NLUO CPHL RESEARCH ESSAY

On

THEME:

PRIVACY AND HEALTH DATA SHARING: EMERGING CONCERNS

Titled

THE DRAFT FRAMEWORK FOR THE GOVERNANCE OF NON-PERSONAL DATA AND ITS LEGAL IMPLICATIONS ON NON-PERSONAL DIGITAL HEALTH DATA IN POST-COVID INDIA*

CONTENTS

* I dedicate my writing to my parents, who have always encouraged in me a deep respect and desire for reading. I also take this opportunity to extend a special thanks to Prof. Rashmi V and Prof. Joga Rao's for their guidance in the term papers for Human Rights Law and Healthcare Law and Ethics courses at NLSIU, on which this paper builds on, by extensively revising its arguments in light of suggestions made therein.

PAGE INTENTIONALLY BLANK

RESEARCH ESSAY

THE DRAFT FRAMEWORK FOR THE GOVERNANCE OF NON-PERSONAL DATA AND ITS LEGAL IMPLICATIONS ON NON-PERSONAL DIGITAL HEALTH DATA IN POST-COVID INDIA

Abstract:

Datafication and dataveillance of consumers is becoming more commonplace, and is often not limited to only personal data of consumers. Non-personal data quite often forms a large and essential component of such datafication. At present, it is no exaggeration to state that the contemporary Indian privacy and data protection frameworks focus' majorly on personal data and often deals with NPD almost as an afterthought.

This essay thus seeks to demonstrate the legal and regulatory implications of the absence of a more nuanced approach to NPD collection, processing, storage, and utilization in the medical sector. The essay also seeks to demonstrate that the present digital health data protection legal framework in India is insufficient for protecting patients' electronic health records and thereby goes ahead to argue that ad hocism in digital health data should be avoided but till that happens the essay provide certain stopgap measures to assuage data misuse till enactment of a comprehensive legislation.

This is elaborated through: First, evaluating the Draft Digital Information Security in Healthcare Act 2017 on the normative data protection and privacy roadmap presented by the recent Personal Data Protection Bill 2019 and the revised Draft Framework for the Governance of Non-Personal Data. Second, an illustrative case study on the misuse of broadly-worded purpose limitation provisions to exploit NPD by contact tracing applications like Aarogya Setu is demonstrated and evaluated on the privacy and proportionality principles.

I. INTRODUCTION

There has been a slew of important changes, caused due to the COVID-19 pandemic. Primary among them has been the increased dependence on digital platforms, digital identities and transactions for the efficacious conduct of an individual's mundane everyday activities. That growing digitisation shall increasingly inform interactions between the citizens

and concerned nation-states hereon forth, is a moot point now. It is unreasonable to expect governance and administration of justice to not remain untouched by such altered environs.

The recent draft of Government of India's Science and Technology Policy of Dec 2020 looks forward to strengthen public health surveillance system through technologies such as digital health, artificial intelligence, etc.[2] Prior to this the *National Health Policy 2017* also recognized the need for establishing an integrated, 'federated National Health Information Architecture'.[3] This has significant consequences for Indian context.

As someone noted early on, 'You are not the consumer, you are the product'.[4] In a similar vein, Marc Goodman's *Future Crimes* describes certain instances of 'datafication' wherein consumer's intimate stories of chronic illness and treatment experience shared on a particular website were being added to a site's information repository and thereafter sold to third party advertisers, data brokers, marketers. In this case, major pharmaceutical companies acquired these as raw materials in a multi-billion-dollar global data mining industry, without the consumer's consent.[5] Indian parallels of such underhanded dealings in consumer data are not hard to find. More recently, in India there have been allegations of non-consensual storing of health data by online medical platforms for creating a common health ID.[6]

Recent Developments in Data Protection and Privacy Laws

As recently as April 2020, the Kerala High Court in *Balu Gopalakrishnan v State of Kerala* (2020) issued interim orders to protect the data of COVID+ patients in Kerala.[7] The Court noted the duty of the State government to anonymise the data before sharing it with a third party

[2] Department of Science and Technology, *Science, Technology, and Innovation Policy* (Draft STIP Doc 1.4, Dec 2020) ¶[10.2.14] <https://dst.gov.in/sites/default/files/STIP_Doc_1.4_Dec2020.pdf> accessed 23 March 2022.
[3] Ministry of Health & Family Welfare-Government of India, *National Health Policy* (2017) 25, ¶[23] <https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf> accessed 23 March 2022.
[4] 'You're Not the Customer; You're the Product' (*Quoteinvestigator.com*, 17 July 2017) <https://quoteinvestigator.com/2017/07/16/product/> accessed 21 March 2022.
[5] Marc Goodman, *Future Crimes Inside the Digital Underground and The Battle for Our Connected World* (Penguin Random House: UK, 2015) 70-89.
[6] 'Indian Digital Health Platforms Are Collecting Patient Data without Consent' (*MediaNama*, 22 September 2021) <https://www.medianama.com/2021/09/223-india-digital-health-medical-platforms-data-consent-records/> accessed 23 March 2022.
[7] *Balu Gopalakrishnan v State of Kerala*, 2020 SCC OnLine Ker 7746.

(which was a US company in this instance) and further ordered to return the data to the State government after processing it as per the contract terms.[8] This the Kerala HC did to ensure that there is no 'data epidemic' after the COVID-19 epidemic is controlled.[9] Such cases are merely symptomatic of the larger digital malaise implicit in the improper handling of data in India since long.[10]

II. AIM AND OBJECTIVE OF THE ESSAY

Such datafication (and even dataveillance) of consumers is becoming more commonplace and is often not limited to merely personal data.[11] Non-personal data ('**NPD**') quite often forms a large and essential component of such datafication. At present, it is no exaggeration to state that the contemporary Indian privacy and data protection frameworks focus' majorly on personal data and often deals with NPD almost as an afterthought.[12]

Therefore, this essay seeks to demonstrate the legal and regulatory implications of the absence of a more nuanced approach to NPD collection, processing, storage, and utilization in the medical sector. The essay also seeks to demonstrate that the present digital health data protection legal framework in India is insufficient for protecting patients' electronic health records and thereby goes ahead to argue that *ad hocism* in digital health data should be avoided

[8] 'Balu Gopalakrishnan v. State of Kerala and Ors. - Global Freedom of Expression' (*Global Freedom of Expression*, 10 November 2020) <https://globalfreedomofexpression.columbia.edu/cases/balu-gopalakrishnan-v-state-of-kerala-and-ors/> accessed 21 March 2022.

[9] 'Nishith Desai Associates: Indian Judiciary's Take on Storage of Covid-19 Patient Data Outside India' (*Nishith Desai*, 2012) <https://nishithdesai.com/information/news-storage/news-details/article/indian-judiciarys-take-on-storage-of-covid-19-patient-data-outside-india.html> accessed 22 March 2022.

[10] A short history of various government initiatives to deal with digital health data through the years can be seen in: eHealth Network, 'India's Digital Health Evolution, Explains Dr K Madan Gopal, Sr Consultant, NITI Aayog' (*Elets Online*, 13 September 2021) <https://ehealth.eletsonline.com/2021/09/indias-digital-health-evolution-explains-dr-k-madan-gopal-sr-consultant-niti-aayog/> accessed 23 March 2022.

[11] Katherine J Strandburg, 'Monitoring, Datafication and Consent: Legal Approaches to Privacy in the Big Data Context' in J Lane and Others (eds), *Privacy, Big Data and the Public Good: Frameworks for Engagement* (CUP 2014) 5, 40 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3728973> accessed 14 September 2021.

[12] 'Our Response to the Report by the Committee of Experts on Non-Personal Data Governance Framework' (*Dvara Research Blog*, 6 October 2020) <https://www.dvara.com/blog/2020/10/06/our-response-to-the-report-by-the-committee-of-experts-on-non-personal-data-governance-framework/> accessed 23 March 2022. Also, Response dated 13 September 2020 to the Report by the Committee of Experts on Non-Personal Data Governance Framework released by the Ministry of Electronics and Information Technology in July 2020 (*Dvara Research*, 2020) <https://www.dvara.com/research/wp-content/uploads/2020/10/Our-Response-to-the-Report-of-the-Committee-of-Experts-on-Non-Personal-Data.pdf> accessed 23 March 2022.

but till that happens the essay provide certain stopgap measures to assuage data misuse till enactment of a comprehensive legislation.[13]

This is elaborated through: *First*, evaluating the Draft Digital Information Security in Healthcare Act 2017 ('**DISHA**')[14] on the normative data protection and privacy roadmap presented by the recent Personal Data Protection Bill 2019 ('**PDP**') and the revised Draft Framework for the Governance of Non-Personal Data ('**NPD Draft Framework**'). *Second*, an illustrative case study on the misuse of broadly-worded purpose limitation provisions to exploit NPD by contact tracing applications like *Aarogya Setu* is demonstrated and evaluated on the privacy and proportionality principles.

III. DISHA, PDP AND THE NPD DRAFT FRAMEWORK

The PDP does not govern nor extend protection to the 'non-personal data' of consumers or more appropriately in the medical context patients.[15] The PDP defines NPD to means 'data other than personal data'.[16] Last year, the expert committee under the Ministry of Electronics & Information Technology ('**MEITY**') released the revised Draft Framework.[17] Besides elaborately defining NPD, the report also classified NPD into different categories.[18] Thus, at present the normative understanding of NPD in India is that the regime applies to all data that is non-personal data under the PDP Bill or which does not have any personally identifiable information.[19]

---

[13] A caveat that this paper shall primarily reference such information collected by Health Care Establishments since the data collected by non-HCOs is often limited as compared to those collected by HCOs. Thus, the threat from porosity remains high. See Sajai Singh, 'How Will the Healthcare Sector Comply with the PDP Bill?' (*ET Health World*, 3 January 2020) <https://health.economictimes.indiatimes.com/news/policy/how-will-the-healthcare-sector-comply-with-the-pdp-bill/73077709> accessed 23 March 2022.

[14] Ministry of Health & Family Welfare-Government of India, *Digital Information Security in Healthcare Act 2017* (F.No Z-18015/23l2017-eGov, Nov 2017) <https://www.nhp.gov.in/NHPfiles/R_4179_1521627488625_0.pdf> accessed 27 March 2022.

[15] NPD Draft Framework, ¶[5(iii)].

[16] PDP, expl to s 91(2).

[17] Tanmay Mohanty, "Non-Personal Data Governance Framework" (*Mondaq*, 16 September 2020) <https://www.mondaq.com/india/privacy-protection/985574/non-personal-data-governance-framework> accessed 23 March 2022.

[18] NPD Draft Framework, Appendix 3.

[19] NPD Draft Framework, ¶[4].

A. Need for Harmonization of Data Protection and Privacy Laws

However, there is now an expedient need to harmonize all data protection and privacy laws, both old and new. In the absence of such harmonization, there may remain loopholes that data businesses, custodians and processors may take unfair advantage of. DISHA is a useful case-in-point which can be used to illustrate the legal and regulatory implications of not having a more nuanced approach to NPD in the medical sector. DISHA envisions such harmonization of digital health data laws in ch VII.

S 52 mentions that DISHA would supersede any other Act with regard to protection of health data record, for the time being in force.[20] Furthermore, s 55(5) provides for comprehensive review of all laws and regulations relating to health by Union as well as State governments within one year of coming into force of DISHA. However, due to its prior date of drafting, there is lack of contemplation of its relationship with the principle-based legislative intent and structure of the long-awaited privacy and data protection laws in the form of PDP and NPD Draft Framework.

Therefore, administrative effort should be expended and expedited towards updation and harmonization of DISHA in line with the contemplated principles and rules under these legal instruments is crucial to successful NPD governance. The consultative process should be towards reconciling these different frameworks and their cumulative disjunctions for higher effectiveness and predictability of legislative structure in the country.

