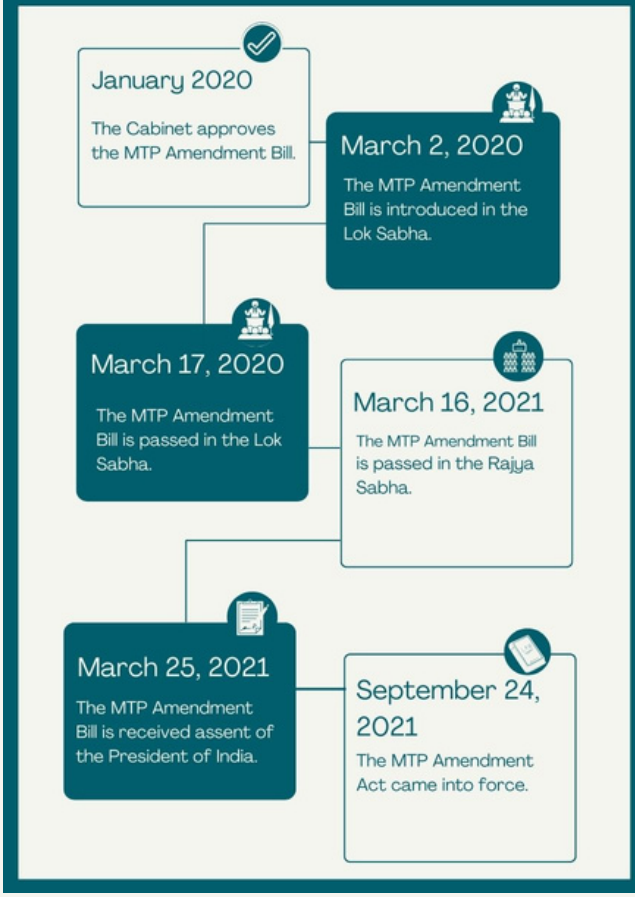
FACTSHEET: THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) ACT, 2021

CENTER *for* REPRODUCTIVE RIGHTS

In 2021, the Parliament of India passed the Medical Termination of Pregnancy (MTP) Amendment Act, amending India's 50-year-old abortion law that legalized abortion. The Amendment passed following calls by advocates to make safe, quality abortion more accessible, particularly in the context of the Indian Penal Code, which continues to criminalise "causing a miscarriage"[i]. The MTP Amendment Act brought much-needed reforms to the existing abortion law but falls short of undoing certain key barriers to access.

TIMELINE



THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

The purpose of the 1971 MTP Act was to "provid[e] for the termination of certain pregnancies by registered medical practitioners"[ii] and was introduced as an exception to criminal liability under the Indian Penal Code.[iii] While the MTP Act legalized abortion by a registered medical practitioner (RMP), the Act stipulated the allowable grounds, gestational limits, and procedures. For gestational limits of 20 weeks and 24 weeks, the right to seek abortion is determined by the RMP on the following grounds:

- If continuation of pregnancy poses a risk to the life of the pregnant woman or of grave injury to her physical or mental health
- Substantial risk of serious fetal anomaly
- Pregnancy up to 20 weeks due to failure of contraception and pregnancy up to 24 weeks as a result of rape, both considered a 'grave injury to mental health' of the woman

Before the recent amendments, several pregnant women sought judicial authorization for abortions beyond the 20-week gestational limit.[iv]

KEY FEATURES

Gestational limits increased.

In an important step, the MTP Amendment Act expanded access to abortion by increasing gestational limits.

GESTATIONAL LIMITS	MTP ACT 1971	MTP AMENDMENT ACT, 2021
Until 12 Weeks	Advice of one doctor	Advice of one doctor
12 to 20 Weeks	Advice of two doctors	Advice of one doctor
20 to 24 Weeks	Only to save the life of the pregnant woman	Advice of two doctors if the pregnant woman falls under categories prescribed below.[v]
After 24 Weeks	Only to save the life of the pregnant woman	Approval of Medical Board, and only if there is substantial foetal "abnormality"

Categories of women & girls to access abortion until 24 weeks enumerated.

Are[vi]:

1. survivors of sexual assault, rape, or incest;
2. minors;
3. women who experience a change in marital status during pregnancy, including widows and women who are divorced;
4. women with physical disabilities that qualify as "major disability" according to the Rights of Persons with Disabilities Act, 2016;
5. women living with mental illnesses;[vii]
6. pregnancies where "foetal malformation has substantial risk of being incompatible with life" or if a child, "may suffer from such physical or mental abnormalities to be seriously handicapped"; and
7. pregnant women in humanitarian settings, disaster, or emergency situations as declared by the Government.

Failure of contraception as a ground for abortion until 20 weeks now available to a woman and "her partner".

