregnancy has surpassed 20 weeks but the pregnant person seeks an abortion is even more common in cases of child assault or underage rape victims, where the pregnancy remains

unrecognised by the child herself and only becomes evident much later than 20 weeks, when visible symptoms are developed. Even in such instances, the courts have been known to rule unfavourably towards the child.[6] Judicial lags also become evident when the court proceedings are so long drawn out that by the time a decision is made, it becomes too late to safely abort the pregnancy.[7]

According to a recent study by the Center for Reproductive Rights, judicial and medical board authorisation requirements endanger women's and girls' reproductive rights due to delays, denials, public scrutiny and trauma (Shah 2019). The report recommends that abortions seize to be within the purview of the courts, the decision resting instead with medical personnel and more importantly with the pregnant woman herself. "Third-party authorisation violates women's equality and constitutes a form of discrimination against women", it states.

The 2020 Amendment Bill seeks to reform this very problem, by raising the legal gestational limit of abortion from 20 to 24 weeks. However, due process continues to be a long drawn out process, causing women months of physical and emotional turmoil in trying to get abortions legally.[8] It is unlikely that increasing the gestational limit is going to change this fact, without first putting in place mechanisms to ensure that judgements are swift as well as sensitive to the plight of the woman, or doing away with the requirement of judicial approval all together.

CONTEMPORARY DEBATES

Although the pro-life vs. pro-choice argument has not taken precedence in India the way it has in the West, this is not to say that India's liberal policy towards abortion has remained entirely unchallenged. The increase in the gestational limit for abortions proposed in the 2020 Bill has sparked several different debates, for instance. Globally, abortion time limits are generally set based on the viability of the foetus, as in the landmark US Supreme Court judgement in Roe V. Wade, with viability being defined as the ability to potentially survive outside the mother's womb, albeit with artificial aid. However, doctors often disagree on the exact time a foetus becomes viable, arguing that it can happen any time between 24 to 28 weeks (Unnamed author, The Hindu 2020). Questions remain unanswered, therefore, on the exact point at which an unborn baby can be considered a "person" and its rights championed on an equal level with the mother.

Another important debate that concerns abortion in India is the complex relationship between seeking abortions owing to foetal anomalies, and the need to secure equal rights and treatment for persons with disability. Many disability activists argue that aborting foetuses due to predicted disabilities in the resulting baby is not only unethical, but goes against the fundamental rights of persons with disability to

[6] In 2016, a 10-year-old girl in Chandigarh had to deliver her uncle-cum-rapist's child, because her abortion request was denied on the grounds that she was too far along (Parischa 2017).
[7] For instance, a 14-year-old from Uttar Pradesh, who was raped, was denied abortion because the legal proceedings took eight weeks, causing her to reach the stage of 'advanced pregnancy' (about 33 weeks). The girl not only gave birth to her rapist's baby, but had to marry her rapist following ostracisation from the family and society (Soni 2017).
[8] Details of the penalty for illegal abortions, for both the receiver and provider, at any stage of pregnancy, can be found here:
https://vikaspedia.in/social-welfare/women-and-child-development/women-development-1/policies-and-acts-1/law-on-abortion

be treated equally with abled people (Manninen 2015). Others such as Addalakha (2010) and Madhiwalla (2008) agree that the debate is highly nuanced with perhaps no right answer. Furthermore, the latter argues that the rights of the mother should, at all times, be championed over an unborn foetus, disabled or otherwise. Regardless, pre-natal testing and subsequent abortions of "faulty" foetuses does require the need to think about the problematic history of eugenic activities, and the fact that eugenics will always be discriminatory towards non-normative populations. As a result, the desire for a just and equal world, and aborting foetuses that are at risk of disability upon birth, will always have a complicated equation.

CONCLUSION

The above illustrates that while abortion is legally backed by the state, in the moral and ideological realms it remains a contested issue. Furthermore, legalisation itself has failed to provide access to abortion services to women, with women from marginalised groups being disproportionately prone to the risks of unsafe abortions. As such, socioeconomic equality in the country is the first step towards securing safe abortion services. Additionally, there is a need to take the decision-making regarding abortion away from the medical practitioner's or judge's discretion and place it in the control of the woman, and to recognise her agency in making autonomous choices for herself.

The last 50 years have taught us that merely legalising abortion is not enough, the government needs to ensure that the healthcare system of the country is equipped to provide the service to its female population. Abortion seeking is intrinsically linked to the larger issue of sexual and reproductive health and rights (SRHR) in India. While the 2020 amendment Bill, if it becomes an Act, is expected to have some positive benefits, without simultaneously increasing awareness, access, and affordability to SRH services it will remain inadequate in tackling the myriad of issues surrounding unsafe abortions in India.

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