B. The Perils of Anonymisation Reversal

Again, DISHA only defines the term ‘digitial health data’,[21] but the National Digital Health Mission’s Strategy Overview (2020) makes a more nuanced characterization of ‘health data’ into ‘personal health data’ and ‘non-personal health data’.[22] The latter includes (i) data which was

[20] DISHA, s 52.
[21] DISHA, s 3(e).
[22] National Health Authority, *National Digital Health Mission: Strategy Overview* (July 2020) ¶[2.2] <https://ndhm.gov.in/documents/ndhm_strategy_overview> accessed 23 March 2022.

initially personal data but has been anonymised[23] (ii) aggregated health data with no personal identifiers as well as (iii) anonymised health data.[24] S 3(2) of PDP which defines 'anonymisation' as an 'irreversible process of transforming or converting personal data to a form in which a data principal cannot be identified'.[25]

It is thus interesting to note that the present laws as in force in India is silent on the use and regulation of anonymised or aggregated data[26] since they often don't make a distinction between NPD and personal data which leads to confusion in determining the subject-matter of regulation.[27] So here on forth our discussions w.r.t. DISHA shall refer to the use of such anonymised data or aggregated. However, as the report also observed no anonymisation technique is perfect[28] and hence the PDP providing for penalties for de-anoymisation.[29] We have seen research by Prof Latanya Sweeney of Harvard in 1997 wherein Sweeney was able to correctly identify 87% of people using medical datasets of General Insurance, Boston using just three identifiers of date of birth, pin-code and gender metrics.[30]

The *proviso* to s 29 which is a purpose limitation provision provides that in case of use of medical data for public health purposes, 'only de-identified or anonymised data shall be used'.[31] The use of the term "or" is problematic due to the significant difference between 'de-identified'[32] and 'anonymised data'. 'De-identified' means that the personal identifiers in a record have been extracted and that it would be very difficult but not impossible to re-establish identities any of the people mentioned in the original record.[33]

---

[23] See PDP, s 3(21) with NPD Draft Framework, ¶[4] r.w. Appendix 3(1)(iii) and 3(4).
[24] Strategy Overview ¶[2.2.1(2)].
[25] PDP, s 3(2). Also see DISHA, s 3(1)(a).
[26] Neetika Gandhi, Saumya Kapoor and Shivarpita Nailwal, 'At a Glance: Data Protection and Management of Health Data in India' (*Lexology*, 6 January 2021) <https://www.lexology.com/library/detail.aspx?g=0fdcef36-61a8-4e00-9bed-8abcf6866c96> accessed 23 March 2022.
[27] Ayush Tripathi, 'Changes and Challenges in the Revised Regulatory Framework for Non-Personal Data' (*The Print*, 15 January 2021) <https://theprint.in/theprint-valuead-initiative/changes-and-challenges-in-the-revised-regulatory-framework-for-non-personal-data/586117/> accessed 21 March 2022.
[28] NPD Draft Framework, ¶¶[8.15] and [10.1(viii)].
[29] PDP, s 82.
[30] Caroline Perry, 'You're Not so Anonymous' (*Harvard Gazette*, 2011) <https://news.harvard.edu/gazette/story/2011/10/youre-not-so-anonymous/> accessed 21 March 2022.
[31] DISHA, s 29.
[32] See both DISHA, s 3(d) and PDP s 3(16).
[33] Aditya Chunduru, '#NAMA: What Does the Non-Personal Data Framework Mean for Businesses? Will It 'Unlock' Economic Potential of Data?' (*MediaNama*, 22 January 2021)

'Anonymised', on the other hand, means that all of the links between a person and the person's record have been irreversibly broken so that it would be virtually impossible to re-establish any of the people in the original record. Once anonymised, the data goes outside the purview of PDP and by logic, outside the ambit of the Data Protection Authority u/PDP.[34] But this reversibility in de-identification is of prime importance and could be a determinant factor in the subject deciding whether he wants to consent to the use of his data or not. Hence, we believe there should be greater clarity on whether the data would be de-identified or anonymised.

C. Determining Ownership Interest in NPD

Again, we see that in the DISHA framework, the use of the term 'generated' in s 29(1) is problematic in the context of NPD. The term may indicate that any data 'produced' or 'developed' by the medical institution about the subject, maybe through the use of some data which the subject has consensually provided, is owned by the medical institution.[35] This would further imply that the medical institution may not need to seek the consent of the subject for use of this 'generated' data. It would be in the best interests of the data subject to clarify what is the legal status of ownership of this 'generated' NPD by definition, belongs to no one person in particular due to anonymisation.[36] The report also doesn't envisage a scenario wherein the data trustee may also be the data custodian leading to conflict of interest.[37]

D. Issues with Withdrawing Consent for NPD Processing

Such NPD collection also needs a re-check when we notice that s 28(5) provides the owner with the right to have only 'specific' and 'relevant' data collected from him, with is not

---

<https://www.medianama.com/2021/01/223-nama-non-personal-data-framework-compliance-businesses/> accessed 21 March 2022.

[34] Rohin Garg, 'Unconstitutional Draft Report on Non-Personal Data Ignores Concerns about Privacy and Data Monopolies' (*Internet Freedom Foundation*, 18 January 2021) <https://internetfreedom.in/unconstitutional-draft-report-on-non-personal-data-ignores-concerns-about-privacy-and-data-monopolies/> accessed 21 March 2022.

[35] DISHA, s 29(1).

[36] 'Non-Personal Data Governance Framework' (*PRS India*, 28 July 2020) <https://www.prsindia.org/report-summaries/non-personal-data-governance-framework> accessed 21 March 2022.

[37] 'Our Comments on the Non-Personal Data Governance Framework Report' (*SLFC*, 2020) 9 and 10 <https://sflc.in/our-comments-nonpersonal-data-governance-framework-report> accessed 24 March 2022.

'excessive' for the concerned purpose. This provision of DISHA is in line with the PDP, s 11(1) which requires that 'Consent' should be given at the commencement of processing and that data cannot be collected prior to acquiring such consent. Furthermore, s 11(2) provides **five** requirements of a 'valid' consent. They are: ***free, informed, specific, clear and capable of being withdrawn***, with each term having its peculiar definition.[38] Since the anonymised data that will be utilized was personal data at its origin, it is imperative that the consent for such anonymous data shall also have to adhere to the thresholds enshrined in PDP by the data fiduciary, processor, or custodian. The General Data Protection Regulation ('**GDPR**') and PDP have similar definitions of consent.[39]

These five requirements bring with it the additional burden on data fiduciary under PDP Bill or under DISHA the 'clinical establishment'[40] of explaining to the data principle the: **Why** (Purpose), **What** (Nature and categories of personal data collected), **Who** (identity of the data fiduciary),[41] **Whom** it will be shared with,[42] **How** (relevance if you collect data not based on consent,[43] **Where** and **When** ('retention policy' as well as 'right to withdraw consent'),[44] and even to file complaint.[45]

S 30(5) of DISHA introduces the innovative concept of a data subject being allowed to withdraw the proxy consent provided on his behalf.[46] Again, the PDP s 11(6) provides the ability to withdraw consent.[47] The GDPR says that the data principal can withdraw consent and it does not affect the lawfulness of the processing before the withdrawal.[48] However, the crucial questions to ask are: *Would the medical institution be obliged to permanently delete all the collected data? What would be the timeframe of the said process? What would be the obligation*

[38] PDP, s 11(2).
[39] General Data Protection Regulation 2016 ('**GDPR**'), art 7.
[40] DISHA, s 3(i).
[41] PDP, s 7(1)(c).
[42] PDP, s 7(1)(g). As per s 7(1)(h), the PDP also deals with situations where data collectors are outside India.
[43] PDP, ss 12-14.
[44] PDP, ss 7(1)(d) and 11(6).
[45] PDP, s 2(1)(l).
[46] DISHA, s 30(5).
[47] PDP, s 11(6).
[48] GDPR, art 11(3).

on third-parties that the data has been shared with? And most importantly, *do such withdrawals also extend to NPD?*

However more to the point, enforcement of such consent withdrawal right may prove problematic in light of how the burden is on the data subject to determine whether the data collected is excessive or not,[49] and since the said data subject will usually not have the requisite knowledge to make such an informed decision. Since it is found to be commercially beneficial for medical intuitions to collect more patient data, we may find such institutions making undue advantage of the subject's inability to make a reasoned decision.

E. Countering Ambiguously Drafted Purpose Limitation Provisions

In my opinion, certain subs of s 29(1), are too broadly worded in terms of purposes the NPD can be used for. It would be fairly simple for a medical institution to show the link between collection of personal data and an improvement in the 'delivery of patient centered medical care',[50] or for academic research and 'other related purposes'.[51] *What is of importance in this regard, however, is the degree of such improvement or whether private players shall be entertained and what is the protocol for the same?* Therefore, it is imperative that we seek greater clarity and specify on what advancement in the delivery of patient centered medical care or 'other related purposes' connotes.

However, s 37(c) of DISHA is a provision which doesn't have equivalent parallels in either the PDP or the NDP and it classifies even the sub-standard storage or transmission of data as a breach.[52] I believe introduction of such a provision as 37(c) for sub-standard storage or transmission in PDP or NDP would be a step up from the 'bests effort basis' employed by public

[49] Future of Non-Personal Data Governance in India: A Consumer Perspective (*CUTS-CCIER*, April 2021) 4 and 5 <https://cuts-ccier.org/pdf/policy-brief-future-of-npd-governance-in-india.pdf> accessed 21 March 2022.
[50] DISHA, s 29(1)(a).
[51] DISHA, s 29(1)(h).
[52] 'Overview: Digital Information Security in Healthcare Act (#DISHA)' (*Ikigai Law*, 7 May 2018) <https://www.ikigailaw.com/overview-digital-information-security-in-healthcare-act-disha/> accessed 21 March 2022.

data fiduciaries, processors and custodian in India.[53] It is a desirable step as it would drive medical institutions to ensure that they do not try to dodge the new technical and security requirements.

Moreover, by a reading of s 37(a), since even mere generation which is not in conformity with the provisions of the Act is a breach,[54] we get the indication that even merely collecting excessive data, not needed for the concerned purpose, may be classified as a breach. I think duplication of this provision in PDP and NPD will be a desirable step as it raises the pedestal the data subject is seated on and places privacy and data protection at the heart of the collection of medical/health data.

IV. AMBIGUOUSLY-WORDED PURPOSE LIMITATION PROVISIONS AND POTENTIAL FOR MISUSES OF NON-PERSONAL HEALTH DATA: THE *AAROGYA SETU* CASE STUDY

The above sub-section on vaguely and ambiguously-phrased purpose limitation provisions is reminiscent of the problems encountered during the India-wide implementation exercise of *Aarogya Setu* App ('**AS**').[55] AS is a contact tracing app[56] and with nationwide rollout of AS, concerns with respect to its scope and application in respect to privacy soon became ostensible. No one can be subject of 'arbitrary or unlawful interference with his privacy ...' as per the art 17 of ICCPR.[57] Furthermore, u/art 17 the concept of 'non-arbitrary interference' incorporates the criterion of reasonableness.[58] This as a result implies that any interfering into a person's privacy

[53] Home Min-Government of India, *Guidelines on the Measures to be taken by Ministries/Departments of Government of India, State/ UT Governments and State/UT Authorities for Containment of COVID-19 in the Country upto 31st May, 2020.* (Notification No. 40-3/2020/DM-A(I), 17 May 2020), cl 9 <https://www.mha.gov.in/sites/default/files/MHAOrderextension_1752020_0.pdf> accessed 21 March 2022.
[54] DISHA, s 37(c).
[55] Notification of Aarogya Setu Data Access and Knowledge Sharing Protocol 2020 in Light of the COVID-19 Pandemic (Order No 2(10)/2020-CLeS, MEITY: New Delhi, 11 May 2020) <https://static.mygov.in/rest/s3fs-public/mygov_159051652451307401.pdf> accessed 21 March 2022 ('**DSP**').
[56] DSP, cl 7(b). IFF's ClausebyClause Analysis of the AS DSP (*IFF*, 2020) ¶[24] <https://drive.google.com/file/d/1CsDRlMDvqAH1Dq2xU5nP7GxdnDPIKhWp/view> accessed 21 March 2022.
[57] ICCPR, art 17(1).
[58] *CCPR GC No 16* (UNHRC, 1988) ¶[7] <https://www.refworld.org/docid/453883f922.html> accessed 23 March 2022.

must be 'proportional' to the ***valid end*** required to be attained.[59] These tests were the same as incorporated in *Puttaswamy* judgement on Privacy.[60]

'Proportionality' as a result is understood when all three prongs of a 'three-part test of proportionality' are satisfied. The three prongs are as follows: (1). The 'suitability' test is one which evaluates whether the envisaged measure is appropriate to achieve the legitimate aim. (2). Determining whether the disputed measure is the least intrusive alternative of an individual's rights is called the 'less restrictive alternative' test. (3). The test that determines if the benefits of a proposed measure offset the costs to an individual's right(s) is appropriately called the 'disproportionate burden' test.[61] Thus, the proportionality method would require any proposed executive action like implementation of a contact tracing technology to follow closely all the three portions of the test: (i) less restrictive alternative (ii) suitability (iii) disproportionate burden.