Under the 1971 law, failure of contraception as a ground for abortion was available only to a "married woman or her husband".[viii]

In a welcome step, the MTP Amendment Act expanded this to "any woman or her partner," which means that unmarried women in relationships can now invoke failure of contraception as a ground to seek abortion.[ix]

Medical Boards to decide abortions beyond 24 weeks under specific circumstances.

The MTP Amendment provides for the constitution of Medical Boards at approved facilities, which may "allow or deny termination of pregnancy" beyond 24 weeks.[x] The 1971 MTP Act did not have this additional layer of third-party authorization although Medical Boards had been set up in post 20-weeks cases at the courts' direction.

Medical abortion timeline increased to nine weeks of gestation .

The MTP Amendment Act increased gestational limits for medical methods of abortion (i.e., abortion using approved pharmacological drugs, also known as medication abortion)[xi] from seven weeks to nine weeks, assisted by an RMP whose qualifications and experience have been prescribed.[xii]

ANALYSIS

While the MTP Amendment Act did progressively increase gestational limits, it continues to restrict abortion access and creates additional barriers:

- The MTP Amendment Act perpetuates the **lack of rights-based framing** from the original Act. Instead of being grounded in rights, it merely grants exemption from criminal liability. This is in contrast with international law standards which state that restrictions on abortion infringe on several human rights including the rights to life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[xiii] The UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Committee in its General Recommendation No. 24 advises that States should ensure access to abortion and health services for women and not impose any restrictions on access.[xvi] The World Health Organization (WHO) has termed arbitrary, gestational limits.[xv] The most recent WHO Abortion Guideline, created in 2022[xvi], recommends complete decriminalization of abortion; removal of grounds-based abortion access; provision of abortion on demand for girls, women, or any pregnant person; removal of gestational limits to ensure access to abortion is not delayed; and removal of mandatory waiting periods to access abortion.

- Provisions under laws such as the **mandatory reporting requirement** under the Protection of Children from Sexual Offences Act (POCSO Act)[xvii] create **additional barriers to accessing safe and legal abortions**. Without a holistic review of laws that impact abortion access, therefore, including relevant provisions of the Indian Penal Code and the POCSO Act [xviii]Current law protects access to abortion only for pregnant women and does not recognize the diverse experiences of all persons including transgender and nonbinary people. This restrictive application of the MTP Act is not aligned with legislation such as the Transgender Persons Protections and Rights Act, 2019, which recognizes transgender persons' right to non-discriminatory access to medical facilities and care. [xix]

- The inclusion of a diagnosis of **"severe foetal abnormalities"** for accessing abortions after 24 weeks is **rooted in eugenics**. This stigmatizes persons with disabilities and instead of a framework based on bodily autonomy and self-determination, continues to advance an ableist framework.[xx]

- The addition of **third-party authorizations** like that of Medical Boards could act as **a significant barrier to accessing safe abortion**, especially for pregnant women and girls living in rural and tribal areas, and those coming from marginalized socio-economic backgrounds. Studies have highlighted the shortfall of qualified medical practitioners within the public health system[xxi] which is often the only accessible healthcare system in least-served areas. Even where accessible, the additional authorization requirement is likely to cause delays in receiving urgent abortion care. Several international bodies and institutions have echoed that requiring women to secure permission and/or authorization from a third party—including medical boards, courts, panels of doctors, or a spouse—infringes women's equality and constitutes discrimination.[xxii] Further, it manifests as a huge barrier for women to access other reproductive health services.

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- Limited recognition of **medical methods of abortion**, including the ability to self-manage, continues to **restrict access to safe** and legal abortion in India. While the expansion of abortion access using medical methods of abortion (medical abortion) until 9 weeks is a step in the right direction, there are opportunities for further liberalization in accordance with international human rights and public health standards. The 2022 WHO Abortion Care Guideline, for example, recognizes various regimens of supported and self-managed medical abortion, in whole or in part, and across different gestational periods.[xxiii] Most importantly, the Guideline underscores that "[i]t is the individual (i.e. the "self") who drives the process of deciding which aspects of abortion care will be self-managed and which aspects will be supported or provided by trained health workers or in a health-care facility."[xxiv]

Not providing for **abortion on demand leads** to forced pregnancies, which is a denial of a pregnant person's human rights. The UN CEDAW Committee interprets Article 16 of CEDAW to include the right to not experience forced pregnancy. Article 16 guarantees women the right to decide on the number and spacing of their children.[xxv] The UN Committee on Economic, Social and Cultural Rights, in its General Comment 22, has reiterated that forcing women to carry pregnancies violates their human rights.[xxvi]

Laws and policies regarding abortion must respect the pregnant person's **bodily and reproductive choices**. The rights to health; freedom from torture and cruel, inhuman, and degrading treatment; and the right to privacy have been understood to include women's right to bodily autonomy.[xxvii]