It was seen that w.r.t. part one of the tests, that AS does not balance the purpose it collects said data for, with the ends it seeks to achieve. The Government of India as recent as in May 2020, announced a protocol for AS data sharing which contains imprecise conditions for collecting and anonymising or aggregating of useful data sets in the manner - 'shall *ordinarily not* be onward shared with any third party'.[62] However, the such aggregated/ anonymised respondent's data was allowed to be shared with private, non-governmental agencies and was being undertaken without any hint of the specifics in relation to the end usage purposes.

Yet again, there have been questions raised on the vague purpose enshrined in the Data Sharing Protocol 2020 of AS which reads as, 'formulating or implementing appropriate health responses and constantly improving such responses' for which this data is being collected.[63] In absence of a singular purpose for data collection (example given - for intimation and contact

[59] See S Joseph and M Castan, *The International Covenant on Civil and Political Rights* 2013) 537, ¶[16.10].
[60] SK Singh, 'Panoptic Jurisprudence of a Big Brother State' (2020) (2) GNLU Law & Society Review 89, 94 <https://www.academia.edu/43535279/Digital_Infrastructures_and_Inequalities_Policy_and_Political_Considerations_associated_with_Ridesourcing_Platform_Work_in_Australia> accessed 23 March 2022.
[61] Yutaka Arai-Takahashi, 'Proportionality' in Dinah Shelton (ed), *The Oxford Handbook of International Human Rights Law* (OUP: UK 2013) 3 of 18 and 19.
[62] DSP, cl 7(b).
[63] DSP 2020, cl 5(b).

tracing of person who has faced exposure to COVID-19). Such phrasing was disapproved of, for lack of compatibility with the proportionality principle.[64]

In India, protections w.r.t. data processing and gathering from contact tracing are few and far between. Thus, individuals who use AS are essentially setting themselves up for potential 'function creep'. Function creep occurs wherein information collected for a specific initial purpose is thereafter utilised for another purpose. These purposes may run onto things like - digitisation, extraction, and database purposes, for which explicit consent was not initially obtained at the point of collection.[65] Besides, when anyone peruses the 'objective' of the AS protocol they notice that the explicit object is enumerated as - to 'take effective actions to mitigate the spread of the pandemic and enhance their preparedness'.[66] This is a cause for concerns since, questions arise on the adherence of AS protocol to the second portion of the three-part test. As mentioned beforehand, the correct question herein becomes, are there other 'privacy-respecting' and less intrusive available alternatives to choose from that can deliver the same function as a substitute? Herein an astute observer may ask why the existing anonymised or aggregated data with ICMR, hospitals, on-field surveillance, and IDSP, etc., are not enough to ensure the public health objective in the protocol?[67] Such NPD Sharing Protocol continues till today.

V. INTER-JURISDICTIONAL COMPARATIVE WITH THE COMMONWEALTH OF AUSTRALIA

Australia is chosen due to the high rate of implementation of electronic health record systems and authors personal familiarity with the legal jurisdiction.[68] Australia has a comprehensive law

[64] 'IFF's Clause-by-Clause Analysis of the AS DSP' (*IFF*, 2020) ¶[24] <https://drive.google.com/file/d/1CsDRlMDvqAH1Dq2xU5nP7GxdnDPIKhWp/view> accessed 23 March 2022.
[65] T Chakraborti, 'Data Protection, Information Security and International Data Transfers' in Jelena Madir, *Healthtech* (Elgar Commercial Law and Practice Series, 2020) 24, 35 and 36.
[66] DSP at ¶[1].
[67] F Zahoor, 'We Studied the Protocol: And No This Doesn't Sufficiently Protect Your Privacy' (*IFF*, 13 May 2020) <https://internetfreedom.in/we-studied-the-protocol-and-no-this-doesnt-sufficiently-protect-your-privacy/> accessed 23 March 2022.
[68] J Scheibner et al, 'Data Protection and Ethics Requirements for Multisite Research with Health Data: A Comparative Examination of Legislative Governance Frameworks and the Role of Data Protection Technologies' (2020) 7(1) Journal of Law and the Biosciences 1-30.

on privacy wherein the entities covered under 'Australian Privacy Principles' must adhere.[69] The same governs different sectoral regulations w.r.t. data limitation of use, disclosure, etc,[70] even on health authorities[71] dealing with health information.[72] This means that all health providers including those who are just privy to health information are subject to these laws.[73] Additionally, there are only a few instances wherein an organization is permitted to collect, use or disclose health information (like when it is impractical to get consent, or permitted health situation, etc).[74]

Furthermore, the Office of the Australian Information Commissioner, which is the enforcement and regulatory agency for information access rights and privacy,[75] has approved two guidelines[76] which (a) provides procedure to be followed medical researchers when disclosing personal health information for research requirements[77] as well as (b) provide a framework for evaluating proposals to handle health information without consent of individuals, by certain organizations.[78]

Interestingly, an amendment in 2020 to the Privacy Act sought to protect consumers of Australia against contact tracing.[79] It created offenses in connection to misuse of COVID app data for non-consensual collection, use or disclosure, uploading, retention or transfer outside Australia as well as decryption.[80] However, questions still persist with respect to anonymized data sets and there is a need to explore contractual solutions for effecting multi-site research in

[69] The Privacy Act 1988 (Australia), s 6 <https://www.legislation.gov.au/Details/C2021C00242> accessed 23 March 2022.
[70] The Privacy Act 1988 (Australia), principles 10 and 11.
[71] As defined in The Privacy Act 1988 (Australia), s 6FB.
[72] See The Privacy Act 1988 (Australia), s 6FA.
[73] A Tripathi and T Behl, 'Protecting the Health Data of Consumers: Need for an Iron-Clad Law in India' (2020) 8 International Journal on Consumer Law and Practice 105, 111-112 <https://clap.nls.ac.in/wp-content/uploads/2021/01/PROTECTING-THE-HEALTH-DATA-OF-CONSUMERS-NEED-FOR-AN-IRON-CLAD-LAW-IN-INDIA-Ashutosh-Tripathi-and-Tushar-Behl.pdf> accessed 23 March 2022.
[74] See The Privacy Act 1988 (Australia), ss 16B, 95 and 95A.
[75] 'What We Do' (*OAIC*, 2021) <https://www.oaic.gov.au/about-us/what-we-do/> accessed 23 March 2022.
[76] Australian Government, Office of the Australian Information Commissioner <https://www.oaic.gov.au/privacy/the- privacy-act/health-and-medical-research/> accessed 26 March 2022.
[77] The Privacy Act 1988 (Australia), Guidelines under s 95 <https://www.legislation.gov.au/Details/F2014L01500> accessed 23 September 2020.
[78] The Privacy Act 1988 (Australia), Guidelines under s 95A <https://www.legislation.gov.au/Details/F2014L00243> accessed 23 September 2020.
[79] Privacy Amendment (Public Health Contact Information) Act 2020 <https://www.legislation.gov.au/Details/C2020A00044> accessed 27 March 2022.
[80] See The Privacy Act 1988 (Australia), ss 94A and 94D-J.

NPD.[81] The difficulty arises in relation to there being disagreements on how to define anonymization, pseudonymization, and de-identification,[82] and at any cost the risk of re-identification persist anyways.

VI. CONCLUSION AND THE WAY FORWARD

In conclusion, in this manner the essay demonstrates the legal and regulatory lacunae and implications of the absence of a more nuanced approach to NPD collection, processing, storage, and utilization in the medical sector. The draft DISHA law was an extremely helpful hypothetical on how one is to develop data protection and privacy laws post-advent of the PDP and NPD Draft Framework. Those misuses of non-personal health data are very much a reality through broadly-worded purpose limitation provisions are illustrated in the *Aarogya Setu* case study.

Therefore, the need of the times is for: (i) standardisation of anonymisation technique wherein certain minimum technical marks of anonymisation can be adhered to avoid privacy risks in datasets.[83] (ii) Again as noted before a provision akin to s 37(c) of DISHA is required that shall classify even sub-standard storage or transmission of data as a breach and replace the less onerous 'bests effort basis' which is employed by data fiduciaries, processors and custodian. (iii) There is also a need to encrypt the health data thereby reducing chances of data leaks in the future.

(iv) There is also a need for 'patients rights' like right to be informed, restrict processing and to object to be spelt out in the consent form during the very first admission/attendance of the patient at the hospital. This would be in line with objectives of the standards and regulations enunciated in *National Digital Health Blueprint 2019* and *Health Data Management Policy 2020*.[84] (v) There were also talks of bringing up a regulator in the form of the *National e-Health*

[81] Scheibner (n 68) 25.
[82] Scheibner (n 68) 29.
[83] Future of Non-Personal Data Governance in India: A Consumer Perspective (*CUTS-CCIER*, April 2021) 13 and 14 <https://cuts-ccier.org/pdf/policy-brief-future-of-npd-governance-in-india.pdf> accessed 26 March 2022.
[84] The document puts forward standards such as 'patient control' over their data (see p. 35), and data collection and use (pp. 31 and 32). See *National Digital Health Blueprint (2019)*

Authority (NeHA) at the central and SeHA at the State level to give effect to a federated institutional framework, but the same has been lying dormant since some time.[85]

(vi) And the PDP Bill 2019 was supposed to provide the first cross sectoral data protection framework and a health data management policy in absence of a PDP is Creating a standalone health data management policy, may not have the force of law and therefore create avoidable confusion.[86] Thus at present reliance is placed on the IT Act 2000 and IT Rules 2011 for protection of health data.[87]

Therefore, the issues raised in the essay are to be gainfully addressed so as to minimize the impact of the misuse of NPD in post-COVID digital economy. How we respond to this proposition will determine whether the present generation lodges its name in the pages of history, by taking a principled stand for the strengthening of data protection and privacy laws in Indian context or remain deliberately ignorant of the digital future at stake. If India chooses the latter, it very well risks being forever overlooked as an irrelevant footnote in the books of history.

***** * *****

<https://www.nhp.gov.in/NHPfiles/National_Digital_Health_Blueprint_Report_comments_invited.pdf> as well as *Health Data Management Policy (2020)* <https://ndhm.gov.in/health_management_policy> accessed 26 March 2022. Also see 'India: Health Data Management Policy in Detail' (*Data Guidance*, 4 January 2021) <https://www.dataguidance.com/opinion/india-health-data-management-policy-detail> accessed 26 March 2022.

[85] 'Invest India' (*InvestIndia.gov.in*, 2019) <https://www.investindia.gov.in/team-india-blogs/importance-national-e-health-authority-neha-during-covid-19> accessed 26 March 2022.

[86] Asmita Bakshi, 'Why the Draft Health Data Management Policy Raises Red Flags about Privacy' *LiveMint* (3 September 2020) <https://www.livemint.com/mint-lounge/features/why-the-draft-health-data-management-policy-raises-red-flags-about-privacy-11599060874405.html> accessed 26 March 2022.

[87] Neetika Gandhi, Saumya Kapoor and Shivarpita Nailwal, 'At a Glance: Data Protection and Management of Health Data in India' (*Lexology*, 6 January 2021) <https://www.lexology.com/library/detail.aspx?g=0fdcef36-61a8-4e00-9bed-8abcf6866c96> accessed 24 March 2022.

PROTECTING REPRODUCTIVE AUTONOMY OF INDIVIDUALS

A critical analysis of the Medical Termination of Pregnancy (Amendment) Act, 2021

ABSTRACT

The Medical Termination of Pregnancy (Amendment) Act, 2021 came into force with effect from 24th September 2021. Regrettably, this Act falls short of the Supreme Court's reproductive rights jurisprudence in the recent past and the guarantee of fundamental rights to autonomy, bodily integrity, and privacy under Article 21 of the Indian Constitution. This paper aims to critically review and highlight severe lacunae and problems with the MTP Amendment act; it also aims to assess whether the law favours doctors depriving pregnant individuals of their right to bodily and decisional autonomy. It places the decision to abort in the hands of the doctors instead of the pregnant individual. The paper's first section discusses the apprehensions medical practitioners face because of Section 312 of the IPC, which criminalizes the act of inducing abortion and terms it as culpable homicide. It also discusses the issues caused by unsafe abortion in the public health sector, mainly because of the stigma behind abortion practices. The forthcoming section of the paper critically analyses the MTP Amendment Act of 2021 and highlights the underlying issues in the Act. The paper, in this section, also discusses the violation of principles of fundamental rights resulting from the 1971 Act and the Amendment Act by virtue of the Act itself and the judicial decisions of courts at all levels. The paper then attempts to compare the provisions of the MTP Act with similar laws existing in different countries. It concludes by suggesting reforms and amendments to safeguard the reproductive autonomy of an individual.

TABLE OF CONTENTS

INTRODUCTION

In August 2017, the Supreme Court rejected the abortion plea of a 10-year-old rape survivor. The Court relied on the medical report, which stated that "the girl is too advanced into her pregnancy;" hence, the abortion was not legally permissible.[1] Abortion was denied to Z, a 35-year-old woman who was raped; her conditions were such that firstly, she was homeless, and secondly, as a result of the rape, she was 17 weeks pregnant and was suffering from HIV; she was then admitted to a government shelter. Although the Medical Termination of Pregnancy Act, 2017 allowed abortion up to 20 weeks, Z was denied abortion by the government hospital due to an arbitrary reason of not obtaining parental or spousal consent, which was not required in case of an adult woman as per the law. The refusal led her to file a complaint in the High Court Judicature of Patna; the appeal was dismissed based on a Supreme Court ruling that stated that there was no requirement of medical termination unless there was a threat to the woman's life. That condition was not present in the case of Z. When Z approached the Supreme Court, the Court recognized that the woman's rights were completely violated; however, by the time Z reached the Supreme Court, she was already 26 weeks pregnant. She was thus denied medical termination of pregnancy.[2]

The case of the 10-year-old girl and Z are just two out of the 173 cases filed in High Courts alone in the past three years. Out of the 173 cases, Medical Termination of Pregnancy (MTP) was permitted in 139 cases and was denied in 29 instances; 5 petitions were subsequently withdrawn.[3] This may seem like a relatively more significant number regarding the acceptance of MTP pleas as compared to past data. However, this asserts that MTP is considered more of a privilege than a right. The Supreme Court of India, however, has built a strong reproductive rights jurisprudence in the recent past. Justice Chandrachud observed in the historic privacy decision that reproductive choice should be viewed in the context of the personal liberty granted by Article 21[4] of the Indian Constitution.[5] The MTP Amendment Act 2021 also emphasizes the necessity of providing "dignity, autonomy, confidentiality, and justice" to individuals who need to terminate their pregnancy.

The Medical Termination of Pregnancy (Amendment) Act, 2021, has come into force from 24th September 2021.[6] The Amendment, however theoretically, sets a stage for small but progressive steps to ensure that individuals' rights are safeguarded. Nevertheless, in a nation where unsafe abortion is the third

---

[1] Krishnadas Rajagopalan, 'SC rejects the plea of a 10-year-old', The Hindu (New Delhi, July 28 2017)

[2] Ms. Z v. The State of Bihar and Others, C.A. 10463 of 2017, S.C.C. 17 Aug. 2017

[3] Jyoti Shelar, 'Highest number of abortion petitions filed in Bombay HC', The Hindu (Mumbai, October 02 2019)

[4] Ministry of Law and Justice, Govt of India. The Constitution of India, Article 21 of the Constitution

[5] Justice K.S.Puttaswamy (Retd) v. Union Of India And Ors, 24 Aug. 2017, (2017) 10 SCC 1; AIR 2017 SC 4161

[6] Ministry of Law and Justice, Govt of India, The Medical Termination of Pregnancy (Amendment) Act 2021, no 8 of 2021, The Gazette of India.

leading cause of maternal mortality, claiming the lives of 13 individuals every day[7], India needs a giant leap in terms of its healthcare system and concerning legislation. Since the passage of the Medical Termination of Pregnancy (MTP) Act 1971, which created an exception to the crime of abortion under Section 312 of the Indian Penal Code, 1860[8], abortion has been permitted in restricted circumstances in India. The need for formulating the MTP Act of 1971 was recognized not primarily as a right-based framework but mainly to facilitate family planning and population control. Complications resulting from spontaneous and unsafe induced abortions are recognized as a severe public health concern worldwide, and they are one of the critical factors determining maternal morbidity and mortality.

ABORTION AND THE INDIAN PENAL CODE

The British Colonial Government enacted the Indian Penal Code of 1860 and inserted Section 312, which criminalized the act of inducing abortion and words it as culpable homicide. Section 312 of the IPC reads as follows:

> *'Causing miscarriage- Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage is not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.*
>
> *Explanation- A woman who causes herself to miscarry is within the meaning of this section.*[9] *'*

Abortion laws in India are primarily governed by two significant provisions/acts: Section 312 of IPC and the MTP Act and Amendments. The IPC provision criminalizes abortion to the extent that anyone (medical practitioner or doctor) inducing an abortion on a pregnant individual is liable to be prosecuted, the only exception to this provision is found in section 2 and section 3 of the MTP Act[10], i.e., when the abortion is for the purpose of saving the life of the individual(grave physical or mental injury) or the child if born shall suffer from grave abnormalities. It is important to note that the word 'abortion' has not been

[7] Office of the Registrar General and Census Commissioner, India. (2016). Annual Health Survey report: a report on core and vital health indicators (Part1).

[8] Ministry of Home Affairs, Government of India. Section 312 of the Indian Penal Code, 1860. New Delhi: MoHA

[9] *Ibid*

[10] Ministry of Law and Justice, Govt of India, Section 2 and Section 3 of The Medical Termination of Pregnancy (Amendment) Act 2021, no 8 of 2021, The Gazette of India.

used by the framers of the code; in addition, the words' miscarriage' and 'unborn child' have not been defined in the code, leaving it for wider interpretation.[11]

The Medical Termination of Pregnancy Act of 1971[12] established a 20-week gestational limit for abortion, after which abortions can only be administered with a court order obtained through a writ petition. The amendments to the act, which focused on extending this gestational limit, were brought about primarily because of the rising number of pleas in the Court (23 petitions in the Supreme Court and several hundred cases in the High Court).[13] Pursuant to the Act of 1971, it is interesting to note that even if the pregnant individual were within the gestational limit, medical practitioners were often hesitant to provide medical abortion services due to the fear of prosecution and investigation.

The effect of this section was such that it placed the discretion of abortion at the hands of the doctors, who may or may not be influenced by social stigma, cultural or religious differences.[14] It took the decision of abortion away from the hands of the pregnant individual, making it doctor-centric legislation. The fear induced by the section was detrimental to the victims of rape, as it put them through the agony of the system at the hands of the doctor or medical practitioner. The following section shall discuss the provisions of the Act and the Amendment and highlight the severe lacunae in its approach.

MEDICAL PRACTITIONERS AND UNSAFE ABORTION

In 1967, the Penal Code was amended in Britain, changing the provision mentioned in section 312; however, ironically, the section prevailed in India. The effect of this section in Indian society was seen when innumerable individuals died due to unsafe, illegal abortions. The government was compelled to re-examine the existing law in 1971 by adopting an Act as a consequence of high mortality in individuals and the constraints of a growing population.[15] The Medical Termination of Pregnancy Act 1971 provides an exemption from the IPC section and decriminalizes abortion; however, the abortion must be done in good faith as per the MTP (Amendment) Act, 2021.[16] Five decades ago, the Act came into existence to "*provide abortion services to certain pregnancies by registered medical practitioners.*"[17] It can be inferred from the

[11] Upendra Baxi, Abortion and the law in India, Journal of the Indian Law Institute,1986-87, Vol-28-29, Alice Jacob, New Delhi

[12] Ministry of Law and Justice, Govt of India, The Medical Termination of Pregnancy Act 1971, The Gazette of India.

[13] Hirve, Siddhivinayak S. "Abortion law, policy and services in India: a critical review." *Reproductive health matters* 12.sup24 (2004): 114-121.

[14] Unnithan-Kumar, Maya. "Female selective abortion–beyond 'culture': family making and gender inequality in a globalising India." Culture, health & sexuality 12.2 (2010): 153-166.

[15] Chhabra R, Nuna S. Abortion in India: an overview. New Delhi: Veerenda Printers, 1994.

[16] *Supra* at 11

[17] Bhavani Giddu, The Wire, Untangling the Legal Knots on Reproductive Rights Is a Step Towards Helping Indian Women (2017).

aim of the Act itself that the purpose was to provide an exemption to medical practitioners from criminalization under the IPC and not to provide a rights-based framework to the pregnant individual.[18]

With the advancement of technology in both ultrasonography and genetics, prenatal diagnosis of a wide range of foetal abnormalities became possible. The diagnosis of foetal abnormalities is frequently made after 20 weeks of pregnancy for various scientific and biological reasons, emphasizing the necessity to raise the upper gestational limit for terminating pregnancies. The MTP (Amendment) Act of 2021 upped the gestational limit from the previous 20-week ceiling to 24 weeks in response to the steady growth in writ petitions seeking pregnancy termination in events of severe foetal abnormalities.[19]

Doctors frequently advise pregnant individuals to obtain a court order authorizing them to terminate the pregnancy. Individuals have been obliged to approach the Court for authorization to abort due to this denial of assistance.[20] Furthermore, doctors have persuaded individuals to seek legal help even for pregnancies of less than twenty weeks; this nudge appears to be motivated by a fear of prosecution as a result of the IPC's stiff punishments, as well as the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1941[21], which seeks to prevent sex-selective abortions. Due to the introduction of the Protection of Children from Sexual Offences Act, 2012 ('POCSO Act')[22], medical practitioners are most often hesitant to offer care to impregnated adolescent individuals without a court order.

When such individuals are denied services by registered medical practitioners or are apprehensive in terms of the social stigma associated with abortion, they often tend to rely on unsafe methods for abortion. Complications resulting from spontaneous and unsafe *'induced abortions'* are recognized as a severe public health concern worldwide, and they are one of the critical factors determining maternal morbidity and mortality.[23] It is always advised that all types of abortions, including medical abortions, be supervised by skilled health care providers with a medical prescription.[24] However, many individuals, particularly those living in rural and distant locations, still lack access to safe abortion services.

Due to inaccessibility and a lack of information, individuals turn to dangerous abortion practices. In 2003, the law was altered to allow trained practitioners to prescribe medication abortion drugs outside of a licensed facility if emergency facilities were available. Despite such clear guidelines and advice, the self-

[18] Duggal R, Ramachandran V. The abortion assessment project - India: key findings and recommendations. Reprod Health Matters. 2004; 12 (24 Suppl): 122–9

[19] Ibid

[20] Pratigya Campaign, Assessing the Judiciary's Role in Access to Safe Abortion

[21] The Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994.