IN STATISTICS

- **44%** of the 48.5 million pregnancies that occur annually in India are unintended.[xxviii] Approximately 16 million (77%) of these unintended pregnancies result in abortion[xxix] 800,000 unsafe abortions occur in India every year.[xxx] 10% of unsafe abortions in India result in maternal mortality.[xxxi]

- Between January to June 2020 during the COVID-19 pandemic in India, an estimated **1 million** additional unsafe abortions, 650,000 additional unintended pregnancies, and 2,600 maternal deaths were likely to have occurred.[xxxii]

- Girls and women who are poor and illiterate, from marginalized castes and religions, and from rural regions have more severe access barriers and are at a higher risk of criminalization.[xxxiii]

- Restrictive abortions do not decrease abortion rates. Instead, they increase maternal mortality and morbidity.[xxxiv]

ENDNOTES

[i] S. 312, Indian Penal Code 1860.

[ii] Bhavani Giddu, Untangling the Legal Knots on Reproductive Rights Is a Step Towards Helping Indian Women, The Wire, 27 September 2017, available at <https://thewire.in/181568/abortion-law-reproductive-rights/>.

[iii]S. 312, Indian Penal Code 1860: “Causing miscarriage.—Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be 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.”

[iv]CENTER FOR REPRODUCTIVE RIGHTS, REFORM TO ADDRESS WOMEN’S AND GIRLS’ NEED FOR ABORTION AFTER 20 WEEKS IN INDIA (2018) available at https://reproductiverights.org/sites/default/files/documents/Post-20-Week-Access-to-Abortion-India-0218.pdf; CENTER FOR REPRODUCTIVE RIGHTS, LEGAL BARRIERS TO ACCESSING SAFE ABORTION SERVICES IN INDIA: A FACT FINDING STUDY (2019) available at https://reproductiverights.org/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India_Final-for-upload.pdf.

[v] S. 3(b), The Medical Termination of Pregnancy (Amendment) Act, 2021

[vi] Rule 3B, The Medical Termination of Pregnancy (Amendment) Rules, 2021

[vii] As per Rule 3B(e) of the MTP Amendment Rules: ”mentally ill women including mental retardation” are eligible for termination of pregnancy for a period up to 24 weeks. A legal distinction between “mental illness” and “mental retardation” in the context of SRHR was drawn by the Supreme Court of India in Suchita Shrivastava v. Chandigarh Administration (2009). In this case, the court recognised that the right to reproductive choice flows from the right to personal liberty under Article 21 of the Constitution of India. The court, however, went on to draw a distinction between mentally ill persons on whose behalf a guardian is required to make decisions under Section 3(4)(a) of the MTP Act, and those with mental retardation (or intellectual disability) such as the petitioner, supporting her decisional autonomy. Significantly, the Court rejected the High Court‘s application of the “substituted judgment“ test in favour of the “best interest“ principle but ended up creating a classification that prioritises certain kinds of disabilities over others. See Suchita Shrivastava v. Chandigarh Administration (2009) 9 SCC 1, paras 13-16.

[viii] S.3, Explanation 2, MTP Act, 1971

[ix] S.3 Explanation 1, MTP Amendment Act, 2021

[x] Rule 3A(a)(i), The Medical Termination of Pregnancy (Amendment) Rules, 2021

[xi]The recommended medications for induced abortion by WHO are the drugs mifepristone and misoprostol in combination or misoprostol alone. Both drugs are in the WHO Model List of Essential Medicines, which means that they should be “available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and adequate information, and at a price the individual and the community can afford”. See CENTER FOR REPRODUCTIVE RIGHTS and SARJAI, Safe Abortion Through Medical Abortion and Self-Management in Select Asian Countries, available at https://reproductiverights.org/publication-asia-advancing-public-health-and-human-rights-standards-safe-abortion/. In India, the use of the combi-pack of MA drugs (one tablet of mifepristone 200 mg and four tablets of misoprostol of 200 mcg each) (“MA Kit”) was approved in 2008 but since these drugs are classified under Schedule ‘H’ of the Drugs and Cosmetic Rules, 1945, they can only be sold based on an RMP’s prescription. See CENTER FOR REPRODUCTIVE RIGHTS, LEGAL BARRIERS TO ACCESSING SAFE ABORTION SERVICES IN INDIA: A FACT FINDING STUDY (2019) available at https://reproductiverights.org/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India_Final-for-upload.pdf p. 123. The MTP Amendment Rules have further laid down the qualifications & experience of an RMP who can conduct termination by MMA up to nine weeks of gestation. Rule 4(ca), MTP Amendment Rules, 2021.

[xii]Rule 4 (ca) The Medical Termination of Pregnancy (Amendment) Rules, 2021

xiii] See, e.g., K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); CRC Committee, Gen. Comment No. 15, supra note 4, para. 70.