[22] The Protection of Children from Sexual Offences Act, 2012.

[23] World Health Organization, Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, 6th ed. (2011).

[24] Adler, Alma J., et al. "Quantifying the global burden of morbidity due to unsafe abortion: Magnitude in hospital-based studies and methodological issues." International Journal of Gynaecology & Obstetrics 118 (2012): S65-S77.

administration of these drugs by pregnant individuals has become increasingly widespread due to the availability of these drugs over the counter. Only specialists who specialize in gynaecology or obstetrics are allowed to perform terminations under the new Amendments. India has one government doctor for every 10,189 people[25], against the World Health Organization's (WHO) recommendation of a 1:1000 ratio.[26] In contrast, the MTP Act's limitations encourage desperate individuals to seek unsafe abortions from unlicensed medical practitioners, endangering their lives.

While the enhanced availability of M.A. medications has resulted in increased access to abortion, the regulatory structure remains inadequate. On the other hand, the government has failed to ensure that a sufficient amount of public healthcare facilities are competent to perform abortions; as a result, the majority of abortions are conducted in the private sector. Higher pricing may ensue, which may be prohibitive for marginalized communities.[27] Medical Boards with at least five experts shall be established under the 2021 Act to grant third-party authorization for abortions after 24 weeks. Because most specialists are located in urban areas, marginalized individuals, particularly those in rural regions, may face enormous costs and delays in obtaining authorization from these boards.[28] As previously noted, Dalits and Adivasis will be disproportionately affected, as caste and class hierarchy already act as barriers to access adequate care.

In comparison to individuals in rural areas or Dalit and Adivasi individuals, those in a more advantageous situation in the caste system experience higher probabilities of abortion, according to data from the 1998-1999 National Family Health Survey.[29] The reality that state governments frequently leave significant amounts of the health budget unspent, resulting in crumbling healthcare infrastructure, particularly in rural areas, magnifies inequality in access to healthcare. As a result, individuals without family support or who live below the poverty line face disproportionately high hurdles to abortion services. They lack the financial means to get both legal and illegal abortions. This exemplifies how reproductive justice is a social justice concern.[30]

THE RIGHT-BASED APPROACH TO THE MTP ACT AND AMENDMENT

In K.S. Puttaswamy v. Union of India ('Puttaswamy'),[31] a nine-judge panel of the Supreme Court of India, concluded that the practice of reproductive decisions is embedded within a constitutionally protected

[25] Indian Express, 'India has a doctor for every 10,189 people, finds WHO survey' (New Delhi, July 22 2019)

[26] *Supra* at 20

[27] *Supra* at 18

[28] Iyengar, Kirti, and Sharad D. Iyengar. "Improving access to safe abortion in a rural primary care setting in India: experience of a service delivery intervention." Reproductive health 13.1 (2016): 1-10.

[29] Parisa Patel, Mahua Das & Utpal Das, The perceptions, health-seeking behaviours and access of Scheduled Caste women to maternal health services in Bihar, India, 26 Reproductive Health Matters 54, 114-125 (2018)

[30] Sobin George, Reconciliations of Caste and Medical Power in Rural Public Health Services, 54 Economic and Political Weekly (2019)

[31] K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

right to life and personal liberty within the ambit of Article 21 of the Constitution. As a result, every time the MTP Act is enforced, the petitioner's right to life under Article 21 is violated. In the case of Suchita Srivastava & Anr. Vs Chandigarh Administration (2009) 9 SCC 1)[32], the Court has expressed that the right of an individual to have a reproductive choice is an insegregable part of her liberty, as envisaged under Article 21 of the Constitution. She has an inalienable right to have her bodily integrity.[33]

Despite proof that medical abortion is safe and non-invasive, the amendments do not recognize abortion at will at any stage of pregnancy. Instead, the Act maintains that doctors must approve abortions. The MTP (Amendment) Act of 2021 prescribes the approval of one registered medical practitioner uptil the gestational limit of 20 weeks and the opinion of two registered medical practitioners uptil the gestational limit of 24 weeks. Previously, individuals had to seek judicial authorization to terminate the pregnancy medically if they crossed the 20-week mark. The Amendment is definitely a progressive step; however, the essence of the provision in the MTP (Amendment) Act makes the Act a doctor-centric legislation.[34] The right to bodily autonomy envisaged under Article 21 of the constitution is stripped with the implementation of this Act. The Act is designed to help individuals who "*need to terminate the pregnancy*" rather than "*individuals who want to terminate the pregnancy*."[35] By failing to account for the right to an abortion at any time, the Bill effectively forces individuals to claim "severe bodily or mental health impairment" in order to end a pregnancy, ultimately undermining their bodily autonomy. Importantly, even though the act needs the individual's consent to abort in the above-mentioned circumstances, her consent is insufficient without a medical practitioner's opinion verifying her decision.[36] In that case, the right no longer functions as a right but becomes a privilege.

In the case of High Court on its Own Motion v. the State of Maharashtra, the Bombay High Court[37] addressed a scenario in which pregnant individuals in jail were sent to a Committee that would authorize them to induce abortion. The Court noted that the entire burden of an unplanned pregnancy rests on the individual. The Court questioned why only an individual should end up suffering, concluding that such a referral to a Committee is unjustified. The Court also stated that an unborn foetus does not possess human rights; rights are only conferred at birth.[38] On the contrary, a pregnant Individual's fundamental rights, particularly her right to life and liberty, are gravely harmed if compelled to endure an *"unwanted"* pregnancy. As a result, the High

[32] Suchita Srivastava & Anr. Vs Chandigarh Administration (2009) 9 SCC 1)

[33] *Ibid*

[34] Reva B. Siegel, The New Politics of abortion: An EqualityAnalysis of Woman-ProtectiveAbortion Restrictions, Faculty Scholarship Series (2007)

[35] Sumi Madhok et al., On reproductive justice: 'domestic violence, rights and the law in India, 16(10) Culture, Health & Sexuality: An International Journal for Research, Intervention and Care (2014) at 1239.

[36] Alka Barua, Hemant Apte, & Suchitra Dalvie, Safe Abortion as a Women's Right: Perceptions of Law Enforcement Professionals, 50 Economic and Political Weekly 33 (2015).

[37] High Court on its Own Motion v. the State of Maharashtra, 2016 SCC OnLine Born 8426

[38] *Ibid*

Court concluded that only individuals have the right to decide how they wish to deal with pregnancies and have the *"right to autonomy and to determine what to do with their own bodies."*

Furthermore, pregnancies may be terminated only if continuing the pregnancy would endanger the pregnant individual's life or cause substantial harm to her mental or physical health, or if the child would suffer from any severe physical or mental abnormalities if born.[39] On the other hand, the upper gestational restrictions do not apply to abortions caused by "substantial foetal abnormalities," as determined by the Medical Board. Because an individual's right to abortion may only be exercised in such dire circumstances, motherhood becomes a norm, and abortion becomes the exception. The particular categories of "severe physical or mental abnormalities" and "significant foetal abnormalities" also scream of societal prejudices against people with disabilities.[40] Without a doubt, an individual's right to terminate a pregnancy involving a child who is likely to suffer from physical or mental defects, or one who has been identified with foetal abnormalities, on socioeconomic or other grounds, deserves to be recognised. The Act's ableist attitude is revealed when it treats "physical or mental incapacity" and "foetal defects" as different categories that equate to heightened grounds for terminating the foetus.[41] This demonstrates a belief that certain people are societally unproductive, undesired, and thus more justifiably eliminateable than others.

Additionally, the Amendment creates a hierarchy of "victimhood" by classifying only individuals whose pregnancies result from sexual abuse as eligible claimants to abortions beyond 20 weeks. They also set a 24-week gestational limit for them. An analysis of Supreme Court and High Court judgements regarding abortion post-twenty-week pregnancies from 2016 to 2019 reveals that the judiciary has been unpredictable in its application of the MTP Act. The Pratigya Campaign's report shows how courts have used varied thresholds to allow or deny abortion.[42] Even when rape survivors have demanded abortions, courts have relied on medical boards' opinions, which have given advice based on different parameters. The possibility of having to seek court permission is intimidating. For some individuals, this deters them from seeking the option, causing them to revert to unsafe abortion procedures.[43]

While the MTP (Amendment) Act of 2021 expands the definition of contraception failure to include any "Individual or her partner" rather than just married individuals, the use of the term "partner" suggests that individuals will still have to justify abortions based on their relationships.[44] This structure will disadvantage

[39] Joanna N. Erdman, The gender injustice of abortion laws, 27 Sexual and Reproductive Health Matters 1 2 (2019).

[40] Rashmi Luthra, Toward a reconceptualization of "Choice": Challenges by Women at the Margins, Feminist Issues (1993).

[41] Malhotra, Anju, et al. Realizing reproductive choice and rights: Abortion and contraception in India. International Center for Research on Women, 2003.

[42] Pratigya Campaign, Assessing the Judiciary's Role in Access to Safe Abortion

[43] *Ibid*

[44] Dipika Jain & Brian Tronic, Conflicting abortion laws in India: Unintended barriers to safe abortion for adolescent girls, Indian Journal of Medical Ethics (2019).

many unmarried individuals, particularly those from marginalised groups such as sex workers. Furthermore, the term "Individual" is still used in this clause, excluding transgender, intersex, or gender-diverse. This article has attempted to be gender inclusive by replacing the words "woman" or "women" with the word "individual."

REFORMS AND SUGGESTIONS

Threats to physical and mental health have been acknowledged as a reason for abortion without a gestational restriction in countries worldwide, including Nepal in South Asia and more than 20 European countries. Furthermore, while recognising the consequences of legal limits on an individual's mental and bodily integrity, the Supreme Court of Canada has knocked down prohibitions on abortion, allowing abortion on any ground during pregnancy.[45] Abortion care in Canada has been the prerogative of the pregnant woman and her doctor since the Morgentaler judgement, with no third-party intervention and abortion is not governed by any criminal statute or other legal provisions.[46]

However, the Indian legislature has been explicit about when abortions can be performed. With the growing threat to maternal health, the perception of the Medical Termination of Pregnancy Act of 1971's failure seems overwhelming, indicating that the right to safe abortion is still stigmatised in society. This societal stigma is represented in three instances: first, in restrictive legislation and national maternal health programmes; second, a shortage of skilled abortion providers; and third, a lack of awareness of abortion regulations, which cause many women to have unsafe abortions.[47] The paper suggests the following reforms to ensure that an individual's fundamental rights are not violated due to the MTP Act.

1. The MTP Act should develop a right-based and individual-centric approach by incorporating the following amendments.[48]
    - Allowing for the legal termination of a pregnancy at any point in pregnancy when the pregnant individual's life, bodily or mental health is endangered, mainly when the pregnancy is the consequence of rape or involves foetal impairment;
    - Emphasising that an abortion does not require judicial or medical board approval, even if performed beyond 24 weeks.[49]
    - Amend the Indian Penal Code to legalise abortion to reduce stigma and provide access to safe, legal procedures.

[45] BBC News, Australia abortion laws: Terminations now legal in New South Wales, September 26, 2019,

[46] Henry Morgentaler v. R., 1988 SCC OnLine Can SC 4 : (1988) 1 SCR 30

[47] Supra at 41

[48] April L. Cherry, shifting our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses, 28 Journal of Law and Health 641 (2015).

[49] *Ibid*

2. Acknowledge that requiring third-party authorizations for abortions before and after 20 weeks of pregnancy from both courts and medical boards breaches an individual's fundamental rights under Article 21 of the Constitution.
3. Ensure that attempts to overcome male preference or gender-biased sex selection do not obstruct abortion access, particularly after 20 weeks.[50]
4. Develop regulations that enable a human rights-based procedural framework for abortion, including after 24 weeks that is time-sensitive, permits for an MTP with the decision of one physician at all stages of pregnancy, and prioritises individual's evaluation of mental health issues.
5. It is necessary to ensure that individuals do not face any delays or rejections because of barriers resulting from access to services, including:
    - Providing a sufficient pool of professionals and registered healthcare practitioners across India, as well as in rural and remote places;
    - ensuring that MTP treatments, including medicinal abortion pills and surgical facilities, have enough infrastructure, drugs, and other resources at different stages of pregnancy;
6. Adopt a comprehensive national sex education programme to ensure that individuals are conscious of the risks of pregnancy after adolescence, aware of their rights to MTPs, where to access safe procedures, and aware of initial pregnancy symptoms.[51]
7. Establish a judicial training curriculum on reproductive rights, including MTP, to deliver judgements, provide conceptual clarity that MTP is a woman's right, and raise awareness about the importance of MTP access for women and girls who face physical or mental health concerns as a result of pregnancy.