[xiv] Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (women and health), (20th Sess., 1999), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 12, para 24, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, Gen. Recommendation No. 24].

[xv] World Health Organization, Safe Pregnancy: Technical and Policy Guidance for Health Systems 91 (2003), available at https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf.

[xvi] CENTER FOR REPRODUCTIVE RIGHTS, WHO'S NEW ABORTION GUIDELINE: HIGHLIGHTS OF ITS LAW AND POLICY RECOMMENDATIONS (2022) available at https://reproductiverights.org/wp-content/uploads/2022/03/CRR-Fact-sheet-on-WHO-Guidelines.pdf

[xvii]S. 19, The Protection of Children from Sexual Offences Act, 2012 puts in place a mandatory reporting provision on "any person" who is aware of or apprehends that a child sexual offence is likely to be committed. Although meant as a protective measure, this mandatory reporting provision has been demonstrated to have created a chilling effect on adolescent girls' access to SRHR services, including safe abortion services and the fear of criminal law upon service providers. For more on the POCSO Act and its impact on access to SRHR services, see CENTER FOR REPRODUCTIVE RIGHTS.

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[xix] S. §15 (f) and S.15(e), Transgender Persons (Protections and Rights) Act 2019.

[xx] CREA, Nairobi Principles on Abortion, Pre-Natal Testing, and Disability (2019), The principles recognize that there is no incompatibility between guaranteeing access to safe abortion and protecting disability rights, given that gender and disability-sensitive debates on autonomy, equality and access to health care benefit all people, available at https://nairobiprinciples.creaworld.org/principles/.

[xxi] DIPIKA JAIN ET AL, MEDICAL BOARDS FOR ACCESS TO ABORTION UNTENABLE: EVIDENCE FROM THE GROUND, (Jindal Global Law School, 2021) at 3, available at https://jgu.s3.ap-south-1.amazonaws.com/cjls/CJLS_Medical_Boards_Report_Final.pdf/.

[xxii] UN Doc. CEDAW/C/TLS/CO/2-3, para. 31(a)); UN SRRH report on criminalization, para. 23; K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); CRC Committee, Concluding Observations: India, para. 66(b), U.N. Doc. CRC/C/IND/CO/3-4 (2014).

[xxiii] WHO, Abortion Care Guideline (2022), Recommendations 27 and 50

[xxiv] WHO, Abortion Care Guideline (2022), Self-management Recommendation 50.

[xxv] CEDAW, art. 16(1)(e).

[xxvi] GC 22, paras. 57-61.

[xxvii] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary General, para. 21, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).

xiii] See, e.g., K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); CRC Committee, Gen. Comment No. 15, supra note 4, para. 70.

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[xv] World Health Organization, Safe Pregnancy: Technical and Policy Guidance for Health Systems 91 (2003), available at https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf.

[xvi] CENTER FOR REPRODUCTIVE RIGHTS, WHO'S NEW ABORTION GUIDELINE: HIGHLIGHTS OF ITS LAW AND POLICY RECOMMENDATIONS (2022) available at https://reproductiverights.org/wp-content/uploads/2022/03/CRR-Fact-sheet-on-WHO-Guidelines.pdf

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[xxiii] WHO, Abortion Care Guideline (2022), Recommendations 27 and 50

[xxiv] WHO, Abortion Care Guideline (2022), Self-management Recommendation 50.

[xxv] CEDAW, art. 16(1)(e).

[xxvi] GC 22, paras. 57-61.

[xxvii] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary General, para. 21, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).

[xxviii]Guttmacher Institute, Country Profile: India, available at https://www.guttmacher.org/geography/asia/india#

[xxix] Ibid.

[xxx]Susheela Singh and others, ‘The incidence of abortion and unintended pregnancy in India, 2015’(2015) 6(1) The Lancet Global Health e111 accessed 9 July 2021 (reporting that in 2015 there were 144 pregnancies per 1000 women in the 15-49 age group, of which 70 pregnancies per 1000 women in this age bracket were unintended).

[xxxi] Ibid.

[xxxii]Marie Stopes International, R’ESILIENCE, ADAPTATION AND ACTION: MSI’s Response to COVID-19’ (2020) available at https://www.msichoices.org/media/3849/resilience-adaptation-and-action.pdf.

[xxxiii] Ryo Yokoe and others, ‘Unsafe Abortion and Abortion-Related Death Among 1.8 million Women in India’ (2019) 4(3) BMJ Global Health 1, 11 <http:// dx.doi.org/10.1136/bmjgh-2019-001491> accessed 9 July 2021.

[xxxiv]World Health Organization, ‘Abortion’, available at https://www.who.int/health-topics/abortion#tab=tab_3