CONCLUSION

It is imperative for lawmakers to develop a gender-justice and equality-based framework for abortion that guarantees services only at the will of the pregnant individual. Article 21 provides an absolute right to individuals, however, the language of the MTP Act forces the individuals to make difficult choices by either having a potentially unsafe abortion or losing their decisional autonomy on their body. To combat this, and to assure that the structural barriers to abortion access can be overcome, an approach to abortion rights based on equality and non-discrimination is required. Judicial rulings in Indian law have already prepared the road for this by recognising decisional autonomy as interwoven with the right to equality. Furthermore, an equality-based approach would enable more resilient and absolute reproductive rights by taking into account the effect of intersecting identities (gender, caste, disability, socioeconomic status, and so on).

Only by hearing from marginalised groups about their struggles with impediments to abortion and reproductive healthcare will we be able to grasp the subtleties and intricacies of this issue. The impact of legal

[50] *Supra* at 36

[51] Joanna N. Erdman, The gender injustice of abortion laws, 27 Sexual and Reproductive Health Matters 1 2 (2019).

reforms is dependent on public participation in the decision-making process; denying them the opportunity to express their concerns throws doubt on democratic institutions' legitimacy. As a result, this paper believes that discussion and discourse, as well as voicing different perspectives, are vital to effectively developing a gender justice approach to abortion rights.

Duty of State *vis-a-vis* Mental Health

ABSTRACT

Mental Health is one of the most neglected aspects of health in India. The essay discusses evolution of the laws governing mental health in India, their critical analysis and points out the various grey areas in the current legislation that needs to be addressed. A comparative analysis of some remarkable legislations around the globe gives the reader an enriching experience of the legislations and innovations prevailing in the world regarding mental health. Covid-19 brought mass population under deteriorating mental health conditions, lockdown along with physical restriction brought depression in its company, it is pertinent to note the actions the state has taken to combat the effects of a pandemic on mental health. The essay analyzes the role of the Judiciary in addressing the mental health standards across the country. Due to advancements in technology, new methods are evolving such as applications, artificial stimulators, etc., that can be used to tackle the problem of mental health. The essay emphasizes the various societal stigma related to mental health and steps the state should take to overcome the same, various futuristic concerns have been raised by the author regarding current policies and laws prevalent in India.

Mentality Towards the Mental

Hey, you mental! Yes, the one who is reading this I called you mental. Certainly, you may have gotten angry while reading it but let's take a break here and think why we get angry or annoyed when someone calls us mental? Undoubtedly, it's just a word that means *of, in, or relating to the mind*[1] then why get angry over that simple harmless word? Well, thankfully being raised in a society among humans I feel, I can surely answer this question! Etymologically speaking word mental has its origin in the Latin word ***'mentalis'*** which means 'of the mind'. So, a word that has only relation to mind how did it become a taunt for the one suffering from mental illness[2]? I congratulate the society for its credit! One may ponder who is society? Aren't the ones who are reading this, a part of it? So, it's us, it's you and me who are responsible for making the word 'mental' as 'the mental' and I am as sure as eggs are eggs!

Can a mother leave her child at the mercy of society? Obviously NO! Then why should a State leave its citizens at the mercy of society? The state must act as the sole caretaker of its citizen when the citizen battles a mental disorder. So, is it the only Democratic States who should look into the mental health issues of their subjects? State means any State to be it Constitutional Monarchy, Absolute Monarchy, Democratic, Socialists, or Pseudo-Democratic (Well, I meant North Korea here). Every State, word State being popularized by Machiavelli[3], has a duty towards its citizens, a duty to care, and a duty to make its citizens aware of mental health issues. But everything depends upon the mentality that the State carries towards the people suffering from mental health problems.

Indian Constitution under article 14 guarantees the right to equality but such equality is never in the strict sense. It is important to classify citizens who suffer from mental illness reasonably[4] and provide them more facilities as compared to any other illness as it's an invisible disease without any physical injuries. Correlation of rights and duties is not a new concept as far as the law is concerned, if a citizen has right then the state has a corresponding duty towards its citizen.[5] A duty that can never be ignored! As Winston Churchill has rightly said, *"Healthy citizens are the greatest asset any country can have!"*

---

[1] Oxford Advanced Learners Dictionary, 777 (A P Cowie Indian Ed., 4th ed., 1989)
[2] The Mental Healthcare Act, 2017 § 2(s)
[3] Machiavelli, Niccolò, The Prince. Harmondsworth, Eng. ; New York, N.Y. :Penguin Books, 1981.
[4] See Simran Vishal Bafana , Doctrine of Reasonable Classification, 4 (4) IJLMH Page 3958 - 3964 (2021), DOI: < https://doij.org/10.10000/IJLMH.111836 > Accessed 07 March 2022
[5] For detailed discussion on Rights & Duties See Salmond, On Jurisprudence (7th ed., 2016 P J FitzGerald).

State: I made the law; My duty is over!

Well, the concern of mental health among Indians is gaining popularity for the past decade. Negligent attitude towards one's mental health and lack of address of the issue by society is nothing new. What caught my attention is that we were negligent and indolent towards making mental health care legislations too. Before independence, we were governed by colonial legislation like the Lunatic Removal Act 1851, the Indian Lunatic Asylum Act 1858, the Military Lunatic Act 1877, and the Indian Lunacy Act 1912 (ILA,1912)[6]. *Lunacy Act*[7] was enacted with the purpose of custodial sentences and human rights were completely neglected in it. In the opinion of the Indian Psychiatrist Society, the lunacy act[8] was inappropriate and outmoded and hence the society helped in drafting the Mental Health Act (MHA) in 1950.[9] It took 37 years for this draft to become an Act in the year 1987[10] and it got implemented in 1993[11] after a delay of 6 years from its enactment, so we waited nearly **43 years** for our mental health concerns!

Legislators have completely misunderstood the concept of Mental Health with the administration of mental hospitals in the MHA-1987. It seems like as ILA,1912 missed out on Human Rights hence legislators gave a namesake provision of Human Rights[12] in the enactment whereas no description of patient rights was found. MHA was more concerned with the procedural aspect of governing the mental hospitals, licensing,[13] guardianship, and manager, etc., whereas aspects such as consent for treatment, Psychiatric Emergency Services were not paid attention to. Further, loopholes in the definition of mental illness, exempting the government from licensing which was a gross mistake as govt. hospitals didn't maintain minimum standards of health care. Also, private hospitals found it difficult to pass through the complicated licensing procedure, the minimum standards mentioned for the patients were also not up to the mark,[14] it also curtailed the liberty of the patients without a proper judicial review

[6] Indian Lunacy Act, 1912. [ACT No IV of 1912]
[7] ibid
[8] ibid
[9] Firdosi, M. M., & Ahmad, Z. Z. Mental health law in India: origins and proposed reforms. (2016) *BJPsych international*, *13*(3), 65–67. < https://doi.org/10.1192/s2056474000001264 > Accessed 03 March 2022
[10] Firdosi, M. M., & Ahmad, Z. Z. Mental health law in India: origins and proposed reforms. (2016). BJPsych international, 13(3), 65–67. < https://doi.org/10.1192/s2056474000001264 >
[11] Trivedi J. K. The Mental Health Legislation: An Ongoing Debate. Indian journal of psychiatry, (2002). 44(2), 95–96. < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2954355/ > Accessed 03 March 2022
[12] Mental Health Act , 1987.Chapter IV (Protection of Human Rights of Mentally Ill Person) §81.
[13] Mental Health Act , 1987. § 7-12
[14]For further detailed analysis see Math, S. B., Murthy, P., & Chandrashekar, C. R. Mental Health Act (1987): Need for a Paradigm Shift from Custodial to Community Care. (2011) *The Indian journal of medical*

system,[15] perhaps a patient might have been inside the hospital for decades until the Hon'ble Supreme Court might have interrupted! It was unforeseen that a wait of 43 years would complicate the access to mental health care itself! Duty of State certainly doesn't end at enacting legislation. The state has to form various policies and programs to implement such legislation. In the year 1982 under the leadership of leading psychiatrists time the recommendations made by the WHO formed the National Mental Health Programme (NMHP) which was a milestone achievement as far as a developing country was concerned.[16] Under this program, the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore[17] in 1985 formed a District Mental Health Programme (DMHP) which would monitor a unit district (Primarily Bellary district) and it was further incorporated with National Rural Health Mission (NRHM) for better program implementation and periodic evaluation.[18] The DMHP was started in 27 districts across the country in 1996.[19]

The NMHP was a remarkable achievement and was applauded globally but the original guidelines of NMHP were ambiguous; also, no budgetary provisions were made for implementation of the program, further, there was confusion between the State and central govt. as to the funding for the program.[20] The first 50 years of Independence seemed to be very disturbing regarding the concerns of mental illness but hold importance as they connote the evolution of the role and duty of the State.

research, *133*(3), 246–249.< https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103146/ > Accessed 03 March 2022

[15] Dhandha A. Status Paper on Rights of Persons living with Mental Illness in light of the UNCRPD, in Harmonizing Laws with UNCRPD, Report prepared by the Centre of Disability Studies. (2010) *Human Right Law Network.* < *http://www.slic.org.in/uploads/2018/10/Harmonizing-Laws.pdf* > Accessed 03 March 2022

[16] Gupta, S., & Sagar, R. National Mental Health Programme-Optimism and Caution: A Narrative Review. (2018) *Indian journal of psychological medicine*, *40*(6), 509–516. <https://doi.org/10.4103/IJPSYM.IJPSYM_191_18 > Accessed 03 March 2022. See also Wig, N. N., & Murthy, S. R. The birth of national mental health program for India. (2015) *Indian journal of psychiatry*, *57*(3), 315–319. < https://doi.org/10.4103/0019-5545.166615 > Accessed 03 March 2022; Thara, R., Padmavati, R., Aynkran, J. R., & John, S. Community mental health in India: A rethink. (2018) *International journal of mental health systems*, *2*(1), 11. <https://doi.org/10.1186/1752-4458-2-11> Accessed 03 March 2022

[17] Sushovan Roy& Nazish Rasheed: The National Mental Health Programme of India; ; International Journal of current Medical and Applied sciences; 2015, 7(1), 07-15. Accessed 03 March 2022<https://www.ijcmaas.com/images/archieve/IJCMAAS_JUNE_2015_VOL7_ISS1_03.pdf>

[18] Wig, N. N., & Murthy, S. R. The birth of national mental health program for India. (2015) *Indian journal of psychiatry*, *57*(3), 315–319. < https://doi.org/10.4103/0019-5545.166615 > Accessed 03 March 2022;

[19] Supra note 18

[20] ibid

State: I learned from my past, 21st century! I will improve my standard of duty towards my citizen!

(A Critical Analysis of Mental Health legislation in 21st century)

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD),2006 proved to be a boon for the long-going struggle for mental health rights and disability rights in India as India became its signatory in 2007[21] and it was necessary to harmonize the existing laws with the said Convention.[22] Ten years after the convention was signed, we saw the face of The Mental Healthcare Act, 2017 which repealed the MHA,1987. Confusion arose in my mind as to interpret the word "*disability"* as the convention concerned the person who is disabled.

If we closely analyse the definition of 'mental illness' under MHA, 2017 we do not find 'mental retardation' as a part of mental illness but we find the word 'mental' in the definition of the 'person with a disability under The Rights of Persons with Disabilities Act,2016 (PDA). Thus, it is clear that mental illness does not include mental disability as retardation is exempted. So, MHA, 2017 completely failed to categorize 'Mental Illness' and 'Psychiatrist disability' under it. Mental illness is not by itself a disability. However, there is a class of mental health disabilities called psychiatric disabilities.[23] So which disease is a mental illness and which disease is a mental disability can significantly make confusion as to which Act should govern the patient? The MHA, 2017 or PDA, 2016? One solution which I can suggest is forming a schedule under the MHA, 2017 which mentions the name of every mental illness which comes under the ambit of MHA, 2017. Under PDA, 2016[24] ***"Person with a disability"*** *means a person with long term physical,* ***mental, intellectual,*** *or sensory impairment which, in interaction with barriers,* ***hinders his full and effective participation in society equally with others*** whereas under MHA,2017[25] ***"mental illness"*** mean *"a substantial disorder of thinking, mood, perception, orientation or memory that* ***grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life,*** *mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation....."* Let me elucidate with an example, Schizophrenia is a psychiatric disorder that can affect a person's

[21] Kelly B. D. Mental health, mental illness, and human rights in India and elsewhere: What are we aiming for? (2016). Indian journal of psychiatry, *58*(Suppl 2), S168–S174. < https://doi.org/10.4103/0019-5545.196822 > Accessed 07 March 2022
[22] ibid
[23] Jack Wolstenholm Is mental illness technically considered a disability? Breeze (2021) < https://www.meetbreeze.com/blog/is-mental-illness-a-disability/> Accessed 04 March 2022
[24] The Rights of Persons with Disabilities Act, 2016 §2 (s)
[25] The Mental Healthcare Act , 2017§2 (s)

thinking, emotion, and behaviour. Further, they have impairment in memory and decision-making ability hence it can hinder social participation also.[26] So, it is a psychiatric disability as well as a mental illness. So which Act should govern the patient as the set of rights mentioned in one are not found in the other Act. Certainly, it will create problems shortly when a new disorder gets discovered.

The MHA, 2017 completely ignores NMHP, the Act should have made a provision for compulsory implementation of NMHP in every Indian State, this seems like an escape route for states under the glittering veil of new legislation.[27] Chapter V seems to be the golden chapter of the Act as it mentions the Rights of the Patients, expressly **ten rights**[28] are mentioned under the chapter. Chapter VI talks about the Duty of State.[29] MHA 2017 has a provision of the advanced directive which empowers a mentally ill person to have the right to make an advance directive toward the way she/he wants to be treated for the requisite illness and who her/his nominated representative shall be. The concept of Advance Directive (AD) [30] is new to the Indian Society and not every citizen is aware of this concept further the working labour class having the least knowledge of technicalities can fall easy prey to a person who can misguide them towards making ADs, it is the duty of the state to form a separate wing in each infrastructure where certified legal professionals and medical professionals will guide such peoples regarding the formulation of AD.

A plain reading of UNCRPD can lead to a conclusion that not all proviso of the convention were moulded in MHA, 2017. The 2017 Act took gender equality too seriously in my opinion, as the legislation failed to recognize that women and girls with mental illness are often at greater risk both within and outside the home, so, they need more attention in the legislation and such classification will certainly be not discriminatory rather reasonable further this has

[26] Mental Illness Research Education and Clinilical Centre, CA. What is Schizophrenia? (2013) <https://www.mirecc.va.gov/visn22/schizophrenia_education.pdf> Accessed 03 March 2022

[27] Math, S. B., Basavaraju, V., Harihara, S. N., Gowda, G. S., Manjunatha, N., Kumar, C. N., & Gowda, M. (2019). Mental Healthcare Act 2017 - Aspiration to action. *Indian journal of psychiatry*, *61*(Suppl 4), S660–S666.< https://doi.org/10.4103/psychiatry.IndianJPsychiatry_91_19 > Accessed 03 March 2022

[28] **The Mental Healthcare Act , 2017** Chapter V: §18 (Right to access mental health care); §19 (Right to community living);§ 20 (Right to Protection from cruel, inhuman and degrading treatment); §21 (Right to equality and non- discrimination);§22(Right to information); §23 (Right to Confidentiality); §25 (Right to access medical records) §26 (Right to personal contacts and communication);§27 (Right to Legal Aid); § 28 (Right to make complaints about deficiencies in provision of services).

[29] **The Mental Healthcare Act , 2017** Chapter VI: §29 Promotion of mental health and preventive programmes); §30 (Creating awareness about mental health and illness and reducing stigma associated with mental illness); §31 (Appropriate Govt. to take measures as regard to human resource development and training etc.) ; § 32 (Co-ordination within appropriate Government)

[30] The Mental Healthcare Act , 2017 Chapter III: §5.

been enshrined in the UNCRPD.[31] If the frequency of showing mental health awareness advertisements on television is as great as that of a political party campaign then certainly common masses will get aware! Further UNCRPD mentions concepts like protection of the integrity,[32] assistance to the sufferer in performance of child-rearing responsibilities,[33] supporting their participation in political life, provision for collection of appropriate information, including statistical and research data,[34] provision for bringing international co-operation[35] and list continues but none of these are implemented in the MHA,2017. Comparing it with its past 20th-century legislation MHA,2017 is much better but still has scope for various amendments! Further, state actions like National Mental Health Plan-365 (2013)[36], National Mental Health Policy, 2014[37] (NMHPol 14), and National Mental Health Policy, 2017[38] (NMHPol 17) were significant steps taken towards the benefit of mentally ill people but these policies are still under- implemented.[39]

Around the world on a mental voyage!

Who is WHO?

Nearly one billion people around the globe are living with mental disorders and one person dies every 40 seconds by suicide![40] 10% of children and adolescents around the world suffer from a mental health issue but the problem is they don't speak about it.[41] Mental Health is an

[31] United Nations Convention on the Rights of Persons with Disabilities, 2006. Preamble pt.16 & Article 6 **(**Women with disabilities)
[32] United Nations Convention on the Rights of Persons with Disabilities, 2006. Article 17.
[33] United Nations Convention on the Rights of Persons with Disabilities, 2006. Article 23.
[34] United Nations Convention on the Rights of Persons with Disabilities, 2006. Article 31.
[35] United Nations Convention on the Rights of Persons with Disabilities, 2006. Article 32.
[36]Kundan Pandey 'India gets it first mental health policy'(2014) Down to Earth < https://www.downtoearth.org.in/news/india-gets-it-first-mental-health-policy--46810 > Accessed 07 March 2022
[37] Rajesh Sagar & Snehil Gupta National Mental Health Policy, India (2014): Where Have We Reached? (2021) Indian Journal of Psychological Medicine < https://doi.org/10.1177/02537176211048335 > Accessed on 05 March 2022.
[38] Available at < https://nhm.gov.in/images/pdf/National_Health_Mental_Policy.pdf> Accessed 07 March 2022.
[39] Rajesh Sagar & Snehil Gupta National Mental Health Policy, India (2014): Where Have We Reached? (2021) Indian Journal of Psychological Medicine < https://doi.org/10.1177/02537176211048335 > Accessed on 05 March 2022.
[40] World Health Organization (WHO) 'World Mental Health Day: an opportunity to kick-start a massive scale-up in investment in mental health' (27 August 2020) < https://www.who.int/news/item/27-08-2020-world-mental-health-day-an-opportunity-to-kick-start-a-massive-scale-up-in-investment-in-mental-health#:~:text=Mental%20health%20is%20one%20of,every%2040%20seconds%20by%20suicide.> Accessed 07 March 2022.
[41] World Health Organization (WHO) 'Improving the mental and brain health of children and adolescents' <https://www.who.int/activities/Improving-the-mental-and-brain-health-of-children-and-adolescents#:~:text=Half%20of%20all%20mental%20health,15%2D19%20year%2Dolds.> Accessed 07 March 2022.

important element in the definition of health[42] sadly the most neglected part of it. Nearly 80% of people in the world don't receive mental health care facilities due to some other reason.[43] In 2013 World Health Organization WHO launched its Mental Health care Action Plan (2013-2020) which was extended until 2030 by the 72nd World Health Assembly in May 2019[44] is aimed at mental health governance around the globe.[45]

The Mental Health (Compulsory Assessment and Treatment) Act (MHCATA)1992[46] of **New Zealand** caught my attention for two express rights which seem to be missing in Indian MHA, 2017. These are ***Right to Legal Advice***[47] and ***Right to Independent Psychiatric Advice.***[48] MHCATA further has a concept of "special patients"[49] who under particular circumstances have to take compulsory non-consensual treatment, these special patients are mostly prisoners or people who are declared unfit for a trial, whereas in India these peoples are vested with the option to treatment, in my opinion, treatment for mentally ill criminals should be made compulsory rather than being a mere option. Further MHA,2017 laid down the treatment of prisoners in prison[50] rather I would suggest an environment of prison can never be suitable for any mental patient, prisoners with only grave mental illness after thorough inspection by psychiatrist and approval by Mental Health Review Board[51] should be shifted to mental hospitals for their speedy recovery as special patients. Indian MHA, 2017 mentions the term 'relative' in the interpretation clause but it's too vague in my opinion, here I would like to refer to the **British** Mental Health Act, 1983 which mentions it more particularly as ***'nearest relative'***[52] first, legislation needs to be precise in which sequence the relative should be referred in the enactment.

---

[42] Constitution of World health Organization

[43] World health Organization "The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health" Page 2 < https://apps.who.int/iris/bitstream/handle/10665/310981/WHO-MSD-19.1-eng.pdf?sequence=1&isAllowed=y > Accessed 03 March 2022

[44] Singh O. P. Comprehensive Mental Health Action Plan 2013-2030: We must rise to the challenge. (2021) Indian journal of psychiatry, *63*(5), 415–417. <https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_811_21 > Accessed 06 March 2022.

[45] Saxena, S., Funk, M., & Chisholm, D. WHO's Mental Health Action Plan 2013-2020: what can psychiatrists do to facilitate its implementation? (2014). World psychiatry : official journal of the World Psychiatric Association (WPA), *13*(2), 107–109.< https://doi.org/10.1002/wps.20141 > Accessed 06 March 2022.

[46] See Soosay, I., & Kydd, R. (2016). Mental health law in New Zealand. *BJPsych international*, *13*(2), 43–45. < https://doi.org/10.1192/s2056474000001124> Accessed 06 March 2022.

[47] The Mental Health (Compulsory Assessment and Treatment) Act 1992 § 70.

[48] The Mental Health (Compulsory Assessment and Treatment) Act 1992 § 69.

[49] The Mental Health (Compulsory Assessment and Treatment) Act 1992 § 2

[50] The Mental Healthcare Act , 2017 § 103 (6).

[51] The Mental Healthcare Act , 2017 §73.

[52] Mental Health Act, 1983. §26.

While comparatively analysing MHA, 2017 with the Mental Health Act, 2007 of **New South Wales(NSW) Govt. (Australia)**, I was fascinated with the two concepts that were missing in Indian legislation viz., section 4A of NSW's Mental Health Act (MHA),2007, mandates to treat mentally ill patients ***'least restrictive environment consistent with their safe and effective care*** which is a very important mandate as you really cannot expect a mental patient to recover in a caged and restrictive environment. A second striking feature which I came across was ***'The National Disability Insurance Scheme'*** described in detail under section 12A of their legislation, as a prime duty of state, Indian legislators should also have worked upon mandating such schemes under the Act as it would have gained the sanction of law and benefited the ill. A mentally ill patient completely relies upon the caretaker who takes care of him/her. A caretaker has to balance his/her role with his duty to care for the patient and his paid employment, in some cases they have to give more time to the patient hence affecting their job or even a fear to lose their jobs, carers should be provided with extra leaves in govt undertaking as to the NSW's MHA,2007[53] has provided ***Rights of carers to equality and protection of carers against discrimination in employment***[54] because a mentally ill patient is not the only one who suffers it's the whole family that suffers and in a society like India these reforms should find a place under MHA. 2017. One thing that the legal fraternity in India can learn from **Ireland** is that they have formed the 'Irish Mental Health Lawyers Association'[55](IMHLA).

Mind your Mind in Pandemic!

Humans got to know the pain of a caged bird as they got caged in their households due to pandemics. Online public surveys are myths in my opinion and every such attempt will only distract us from reality**.** Lockdown added fuel to fire in the ongoing mental health conditions of the Indians. Indians befriended anxiety, stress, depression, work from home trauma, gluing eyes to the screens of phones and laptops, found suicide as their soulmate and what not. What my concern is, did the state see the mind of citizens? As a concerned state Indian Govt. could have possibly passed an Act I suggest *"Covid 19 Regulation of Mental Health Emergency Act"* to look into the mental health concerns as Ireland did pass ***"Emergency Measures in the***

[53] Mental Health Act, 2007
[54] Mental Health Act, 2007. §9D
[55] 'Irish Mental Health Lawyers Association' < http://imhla.ie/> Accessed 06 March 2022.

Public Interest (Covid-19) Act, 2020"[56] which addresses the psychiatrist concerns. Similarly, the New South Wales[57] Government in Australia passed ***COVID-19 Legislation Amendment (Emergency Measures—Miscellaneous)*** Act on 13 May 2020 which will be repealed on 31 March 2022. ***"Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021"***[58] passed by New Zealand was a specific step towards what an ideal state should do when the problem of mental health is foreseen instead of an ongoing pandemic. In India, we witnessed ***'Guidelines for Delivery of Mental Healthcare Services during the Covid-19 Pandemic',***[59] my concern is that these are guidelines and hence are not compulsorily binding or have as much legal force as legislation holds. I won't jargonize the concern by stating some statistics as we are aware suicide does happen in India what matters is the question, why? Govt. launched a helpline named **'KIRAN'**[60] in covid-19 pandemic for people to seek mental health counseling, KIRAN which means Ray of Sunlight (Hopefully hope here), did really proved to be useful or not will only be revealed in the upcoming future!

[56] Kelly B. D. Emergency mental health legislation in response to the Covid-19 (Coronavirus) pandemic in Ireland: Urgency, necessity and proportionality. (2020) *International journal of law and psychiatry*, *70*, 101564. < https://doi.org/10.1016/j.ijlp.2020.101564 > Accessed 05 March 2022.
See also O'Connor, K., Wrigley, M., Jennings, R., Hill, M., & Niazi, A. Mental health impacts of COVID-19 in Ireland and the need for a secondary care mental health service response. (2021) *Irish journal of psychological medicine*, *38*(2), 99–107. Accessed 05 March 2022.
[57] NSW Government Website , Changes to the Mental Health Act 2007 under the COVID-19 emergency legislation. (29 March 2021) < https://www.health.nsw.gov.au/mentalhealth/legislation/Pages/chnge-mha2007-undercovid19-legis.aspx > Accessed 05 March 2022.
[58] For further actions by New Zealand ***See*** Bandyopadhyay, G., & Meltzer, A. Let us unite against COVID-19 - a New Zealand perspective. *Irish journal of psychological medicine*, (2020) *37*(3), 218–221. < https://doi.org/10.1017/ipm.2020.44 > Accessed on 05 March 2022.
[59] Ministry of Health & Family Welfare 'Guidelines for Delivery of Mental Healthcare Services during the Covid-19Pandemic' <https://www.mohfw.gov.in/pdf/GuidelinesforDeliveryofMentalMentalHealthcareServicesduringtheCOVID19.pdf > Accessed 05 March 2022.
[60] Agrawal S Govt launches KIRAN, a 24 × 7 helpline for people to seek mental health counselling.(Sept 7, 2020) < https://theprint.in/health/govt-launches-kiran-a-24x7-helpline-for-people-to-seek-mental-health-counselling/497542/ > Accessed 05 March 2022.

Feels like nobody is with me, even the state!

Most depressed country in the world? Yes, welcome to India![61] One in twenty among Indians suffers from depression the figure is as high as 200 million[62] and depression is ranked as the single largest contributor to global disability.[63] Only 10% of mentally ill patients in India get treated whereas this figure is as high as 82% in South Korea and 44% in the USA.[64] There is not even one psychiatrist per million heads in India.[65] The state does play an important role in regulating mental health but the actual work has to be done by society as every mental patient is scared to speak up because of one question 'what will people say?' lack of education at early stages of intellectual growth and the social image associated with a mental patient are some of the major reasons why stigma still prevails in the society. Someone has done Blackmagic or something supernatural happened to him are the reasons given by the self-proclaimed doctors of the society for mental illness!

The right to health got recognized as a fundamental right in the ***Bandhua Mukti Morcha case.*** Certainly, State is not limited to the legislature and executive but the judiciary too! And hence judiciary does owe a duty towards us. In ***Upendra, Baxi[66]*** directions were issued that inmates in Protective Home at Agra should not continue to live in inhuman and degrading conditions further in ***Veena Sethi[67]*** SC ordered the release of illegally detained prisons who were in jail for decades similarly in ***Sheela Barse[68]*** apex court observed that treatment of non-criminal mentally ill patients in jail is unconstitutional. Also, it ordered psychological rehabilitation of children accused of offenses. ***R.C. Narayan[69]***pinned itself as a landmark when it comes to the condition of mental health hospitals (MH), where SC interpreted the right to life broadly and ordered the renovation of MH at Ranchi further SC ordered the Nation Human Right

[61] Niharika Rajagopalan 'Lonely, under pressure and young: The mental wellbeing of India's young' (2019) The London School of Economics and Political Science < https://blogs.lse.ac.uk/southasia/2019/09/27/lonely-under-pressure-and-young-the-mental-wellbeing-of-indias-young/ > Accessed 07 March 2022

[62] Dr. Anuneet Sabharwal 'Around 200 million people in India suffer from depression! Are Indians taking their Mental Health seriously?' (2019) The Financial Express < https://www.financialexpress.com/lifestyle/health/around-200-million-people-in-india-suffer-from-depression-are-indians-taking-their-mental-health-seriously/1529675/ > Accessed 07 March 2022

[63] World Health Organization, Health Topic: Depression < https://www.who.int/india/health-topics/depression> Accessed 07 March 2022

[64] Nikita Taniparti 'The Worries of 'Log Kya Kahenge?' on Mental Health' (2018) The Wire < https://thewire.in/health/social-factors-behind-the-stigma-that-surrounds-mental-health-in-india > Accessed 07 March 2022

[65] Supra note 64

[66] Dr. Upendra Baxi vs State of Uttar Pradesh and Anr. 1982 (1) SCALE 502 a, (1983) 2 SCC 308

[67] Mrs. Veena Sethi vs State of Bihar and Ors. AIR 1983 SC 339, 1983 CriLJ 675, 1982 (1) SCALE 793, (1982) 2 SCC 583, 1982 (14) UJ 543 SC

[68] Sheela Barse & Ors vs Union of India & Ors JT 1986 136, 1986 SCALE (2)230.

[69] Rakesh Chandra Narayan vs State of Bihar 1989 AIR 348, 1988 SCR Supl. (3) 306.

Commission (NHRC) to be involved in the supervision of mental health hospitals at Agra, Ranchi, and Gwalior.[70] In ***BR Kapoor***[71] court constituted a committee of a psychiatrist to look into the functioning of Shahdara Mental Hospital, Delhi as various complaints were received, the committee made 35 recommendations regarding the rights of patients and the environment they should be treated in.[72] Even though MHA, 2017 made significant advances but it lacks retrospection sanction so cases of all patients before 2017 are treated with the same old MHA, 1987, it was recently decided in the case of ***Minu Seth.***[73] Over the past five decades by exercising the tool of PIL, the judiciary has notably done its duty towards the mentally ill![74]

Indians were aware of the importance of Mental Health since the reign of emperor Ashoka where we find an account of separate mental hospitals as described in Ashoka Samhita.[75] One important aspect that one should ponder upon is the structure of Mental Hospital (MH), they must be constructed in such a manner that it provides the least restrictive environment for the ill also such hospitals should be different from normal hospitals as they should include garden and playground within it for the mental refreshment of the patients as they cannot recover in damp rooms behind closed doors. But the question which troubles me is where is the budget? We may provide dozens of ideas but we require money to implement the same. The main problem in implementing schemes, policies, and various programs is the lack of sufficient budget specifically for mental health, the amount of money is minuscule and no substantive progress can be made with such meagre allocation of budget. Govt. has initiated an application named MANAS[76] for providing mental health care services and the same is under development. Further in the budget of 2022 union finance Minister announced 23 tele-mental health centres

[70] National Human Rights Commission India 'Care and Treatment in Mental Health Institutions– Some Glimpses in the Recent Period' (2012)
< https://nhrc.nic.in/sites/default/files/Care_and_Mental_Health_2012.pdf> Accessed 07 March 2022
[71] B. R. Kapoor and Another v/s Union of India and Others Writ Petitions (Criminal) Nos. 1777-78 and 2848 of 1983
[72] Supra note 70 at page 13.
[73] Minu Seth v. Binu Seth, FAO No. 411/2017.
[74] See Dhanda, A. Public Interest Litigation for Mentally Ill. (1990)*Journal of the Indian Law Institute*, *32*(3), 378–385. < http://www.jstor.org/stable/43952310 .> Accessed 07 March 2022
[75] Nizamie, S. H., & Goyal, N. History of psychiatry in India.(2010) Indian journal of psychiatry, 52(Suppl 1), S7–S12. < https://doi.org/10.4103/0019-5545.69195 > Accessed 02 March 2022
[76] PIB Delhi 'Community Mental-Health Digital platform MANAS launched by the Principal Scientific Adviser' (2021) < https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1711860 > Accessed 07 March 2022
See also : 'Principal scientific advisor launches MANAS mobile app to promote mental health, wellbeing'(2021) The Print < https://theprint.in/health/principal-scientific-advisor-launches-manas-mobile-app-to-promote-mental-health-wellbeing/640143/> Accessed 07 March 2022

in association with the National Institute of Mental Health and Neuro Sciences (NIMHANS) as the nodal centre.[77]

With concerns, I rest!

The happiness of Indians seems to be deteriorating as India ranks 139 out of 149 nations in Global Happiness Index.[78] India has made significant steps to enhance the mental health of its citizen, MHA, 2017 brought a ray of hope for the mentally ill, notable changes in my opinion were decriminalization of suicide,[79] specific mention of patient rights,[80] Mental Health Review Board[81], etc., although act lacks on many aspects as discussed by me earlier. Mental health is not all about the patient it's also about the doctor who treats the patient. In my opinion, the Act completely missed out duties of psychiatrist further doctors should have been vested with the powers to refer a severely ill patient to the board when such patient denies his/her treatment because the act enables treatment at the option of the patient. Mental patients above the age of 60 should be provided with mental health pension monthly for their future life. Awareness can't be spread by mere enacting the provisions under a statute, ground-level implementation of policies, usage of social media to run govt. awareness campaigns are some solutions which I rely upon. Depression is eating the youth from inside and a depressed youth amounts to depressed India!

[77] FP staff, 'Union Budget 2022: Mental health finds rare mention in Budget; what does it mean and how will it help' 2020. First post < https://www.firstpost.com/business/union-budget-2022-mental-health-finds-rare-mention-in-budget-what-does-it-mean-and-how-will-it-help-10340621.html#:~:text=Funding%20for%20mental%20health&text=In%20fact%2C%20last%20year's%20Budget,total%20of%20Rs%20597%20crore.> Accessed 07 March 2022

[78] 'India ranks 139 in World Happiness Report, Pak happier at 105: Here's list of 20 happiest nations' (2021) < https://www.livemint.com/news/india/india-ranks-139-in-world-happiness-report-here-s-list-of-20-happiest-countries-11616202779157.html> Accessed 07 March 2022

[79] The Mental Healthcare Act, 2017 § 115

[80] Supra note 28

[81] The Mental Healthcare Act, 2017 Chapter XI